
Christine Michelle Duffy, Esq.
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I. INTRODUCTION

A. Chapter Overview

When lawyers contemplate potential claims to assert under federal law on behalf of individuals who have been subjected to workplace discrimination based on their gender identity, gender expression, or sexual orientation, seldom do the Americans with Disabilities Act of 1990 (ADA)\(^1\) or the Rehabilitation Act of 1973 (Rehabilitation Act)\(^2\) come to mind as viable options. Most publications have relegated any discussion of the use of these disabilities laws in the context of lesbian, gay, bisexual, and transgender (LGBT) individuals to a passing reference that summarily explains that (1) both laws do not cover homosexuality, bisexuality, transvestism, transsexualism, or gender identity disorders (GIDs)\(^3\)—the so-called “LGBT exclusions”—and (2) individuals who have the human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) have a protected disability. This brief treatment of these topics is understandable given that both laws, as will be discussed in this chapter, expressly exclude from the definition of “disability” homosexuality, bisexuality, transvestites, and “sexual behavior disorders,” including transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, and GIDs not resulting from physical impairments. After reading such clear, one-sentence dismissals of such claims, lawyers and judges understandably focus their attention on more familiar theories of recovery, such as sex-stereotyping claims under Title VII of the Civil Rights Act of 1964\(^4\) and analogous state laws, as well as disability discrimination claims under state laws.\(^5\)

Advocates have begun to take a fresh look at the ADA and the Rehabilitation Act as possible avenues for relief. Although sexual orientation is not a disability and thus these laws are not applicable to discrimination against gays, lesbians, bisexuals, or heterosexuals because of their sexual orientation, a closer examination of the “sexual behavior disorders” exclusion and its legislative history, the significantly evolved understanding of the etiology of GIDs (including transsexualism),\(^6\) and the 2008 liberalizing

\(^3\)Many of these publications simply refer to “gender identity disorders” and not to the actual language of the ADA or Rehabilitation Act, both of which exclude “gender identity disorders not resulting from physical impairments.” 42 U.S.C. §12211(b)(1).
\(^5\)The state-law disability discrimination cases involving gender identity and expression, as well as state laws that contain LGBT exclusions, are briefly covered in this chapter, because there are too few of them to warrant a separate, state-law disability chapter. See Section III.G.2.c. infra. They are also cited in the appropriate state law summaries in Chapter 20 (Survey of State Laws Regarding Gender Identity and Sexual Orientation Discrimination in the Workplace).
\(^6\)The etiology of GIDs is discussed in Sections III.E. and III.G.2. infra.
amendments to both laws has revealed a potentially significant use for these laws in the context of individuals with gender dysphoria and individuals who are gender nonconforming but wrongly “regarded as” having a mental impairment. As of the time this chapter was completed in December 2013, there have been no significant published decisions subsequent to the ADA’s enactment in 1990 that discuss the affirmative use of these laws to protect transgender individuals. The few decisions on point summarily dismiss claims by such individuals, citing the sexual behavior disorders exclusion.

This chapter explores the feasibility of using the ADA and the Rehabilitation Act to protect gender-affirmed and gender-diverse people. After providing an overview of the key aspects of both laws and the 2008 amendments, the chapter discusses the LGBT exclusions, the disability protections afforded to individuals with HIV or AIDS (as well as the legislative battle with respect thereto), and the meaning of the “sexual behavior disorders” exclusion. The chapter also explores whether it is philosophically appropriate to bring disability claims on behalf of transgender individuals; reviews the limited federal, state, and local case law relating to such claims; and examines in detail the legislative history of the sexual behavior disorders exclusion, the medical definition of “sex,” the etiology of GIDs (including transsexualism), and the treatment of such disorders in the eight iterations of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM). In addition, this chapter explains that individuals with gender dysphoria are unquestionably protected by the ADA and the Rehabilitation Act if their dysphoria results from a physical impairment and that all LGBT individuals are indisputably covered by these laws if they have other conditions that qualify as “disabilities” (e.g., cancer or depression).

The chapter also sets forth two arguments in favor of giving both federal laws a broader interpretation. First, GIDs not resulting from physical impairments and transsexualism were inappropriately classified as “sexual behavior disorders” in both laws as a result of the hidebound views of two U.S. senators and the lack of understanding of the DSM by the other members of Congress. Courts should (1) limit the sexual behavior disorders exclusion to just those conditions that the DSM actually recognized as sexual behavior disorders—referred to as “paraphilias” in the DSM—at the time the exclusion was enacted; (2) strike the exclusion of GIDs not resulting from physical impairments and transsexualism, as having been erroneously included among the sexual behavior disorders; or (3) find that “gender dysphoria,” as currently defined by the medical community, is not within the scope of either law’s sexual behavior disorders exclusion. Second, the exclusion of

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7 Readers interested in exploring the meaning of the terms “gender identity disorder,” “gender dysphoria,” “gender affirmed,” “gender nonconforming,” “gender diverse,” and “sex” before delving into the full text of this chapter should first read Sections III.E. and III.G. infra, as well as Chapter 2 (The Transformative Power of Words), which discusses LGBT-related terminology.

8 As discussed in Section III.G.2.b.viii. infra, in the 2013 edition of the DSM—commonly referred to as the DSM-5—GID was replaced with a new diagnosis called “gender dysphoria,” a term that had already gained some acceptance in the medical community. Inasmuch as the
individuals with GIDs not resulting from physical impairments, transsexualism, and transvestism, as well as transvestites, violates their rights to equal protection of the laws and thus should not be enforced.

Finally, the chapter briefly discusses employers’ obligations to reasonably accommodate transgender individuals who have disabilities protected by the ADA and the Rehabilitation Act.

In one respect, this chapter might be deemed academic given the inroads that advocates have made in pursuing relief for transgender employees under Title VII, the federal Equal Protection Clause, and state laws, and in view of the possibility that the Employment Non-Discrimination Act (ENDA) might become law. However, not all jurisdictions have transgender-friendly statutes or case law, so understanding the basics of the ADA and the Rehabilitation Act may be helpful, especially because some states have modeled their disability discrimination laws on the ADA or the Rehabilitation Act and/or have followed case law arising under these laws. More important, the history behind GIDs not resulting from physical impairments and transsexualism being included in the ADA and the Rehabilitation Act’s sexual behavior disorders exclusion and GIDs (including transsexualism) being included in the DSM is not widely known. Understanding this history helps explain what GIDs are and are not and how both the ADA the Rehabilitation Act wrongly stigmatizes transgender individuals. Congress used the ADA the Rehabilitation Act to express moral disapproval of transsexuals and individuals with GIDs, a practice the U.S. Supreme Court again disapproved of its 2013 decision in *United States v. Windsor,* which struck down as unconstitutional Section 3 of the Defense of Marriage Act (DOMA). In addition, the medical discussion in Sections III.E. and III.G.2. should assist human resource and legal professionals in understanding that persons with gender dysphoria or differences in sex development (DSDs) are normal people, which in turn should help these professionals in educating managers and others about these medical conditions and ensuring that workplace policies are not applied in a manner that further stigmatize employees with either of these conditions.

ADA and the Rehabilitation Act use the term GIDs, that term is generally used in this chapter when referring to those two laws.

9 See Chapter 14 (Title VII of the Civil Rights Act of 1964).
10 See Chapter 15 (Federal Equal Protection).
11 See Chapter 20 (Survey of State Laws Regarding Gender Identity and Sexual Orientation Discrimination in the Workplace).
13 570 U.S. ___, 133 S. Ct. 2675, 118 FEP 1417 (2013). *Windsor* is discussed in Section III.G.3. *infra*, as well as in Chapters 15 (Federal Equal Protection), 18 (Immigration and LGBT Employees), and 37 (Employee Benefit Issues).
15 Workplace training, policies, and practices are discussed extensively in Part VII (Workplace Solutions).
B. Cautionary Comments

It is important to mention at the outset that the vast majority of individuals with disabilities are normal people. They might have a condition that needs medical attention or a workplace accommodation. In many cases, the disability they have arises not from the condition itself but from the perceptions and reactions of others to their condition. As the Supreme Court observed in *School Board of Nassau County v. Arline*,16 “society’s accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment.”17 Individuals who have gender dysphoria have a recognized medical condition that can be resolved with generally accepted nonpsychiatric medical treatment. Their medical condition is no different from other recognized conditions, such as cancer, that were once shrouded in secrecy and merely whispered about. Today, no one would doubt the legitimacy of pursuing a disability discrimination claim on behalf of an individual who has or had cancer, or was regarded as having cancer, and was discriminated against as a result. The same should be true with respect to gender dysphoria, for the reasons set forth in this chapter.

As is discussed in Chapter 2 (The Transformative Power of Words), terminology often adds to confusion and feeds into stereotypes about individuals who may have medical conditions, such as gender dysphoria, that are not widely understood by the public. This treatise generally uses the terms that the tribunals used when deciding cases. Over time language has become less pejorative—or not pejorative at all—as demonstrated, for example, by the evolution of phraseology from “sex change operation” to “sex reassignment surgery” to “gender reassignment surgery” to “gender confirming surgery” to “gender identity disorder,” which is now being replaced with “gender dysphoria.” Likewise, “transsexualism” has faded somewhat into “gender identity disorder,” which is now being replaced by “cross-dresser,” although an employer likely would not use these terms in the workplace because they both have negative connotations. By reciting the terminology used in opinions and articles, this treatise is neither endorsing the continued use of language that is pejorative or stigmatizing nor suggesting that individuals who may be gender affirmed or gender diverse are anything other than a normal part of the richness of human diversity.18

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16 480 U.S. 273, 43 FEP 81, 1 AD 1026 (1987).
17 480 U.S. at 284.
18 See Milton Diamond & Hazel Beh, *Variations of Sex Development Instead of Disorders of Sex Development*, ARCHIVES DISEASE CHILDHOOD (July 27, 2006 e-letter), available at http://adc.bmj.com/content/91/7/554/reply and www.hawaii.edu/PCSS/biblio/articles/2005to2009/2006-variations.html (“It is undeniable that medical labels have a power that transcends medical treatment. Those who influence how medicine classifies individuals must be sensitive to the potential transformative power of the labels they assign. Medical labeling affects social and legal order. But most importantly, labeling affects individuals. While medicine from time to time may reconsider terminology, the labels assigned to persons born today with sexual
As will be discussed in this chapter, some individuals are born with the anatomic body of one gender and the brain gender of a different gender. For some of these people, they have no gender dysphoria and are completely comfortable living just the way they are. There are also people who are gender nonconforming in that their gender expression does not match some normative “ideal” of how a man or a woman should act or look. Many of the foregoing individuals do not have a disability, but some people might perceive them as having a disability. If adverse employment action is taken against them based on a perception that they have an impairment or a disability, they should have the right to pursue a remedy under the ADA or the Rehabilitation Act, just as would individuals who are mistreated in the workplace because they are wrongly perceived to have diabetes, epilepsy, or some other impairment or disability.

Finally, in the discussion below, no suggestion is being made that individuals are born with “birth defects” or that something is socially or morally “wrong” with them. Some people are born with or develop variations from others’ perceptions of what is “perfect” or “normal.” The reality is that all people have one or more variations from some idealized conception of “perfection” or “normal.” Some of these individuals may need medical assistance to resolve a medical condition that can be ameliorated. On the other hand, some of these individuals are content as they are and they see their “variation from the norm” as actually normal. To pursue disability discrimination claims on behalf of either group so that their rights to be free from such discrimination are protected is not to suggest in any way that they are not normal. Indeed, the point of disability antidiscrimination laws is to allow individuals with disabilities or perceived disabilities to live normal lives, unfettered from stereotypes, ignorance, and bigotry.


A. Introduction

There are two main federal statutes that pertain to employment discrimination based on disabilities—the Rehabilitation Act of 1973 (Rehabilitation
1990 (ADA). Both were amended by the ADA Amendments Act of 2008 (ADAAA). Each of these laws is briefly summarized below.

1. The Rehabilitation Act of 1973

The Rehabilitation Act was the first major federal legislation aimed at providing equal rights for qualified individuals with disabilities who are employed by federal executive agencies or by organizations that either have federal contracts or subcontracts in excess of $10,000 or receive federal financial assistance. The Rehabilitation Act also requires federal executive agencies and federal contractors to take affirmative action to employ, and advance in employment, qualified individuals with disabilities.

2. The Americans with Disabilities Act of 1990

The ADA provided a national response to persistent discrimination that individuals with disabilities faced in the workplace and elsewhere. In signing the legislation into law, President George H.W. Bush explained that the ADA “is powerful in its simplicity. It will ensure that people with disabilities are given the basic guarantees for which they have worked so long and so hard: independence, freedom of choice, control of their lives, the opportunity to blend fully and equally into the rich mosaic of the American mainstream.

The ADA built on the foundation of the Rehabilitation Act and Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination based on color, national origin, race, religion, and sex. Congress directed that the ADA provide at least as much protection as does the Rehabilitation Act and its implementing regulations. One significant aspect of the Rehabilitation Act that was not carried over into the ADA is the Rehabilitation Act’s affirmative action requirements.

Title I of the ADA, which relates to disability discrimination in the workplace and is administered by the U.S. Attorney General, is the “Heart of the ADA.” Title I applies to employers with 15 or more employees and protects individuals with disabilities from discrimination in all aspects of employment, including recruitment, hiring, training, and advancement. The ADA also includes requirements for government and public accommodations, transportation, and telecommunications accessibility.

Amendments to the ADA in 2008 (ADAAA) have expanded the definition of “disability” to include more conditions and have clarified the definition of “reasonable accommodations.” The ADAAA also includes a provision that requires the Equal Employment Opportunity Commission (EEOC) to issue regulations implementing the ADAAA within two years.

The Rehabilitation Act and the ADA are closely intertwined and are often referred to as the “ADA family.” The Rehabilitation Act provided the legal framework for the ADA, and the ADA expanded and strengthened the legal protections for individuals with disabilities.

The ADA has had a significant impact on the lives of people with disabilities. It has helped to remove barriers to employment, education, and access to goods and services. However, there are ongoing challenges to fully implementing the ADA and ensuring that people with disabilities have equal opportunities.

The ADA has also been a catalyst for other disability rights laws at the federal, state, and local levels. The ADA has inspired similar laws in other countries, including the United Kingdom, Australia, and Canada.

In conclusion, the Rehabilitation Act and the ADA have had a profound impact on the lives of people with disabilities in the United States and around the world. These laws have helped to create a more inclusive society, and they continue to evolve and adapt to meet the needs of people with disabilities.

References:


Equal Employment Opportunity Commission (EEOC), became effective on July 26, 1992, two years after the law was enacted.

3. The ADA Amendments Act of 2008

Both the Rehabilitation Act and the ADA were amended, effective January 1, 2009, by the ADAAA. The ADAAA significantly clarified and expanded the definition of the term “disability,” which has now made the Rehabilitation Act and the ADA potentially more valuable tools for advocates seeking workplace protection for employees discriminated against based on their gender dysphoria or because their gender nonconformity was regarded as a disability.

In this chapter, the focus is on the definition of “disability” as amended by the ADAAA. To the extent cases decided under the pre-ADAAA versions of the Rehabilitation Act and the ADA correctly interpreted the more narrow definition of “disability” in favor of individuals with disabilities, the impairments found to constitute disabilities in those cases likely will continue to be treated as disabilities. In contrast, to the extent pre-ADAAA cases were decided adversely to individuals with disabilities based on the narrower definition of “disability,” the impairments in those cases will need to be reevaluated under the broader definition of “disability.” That said, given that the determination of whether an individual has a disability is made on an individualized basis and that outcomes in litigation may turn on, among other things, the quality of the proofs and advocacy, care should be exercised in drawing conclusions regarding whether the determination in one case that an impairment does or does not rise to the level of a disability will result in similar determinations in later cases. However, as will be discussed below, there are certain impairments that will almost always qualify as disabilities (e.g., blindness and deafness).

B. Key Principles

This section briefly sets forth a few of the key underlying principles of the ADA and the Rehabilitation Act to lay a foundation for a discussion of both laws in the context of gender identity, gender expression, and sexual orientation. The primary focus is on the definition of “disability”

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29 The EEOC website contains extensive guidance documents explaining the ADA at www.eeoc.gov/laws/types/disability.cfm. The website includes the text of the ADA as amended (www.eeoc.gov/laws/statutes/ada.cfm), the text of the ADAAA (www.eeoc.gov/laws/statutes/adaaa.cfm), and the EEOC’s regulations implementing the ADA (www.eeoc.gov/laws/regulations/index.cfm). Note that the EEOC’s ADA regulations, 29 C.F.R. §1630.1 et seq., contain an extensive appendix that sets forth the EEOC’s interpretative guidance on the ADA.

30 The EEOC has published two very useful guidance documents that provide many illustrations of the applicability of the ADA at various stages of the employment life cycle: Questions and Answers about Health Care Workers and the Americans with Disabilities Act (Feb. 26, 2007), available at www.eeoc.gov/facts/health_care_workers.html, and The Americans with Disabilities Act: Applying Performance and Conduct Standards to Employees with Disabilities (Sept. 3, 2008), available at www.eeoc.gov/facts/performance-conduct.html. Although one of the documents is written in the context of the health care industry, the illustrations help to
under both laws. Because the ADAAA amended the Rehabilitation Act to
incorporate by reference the ADA’s amended definition of “disability” into
the Rehabilitation Act, most of the discussion below will focus on the
language of the ADA.

It is beyond the scope of this treatise to explain all facets of the Reha-
bilitation Act and the ADA in the employment setting. Readers who want to
delve further should consult Peter Susser and Peter Petesch’s comprehensive
analysis of federal and state disabilities law—Disability Discrimination and
the Workplace.

1. Entities Covered and Individuals Protected by the Americans with
Disabilities Act and the Rehabilitation Act

Susser and Petesch succinctly summarize the workplace reach of the
ADA and the Rehabilitation Act as follows:

Under Title I of the ADA, “covered entities” are prohibited from engaging in
employment discrimination. Those covered entities include employers, employ-
ment agencies, labor organizations, and joint labor-management committees.
Employers are defined as those entities that employ 15 or more individuals
over a 20-week period and also include those persons who are “agents” of an
employer. According to the EEOC, agents are those managers, supervisors,
foremen, or others who act for or on behalf of the employer, such as agencies
used to conduct background checks on candidates. Like Title VII [of the Civil
Rights Act of 1964], the language of the ADA does not include the federal
government and corporations wholly owned by the federal government; such
organizations are covered under the Rehabilitation Act. Unlike Title VII,
however, the ADA does not exempt state-elected public officials or members
of their personal staff from its coverage.

Under Title II, the ADA prohibits discrimination on the part of public
entities, including any state, city, or local government, or agency or department
within the government. This extends to those activities carried out by govern-
ment contractors as well. Finally, Title V affords protections to applicants,
employees, and former employees of several government bodies, including the
House of Representatives, the Senate, and the Congressional Budget Office.

The Rehabilitation Act also covers a substantial number of employing
entities within the U.S. government. Section 501 applies to every department,
agency, and instrumentality in the executive branch.

Under section 503, those private entities that hold government contracts
and subcontracts in excess of $10,000 that furnish supplies and services and
use real or personal property are covered.

Finally, section 504 [applies] to any “program or activity” that receives
federal assistance or is under the direction of any executive branch agency
or the U.S. Postal Service.

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31 ADAAA §7 (amending §7 of the Rehabilitation Act of 1973, 29 U.S.C. §705(9)(B), 20(B)).
32 See Disability Discrimination and the Workplace. See also Barbara T. Lindemann,
Paul Grossman, & C. Geoffrey Weirich, Employment Discrimination Law ch. 13 (Disability)
33 Disability Discrimination and the Workplace 18–19 (footnotes omitted). Similar to
the principles under Title VII, supervisors and managers generally are not liable under the
2. Impermissible Discrimination

The ADA prohibits discrimination against a “qualified individual” based on disability with respect to “job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.” A “qualified individual” is someone (1) who has the requisite education, experience, skill, and other job-related requirements; and (2) who, with or without a reasonable accommodation, can perform the essential functions of the job.

The ADA sets forth a number of specific ways an employer can violate the ADA. For example, an employer can violate the ADA if it discriminates against “a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a relationship or association.” Similarly, an employer can violate the ADA if it fails to “reasonably accommodate” “the known physical or mental limitations of an otherwise qualified individual with a disability,” unless the employer can establish that the accommodation would impose an “undue hardship.”

In addition, an employer can violate the ADA by requiring impermissible medical examinations or making impermissible disability-related inquiries, or by not properly protecting the confidentiality of medical information that the employer lawfully collected.

3. Three-Pronged Definition of a Protected Disability

The ADA defines a “disability” as:

(A) a physical or mental impairment that substantially limits one or more of the major life activities of [an] individual;
(B) a record of such an impairment; or
(C) being regarded as having such an impairment….
Other federal, state, and local disability discrimination statutes use a similar three-pronged definition of “disability.” The ADA’s definition of “disability” is incorporated by reference into the Rehabilitation Act.

Determining whether a qualified individual has a disability is a decision made on a case-by-case basis and, therefore, the results are not always predictable. In enacting the ADAAA, Congress expressed its concern that the ADA had been too narrowly construed by the courts and the EEOC, thereby removing many qualified individuals the law was originally intended to protect. Accordingly, Congress amended the ADA to expressly provide that the definition of “disability” be “construed in favor of broad coverage of individuals.”

Each of the three prongs of the definition is independent of the other prongs. The first two prongs—“current disability” and “record of a disability”—require a showing that an impairment “substantially limits” one or more “major life activities,” whereas the third prong—“regarded as having an impairment”—does not. The “regarded as” prong does not apply to an impairment that is both “transitory and minor,” and does not entitle an individual to a reasonable accommodation. Key aspects of each of these prongs are set forth in the following subsections.

4. Prongs One and Two: Current Disability and Record of a Disability

To establish a claim of discrimination based on a current disability or a record of a disability, qualified individuals need to establish that they have (1) a physical or mental “impairment” (2) that “substantially limits” (3) one or more “major life activities.” This subsection briefly discusses each of the three elements and explains what is meant by having a “record of a disability.” This discussion focuses on the language of the ADA as amended by the ADAAA.
a. Physical or Mental Impairment

The EEOC’s ADA regulations define a “physical impairment” as “[a]ny physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine.” 51 A “mental impairment” is defined as “[a]ny mental or psychological disorder, such as an intellectual disability . . . , organic brain syndrome, emotional or mental illness, and specific learning disabilities.” 52 The EEOC’s interpretive guidance on the ADA states that the definition of “impairment” does not include physical characteristics such as eye color, hair color, left-handedness, or height, weight, or muscle tone that are within “normal” range and are not the result of a physiological disorder[;] . . . characteristic predisposition to illness or disease[;] [o]ther conditions, such as pregnancy, that are not the result of a physiological disorder. . . . [“Impairment”] also does not include common personality traits such as poor judgment or a quick temper where these are not symptoms of a mental or psychological disorder[;] [e]nvironmental, cultural, or economic disadvantages such as poverty, lack of education, or a prison record . . . [; or] [a]dvanced age, in and of itself . . . 53

b. Substantially Limits

Before enactment of the ADAAA, the U.S. Supreme Court in its decisions and the EEOC in its guidance documents provided meaning to the term “substantially limited,” which is not defined in the ADA. In enacting the ADAAA, Congress rejected as too strict the limits the Supreme Court and the EEOC had placed on the term. Although Congress chose not to define the term, it did provide certain rules of construction that reflect its desire that the definition of “disability” be “construed in favor of broad coverage of individuals” under the ADA. 54 Based on this, the EEOC revised its ADA regulations to set forth a series of criteria against which one evaluates whether an impairment is “substantially limiting,” including the following:

- “The term ‘substantially limits’ shall be construed broadly in favor of expansive coverage, to the maximum extent permitted by the terms of the ADA. ‘Substantially limits’ is not meant to be a demanding standard.” 55
- “An impairment need not prevent, or significantly or severely restrict, the individual from performing a major life activity in order to be considered substantially limiting.” 56

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51 29 C.F.R. §1630.2(h)(1).
52 Id. §1630.2(h)(2).
53 Id. pt. 1630, app. §1630.2(h).
55 29 C.F.R. §1630.2(j)(1)(i).
56 Id. §1630.2(j)(1)(ii).
• “An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.”

• “An impairment that substantially limits one major life activity need not substantially limit other major life activities in order to be considered a substantially limiting impairment.”

• “[T]he non-ameliorative effects of mitigating measures, such as negative side effects of medication or burdens associated with following a particular treatment regimen, may be considered when determining whether an individual’s impairment substantially limits a major life activity.”

The determination of whether a person is substantially limited is based on an individualized assessment—there are no per se disabilities. Nonetheless, as a result of the ADAAA, individualized assessments of some impairments “will virtually always result in a determination of disability” because the “inherent nature of these . . . medical conditions will in virtually all cases give rise to a substantial limitation of a major life activity.”

Being substantially limited does not mean totally incapacitated. There are many individuals with disabilities who are able to function as a result of accommodations they have made themselves or that are provided by their employers. Although these individuals may not appear to have disabilities, they may have substantial limitations on one or more major life activities.

For example, a person with monocular vision and thus no depth perception can appear to be fully functional by using compensatory strategies. Similarly, an individual with a substantially limiting learning disability may excel academically and in the workplace by spending more time than most individuals do in the general population to read and write. As one of the lead sponsors of the original ADA testified during the consideration of the ADAAA, “we could not have fathomed that people with diabetes, epilepsy,
heart conditions, cancer, mental illnesses and other disabilities would have their ADA claims denied because they would be considered too functional to meet the definition of disability."65

In *Bragdon v. Abbott*,66 a pre-ADAAA case, the Supreme Court held that a woman with the HIV infection was an individual with a disability. The Court determined that the infection was substantially limiting to the woman in the major life activity of reproduction because if she tries to conceive a child, she exposes both the man (during sex) and her child (during gestation and childbirth) to a significant risk of becoming infected.67 The Court explained the following:

The [ADA] addresses substantial limitations on major life activities, not utter inabilities. Conception and childbirth are not impossible for an HIV victim but, without doubt, are dangerous to the public health. This meets the definition of a substantial limitation. The decision to reproduce carries economic and legal consequences as well. There are added costs for antiretroviral therapy, supplemental insurance, and long-term health care for the child who must be examined and, tragic to think, treated for the infection. The laws of some States, moreover, forbid persons infected with HIV to have sex with others, regardless of consent.

In the end, the disability definition does not turn on personal choice. When significant limitations result from the impairment, the definition is met even if the difficulties are not insurmountable.68

c. **Major Life Activities**

The original ADA did not define what qualifies as “major life activities.” The ADAAA added a nonexclusive list of such activities,69 which the EEOC expanded on in its revised ADA regulations:

Major life activities include, but are not limited to:

(i) Caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working; and

(ii) The operation of a major bodily function, including functions of the immune system, special sense organs and skin; normal cell growth; and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive functions. The operation of a

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65 29 C.F.R. pt. 1630, app. §1630.2(j)(3) (quoting Representative Steny H. Hoyer, and also noting that a major depressive disorder may substantially limit major life activities such as concentrating, interacting with others, thinking, and sleeping).
66 524 U.S. 624, 8 AD 239 (1998). *Bragdon* involved a dentist who refused to treat an individual with the HIV infection in his private office. The lawsuit was commenced pursuant to Title III of the ADA, which pertains to disability discrimination in public accommodation.
67 *Bragdon*, 524 U.S. at 639–40. The EEOC’s regulations note that HIV infection also substantially limits immune system functions and is presumptively a disability. 29 C.F.R. §1630.2(j)(3)(iii).
68 *Bragdon*, 524 U.S. at 641 (citations omitted).
69 42 U.S.C. §12102(2).
major bodily function includes the operation of an individual organ
within a body system.”

Thus, for example, diabetes affects the operation of the pancreas and the
function of the endocrine system, and the HIV infection affects the immune
system and reproductive functions.

In Bragdon, the Supreme Court held that, from the moment of infection,
the HIV infection (whether asymptomatic or symptomatic) is a physiological
disorder of the hemic and lymphatic systems (thus an impairment) that can
substantially limit a person in the major life activity of reproduction. The
Court noted that the word “major” denotes “comparative importance” and
that “[r]eproduction and the sexual dynamics surrounding it are central to
the life process itself.” The Court indicated that “[g]iven the pervasive,
and invariably fatal, course of the disease, its effect on major life activities
of many sorts might have been relevant.” The Court rejected the argument
that major life activities cover only “those aspects of a person’s life which
have a public, economic, or daily character.”

d. Record of a Disability

Susser and Petesch concisely summarize the main thrust of the “record
of” prong as follows:

The federal statutes also provide protection to those individuals who
have a history of, or have been misclassified as having, a mental or physical
impairment that substantially limits one or more major life activities. This
aspect of the statutory provision was enacted, in part, to protect individuals
who have recovered from a physical or mental impairment that previously
limited them in a substantial manner in a major life activity, with the goal of
preventing discrimination due to either prior conditions or misclassifications.

For example, in School Board of Nassau County v. Arline, a pre-
ADAAA case, the Supreme Court held that a schoolteacher with tuberculosis,

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70. 29 C.F.R. §1630.2(i)(1).
71. Id. pt. 1630, app. §1630.2(i), (j)(1)(viii).
73. Bragdon, 524 U.S. at 637. Accord Hernandez v. Prudential Ins. Co. of Am., 977 F. Supp. 1160, 1163–65 (M.D. Fla. 1997). Although there is no cure for HIV or AIDS, treatment options have improved significantly since the 1998 Bragdon decision, at which time AIDS was the number one cause of death in the United States among people ages 25 to 44. As of 2012, it is the number six cause of death in this age group. AIDS, MEDLINE PLUS (National Institutes of Health Apr. 30, 2012), available at www.nlm.nih.gov/medlineplus/ency/article/000594.htm.
74. Bragdon, 524 U.S. at 638.
75. See also id. at 115–16, 676–78; 29 C.F.R. §1630.2(k).
76. 480 U.S. 273, 43 FEP 81, 1 AD 1026 (1987).
a contagious physiological condition that affected her respiratory system, was an individual with a disability under the Rehabilitation Act. The fact that her condition was serious enough to require her hospitalization years earlier was “more than sufficient to establish that one or more of her major life activities were substantially limited by her impairment,” and that she had a history of a substantially limiting impairment.77 Similarly, individuals misdiagnosed as having learning or intellectual disabilities, or as having psychiatric illnesses such as bipolar disorder, have records of substantially limiting impairments even if they do not actually have these disabilities or impairments.78

5. Prong Three: Regarded as Impaired

As amended by the ADAAA, the third prong of the definition of “disability”—“regarded as having an impairment”—does not require a showing that the impairment substantially limits one or more of the major life activities, does not apply if the impairment is both “transitory and minor” (e.g., a cold or the flu), and does not entitle an individual to a reasonable accommodation.79 The EEOC articulated the following:

Coverage under the “regarded as” prong … should not be difficult to establish….[A]n individual is “regarded as having such an impairment” if the individual is subjected to an action prohibited by the ADA because of an actual or perceived impairment that is not “transitory and minor.”

This third prong … was originally intended to express Congress’s understanding that “unfounded concerns, mistaken beliefs, fears, myths, or prejudice about disabilities are often just as disabling as actual impairments, and [its] corresponding desire to prohibit discrimination founded on such perceptions.” … In passing the original ADA, Congress relied extensively on the reasoning of School Board of Nassau County v. Arline[, 480 U.S. 273, 282–83, 43 FEP 81, 1 AD 1026 (1987),] “that the negative reactions of others are just as disabling as the actual impact of an impairment.” … The ADAAA reiterates Congress’s reliance on the broad views enunciated in that decision, and Congress “believe[s] that courts should continue to rely on this standard.”

In Arline, the Supreme Court provided examples of conditions that have evoked impermissible stereotypical reactions based on fears and prejudice, such as tuberculosis; cerebral palsy that a teacher claimed produced a “nauseating effect” on others; a person with arthritis who school administrators felt “normal students” should not see; cosmetic disfigurements; cancer; and

77 480 U.S. at 281. Courts in some cases decided subsequent to Arline have concluded that “a record of absences and hospital stays, without more, is insufficient to qualify as a record of impairment.” Disability Discrimination and the Workplace 677.
78 29 C.F.R. pt. 1630, app. §1630.2(k).
79 42 U.S.C. §12102(1)(C), (3); 29 C.F.R. §§1630.2(g)(3), (j)(2), (l)(1), (o)(4), 1630.9(e), 1630.15(f); 29 C.F.R. pt. 1630, app. §1630.2(l). “Transitory” means an actual or expected duration of six months or less. 42 U.S.C. §12102(3)(B); 29 C.F.R. §1630.15(f).
80 29 C.F.R. pt. 1630, app. §1630.2(l). For a comprehensive discussion of this topic, including the differences in the ADA before and after the ADAAA, see Disability Discrimination and the Workplace ch. 5 (Disabilities Protected by the Americans with Disabilities Act), §II.E.
epilepsy. The Court observed that the Rehabilitation Act “is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments.” Thus, for example, if an employer refuses to hire an individual with a prominent facial disfigurement because of the adverse attitudes of others, such as anticipated customer reactions, then the employer has regarded the applicant as impaired.

Perhaps one of the most significant impacts of the ADAAA will be on the “regarded as” prong. Before passage of the ADAAA, to prevail in ADA “regarded-as-disabled” cases, workers had to show that their employers perceived them to be substantially limited in the ability to perform a major life activity. As a result of the ADAAA, the concepts of “substantial limitation” and “major life activity” are no longer relevant when evaluating whether an individual is being regarded as having an “impairment.” In other words, the ADAAA significantly reduced the liability threshold from being regarded as “disabled” to merely being regarded as “impaired,” a significantly lower burden of proof for a plaintiff. This should make a significant difference in the realm of mental disabilities. Under the pre–ADAAA law, employees had successful “regarded as” claims in the following situations:

- A high school terminated a guidance counselor because it perceived her as suicidal and therefore regarded her as substantially limited in the ability to care for herself.
- A hospital subjected an anesthesiologist, who had been hospitalized for depression and panic disorder, to more rigorous and critical observation, and eventually terminated him, because it regarded him as substantially limited in his cognitive thinking.
- The U.S. Postal Service subjected a window cashier, who had been treated for anxiety and depression, to harassment by repeated comments that he was “crazy” and posed a danger to coworkers because it regarded him as substantially limited in his ability to work.

82 480 U.S. at 284–85.
83 Disability Discrimination and the Workplace 679; 29 C.F.R. pt. 1630, app. §1630.15(a).
84 29 C.F.R. pt. 1630, app. §1630.2(l).
85 Id.
86 Disability Discrimination and the Workplace 793–95 (discussing, respectively, Peters v. Baldwin Union Free Sch. Dist., 320 F.3d 164, 165, 168–69, 13 AD 1793 (2d Cir. 2003) (claim under the Rehabilitation Act and the New York Human Rights Law; the court also noted that “[a] mental illness that impels one to suicide can be viewed as a paradigmatic instance of inability to care for oneself. It therefore constitutes a protected disability under the Rehabilitation Act.”); Mattice v. Memorial Hosp. of South Bend, Inc., 249 F.3d 682, 684–86, 11 AD 1339 (7th Cir. 2001) (ADA claim; the court also rejected the employer’s attempt to reformulate the major life activity of cognitive thinking into the major life activity of working); and Quiles-Quiles v. Henderson, 439 F.3d 1, 4–8, 17 AD 1089 (1st Cir. 2006) (Rehabilitation Act claim; the court also noted that “[t]he belief that the mentally ill are disproportionately dangerous is precisely the type of discriminatory myth that the Rehabilitation Act and ADA were intended to confront” and rejected the idea that harassment is permissible in blue-collar workplaces)).
If a case would survive dismissal under the more rigorous pre–ADAAA standard of proof, it should also withstand dismissal under the post–ADAAA standard.\textsuperscript{87} The lower burden of proof under the ADAAA should result in a significant increase in successful “regarded as” claims.

6. Association With Individuals With Disabilities

The ADA also prohibits discrimination against a qualified individual based on a known disability of a person with whom the qualified individual is known to have a business, family, social, or other relationship or association.\textsuperscript{88} For example, if an employer decides not to hire an applicant whom the employer knows has a spouse with Alzheimer’s disease because the employer believes the applicant will frequently miss work or leave work early, then the employer would violate the ADA.\textsuperscript{89} Likewise, if an employer terminates an employee because the employee does volunteer work with people who have the HIV infection because the employer is afraid the employee may contract the infection, then this employer also violates the ADA.\textsuperscript{90}

7. Reasonable Accommodation Obligation

Employers have an affirmative duty to provide reasonable accommodations that permit otherwise qualified individuals with disabilities to perform the essential functions of their job, unless those accommodations would impose an undue hardship on the employer’s operations.\textsuperscript{91} There is no need to provide a reasonable accommodation in situations where employees are regarded as impaired.\textsuperscript{92} “Reasonable accommodation” is defined as follows:

\textsuperscript{87}See Peters, 320 F.3d at 169 (if a claim would survive judgment as a matter of law under the pre–ADAAA standard, “then \textit{a fortiori} [plaintiff’s New York Human Rights Law (HRL) claim should have been submitted to the jury” because “a plaintiff under the HRL is not required to show that a perceived disability substantially limits a major life activity.”).

\textsuperscript{88}42 U.S.C. §12112(b)(4); 29 C.F.R. §1630.8. There are similar restrictions under the Rehabilitation Act. See 41 C.F.R. §60-741.21(e). For a comprehensive discussion of this topic, see \textit{Disability Discrimination and the Workplace} ch. 5 (Disabilities Protected by the Americans with Disabilities Act), §§II.G. and V.B.1.c.

\textsuperscript{89}29 C.F.R. pt. 1630, app. §1630.8.

\textsuperscript{90}Id.; \textit{Disability Discrimination and the Workplace} ch. 5 (Disabilities Protected by the Americans with Disabilities Act), §V.B.1.c.


\textsuperscript{92}29 C.F.R. §§1630.2(o)(4), 1630.9(e). See Section II.B.5. \textit{supra} for a further discussion of the “regarded as” prong of the definition of “disability.”
(i) Modifications or adjustments to a job application process that enable a qualified applicant with a disability to be considered for the position such qualified applicant desires; or

(ii) Modifications or adjustments to the work environment, or to the manner or circumstances under which the position held or desired is customarily performed, that enable a qualified individual with a disability to perform the essential functions of that position; or

(iii) Modifications or adjustments that enable a covered entity’s employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities. 93

One type of reasonable accommodation is making existing facilities readily accessible to, and usable by, qualified individuals with disabilities. 94 Facilities include those areas that must be accessible for employees to perform their essential job functions and non-work areas used by employees for other purposes, such as break rooms, lunchrooms, restrooms, and training rooms. 95

A specific accommodation does not have to be provided if it would impose an “undue hardship” on the operation of the employer’s business. 96 The EEOC has articulated the following:

The term “undue hardship” means significant difficulty or expense in, or resulting from, the provision of the accommodation…. “Undue hardship” refers to any accommodation that would be unduly costly, extensive, substantial, or disruptive, or that would fundamentally alter the nature or operation of the business….  

… The fact that that particular accommodation poses an undue hardship, however, only means that the employer is not required to provide that accommodation. If there is another accommodation that will not create an undue hardship, the employer would be required to provide the alternative accommodation. 97

If the need for or the type of accommodation is not clear, both the employee and employer must engage in an ongoing, “interactive dialogue,” which the EEOC summarizes as follows:

The employer and the individual with a disability should engage in an informal process to clarify what the individual needs and identify the appropriate reasonable accommodation. The employer may ask the individual relevant questions that will enable it to make an informed decision about the request. This includes asking what type of reasonable accommodation is needed.

The exact nature of the dialogue will vary. In many instances, both the disability and the type of accommodation required will be obvious, and thus there may be little or no need to engage in any discussion. In other situations, the employer may need to ask questions concerning the nature of the

95 29 C.F.R. pt. 1630, app. §1630.2(o).
96 42 U.S.C. §12112(b)(5)(A); 29 C.F.R. §§1630.2(p), 1630.9.
97 29 C.F.R. pt. 1630, app. §1630.2(p).
disability and the individual’s functional limitations in order to identify an effective accommodation.

... When the disability and/or the need for accommodation is not obvious, the employer may ask the individual for reasonable documentation about his/her disability and functional limitations. The employer is entitled to know that the individual has a covered disability for which s/he needs a reasonable accommodation.

An employer may require that the documentation about the [specific] disability and the functional limitations come from an appropriate health care or rehabilitation professional.

... If an individual’s disability or need for reasonable accommodation is not obvious, and s/he refuses to provide the reasonable documentation requested by the employer, then s/he is not entitled to reasonable accommodation. On the other hand, failure by the employer to initiate or participate in an informal dialogue with the individual after receiving a request for reasonable accommodation could result in liability for failure to provide a reasonable accommodation.98

8. Disability-Related Inquiries and Medical Examinations

The ADA places a number of limitations on an employer’s ability to make disability-related inquiries and require medical examinations with respect to applicants and employees.99 There are three different sets of rules, based on the life cycle of the employment relationship.100 The basic parameters of an otherwise intricate set of guidelines are set forth in the following EEOC summary:

Are the rules about when an employer may make disability-related inquiries and require medical examinations the same for employees and applicants? ... 

- No. The ADA limits an employer’s ability to make disability-related inquiries or require medical examinations at three stages: pre-offer, post-offer, and during employment. The rules concerning disability-related inquiries and medical examinations are different at each stage.
- At the first stage (prior to an offer of employment), an employer may not ask any disability-related questions or require any medical examinations, even if they are related to the job.

100 For a comprehensive discussion of this topic, see DISABILITY DISCRIMINATION AND THE WORKPLACE ch. 7 (The Americans with Disabilities Act and the Hiring Process), §VI.; ch. 8 (Reasonable Accommodation), §III.C.; and ch. 5 (Disabilities Protected by the Americans with Disabilities Act), §§V.B.1.b. and V.B.1.f.
At the second stage (after an applicant is given a conditional job offer, but before he or she starts work), an employer may ask disability-related questions and conduct medical examinations, regardless of whether they are related to the job, as long as it does so for all entering employees in the same job category.

At the third stage (after employment begins), an employer may make disability-related inquiries and require medical examinations only if they are job-related and consistent with business necessity.

What is a “disability-related inquiry”? . . .

- A “disability-related inquiry” is a question that is likely to elicit information about a disability, such as asking employees about: whether they have or ever had a disability; the kinds of prescription medications they are taking; and, the results of any genetic tests they have had.
- Disability-related inquiries also include asking an employee’s co-worker, family member, or doctor about the employee’s disability.
- Questions that are not likely to elicit information about a disability are always permitted, and they include asking employees about their general well-being; whether they can perform job functions; and about their current illegal use of drugs.

What is a “medical examination”? . . .

- A “medical examination” is a procedure or test usually given by a health care professional or in a medical setting that seeks information about an individual’s physical or mental impairments or health. Medical examinations include vision tests; blood, urine, and breath analyses; blood pressure screening and cholesterol testing; and diagnostic procedures, such as x-rays, CAT scans, and MRIs.

101 Although employers are allowed at the second stage to ask disability-related questions and conduct medical examinations regardless of whether they are related to the job, most employers limit such questions and examinations to avoid collecting unnecessary medical information and to decrease the risk of breaching the confidentiality requirements of the ADA. See Chai R. Feldblum, Medical Examinations and Inquiries Under the Americans with Disabilities Act: A View from the Inside, 64 Temp. L. Rev. 521, 537–38 (1991), available at www.law.georgetown.edu/archiveada.

It should be noted that if an employee is not seeking a reasonable accommodation and an employer requests a gender-affirmed or gender-diverse person to undergo psychiatric examinations, ostensibly as part of the interactive process but in reality as a means to coerce the employee to quit or to simply harass the individual, such conduct likely would violate both the ADA and Title VII.103

C. Special Considerations Under the Americans with Disabilities Act and the Rehabilitation Act Relevant to This Treatise

1. Introduction

The ADA and the Rehabilitation Act cover nearly all disabling conditions. However, there are certain conditions that Congress decided to exclude from both laws. For example, individuals addicted to and currently using illegal drugs are not protected from termination if an employer decides to fire them because of the illegal drug use.104 This section of the treatise gives a brief overview of a set of conditions that two senior senators demanded be excluded from the ADA because of the conditions’ “moral content” and the senators’ apparent disdain for LGBT people,105 justifications that also almost led to excluding HIV and AIDS as disabilities and to allowing employers engaged in food handling to freely restrict the employment of individuals with HIV or AIDS.

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103 With respect to Title VII, see Smith v. City of Salem, 378 F.3d 566, 94 FEP 273 (6th Cir. 2004) (firefighter with a GID set forth a claim for sex-stereotyping discrimination where he alleged that, after he started to express a more feminine appearance, he was subjected to comments that his appearance and mannerisms were not “masculine enough” and management schemed to require him to undergo three separate psychological evaluations as a means of intimidating him into resigning), Michaels v. Akal Sec., Inc., 2010 WL 2573988, at *4, 109 FEP 1499, 23 AD 771 (D. Colo. 2010) (security worker set forth a claim for sex-stereotyping discrimination where she alleged that she was subjected to excessive medical evaluations, unwarranted disciplinary actions, and unpaid suspensions once it was revealed during an annual medical examination that she had gender dysphoria), Doe v. United Consumer Fin. Servs., 2001 WL 34350174, at *4–5 (N.D. Ohio Nov. 9, 2001) (temp agency employee adequately pled claims of sex-stereotyping discrimination, slander, and intrusion of privacy with respect to her being questioned about her gender and transsexuality), and Muir v. Applied Integrated Techs., Inc., 2013 WL 6200178, at *3, 6–10 (D. Md. Nov. 26, 2013) (employer’s motions to dismiss and for summary judgment denied where there was a question of fact regarding whether plaintiff was terminated because her security clearance was withdrawn by the government or because of sex discrimination as a result of her commencing a gender affirmation; plaintiff alleged that defendant’s representatives requested “a personal statement from [her] describing why and for how long she has been transgender” in an effort “to satisfy their prurient interest in her gender reassignment”).

104 42 U.S.C. §§12114(a), 12210(a).

105 The legislative history of the “LGBT exclusions,” including particularly the anti-LGBT comments of Senators William Armstrong (R-Colo.) and Jesse Helms (R-N.C.), is discussed in Section III.C.3. infra. As discussed in Section II.C.3.–4. infra, similar comments were made by legislators in the context of how HIV and AIDS would be treated under the ADA.
2. The LGBT Exclusions From the Definition of “Disability”

Since its enactment, the ADA has excluded certain individuals and conditions. Of particular relevance to this treatise, the ADA contains the following exclusions:

- “Homosexuality and bisexuality”: “For purposes of the definition of ‘disability’ . . . , homosexuality and bisexuality are not impairments and as such are not disabilities under [the ADA].” ¹⁰⁷
- “Transvestites”: “For the purposes of [the ADA], the term ‘disabled’ or ‘disability’ shall not apply to an individual solely because that individual is a transvestite.” ¹⁰⁸
- “Certain conditions”: “Under [the ADA], the term ‘disability’ shall not include
  (1) transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;
  (2) compulsive gambling, kleptomania, or pyromania; or
  (3) psychoactive substance use disorders resulting from current illegal use of drugs.” ¹⁰⁹

The ADA was enacted in 1990. Except for the “transvestite” provision, these same exclusions were added to the Rehabilitation Act in 1992.¹¹⁰ The transvestite exclusion had already been added to the Rehabilitation Act in 1988.¹¹¹ The legislative history of the LGBT exclusions and the case law prior to and after the enactment of the exclusions are discussed in detail in Sections III.C. and III.D. infra.

3. HIV and AIDS Are Protected Disabilities

The ADA’s legislative history is replete with discussions of whether individuals with HIV or AIDS were worthy of protection. Most opponents of such protection saw protecting people with HIV or AIDS as an implicit endorsement of homosexuality. Senator Jesse Helms (R-N.C.), one of the most outspoken critics of the ADA, summarized their position:

¹⁰⁶See 29 C.F.R. §1630.3.
¹⁰⁸Id. §12208. Another example of an excluded individual is someone “who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use.” Id. §§12114(a), 12210(a).
¹⁰⁹Id. §12211(b).
¹¹¹Fair Housing Amendments Act of 1988, §6(b)(3), Pub. L. No. 100–430 (Sept. 13, 1988) (codified as a note to 42 U.S.C. §3602) (“For the purposes of [the Fair Housing Act] as well as [the Rehabilitation Act], neither the term “individual with handicaps” nor the term “handicap” shall apply to an individual solely because that individual is a transvestite.”).
What I get out of all of this is here comes the U.S. Government telling the employer that he cannot set up any moral standards for his business by asking someone if he is HIV positive, even though 85 percent of those people are engaged in activities that most Americans find abhorrent. That is one of the problems I find with this bill.\footnote{135 \textit{Cong. Rec.}, S10,772 (daily ed. Sept. 7, 1989). For a further discussion of the homophobic theme of the debates, see Ruth Colker, \textit{Homophobia, AIDS Hysteria, and the Americans with Disabilities Act}, 8 \textit{J. Gender Race \& Just.} 33 (2004), available at http://moritzlaw.osu.edu/sites/colker2/files/2012/12/Homophobia-AIDS-Hysteria.pdf (noting, e.g., at page 44, that a minority committee report “characterized the ADA as a ‘homosexual rights’ bill—even though the ADA specifically exempted homosexuality from statutory coverage”).}

The controversy over including HIV and AIDS as disabilities proved “to be a major stumbling block in the road to the ADA’s final passage.”\footnote{\textit{Disability Discrimination and the Workplace}, ch. 5 (Disabilities Protected by the Americans with Disabilities Act), §V.B.} In the end, however, reason prevailed over prejudice, and discrimination against individuals because they have AIDS or HIV became illegal.\footnote{480 U.S. 273, 43 FEP 81, 1 AD 1026 (1987) (Rehabilitation Act case involving tuberculosis).}

A substantial body of case law has developed under the ADA and the Rehabilitation Act with respect to HIV and AIDS. Because these medical conditions are not ones that affect just the LGBT community,\footnote{524 U.S. 624, 8 AD 239 (1998) (ADA public accommodation case involving asymptomatic HIV infection).} this treatise references case law involving HIV and AIDS only to illuminate a few legal issues.\footnote{\textit{See}, e.g., \textit{Doe v. Deer Mountain Day Camp, Inc.}, 682 F. Supp. 2d 324 (S.D.N.Y. 2010) (ADA public accommodation case).} Despite decisions such as \textit{School Board of Nassau County v. Arline}\footnote{117} and \textit{Bragdon v. Abbott},\footnote{118} both of which are discussed at numerous places in this chapter, and the educational outreach by leading organizations such as Fenway Health and the Centers for Disease Control and Prevention, courts still need to issue decisions finding defendants in violation of the ADA because of discrimination on the basis of unfounded fears of HIV and AIDS.\footnote{119}
4. The Food Industry and the Fear of HIV and AIDS: A Legislative Compromise

One of the “most contentious debates” during the consideration of the ADA related to a proposed amendment that would have allowed the reassignment of food industry workers with HIV or AIDS, despite the fact that there was no scientific evidence to warrant such action.\(^\text{120}\) Highlights of the debate in the House of Representatives include the following:

Representative J. Roy Rowland (D-Ga.), a doctor himself, spoke against the amendment on the grounds that Congress simply did not have the medical knowledge to pass such sweeping legislation. . . . He concluded by stating that these matters need to be left up to health officials, not politicians.

Representative Charlie Rose (D-N.C.) then spoke about his personal view and about sound public policy. First, he declared his sentiments by stating: “Now do not ask me to risk my health, and the health of my children and the health of my family to prove how liberal and unprejudiced I am about communicable diseases.” . . .

. . . [Representative Frank McCloskey (D-Ind.)] stated that, although restaurateurs want this amendment, the National Restaurant Association declared in a recent report that persons with AIDS should not be kept from duties or facilities because there is no evidence linking the transmission of the disease and food-handling. Furthermore, he pointed out that the National Council of Churches and the American Medical Association both opposed the amendment as well. Representative Henry A. Waxman (D-Cal.) reminded the House that, at other times in history, persons have been treated unfairly, based not on medical evidence but because of social prejudices. For example, people used to believe that cancer was contagious and that blood transfusions from another race would not “settle” effectively . . .

Then Representative Steve Bartlett (R-Tex.) addressed the House in favor of the amendment. He began by asking the members to read the amendment again and see that it was not in conflict with the letter or spirit of the ADA. . . . He went on to explain that the change would mean that, if someone had a disease covered by the amendment, moving them to a different job at the same pay would be the reasonable accommodation, along with any other adaptations.

Another doctor, Representative Jim McDermott (D-Wash.), spoke next about the harm of the amendment from a medical standpoint. . . . [A]cknowledging that the amendment was not about public safety, he stated: “Let us be honest: It is about the fear of AIDS.” He called the amendment the product of policy based on myth, fear, and ignorance and declared that making policy without knowing all the facts is one thing, but making policy directly in opposition to what is known is unacceptable. . . .

Representative Beverly B. Byron (D-Md.) . . . stat[ed] that there are people with diseases that should not be handling food, but the instances with actual merit fall under the direct threat provision of the bill, which dictates

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\(^\text{120}\) Disability Discrimination and the Workplace 13, 291–92. HIV is a virus that destroys CD4+ T blood cells, which are critical to helping the body fight diseases. “AIDS is the late stage of HIV infection, when a person’s immune system is severely damaged and has difficulty fighting diseases and certain cancers.” U.S. Department of Health & Human Services, How Do You Get HIV or AIDS? (June 6, 2012), available at http://aids.gov/hiv-aids-basics/hiv-aids-101/how-you-get-hiv-aids. See also Bragdon, 524 U.S. at 633–37 (describing HIV and AIDS and holding that HIV is an impairment under the ADA from the moment of infection).
that they can be fired. Thus, the amendment was unnecessary. Then Representative Chuck Douglas (R-N.H.) addressed the members on the subject of perception versus reality, stating that “perception is reality. [Everyone] in this room knows that.” . . . He made it clear that the restaurant owners know the medical facts, but their patrons may not, and instead of creating a situation in which the business has to close, this amendment balances everyone’s interests by providing for a lateral job change. Later, Representative Paul B. Henry (D-Mich.) would urge, “if you want to vote perception, then support the amendment. But if you want to vote reality, and if you want to vote truthfulness as we understand it in science and the medical profession, you will oppose this amendment.”

Representative John Lewis (D-Ga.) . . . called the arguments used to defend this amendment “tired,” as they had been used for so long to rationalize segregation. He then urged the other representative[s] to listen to the “health experts, not the hate experts.” Finally, he reminded the members that “separate is never equal.” Representative Tom DeLay (R-Tex.) . . . called the continued reference to race “incredible.” He explained that the problem at issue with the . . . amendment was simply about changing employment areas, and nothing else—not racism or sexism. Representative John R. Miller (R-Wash.) responded that “this is as if businesses 40 years ago had pointed to the public perception of blacks and said our customers will not understand our hiring blacks, so allow us to discriminate against blacks.”

The final plea came from Representative Hamilton Fish, Jr. (R-N.Y.), who declared “Mr. Chairman, the Congress must not enshrine ignorance and prejudice in the law.”

Ultimately, a compromise provision was later adopted in the final text of the ADA, which permits the Secretary of Health and Human Services to determine which infectious or communicable diseases can be transmitted through food handling:

In any case in which an individual has an infectious or communicable disease that is transmitted to others through the handling of food, that is included on the list developed by the Secretary of Health and Human Services . . . , and which cannot be eliminated by reasonable accommodation, a covered entity may refuse to assign or continue to assign such individual to a job involving food handling.

III. POSSIBLE USES OF DISABILITY LAW TO ADVOCATE FOR THE RIGHTS OF GENDER-AFFIRMED AND GENDER-DIVERSE INDIVIDUALS

A. Introduction

As discussed earlier in this chapter, the ADA and the Rehabilitation Act expressly exclude from the definition of the term “disability” homosexuality, bisexuality, transvestites, transsexualism, and GIDs not resulting from physical impairments. This section reviews what avenues exist for gender-affirmed and gender-diverse people to pursue a remedy under these two laws.
in view of the exclusions. Although claims asserting discrimination based on individuals’ sexual orientation are not viable, claims brought by persons who have, had, or are regarded as having gender dysphoria may be viable. In addition, although gender nonconformity and sexual orientation are not disabilities, regarding individuals as disabled (e.g., as having a psychotic or personality disorder) because they are gender nonconforming or lesbian, gay, and bisexual (LGB) could give rise to a disability claim.

B. The Debate Over Pursuing Disability Claims to Remedy Discrimination Against Individuals With Gender Dysphoria

Some advocates argue that lawyers should not pursue discrimination claims on behalf of individuals with gender dysphoria because such claims, among other things, may stigmatize these individuals. Other advocates respond by arguing that these individuals are often publicly stigmatized regardless of whether they institute lawsuits to protect their employment rights. These advocates add that even if the employees do not consider themselves having a disability, if their employers regard them as disabled (which, after the ADAAA and as discussed in Section II.B.5, supra, requires merely showing that the employees were regarded as impaired), then they should be protected by both the ADA and the Rehabilitation Act, and they should not abandon a suitable legal remedy for the right to something as vital as employment.

Jennifer Levi, a professor at Western New England University School of Law and director of the Gay & Lesbian Advocates & Defenders’ Transgender Rights Project, offers a detailed and cogent philosophical argument in favor of asserting disability claims in her essay in Chapter 47 (Clothes Don’t Make the Man (or Woman), But Gender Identity Might). In terms of providing effective workplace solutions for transgender employees, Professor Levi explains how disability discrimination laws give judges a compelling—and comfortable—basis for modifying company policies, such as dress codes, which have generally withstood challenge under sex discrimination theories:

Bringing a disability claim along with a sex discrimination claim has sometimes been the key to successful challenges of sex-differentiated dress codes. It humanizes the plaintiff, helps convince courts of the seriousness of the underlying claims, and counteracts the collective hunch theory [traditionally used by courts to uphold such dress codes] by giving a judge a basis for removing him or herself as the evaluator of the harm of a sex-differentiated rule. A disability claim gives a court a construct for understanding why someone cannot conform to a gender stereotype and does so in language a judge can understand. That is, different health conditions are widely understood

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124 Professor Levi’s essay focuses on the use of state disability discrimination laws in view of the sexual behavior disorders exclusion in the ADA and Rehabilitation Act. She does see some potential for these federal laws protecting individuals with GIDs resulting from physical impairments. See Jennifer L. Levi & Bennett H. Klein, Pursuing Protection for Transgender People through Disability Laws, in Paisley Currah, Richard M. Juang, & Shannon Price Minter, Transgender Rights 84 (2006).
to change the way an individual might respond to a particular job requirement, making the judge without the health condition a poor arbiter of the job requirement’s effects. By incorporating a medical claim associated with one’s gender identity or gender expression, courts can distance themselves from the particular facts and circumstances of a case and take seriously the dysphoria experienced by a plaintiff’s forced conformity to a gender norm.125

For further discussion of the philosophical merits of bringing a disability claim, please refer to Chapter 22 (Transgender Discrimination Claims: A Plaintiff Perspective on Proofs and Trial Strategies), Section II.B.1., which was written by Sharon McGowan, the lead trial counsel in the groundbreaking case Schroer v. Billington.126

C. The LGBT Exclusions: Early Case Law and Legislative History

1. Introduction

As explained in Section II.C.2. supra, since its enactment in 1990, the ADA has had three broad categories of exclusions relevant to LGBT employees: (1) homosexuality and bisexuality; (2) transvestite; and (3) “sexual behavior disorders,” including transvestism, transsexualism, and GIDs not resulting from physical impairments.127 Except for the transvestite provision, these same exclusions were added to the Rehabilitation Act in 1992.128 The transvestite exclusion had already been added to the Rehabilitation Act in 1988, less than one year after the federal circuit court’s decision in the Blackwell litigation (discussed in Section III.C.2.b. infra), as a statutory note to the Fair Housing Act.129

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125 See Chapter 47 (Clothes Don’t Make the Man (or Woman), But Gender Identity Might), §II.
126 577 F. Supp. 2d 293, 104 FEP 628 (D.D.C. 2008) (Schroer III). The Schroer litigation is discussed later in this chapter as well as in other chapters. See the Table of Cases at the back of this treatise for specific citations. See also Wilson v. Phoenix House, 978 N.Y.S.2d 748, 755–56 (Sup. Ct. 2013). In Wilson, a case holding that a plaintiff with a GID adequately pled her claim that residential treatment facility violated the New York State and City Human Rights Laws by discriminating against her based on her disability, the court observed:
[There are differences of opinion among lawyers and advocates as to whether to pursue transgender discrimination claims as disability discrimination or as gender discrimination, or on both grounds.]

127 42 U.S.C. §§12208, 12211(a)–(b).
129 Fair Housing Amendments Act of 1988, §6(b)(3), Pub. L. No. 100-430 (Sept. 13, 1988) (codified as a note to 42 U.S.C. §3602) (“For the purposes of [the Fair Housing Act] as well as [the Rehabilitation Act], neither the term “individual with handicaps” nor the term “handicap” shall apply to an individual solely because that individual is a transvestite.”). This amendment
The following discussion sets forth the state of the case law under the Rehabilitation Act relating to gender identity, gender expression, and sexual orientation, at the time the ADA was enacted; reviews the legislative history relating to the enactment of the LGBT exclusions; and summarizes the salient aspects of the sexual orientation, transvestite, and sexual behavior disorders exclusions as enacted by the ADA.

2. Pre–Americans with Disabilities Act Case Law Under the Rehabilitation Act

To place the LGBT exclusions in perspective, it is helpful to first briefly review the pre-ADA case law under the Rehabilitation Act, which held that homosexuality is not a disability but that transsexualism and transvestism can be disabilities.

a. Doe v. U.S. Postal Service: Transsexualism

In Doe v. U.S. Postal Service,130 the plaintiff alleged that an offer of a temporary, six-month position was rescinded after she advised the U.S. Postal Service (USPS) that she intended to have gender reassignment surgery and would like to begin working as a woman rather than changing her physical appearance while employed. Her soon-to-be supervisor was fine with this, but the general manager of the personnel division was not. The plaintiff then offered to serve her entire employment as a man, but the general manager refused to reinstate the job offer. Six months later, the plaintiff had her surgery.

The plaintiff filed a complaint with the USPS, which rejected it. She appealed to the EEOC, which affirmed the dismissal in 1984, holding that transsexualism “is not a cognizable physical or mental impairment . . . which substantially limits one or more of her major life activities.”131 The plaintiff then filed a civil action in federal court, wherein she alleged that her transsexualism substantially impaired her in the major life activity of working. In contrast to the EEOC, in 1985 the district court for the District of Columbia held that the plaintiff alleged sufficient facts to withstand a motion to dismiss and that she might have been regarded as being disabled as a result of the negative attitudes of others toward her transsexualism. Another significant yet subtle difference between the EEOC’s and the district court’s opinions is that the court referred to the plaintiff’s surgery as “gender reassignment surgery,” whereas the EEOC called it a “sex change operation.” The district judge also expressed his apparent dislike for the
manner in which the USPS treated the plaintiff, opening his opinion with the words, “In this sad case . . . .”

b. Blackwell v. U.S. Department of Treasury: Transvestism and Homosexuality

A year later, in 1986, in Blackwell v. U.S. Department of Treasury, the U.S. District Court for the District of Columbia held that a plaintiff stated a claim under the Rehabilitation Act when he alleged that the Treasury Department did not rehire him because, as a transvestite, he was regarded as mentally ill. The plaintiff had been employed by the Treasury Department for eight years until he had been laid off in a reduction in force. Three months later, he interviewed for 1 of 12 open positions. At his interview, he dressed as a woman, the way he had during his eight years of employment. He was not rehired. He alleged that other former employees with less seniority were hired for the other positions while the position he was interviewing for was eliminated.

In declining to dismiss the plaintiff’s Rehabilitation Act claim, the court noted that transvestism is recognized by the American Psychiatric Association as a mental disorder and that if the plaintiff could prove that he was perceived as disabled because he was a transvestite, then “he need not allege or prove that his handicap actually impaired his ability to function in order to seek relief under the Rehabilitation Act,” and the Treasury Department “cannot defend its discrimination by showing that its assumptions were erroneous.”

Later in 1986, after a bench trial, the court concluded that the “plaintiff showed that he is probably a member of a protected class, that he applied for a job, that he was qualified and that the job requirements were changed to avoid hiring.” However, the court found that the government official who changed the job requirements “found plaintiff’s apparent homosexual aspect undesirable” and there was nothing to indicate that the official “had any understanding one way or the other as to the difference between a homosexual and a transvestite or that he focused on the fact that the plaintiff’s dress was somewhat more feminine than that of many homosexuals.”

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132 Doe v. USPS, 1985 WL 9446, at *1. The EEOC and the district court agreed that the plaintiff had no cause of action under Title VII. As discussed in Chapter 14 (Title VII of the Civil Rights Act of 1964), the EEOC and the U. S. District Court for the District of Columbia have overruled the Title VII aspect of their holdings in the Casoni and Doe v. USPS cases.

133 639 F. Supp. 289, 41 FEP 1586, 1 AD 902 (D.D.C. 1986) (Blackwell I). The court noted that the plaintiff exhausted his administrative remedies but provided no details on any rulings by the EEOC in the matter.

134 In a subsequent opinion, the court described the plaintiff as wearing “pants of a feminine style, a broad stretch belt, a shirt-blouse, and his hair . . . in long braids.” Blackwell v. U.S. Department of Treasury, 656 F. Supp. 713, 714, 43 FEP 1804, 1 AD 992 (D.D.C. 1986) (Blackwell II), aff’d in part and vacated in part, 830 F.2d 1183, 44 FEP 1856, 1 AD 1152 (D.C. Cir. 1987).


137 Id.
After observing that transvestites, but not homosexuals, are protected as individuals with disabilities under the Rehabilitation Act, the court denied relief to the plaintiff because the court determined that he had a duty to notify a prospective employer that he has a disability. The court closed its opinion by observing that “the failure to employ plaintiff is highly reprehensible. . . . Hopefully wiser heads will correct the underlying injustice.”

On appeal, the appellate court did not disagree with the trial court’s finding that the adverse action was the result of the plaintiff being perceived as a homosexual, and the court affirmed the lower court’s conclusion that homosexuality is not a disability under the Rehabilitation Act. Nonetheless, the court, in a 1987 opinion by Judge (later Justice) Ruth Bader Ginsburg, vacated the district court’s opinion, holding that the Rehabilitation Act does not require prospective employees to give employers precise notice of their disabilities before they can seek protection under the Act. Such a notice requirement conflicts with the Rehabilitation Act’s restriction on employers asking prospective employees whether they have disabilities.

The determination that homosexuality is not a disability was consistent with the long-standing interpretation of the Rehabilitation Act by the U.S. Department of Health, Education and Welfare, which issued the first regulations interpreting the Rehabilitation Act in 1977.


Subsequent to the trial court’s decision in *Doe v. U.S. Postal Service*, which as discussed in Section III.C.2.a. supra rejected the EEOC’s decision in *Casoni v. U.S. Postal Service*, the EEOC has addressed disability claims related to transsexualism in just four published decisions, all decided under the Rehabilitation Act. Each time, the EEOC dismissed GID disability claims. In none of these cases did the EEOC cite the *Doe* decision.

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138 *Id.* Cf. *Oiler v. Winn-Dixie La.*, Inc., 2002 WL 31098541, at *6, 89 FEP 1832 (E.D. La. 2002) (in dismissing a sex discrimination case under Title VII and the counterpart Louisiana law, “the Court recognizes that many would disagree with the defendant’s decision [to terminate plaintiff] and its rationale. The plaintiff was a long-standing employee of the defendant. He never crossdressed at work and his crossdressing was not criminal or a threat to public safety. Defendant’s rationale for plaintiff’s discharge may strike many as morally wrong. However, the function of this Court is not to raise the social conscience of defendant’s upper level management, but to construe the law in accordance with proper statutory construction and judicial precedent.”).

139 *Blackwell v. U.S. Dep’t of Treasury*, 830 F.2d 1183, 44 FEP 1856, 1 AD 1152 (D.C. Cir. 1987).

140 830 F.2d at 1183–84.


In 1987, in *LaBate v. United States Postal Service*, the EEOC confronted the claim of an employee who maintained that she had been wrongly transferred to a light-duty position after her “gender change surgery” because of her transsexualism. The EEOC rejected her disability claim because she failed to show that “her medical limitations are ongoing in nature and have the effect of substantially limiting one or more of her major life activities.” At best, she had “a temporary physical impairment” that decreased as she recovered from the surgery, which also had no “lasting impact on her mentally.” Similarly, in 1993, in *Campbell v. Espy*, the EEOC held that the plaintiff was terminated for legitimate reasons and had failed to show that her mental disability—referred to as gender dysphoria and transsexualism—substantially limited her in a major life activity. Moreover, the plaintiff, who had gender reassignment surgery after her termination, failed to show that she was regarded as impaired. The alleged incidents of discrimination in *Campbell* occurred prior to October 29, 1992, which is the effective date of the 1992 amendments to the Rehabilitation Act (discussed in Section III.C.1. *supra*) that expressly excluded transsexualism from the Rehabilitation Act’s definition of “disability.” In both *LaBate* and *Campbell*, the EEOC addressed the adequacy of evidence presented to establish a disabling condition.

Finally, in 1994, in *Bell v. Shalala*, the EEOC issued two opinions summarily rejecting disability claims relating to conduct that occurred in 1993. Without addressing the plaintiff’s evidence, the EEOC returned to its categorical holding in *Casoni*, which was rejected by the district court in *Doe v. U.S. Postal Service*, that transsexualism per se is not an impairment that substantially limited a major life activity. In neither *Campbell* nor the

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144 1987 WL 774785 (EEOC Feb. 11, 1987) (overruled on other grounds by Macy v. Holder, 2012 WL 1435995 (EEOC Apr. 20, 2012)). The 2012 decision held that Title VII prohibits discrimination on the basis of gender identity, change of sex, and/or transgender status.

145 *LaBate*, 1987 WL 774785, at *3. In contrast, the district court in *Doe v. U.S. Postal Service* rejected a similar short-term impairment argument, stating, “We disagree with defendants’ contention that because a transsexual’s condition may be alleviated through the use of hormones and gender reassignment surgery, plaintiff’s impairment is merely ‘short term’ and therefore not covered by the Rehabilitation Act. The mere fact that treatment may be available does not automatically remove an afflicted individual from the scope of this statute.” *Doe v. USPS*, 1985 WL 9446, at *2 n.2.

146 *LaBate*, 1987 WL 774785, at *3.

147 1993 WL 1507098 (EEOC Aug. 31, 1993), reconsideration denied, 1994 WL 652840 (EEOC Apr. 20, 2012)). The 2012 decision held that Title VII prohibits discrimination on the basis of gender identity, change of sex, and/or transgender status.

148 In a subsequent opinion denying reconsideration, the EEOC explained that transsexualism is a type of gender dysphoria. *Campbell v. Espy*, 1994 WL 652840, at *1 n.2 (EEOC July 21, 1994) (overruled on other grounds by Macy v. Holder, 2012 WL 1435995 (EEOC Apr. 20, 2012)). The 2012 decision held that Title VII prohibits discrimination on the basis of gender identity, change of sex, and/or transgender status.

first *Bell* decision did the EEOC expressly mention the then recently added sexual behavior disorders exclusion. However, in the second *Bell* decision, the EEOC did note that its ADA regulation’s definition of “disability” does not include transsexualism and that the Rehabilitation Act was amended in 1992 to incorporate ADA standards into the Act.

3. *The Americans with Disabilities Act: Legislative History of the LGBT Exclusions*

   a. *The U.S. Senate Debate*

   The initial version of the LGBT exclusions was introduced on the evening of September 7, 1989, during the only floor debate the Senate had with respect to the second version of the ADA bill. The debate focused on “the moral overtones that might be implicit” if the excluded individuals and conditions were protected by the ADA. Susser and Petesch, in their extensive discussion of the ADA’s legislative history, explained the debate as follows:

   A divisive debate centered on the definition of “disability,” and Senator William J. Armstrong (R-Colo.) stated that the definition of “disability” in the ADA was too broad, because it included “mental disorders” and disorders with a “moral content” as warranting protection. Armstrong questioned whether senators thought that homosexuality, bisexuality, exhibitionism, pedophilia, voyeurism, and kleptomania should be protected by the ADA. Senator Jesse Helms . . . agreed with Armstrong’s views, especially with respect to homosexuality, asserting that 85 percent of individuals infected with the AIDS virus were homosexuals or drug users. He feared that employers would no longer be allowed to maintain “moral standards” in their businesses with such a broad definition. Senator [Edward] Kennedy [(D-Mass.)] argued that the broad protection was necessary to prohibit discrimination against persons with HIV, as it would encourage people to reveal their illness, which is crucial to getting immediate medical care and controlling the epidemic. Although Senators [Tom] Harkin [(D-Iowa)] and Kennedy opposed further restriction of the definition of disability, it was clear that the bill would not proceed further in the Senate unless specific conditions were excluded from the bill. Under relentless pressure from conservatives, an amendment by Senator Armstrong prepared a long list of conditions that would not be considered a disability

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151 Disability Discrimination and the Workplace 11. See, e.g., 135 CONG. REC. S10,753 (daily ed. Sept. 7, 1989) (Senator Armstrong, after noting that the list of medical conditions he wanted to exclude from the ADA were drawn from court cases under other laws with similar definitions, stated that he “could not imagine the sponsors would want to provide a protected legal status to somebody who has such disorders, particularly those who might have a moral content to them or which in the opinion of some people have a moral content.”); id. at 10,765–68, 72 (Senator Helms argued that employers’ “moral standards” should allow them to exclude pedophiles, schizophrenics, kleptomaniacs, manic depressives, psychotics, homosexuals, transvestites, and individuals with AIDS or HIV); and id. at 10,796 (after the disability exclusions were agreed to by the Senate but before he abstained from the vote the same evening to approve the Senate version of the ADA bill, Senator Warren Rudman (R-N.H.) commented that “we are talking about behavior that is immoral, improper, or illegal and which individuals are engaging in of their own volition, admittedly for reasons we do not fully understand.”).
under the ADA. The Armstrong amendment excluded homosexuals, bisexuals, transvestites, pedophiles, exhibitionists, voyeurs, compulsive gamblers, kleptomaniacs, transsexuals, pyromaniacs, those suffering from gender disorders, and drug users. The Senate approved the amendment by a voice vote.152

Senator Armstrong initially had a far longer list of disorders he wanted to exclude from the ADA, extracted from the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised (DSM-III-R).153 He and Senator Helms peppered Senator Harkin with a recitation of mental conditions that they felt were unworthy of protection and would also be an affront to the “moral standards” of employers, including bipolar disorder, delusional disorder, disruptive behavior disorders, hallucinosis, homosexuality, impulse control disorders, manic depression, neurosis, psychotic disorders, schizophrenia, and transvestism.154 Senator Armstrong suggested that Senator Harkin, the chief sponsor of the bill, and Senator Harkin’s staff should study the list overnight, but instead the list was reviewed and pared down to 11 disorders during off-the-record negotiation that evening so that the bill could be approved the same evening, despite Senator Harkin’s admission that he was “not familiar with these disorders.”155 Senator Harkin was not alone in that sentiment. Indeed, the chief proponent of the list, Senator Armstrong, similarly admitted that he was “simply not learned enough or well enough informed to suggest an amendment” to eliminate the morally objectionable disorders.156 It is likely that all individuals with GIDs (including transsexualism) were simply assumed to be homosexuals and transvestites, as that was—and, to a lesser degree, still remains—a common, although inaccurate, assumption.157 Likewise,
as explained in detail in Section III.G.2. *infra*, it is most likely that these senators did not understand that GIDs (including transsexualism) were not, and have never been, classified as sexual behavior disorders in the *DSM*. Indeed, in the *DSM-III-R*, GIDs (including transsexualism) were classified as “disorders usually first evident in infancy, childhood, or adolescence.”

Instead of taking time to more fully understand the etiology of each of the medical conditions that they excluded, or delegating the authority to a governmental agency with appropriate expertise to decide whether one or more of these conditions should be excluded, the lead sponsors of the bill cut a last-minute deal, near the end of a 14-hour debate, so that the bill would pass. By excluding conditions recognized in the *DSM-III-R* without exploring the medical dimensions of these conditions, the senators disregarded the fundamental purpose of the ADA, as stated that same evening by Senator Harkin: “The point of the bill is to start breaking down those barriers of fear and prejudice and unfounded fears, to get past that point so that people begin to look at people based on their abilities, not first looking at their disability.”

One of Senator Armstrong’s concerns about the inclusion of the mental conditions he wanted to exclude from the ADA was that the definition of “disability” was very broad and vague, in contrast to the categories of people protected by the Civil Rights Act of 1964:

> We have said that it is and shall be against the law for a person to discriminate in employment, promotion, public accommodation, and so on because of race, religion, and sex.

> These are easily discernible factual situations. A person is or is not a man or a woman. A person is or is not a Catholic, a Jew, a Mormon, whatever, a Baptist, a Presbyterian. That is something we can readily determine. A person either is or is not Irish, Italian, and so on.

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F.2d 1183, 44 FEP 1856, 1 AD 1152 (D.C. Cir. 1987) (in a case involving whether transvestism is a disability protected by the Rehabilitation Act, Judge (later Justice) Ginsburg held that “the liability of a government department under the Act should not turn on the level of sophistication or ability . . . of the particular interviewing officer . . . [to know] that homosexuality and transvestism are not one and the same”); Millett v. Lutco, Inc., 2001 WL 1602800, at *2 & n.3, 23 Mass. Discr. L. Rep. 231 (Comm’n Ag. Discr. Oct. 10, 2001) (noting that transsexuals are misperceived as gay or lesbian).

As explained in Chapter 2 (The Transformative Power of Words), related confusion often results in “gender identity or expression” incorrectly being understood as a subset of “sexual orientation,” and “transgender” and “transsexual” wrongly being assumed as being synonymous.

158 As discussed in Section II.C.4. *supra*, in connection with the debate over barring individuals with contagious diseases, especially HIV and AIDS, from handling food, Congress realized it did not have the necessary expertise to resolve the issue, so it delegated resolution of the issue to the Secretary of Health and Human Services.


161 Id. at S10,772. The fallacy of Senator Armstrong’s argument is discussed in Section III.E.2. *infra.*
Senator Pete Domenici (R-N.M.) rejected the idea that workers should be denied employment based on subjective bias and the labels attached to their mental illness. He observed that “more times than not, we are wrong in [our] perception of their abilities [and we] certainly overstate their disabilities.”\(^{162}\) He provided two examples of individuals who would not have been protected had the original Armstrong exclusion list been adopted—Winston Churchill and Abraham Lincoln, who both had to cope with manic depression.\(^ {163}\)

Two leading proponents of the Senate bill, Senators Harkin and Kennedy, made it clear that although they did not agree with the Armstrong amendment, they accepted it as a political compromise so that the last significant hurdle to passage of the bill was overcome.\(^ {164}\) They also made it clear that there was no need to include homosexuality and bisexuality as exclusions because they are not disabilities under any medical standards.\(^ {165}\) According to Ruth Colker, a professor at the Moritz College of Law at The Ohio State University, “with the right-wing clamoring about the ‘sodomy lobby,’ there was no room in which to argue that [the transvestism and transsexualism] exclusions were harmful and degrading. The best that the gay rights community was able to achieve was to take ‘homosexuality’ and ‘bisexuality’ out of the sentence that listed ‘sexual behavior disorders.’ This was not much of a victory.”\(^ {166}\) The two senators who led the floor debate in favor of these exclusions, Armstrong and Helms, still voted against the bill.\(^ {167}\)

b. Action in the U.S. House of Representatives

The Senate’s version of the ADA bill included the exclusion for “gender identity disorders,”\(^ {168}\) whereas a subsequent House’s version used the phraseology “gender identity disorders not resulting from physical impairments.”\(^ {169}\) The House version was proposed by the House Committee on the Judiciary, in its May 15, 1990, report, wherein it is explained without elaboration that the Committee made “only minor clarifying changes” to the Senate

\(^{162}\)Id. at S10,779.

\(^{163}\)Id.


\(^{168}\)Id. at S10,954, 10,961.

language.\footnote{H.R. Rep. No. 101-485 pt. 3, p.76 (May 15, 1990). The original version of the House bill did not include any such exclusion. \textit{Id}.} The House Committee on Energy and Commerce, in its May 15, 1990, report, proposed the same set of exclusions without explanation.\footnote{H.R. Rep. No. 101-485 pt. 4, pp.23, 73 (May 15, 1990).} Three members of the Energy and Commerce Committee, in their joint dissenting views on the bill, where they expressly referenced the \textit{DSM-III-R}, stated that they wanted to add additional mental disorders to the exclusion relating to compulsive gambling, kleptomania, and pyromania, and they also wanted to exclude individuals with “currently contagious diseases and sexually transmissible diseases or infections.”\footnote{Id. at 81 (dissenting views of Rep. William E. Dannemeyer (R-Cal.), Rep. Joe Barton (R-Tex.), and Rep. Don Ritter (R-Penn.)).} Their comments made it clear that they considered each of the following conditions—transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, and GIDs not resulting from physical impairments—sexual behavior disorders.\footnote{Id. at 80–81.} As explained in Section III.G.2. \textit{infra}, in the \textit{DSM-III-R}, GIDs (including transsexualism) were not sexual behavior disorders but rather were “disorders usually first evident in infancy, childhood, or adolescence.”

c. Passage of the Americans with Disabilities Act

During the House-Senate conference to resolve differences between the two bills, the conferees elected to adopt the House wording of the various exclusions,\footnote{H.R. Rep. No. 101-596, p.88 (July 12, 1990), reprinted in 136 Cong. Rec. H4582, 4605–06 (daily ed. July 12, 1990).} which was then included in the final version of the ADA.\footnote{136 Cong. Rec. H4629–30 (daily ed. July 13, 1990) (Senate vote to accept the conference report); 136 Cong. Rec. S9695 (daily ed. July 13, 1990) (Senate vote to accept the conference report).} The hostility of some legislators toward LGBT individuals also played out in connection with an unsuccessful attempt to exclude individuals with HIV and AIDS from the ADA. For example, Senator Armstrong included in his list of conditions to be excluded from the ADA “homosexuals and bisexuals, whether or not they have AIDS.”\footnote{Robert L. Burgdorf, Jr., \textit{Disability Discrimination in Employment Law} 147 (1995) (internal quotation marks omitted).} According to Susser and Petesch:

Another controversial aspect of the [original] bill was its inclusion of persons with [AIDS] in its prohibition of discrimination in employment, housing, and public accommodations. In June 1988, President Ronald W. Reagan’s Commission on AIDS issued a draft report which included a controversial call for a federal law banning discrimination against individuals with AIDS and those who are [HIV] positive. Admiral James Watkins, former chairman of the commission, testified at the September 27, 1988, joint hearing of the Senate Labor and Human Resources Subcommittee on the Handicapped and the House Subcommittee on Select Education that “without a strong federal anti-discrimination law, HIV-infected individuals would continue to face the same sort of discrimination that persons with disabilities always faced . . . it’s time for federal action.” The controversy over the proposed bill’s coverage of
individuals with AIDS and those who are HIV positive would prove to be a major stumbling block in the road to the ADA’s final passage.177

Despite the opposition, the final version of the ADA bill did not exclude individuals with HIV or AIDS.178

4. The Americans with Disabilities Act as Signed Into Law: Summary of the LGBT Exclusions

a. Sexual Orientation

The ADA expressly states that homosexuality and bisexuality are not impairments and, thus, not disabilities.179 Because homosexuality and bisexuality were no longer considered a medical condition, having been removed from the DSM prior to the enactment of the ADA,180 there was no need to include this exclusion in the ADA. Nonetheless, certain legislators wanted this to be made explicit in the text of the law.181 Thus, there is no cause of action under the ADA for discrimination against a person because of the individual’s sexual orientation. As discussed in Section II.C.3. supra, although homosexuality is also excluded from the ADA, a person with HIV, AIDS, or some other disability is still protected by the ADA.

b. Transvestites

The ADA expressly states that the term “disability” does not apply to an individual solely because the person is a transvestite.182 Congress excluded transvestites in response to the Blackwell v. U.S. Department of Treasury litigation, discussed in Section III.C.2.b. supra. Because the exclusion of transvestites duplicates the exclusion for transvestism, which is discussed
c. Sexual Behavior Disorders

The ADA lists 11 conditions, broken into three distinct categories, that Congress deemed unworthy of protection as disabilities:

(1) transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;

(2) compulsive gambling, kleptomania, or pyromania; or

(3) psychoactive substance use disorders resulting from current illegal use of drugs.¹⁸³

As discussed in Section III.C.3.a. supra, these exclusions were taken from a significantly longer list of psychiatric conditions, compiled from the DSM-III-R, that Senators Armstrong and Helms tried to have excluded from the ADA. The psychoactive substance use disorders exclusion is not surprising given that the ADA generally does not extend protection to individuals currently using illegal drugs,¹⁸⁴ and the ADA was enacted less than two years after the federal Drug-Free Workplace Act of 1988.¹⁸⁵ Compulsive gambling, kleptomania, and pyromania are part of “a collection of three disorders that seem to have little in common except that they were apparently viewed with disfavor or as particularly dangerous by certain senators.”¹⁸⁶ As is the case with illegal drug use, kleptomania and pyromania are illegal activities.

The sexual behavior disorders exclusion provides six examples of the types of conditions that Congress wanted to exclude: exhibitionism, pedophilia, voyeurism, transvestism, transsexualism, and GIDs not resulting from physical impairments. The first three activities are illegal and, thus, are consistent with the exclusion of the other illegal activities discussed earlier. According to Robert L. Burgdorf, Jr., a disabilities advocate who was actively involved during the ADA legislative process, “the inclusion of transvestism is an obvious redundancy” given that the ADA also excludes transvestites from the range of people protected by the ADA.¹⁸⁷

¹⁸³ 42 U.S.C. §12211(b). The same exclusion was added to the Rehabilitation Act two years after enactment of the ADA. 29 U.S.C. §705(20)(F).

¹⁸⁴ 42 U.S.C. §12210(a) (“the term ‘individual with a disability’ does not include an individual who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use”); 42 U.S.C. §12114(a) (“a qualified individual with a disability shall not include any employee or applicant who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use”).

¹⁸⁵ Pub. L. No. 100-690, Title V, §§5151–60 (Nov. 18, 1988) (codified as amended at 41 U.S.C. §701 et seq.). To read more about substance abuse and the ADA, see Disability Discrimination and the Workplace ch. 5 (Disabilities Protected by the Americans with Disabilities Act), §V.A.


¹⁸⁷ Id. The terms “transvestite” and “transvestism” have been used interchangeably in the medical and general dictionaries. See, e.g., Stedman’s Medical Dictionary 1626 (25th ed. illustrated 1990) (defining “transvestite” as “[a] person who practices transvestism”); Merriam-Webster’s Collegiate Dictionary 1331 (11th ed. 2003) (“transvestite: . . . a person and esp. a
With respect to the final two conditions, GIDs not resulting from physical impairments and transsexualism, there is nothing in the legislative history that explains why they were singled out to be expressly listed, other than they were on Senators Armstrong and Helms’ wish list and these two senators believed that transsexualism is a voluntary lifestyle choice and maintained that the federal court’s decision in Doe v. U.S. Postal Service,188 which held that transsexualism is a protected disability under the Rehabilitation Act, improperly invaded an employer’s prerogative to impose whatever “moral standards” it wants.189 As explained in Section III.G.2.b.vi. infra, in the DSM-III-R, transsexualism was one type of GID, and GIDs were not sexual behavior disorders, but rather were disorders usually first evident in infancy, childhood, or adolescence.

The fact that individuals with “sexual behavior disorders” are excluded from the protections of the ADA should not, and does not, mean that they are not covered by the ADA if they have other medical conditions.190

D. Limited Case Law Subsequent to Enactment of the LGBT Exclusions

Subsequent to enactment of the LGBT exclusions, the few courts that have addressed the applicability of the ADA or the Rehabilitation Act to a transsexual or a person with a GID have summarily dismissed the viability of such claims without any significant analysis. Most of these cases have arisen under state fair employment practices laws or Title VII, in the context of the courts either deciding whether the ADA and Rehabilitation Act exclusion of sexual behavior disorders should be imported into state law or merely noting that the ADA and/or the Rehabilitation Act provide no remedy for the plaintiff.191

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190 See 135 Cong. Rec. S10,786 (daily ed. Sept. 7, 1989) (Senator Harkin observed that the sexual behavior disorders exclusion “is narrowly focused. That is, if a person exhibits only a sexual behavior disorder, that person is not a disabled person under this act and cannot bring a cause of action for discrimination based on that disorder. Of course, this provision cannot be used as a pretext for discrimination based on other disabilities.”).
Just a few cases have actually applied the exclusion in cases brought under the ADA and the Rehabilitation Act. None of these cases discussed the legislative history of the sexual behavior disorders exclusion; the fact that GIDs (including transsexualism) are not now, and never have been, sexual behavior disorders (paraphilias) in the DSM; the progress in medical knowledge regarding GIDs subsequent to the enactment of the ADA; or the impact of the ADA Amendments Act.

1. James v. Ranch Mart Hardware

In James v. Ranch Mart Hardware, the plaintiff was hired as a sales clerk. About a year later, she advised her employer that she planned to begin living and working on a full-time basis as a woman and would begin using a first name commonly associated with the female gender. Two days later, she was terminated. The plaintiff claimed her discharge was because she was a transsexual. The employer claimed it was because she failed to show up for her scheduled work shifts on those two days. On the employer’s motion, the court dismissed the plaintiff’s ADA claim inasmuch as the ADA expressly excludes transsexualism from the definition of “disability.” In a


194 James, 1994 WL 731517, at *2.
subsequent opinion, the court granted the employer’s motion for summary judgment with respect to the plaintiff’s sex discrimination claims under Title VII and the Kansas Act Against Discrimination. In neither opinion did the court state that the plaintiff claimed she had a GID. Thus, the court did not discuss the viability of a claim related to a GID resulting from a physical impairment.

2. Michaels v. Akal Security

In *Michaels v. Akal Security*, the plaintiff was employed by a security company that provided the U.S. Marshal Service (USMS) with security officers for a federal courthouse. During an annual medical examination, the plaintiff disclosed that she had been diagnosed with gender dysphoria. She had been taking female hormones for at least six months. Plaintiff alleged that immediately thereafter Akal and USMS directed her to undergo another medical examination to determine if she was physically able to perform her job, and requested on at least three occasions that she provide additional medical information to USMS’s physician. Shortly after the second exam, the plaintiff commenced presenting at work as a female, using a new, feminine name, and using the women’s restrooms. The plaintiff alleged that her Akal supervisor directed her to use restrooms compatible with her anatomical gender until she provided “tangible evidence proving she had undergone her sex change.”

While still employed, the plaintiff sued Akal and the U.S. Attorney General, who is the head of USMS, asserting various claims, including harassment complaints under the Rehabilitation Act and Title VII. She claimed that she was perceived as disabled, but did not expressly state what her disability was. The court assumed the perceived disability was gender dysphoria. The court dismissed the Rehabilitation Act claim because “[g]ender dysphoria, as a gender identity disorder, is specifically exempted as a disability by the Rehabilitation Act.” The court did not discuss the viability of a claim related to a GID resulting from a physical impairment. However, the court did hold that the plaintiff set forth a claim for sex-stereotyping discrimination based on being subjected to excessive medical evaluations, unwarranted disciplinary actions, and unpaid suspensions once it was revealed she had gender dysphoria.

3. Doe v. United Consumer Financial Services and Johnson v. Fresh Mark

In *Doe v. United Consumer Financial Services* and *Johnson v. Fresh Mark*, after the employer heard rumors that the plaintiff, who had been diagnosed with a GID and had

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195 James, 881 F. Supp. at 481–82.
197 2010 WL 2573988, at *1.
198 Id. at *6.
199 Id. at *4.
undergone hormone therapy and surgery, was being called “Mrs. Doubtfire” by coworkers, it commenced an unusually thorough investigation into her background:

Doe was interrogated about her name change and her gender. [Vice President] Ciszczon asked her, “Are you a man or a woman?” and “What gender are you? … Just looking at you I can’t tell.” Doe told the group that she was a transgendered woman and had been so since 1973. She provided documents showing her legal name change, her then-current Ohio driver’s license (indicating that she is female), her social security card with her current name, and her state of Ohio Notary Public identification card. Ciszczon told her that these documents were “not enough,” and pressed on, asking, “Have you had an operation?” and “Where in the process are you?”

Doe told the group that she considered the questioning inappropriate, highly offensive, and irrelevant to her work performance. Ciszczon told her that several days earlier, a United Consumer employee had complained that “a man dressed as a woman was using the ladies room.” The employee claimed to know that Doe was transsexual because Doe had been seen on a television show in a context that made her transsexuality apparent. Doe, however, has never been on television.

Ciszczon told Doe that he needed medical evidence of her sexuality, and he ended the meeting by instructing Doe to go home and to call the next afternoon to see whether she was to report to work that day.

The following day, Doe was terminated.

The district court held Doe adequately pled claims of Price Waterhouse sex-stereotyping discrimination under Title VII (discussed in Chapter 14, Title VII of the Civil Rights Act of 1964), slander, and intrusion of privacy with respect to her being questioned about her gender and transsexuality. However, the court dismissed her claim that she had a GID resulting from a physical impairment. The court noted that GID and transsexualism are synonymous. It then held that regardless of the fact that the ADA provides that GIDs not resulting from physical impairments are not disabilities, by also expressly excluding transsexualism, Congress was excluding transsexualism “from the definition of disability no matter how it is characterized, whether as a physical impairment, a mental disorder, or some combination thereof.”

A little more than a year later, in Johnson v. Fresh Mark, a case involving a self-identified “pre-operative transsexual,” another judge in the same federal judicial district adopted the reasoning of Doe v. United Consumer

201 Mrs. Doubtfire is a 1993 movie in which Daniel Hillard (portrayed by Robin Williams) pretends to be a Scottish nanny, Mrs. Euphegenia Doubtfire, in order to spend more time with his three children, who resided with his divorced spouse (played by Sally Field).  
206 337 F. Supp. 2d 996, 1001–02 (N.D. Ohio 2003), aff’d, 98 F. App’x 461 (6th Cir. 2004) (also holding that plaintiff failed to set forth a claim for sex-stereotyping discrimination under Title VII).
Financial Services, and the Sixth Circuit Court of Appeals affirmed without elaboration.207

In effect, both judges read out of the ADA the limiting language “not resulting from physical impairments” in the “gender identity disorders not resulting from physical impairments” exclusion. It seems manifestly odd that Congress would have included the limiting language had it wanted to exclude all cases of GIDs. An analysis of the legislative history of the ADA supports the conclusion that Congress intended to allow a transsexual to bring a cause of action under the ADA for GIDs resulting from physical impairments. As discussed in Section III.C.3.b. supra, the Senate version of the ADA bill included the exclusion for “gender identity disorders,” whereas the later House version used the phraseology “gender identity disorders not resulting from physical impairments.” Both bills also included the exclusion of “transsexualism.” It was not uncommon at the time for people to use the terms “transsexualism” and “GID” interchangeably. In fact, as explained in Section III.G.2.b.vi. infra, in the DSM-III-R, transsexualism was one type of GID. During the House-Senate conference to resolve differences between the two bills, the conferees elected to adopt the House wording of the various exclusions,208 which was then included in the final version of the ADA. The fact that individuals with transsexualism are excluded from the protections of the ADA should not, and does not, mean that they are not covered by the ADA if they have a GID resulting from a physical impairment.209 In addition, as discussed in Section II.C.3. supra, although homosexuality is also excluded from the ADA, a gay or lesbian person with HIV, AIDS, or some other disability is still protected by the ADA.

4. Kastl v. Maricopa County Community College District

In Kastl v. Maricopa County Community College District,210 the plaintiff, who was classified as a male at birth based on a genital examination, was an adjunct faculty member and a student within the community college

207 In a subsequent Sixth Circuit case, on appeal from the same federal judicial district, the court affirmed summary judgment against a transsexual social worker who alleged the employer violated both the ADA, by failing to accommodate her adjustment disorder (which was diagnosed by employer’s doctor and is a DSM diagnosis separate and apart from GID) by not relocating her to another office (which she requested because she wanted to work under a different supervisor (instead of the one who allegedly disliked her) in a safer neighborhood that was closer to her home), and Title VII, by terminating her. The court found there was ample evidence that the employer had nondiscriminatory reasons for terminating plaintiff and that she failed to present any evidence that she was limited, let alone substantially limited, in any major life activities. Myers v. Cuyahoga Cnty., 182 F. App’x 510, 98 FEP 959, 18 AD 354 (6th Cir.), cert. denied, 549 U.S. 965 (2006).


209 See 135 CONG. REC. S10,786 (daily ed. Sept. 7, 1989) (Senator Harkin observed that the sexual behavior disorders exclusion “is narrowly focused. That is, if a person exhibits only a sexual behavior disorder, that person is not a disabled person under this act and cannot bring a cause of action for discrimination based on that disorder. Of course, this provision cannot be used as a pretext for discrimination based on other disabilities.”).

district system. About six months after being diagnosed with a GID, the plaintiff commenced living and presenting as a woman. A year after that, her physician determined that she is a biological female. She then legally changed her name and obtained a new driver’s license that reflected her feminine name and female sex.

After some students objected to her use of the women’s restroom, her employer issued a new restroom policy that required her and another transsexual faculty member to use the men’s restroom until they provided proof that they had had “genital correction surgery.” The defendant advised the plaintiff that her driver’s license was “inconclusive and irrelevant.” Because she refused to abide by the new policy, she was terminated. In dismissing the plaintiff’s ADA claims, the court determined that it was “unnecessary to reach whether Plaintiff’s GID constitutes a physical impairment within the coverage of the ADA, or whether it would be excluded as transsexualism,” because the plaintiff had not alleged a substantial limitation in her ability to work.

5. Equal Employment Opportunity Commission Administrative Decisions

As explained in Section III.C.2.c. supra, in the discussion of the pre-ADA cases, subsequent to the 1990 passage of the ADA’s transsexualism exclusion the EEOC has issued just three published decisions relating to transsexualism as a disability—Campbell v. Espy213 in 1993 and two decisions in Bell v. Shalala214 in 1994. All three cases arose under the Rehabilitation Act, which, as discussed above, was amended effective October 29, 1992, to exclude transsexualism as a disability. In both cases, the EEOC dismissed the disability claims. The EEOC further held that Campbell failed to prove a “regarded as” claim of disability discrimination. The statutory exclusion was not applicable in Campbell because the alleged discrimination occurred before 1992. In contrast, the exclusion was applicable in Bell, where the alleged discrimination occurred after 1992. In the last of the three decisions, the EEOC did note that its ADA regulation’s definition of “disability” does not include transsexualism and that the Rehabilitation Act was amended in 1992 to incorporate ADA standards into the Act.

211 Id. at *1.
212 Id. at *5 & n.10. The court denied defendant’s motion to dismiss plaintiff’s other claims, including a claim under Title VII. Those other claims were ultimately dismissed after a summary judgment motion. Kastl v. Maricopa Cnty. Cmty. Coll. Dist., 2006 WL 2460636 (D. Ariz. Aug. 22, 2006), aff’d, 325 F. App’x 492 (9th Cir. 2009).
In all three decisions, the EEOC also expressed its views that Title VII does not protect transsexuals, a view it rejected in 2012 in *Macy v. Holder.*215 The EEOC may begin to look at GID disability claims more carefully in view of its revised interpretation of Title VII in *Macy,* the significantly lower burden for proving a disability under the ADA as a result of the ADAAA, the significantly evolved understanding of the etiology of gender dysphoria, and the arguments set forth in Section III.G. *infra.*

E. Gender Identity Disorders Resulting From Physical Impairments Are Protected by the Americans with Disabilities Act and the Rehabilitation Act

1. Introduction

The GIDs exclusion is limited to GIDs “not resulting from physical impairments.”216 Thus, if an employee’s GID results from a physical impairment, then the individual may be covered under the ADA. As explained in Section II.B.4.a. *supra,* a “physical impairment” is defined as “[a]ny physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine.”217

Lawyers and human resource professionals who have navigated the ADA, the Family and Medical Leave Act,218 and similar state laws generally know when a person has a disability or serious health condition, such as a leg amputation or the impaired ability to use an arm. Similarly, after witnessing a significant, negative change in mood for an extended period, and despite warnings from employment lawyers, they might guess that an employee is seriously depressed.

However, some medical conditions are not self-evident and are beyond our ability to visually recognize.219 For example, without the use of

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217 29 C.F.R. §1630.2(h)(1). “Physiological” means “of or relating to physiology” and “characteristic of or appropriate to an organism’s healthy or normal functioning”; “physiology” means “a branch of biology that deals with the functions and activities of life or of living matter (as organs, tissues, or cells) and of the physical and chemical phenomena involved” and “the organic processes and phenomena of an organism or any of its parts or of a particular bodily process,” *Merriam-Webster’s Collegiate Dictionary* 935 (11th ed. 2003).


an evaluative tool, such as a reading test or medical examination, we do not necessarily know if an individual has a visual impairment, or some other functional limitation, as opposed to a deficient education. This is the quandary when it comes to sex and gender identity. This section reviews the complexity that underlies the definitions of “sex,” “differences in sex development,” and “gender identity,” and shows that GIDs may have their etiology in physical impairments and thus should be treated as disabilities protected by the ADA and the Rehabilitation Act. Although the etiology of GIDs (including transsexualism) is not—and may never be—fully understood, what is evident is that GIDs are not sexual behavior disorders (see the discussion in Section III.G.2. infra), may arise as a result of a physiological condition, and can be resolved with nonpsychiatric treatments, such as hormones and surgery. As discussed in this section, there are a number of medical conditions that have unknown etiologies or that are thought to result from and/or be exacerbated by a combination of congenital, genetic, hormonal, neurological, and/or social-interaction factors, such as polycystic ovary syndrome, cerebral palsy, fibromyalgia, strabismus, dyslexia, stuttering, and Tourette syndrome (the latter two of which were once believe to simply be psychiatric conditions). The ADA and the Rehabilitation Act would protect each of these conditions. For the same reasons, as discussed below, these laws should also protect GIDs.

Before entering into that discussion, it is useful to note that some people have the preconceived, albeit mistaken, notion that GIDs (including transsexualism) must be purely mental conditions inasmuch as they are included in the American Psychiatric Association’s DSM. As explained in Section III.G.2.b. infra, GIDs were added to the DSM in 1980, in the DSM-III. Beginning with the DSM-III, the DSM became agnostic with respect to the biological or physical factors or processes underlying the disorders included in the DSM. Seven years later, the next edition of the manual—the DSM-III-R, which was the version relied on by Senators Armstrong and Helms during the debate on the ADA—made it clear that mental disorders may be related to biological or physical factors or processes. The next two iterations of the manual—the DSM-IV (1994) and the DSM-IV-TR (2000)—observed that “[a] compelling literature documents that there is much ‘physical’ in ‘mental’ disorders and much ‘mental’ in ‘physical’ disorders.”220 The American Psychiatric Association’s working group that revised the current edition of the manual—the DSM-5 (2013)—stated that it decided not to make any decision on whether “gender dysphoria” (the DSM’s new name for GIDs) is a psychiatric or a nonpsychiatric condition in view of gender dysphoria’s uniqueness as a psychiatric diagnosis that does not necessarily


cause emotional distress and is treated with nonpsychiatric modalities.\textsuperscript{221} As explained in Section III.G.2.b.viii. \textit{infra}, gender dysphoria remains as a diagnosis in the \textit{DSM-5} to ensure nonpsychiatric medical treatment and insurance coverage will remain available to anatomically dysphoric trans-gender individuals.

Medicine and the law have a history of demonizing people with conditions that are not readily understandable. In time, both have evolved in their views and belatedly recognized that some of these conditions are not reflective of deviant behavior or poor morals but are the result of a variety of nonpsychiatric conditions that simply are not fully understood. For example, the cause of the neurological condition Tourette syndrome is unknown, although theories suggest that it may be caused by genetics and/or brain abnormalities.\textsuperscript{222} This is in sharp contrast to the belief held until the early 1960s that the syndrome was “a rare, bizarre psychological disorder.”\textsuperscript{223} As a result of the stigma associated with Tourette syndrome, persons with this condition have faced “social ostracism” and “injustice” at the hands of the medical and legal communities.\textsuperscript{224} Individuals with a GID have suffered a similar fate, and only recently have the medical and legal communities begun to look at GIDs anew and better appreciate that GIDs (including transsexualism) are not the result of deviant behavior or bad morals.

\textsuperscript{221} The American Psychiatric Association has removed from public view the draft versions of the \textit{DSM-5} gender dysphoria diagnostic class and criteria, along with the extensive supporting rationales for the changes to the \textit{DSM}, that had appeared at www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?id=482. As of December 2013, that web page was still accessible via the Wayback Machine at http://archive.org/web/web.php. Accord Jack Drescher, \textit{Controversies in Gender Diagnoses}, 1 LGBT HEALTH 1, 3 (2013), available at http://online.liebertpub.com/doi/pdf/10.1089/lgbt.2013.1500 (noting that gender incongruence is a “unique medical condition”); Heino F.L. Meyer-Bahlburg, \textit{From Mental Disorder to Iatrogenic Hypogonadism: Dilemmas in Conceptualizing Gender Identity Variants as Psychiatric Conditions}, 39 ARCHIVES SEXUAL BEHAV. 461, 469, 471 (2010), available at http://dx.doi.org/10.1007/s10508-009-9532-4 (nothing that GID is a “unique” psychiatric condition, “in that it is based on an incongruence between the assigned gender (usually based on the genital appearance) and the experienced gender, and the most successful intervention to date for adults in terms of patient satisfaction appears to be hormonal and surgical body modification.”); see also National Association of Social Workers, Statement on Gender Identity Disorder and the \textit{DSM} (May 18, 2010), available at www.socialworkers.org/diversity/new/lgbtq/51810.asp (GID and gender dysphoria “should be viewed and approached from the perspective of a medical model rather than that of a mental health model…. More appropriate is a medical diagnosis and support for mental health and life coping issues related to the diagnosis.”).


2. **Defining “Sex”**

As discussed elsewhere in this treatise, early case law under Title VII was adverse to gender-affirmed individuals because judges could not get past the idea that sex is black and white, with no shades of gray.225 Crudely summarized, if you have a penis, you are a boy; if you have a vagina, you are a girl. The way the obstetrician labeled you at birth, based on a cursory visual examination, shackled you with that sex designation for life.

However, sex is not one-dimensional, or even three-dimensional, and the courts are beginning to recognize this, although some judges had reached this conclusion earlier, only to be reversed on appeal. For example, in 1983, in *Ulane v. Eastern Airlines,*226 a Title VII case, Judge John Grady observed that

> [before] my participation in this case, I would have had no doubt that the question of sex was a very straightforward matter of whether you are male or female. That there could be any doubt about that question had simply never occurred to me. I had never been exposed to the arguments or to the problem. After listening to the evidence in this case, it is clear to me that there is no settled definition in the medical community as to what we mean by sex.227

He noted testimony that a person’s gender identity (sometimes referred to as “sexual identity”—that is, an individual’s psychological sense of self “in terms of maleness or femaleness”—is part of the definition of sex.228 He saw this as similar to how people self-identify their “race” and a federal law designed to address race discrimination (42 U.S.C. §1981) has been interpreted to protect Hispanics: “[Another judge has] pointed out that many Hispanics are white in the same sense that non-Hispanics are white, and yet they perceive themselves to be of a different race, and they are perceived by some others as being of a different race.”229 Although Judge Grady did not

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225 See Chapter 14 (Title VII of the Civil Rights Act of 1964), Section IV.B.1., and Chapter 39 (Law and Culture in the Making of Macy v. Holder).
227 *Ulane,* 581 F. Supp. at 823.
228 *Id.*
229 *Id.* at 823–24. See Bennun v. Rutgers State Univ., 941 F.2d 154, 172–73, 56 FEP 746, 56 FEP 1066 (3d Cir. 1991), *cert. denied,* 502 U.S. 1066 (1992) (in a Title VII race discrimination case, the court held that a person’s race is composed of an amalgam of culture, language, speech, appearance, mannerism, and way of life); see generally Employment Discrimination Law ch. 7 (Section 1981), §II.C. (discussing cases extending the definition of race in Section 1981 of the Civil Rights Act of 1866, 42 U.S.C. §1981, to include aspects of a person’s ancestry and ethnicity); U.S. Equal Employment Opportunity Commission, Questions and Answers About Race and Color Discrimination in Employment (2006), available at www.eeoc.gov/policy/docs/qanda_race_color.html (“Race discrimination includes discrimination on the basis of ancestry or physical or cultural characteristics associated with a certain race, such as skin color, hair texture or styles, or certain facial features.”). As Professor L. Camille Hébert has observed:

In *Perkins v. Lake County Department of Utilities,* [860 F. Supp. 1262 (N.D. Ohio 1994)], the . . . district court, in refusing to grant the employer’s motion for summary judgment, noted “that the issue of membership in a given racial classification is deceptively
mention it, under Title VII, “color” is a spectrum, such that color discrimination claims can be asserted, for example, based on differences in skin tone among individuals from the same race or ancestry.\footnote{See generally EMPLOYMENT DISCRIMINATION LAW ch. 6 (Discrimination Based on Color), §1.; U.S. Equal Employment Opportunity Commission, Questions and Answers About Race and Color Discrimination in Employment (2006), available at www.eeoc.gov/policy/docs/qanda_race_color.html (“Color discrimination occurs when a person is discriminated against based on his/her skin pigmentation (lightness or darkness of the skin), complexion, shade, or tone. Color discrimination can occur between persons of different races or ethnicities, or even between persons of the same race or ethnicity. For example, an African American employer violates Title VII if he refuses to hire other African Americans whose skin is either darker or lighter than his own.”).} In other words, both “color” and “race,” neither of which is defined in Title VII, are given broad, not narrow, readings.

Judge Grady saw no reason not to give “sex,” also undefined in Title VII, a similarly broad reading, because the discussion regarding race “is illustrative of the fact that the things we think we know we do not necessarily know and that people sometimes react to other people according to stereotypes, misperceptions, and other motivations which are arguably discriminatory and are arguably redressable under statutes which might not be thought ordinarily to apply to those situations.”\footnote{Ulance v. Eastern Airlines, Inc., 581 F. Supp. 821, 824, 35 FEP 1332 (N.D. Ill. 1983). \textit{Cf.} Oncale v. Sundowner Offshore Servs., Inc., 523 U.S. 75, 79, 76 FEP 221 (1998) (“As some courts have observed, male-on-male sexual harassment in the workplace was assuredly not the principal evil Congress was concerned with when it enacted Title VII. But statutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed.”); Price Waterhouse v. Hopkins, 490 U.S. 228, 251, 49 FEP 954 (1989) (in holding that sex stereotyping violates Title VII, the Supreme Court observed, “Congress intended to strike at the entire spectrum of disparate treatment of men and women” (internal quotation marks omitted)).} Accordingly, he ruled that, for purposes of Title VII, “sex” includes, among other things, a person’s chromosomes and gender identity and, therefore, Title VII protects transsexuals.\footnote{Ulance, 581 F. Supp. at 825.} The Seventh Circuit Court of Appeals reversed.\footnote{\textit{Ulance} v. Eastern Airlines, Inc., 742 F.2d 1081, 35 FEP 1348 (7th Cir. 1984), \textit{cert. denied}, 471 U.S. 1017, 37 FEP 784 (1985).} In contrast to Judge Grady, the Seventh Circuit held that “sex,” as used in Title VII, should be narrowly read to mean only the “traditional concept” of sex, and that it was up to Congress, not the courts, to decide whether “sex” included “the untraditional and unusual.”\footnote{\textit{Ulance} v. Eastern Airlines, Inc., 742 F.2d at 1084--86.}
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Judge Grady’s approach has been validated by the medical profession. As noted in a 2008 medical treatise,

we [have] come to realize that an endpoint as seemingly simple as our sex … represents a continuum consisting of many dimensions: the biological, the psychological, the social, and the cultural. What most of us have taken for granted has, perhaps, not been as simple and risk-free a journey as we might have assumed. Indeed, as you read the chapters on genetic sexual development and disorders of sex development, you may think at least twice about the essence of maleness and femaleness.235

Today, “sex” is understood as a mosaic of characteristics that come together to define our sex. These elements include the following:

- **Chromosomal sex**: determined by the presence or absence of the Y chromosome. Although XX is the “norm” for women and XY is the “norm” for men, there are many other combinations that individuals may have, such as XXX, XXY, XYY, YYY, and XO.
- **Genetic sex**: determined by the presence or absence of certain genes, such as the SRY gene on the Y chromosome.
- **Gonadal sex**: determined by the presence of ovaries or testes. Some people have a combination of female and male gonads (ovetestes) or one ovary and one testis.
- **Hormonal sex**: determined by the levels of androgens and estrogens, while in utero and thereafter. Some people’s bodies do not respond, or respond only partially, to the hormones in their bodies. For example, an individual may produce testosterone, but it has no masculinizing effect on the body. In contrast, higher prenatal exposure to and higher circulating levels of testosterone in women have been shown to reduce a woman’s aversion to risk.236 Women have a significantly higher increase in testosterone production than men in relation to athletic competition.237 Pursuant to regulations issued

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235David L. Rowland & Luca Incrocci, Handbook of Sexual and Gender Identity Disorders 327 (2008). See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 14, 451–53, 458, 814 (5th ed. 2013) (the DSM-5 notes that gender-variant behavior and living outside the binary of male/female is not pathological and replaces the diagnosis phraseology “the other sex” with “the other gender” or “some alternative gender,” thereby reflecting that gender is not binary); Peggy T. Cohen-Kettenis & Friedemann Pfäfflin, The DSM Diagnostic Criteria for Gender Identity Disorder in Adolescents and Adults, 39 Archives Sexual Behav. 499, 502 (2010), available at http://dx.doi.org/10.1007/s10508-009-9562-y (noting that some individuals consider their gender identities not as male or female, but as, e.g., “‘bigender/two-spirit,’ ‘third gender,’ ‘genderless,’ ‘gender neutral,’ ‘pan-/poly-/or omnigendered,’ ‘gender fluid,’ [and] ‘intergendered.’”).


237William D. Harnish, Hormones Are Important in Female Athletic Competition, Penn State Press Release (Nov. 13, 2002), available at www.psu.edu/ur/2002/femalestestosterone.html (“The pre-event rise in males averages 9 percent whereas in females it increases by 24 percent. During the game itself women increase their testosterone production by 49 percent while in males, it increases on average 15 percent. The rise in testosterone that accompanies competition is thought to make the individual more willing to take risks, improves psychomotor function
by the International Olympic Committee just one month before the 2012 Summer Olympics, women who produce excess androgens risked disqualification from participation as female athletes, whereas men who produced excess testosterone were not at risk for being disqualified from participation as male athletes.238

- **Internal phenotypic sex**: determined by the internal reproductive organs (which are sometimes also referred to as the internal genitalia). Some individuals may have incomplete organs, may be missing an organ, or may have a combination of male and female organs.

- **External phenotypic sex**: determined by the external genitalia, such as the clitoris/labia or penis/scrotum. These indicators can be ambiguous.

- **Secondary phenotypic sex**: determined by physical body shape, breast development, and body and facial hair. Some men may have gynecomastia (excessive growth of breast tissue) and some women may have hirsutism (excessive body or facial hair growth).

- **Hypothalamic sex**: determined by the sex of the brain, which is impacted by exposure to hormones and other chemicals in utero.

- **Gender or sexual identity**: determined by a person’s innate, deeply felt psychological identification as a man, woman, or something else, which is the “complex result of all genetic, hormonal, and environmental factors.”239 Some individuals have gender identities that do not correspond to the sex assigned to them at birth. Similarly, “[a]ll credible study of sexual orientation establishes that genetic, hereditary and biological influences are major factors in determining sexual orientation.”240

- **Gender expression**: determined by the external manifestation of a person’s gender identity.

- **Assigned sex, gender of rearing, and cultural and social gender roles**: determined by the obstetrician at birth and by whether/how a child is raised as a boy or a girl.241


Despite the multifaceted nature of a person’s sex, the designation of a baby’s sex is normally based solely on a cursory visual examination of external genitalia. However, as Julie Greenberg—a professor at the Thomas Jefferson School of Law, a leading legal scholar on intersexuality and the law, and the author of Chapter 46 (Interacting in the Workplace With Individuals Who Have an Intersex Condition) on that topic—explains, in some cases the initial designation of a baby’s sex may be based on social factors, not solely the anatomy the baby was born with:

If the genitalia appear ambiguous, sex is assigned in part based on sex-role stereotypes. The presence of an “adequate” penis in an XY infant leads to the label male, while the absence of an adequate penis leads to the label female. A genetic male with an “inadequate” penis (one that is incapable of penetrating a female’s vagina) is “turned into” a female even if it means destroying his reproductive capacity. A genetic female who may be capable of reproducing, however, is generally assigned the female sex to preserve her reproductive capability regardless of the appearance of her external genitalia. If her “phallus” is considered to be “too large” to meet the guidelines for a typical clitoris, it is surgically reduced even if it means that her capacity for satisfactory sex may be reduced or destroyed. In other words, men are defined based upon their ability to penetrate females and females are defined based upon their ability to procreate. Sex, therefore, can be viewed as a social construct rather than a biological fact.242

Over time, the healthcare community has come to repudiate a number of medical and psychological interventions that were used to “fix” babies with disorders or differences in sex development (DSDs), in recognition of the enormous damage such interventions have caused.\textsuperscript{243}

The binary conception of sex is partially premised on the mistaken belief that all embryos will follow one of two forks in the road of embryonic development, one path for men and another for women. The reality is that there is not just one fork, but several forks, and not all embryos will make the “right” combination of turns that are needed to yield the normative man or woman, with all the male or female characteristics in normative harmony. A good number of embryos will take unexpected detours along the way.\textsuperscript{244}

Judge James Robertson, in the first of his several opinions in the landmark case \textit{Schroer v. Billington},\textsuperscript{245} commented on the multifaceted nature of sex and the foresight of Judge Grady 22 years earlier:

[I]t may be time to revisit Judge Grady’s conclusion in \cite{Ulane} that discrimination against transsexuals because they are transsexuals is “literally” discrimination “because of . . . sex.” That approach strikes me as a straightforward way to deal with the factual complexities that underlie human sexual identity. These complexities stem from real variations in how the different components of biological sexuality—chromosomal, gonadal, hormonal, and neurological—interact with each other, and in turn, with social, psychological, and legal conceptions of gender.

While the biological components of sex align together in the vast majority of cases, producing a harmony between outward appearance, internal sexual identity, and legal sex, variations of this pattern that lead to intersexed individuals are real, and cannot be ignored. For example, androgen insensitivity syndrome [(AIS)] appears in approximately 1 out of every 20,000 genetic males. Complete AIS can produce an individual with “male” (XY)
Chromosomes and testes, but whose body does not respond to the virilizing hormones the testes produce. As a result, these individuals typically have a female sexual identity, appear feminine, and have female external genitalia, but lack female reproductive organs. Discrimination against such women (defined in terms of their sexual identity) because they have testes and XY chromosomes, or against any other person because of an intersexed condition, cannot be anything other than “literal[]” discrimination “because of . . . sex.” If, as some believe, sexual identity is produced in significant part by hormonal influences on the developing brain in utero, this would place transsexuals on a continuum with other intersexed conditions such as AIS, in which the various components that produce sexual identity and anatomical sex do not align.

... Twenty-plus years after [Ulane], scientific observation may well confirm Judge Grady’s conclusion that “sex is not a cut-and-dried matter of chromosomes.”246

In his subsequent opinion after trial, Judge Robertson set forth the competing views regarding whether gender identity is part of an individual’s sex. The employer’s expert, Dr. Chester Schmidt, said “no,” opining that gender identity is part of a person’s sexuality.247 In contrast, the plaintiff employee’s expert, Dr. Walter Bockting, testified that “it has long been accepted in the relevant scientific community that there are nine factors that constitute a person’s sex”—chromosomal sex, external morphological sex, internal morphological sex, gonads, fetal hormonal sex, hypothalamic sex, pubertal hormonal sex, gender identity, and sex of assignment and rearing. 248 Judge Robertson ultimately determined that he did not have to resolve the dispute between the two testifying experts to decide the case.249 Thereafter, several courts have resoundingly rejected Dr. Schmidt’s opinions, including in cases involving GIDs.250 Instead, many tribunals, before and after Schroer, have

246 Schroer I, 424 F. Supp. 2d at 212–13 & n.5 (citations omitted; formatting modified by incorporating footnote into text).


249 Id. at 306.

250 See Kosilek v. Spencer, 889 F. Supp. 2d 190, 236 (D. Mass. 2012), aff’d, 740 F.3d 733 (1st Cir. 2013), rehe’g en banc granted and majority and dissenting appellate opinions withdrawn by Order of Court, No. 12-2194 (1st Cir. Feb. 12, 2014) (setting hearing en banc for May 8, 2014) (“[T]he court finds that Dr. Schmidt is not a prudent professional. His approach is not within the range of treatment that a prudent professional would prescribe [for GID], and the treatment he recommends is not adequate to treat [plaintiff’s] serious medical need.”); O’Donnabhain v. Commissioner of Internal Revenue, 134 T.C. No. 4, at 54, 66, 2010 WL 364206, Tax Ct. Rep. (CCH) 58,122 (2010), available at www.ustaxcourt.gov/InOpHistoric/ODonnabhain.TC.WPD.pdf (Tax Court found Dr. Schmidt’s views relating to GID unpersuasive, idiosyncratic, and not widely accepted in the medical community). The Kosilek court observed that Dr. Schmidt’s current work focuses on medical billing procedures rather than the treatment of GIDs. Kosilek, 889 F. Supp. 2d at 202. In a criminal case involving medical billing practices, the court determined that Dr. Schmidt’s testimony “lacks credibility.” United
concluded, consistent with Dr. Bockting’s opinion and the medical discussion above, that “sex” is composed of a multitude of factors.\textsuperscript{251}

\begin{footnotesize}
\textsuperscript{251}See Macy v. Holder, 2012 WL 1435995, at *5–10 (EEOC Apr. 20, 2012) (for purposes of Title VII, “sex” includes biological sex and gender, which includes gender identity and “cultural and social aspects associated with masculinity and femininity”); Millett v. Lutco, Inc., 2001 WL 1602800, at *4, 23 Mass. Discr. L. Rep. 231 (Comm’n Ag. Discr. Oct. 10, 2001) (in a sex discrimination case under Massachusetts’ fair employment practices law, the Massachusetts Commission Against Discrimination quoted Kristine W. Holt, \textit{Reevaluating Holloway: Title VII, Equal Protection, and the Evolution of a Transgender Jurisprudence}, 70 TEMP. L. REV. 283, 301 (1997): “‘By definition, the transgendered person literally embodies a plethora of sexual stereotypes that are contrary to her birth sex. The sex of the transgendered person is only partially based upon her genitals; the rest is a sometimes strange admixture of complementary and competing anatomical secondary physical characteristics, behaviors, life histories, psychological presumptions, and stereotypes. Nevertheless, the combination of these factors is what comprises the transgendered person’s “sex”—not always “either/or,” but often “both.” . . . The day when the sexes were rigidly defined by stereotypical behaviors and anatomies is gone.’”); \textit{In re Estate of Araguz}, ___ S.W.3d ___, 2014 WL 576085, at *4 n.10, *10–12 (Tex. Ct. App. Feb. 13, 2014) (in a case involving whether a gender-affirmed female was of the sex opposite that of the her deceased spouse, so as not to violate Texas’ prohibition against same-sex marriage, the court held that there was a genuine issue of material fact regarding her sex and that she had presented sufficient evidence to support a reasonable conclusion that an individual can complete a “sex change” without having surgery; the court quoted the report from the living spouse’s medical expert that ‘“sexuality per se is a complex phenomenon which involves a number of underlying factors’ . . . that ‘should be taken into account when identifying someone as male or female[,]’ ‘includ[ing] chromosomes, hormones, sexual anatomy, gender identity, sexual orientation, and sexual expression.’ . . . ‘Surgery per se is not the definitive point that makes someone female. Rather, it is completion of the real life experience which documents . . . [that] she had this condition at birth, recognized such as she grew up, and took the steps to resolve this issue. And, she pursued the transition in accordance with The Standards of Care of the World Professional Association for Transgender Health; I regard her medically and psychologically as female [regardless of whether she has surgery].’” (footnote omitted)); M.T. v. J.T., 355 A.2d 204, 206–09 (N.J. Super. Ct. App. Div.), \textit{certification denied}, 364 A.2d 1076 (N.J. 1976) (in a case upholding the right under New Jersey law of a gender-affirmed woman to marry a man, the court affirmed the trial court’s finding that there are at least seven factors relevant to the determination of “sex,” including gender or psychological sex, and noted the expert testimony that transsexualism is probably caused by a combination of neurological, chromosomal and environmental factors); Enriquez v. West Jersey Health Sys., 777 A.2d 365, 373, 386 FEP 197, 11 AD 1810 (N.J. Super. Ct. App. Div.), \textit{certification denied}, 785 A.2d 439 (N.J. 2001) (adopting the reasoning of \textit{M. T. v. J. T.} in a disability and sex discrimination case under New Jersey’s Law Against Discrimination and holding that “sex” includes a person’s gender identity and is broader than anatomical sex); Rentos v. Oce-Office Sys., 1996 WL 737215, at *6, 72 FEP 1717 (S.D.N.Y. 1996) (in permitting a sex discrimination case under both the New York and the New York City Human Rights Laws to proceed, the court listed “the multitude of factors that the medical community has deemed to be relevant in identifying an individual’s gender: sex chromosomes (XX configuration for females, XY for males); gonads (ovaries or testes); sex hormones (estrogen or androgen predominance); internal reproductive organs (uterus or sperm ducts); external genitalia (clitoris and labia or penis and scrotum); secondary sex characteristics (presence of breasts, body hair distribution, etc.); and psychological sex (also known as gender identity).”); \textit{In re Lovo-Lara}, 23 I. & N. Dec. 746, 751 (B.I.A. May 18, 2005) (“According to medical experts, there are actually eight criteria that are typically used to determine an individual’s sex. They are as follows: 1. Genetic or chromosomal sex—XX or XY; 2. Gonadal sex—testes or ovaries; 3. Internal morphologic sex—semenal vesicles/
prostate or vagina/uterus/fallopian tubes; 4. External morphologic sex—penis/scrotum or clitoris/labia; 5. Hormonal sex—androgens or estrogens; 6. Phenotypic sex (secondary sexual features)—facial and chest hair or breasts; 7. Assigned sex and gender of rearing; and 8. Sexual identity.”; *In re* Heilig, 816 A.2d 68, 73, 77, 78 (Md. 2003) (in holding that the courts have jurisdiction to order a change of gender on a birth certificate, the court observed that “[t]here is a recognized medical viewpoint that gender is not determined by any single criterion, but that . . . seven factors may be relevant,” citing the same seven factors as in *Rentos*; that the recent “studies imply that transsexualism may be more similar to other physiological conditions of sexual ambiguity, such as androgen insensitivity syndrome, than to purely psychological disorders”; and that “[b]ecause transsexualism is universally recognized as inherent, rather than chosen, psychotherapy will never succeed in ‘curing’ the patient.”); *Doe* v. Miscellaneous Drivers & Helpers Union Local No. 638 Health, Welfare, Eye & Dental Fund, 867 F. Supp. 2d 1023, 1032, 114 FEP 1126, 53 EB 1155 (D. Minn. 2012) (in an Employee Retirement Income Security Act case applying Minnesota law, the court “reject[ed] the [defendant’s] reliance on decades-old Title VII cases for the proposition that ‘sex’ is narrowly defined as an immutable biological determination at birth. . . . An individual’s sex includes many components, including chromosomal, anatomical, hormonal, and reproductive elements, some of which could be ambiguous or in conflict within an individual.”); Smith v. City of Jacksonville Corr. Inst., 1991 WL 833882, at ¶65 (Fla. Div. Admin. Hrgs. Oct. 2, 1991), aff’d in part, rev’d in part on other grounds, FCHR Order No. 92-023 (Fla. Comm’n Hum. Rel. June 10, 1992), available at www.doah.state.fl.us/ROS/1988/88005451%20ATAFO.PDF (in finding disability discrimination under the Florida Human Rights Act, the hearing officer observed that the “majority of people in this world are of the opinion that humankind is divided into males and females. That viewpoint is incorrect. Put simply, there is a certain percentage of humankind [(individuals with a DSD or gender dysphoria)] that [is] a mixture of male and female characteristics.”); National Legal Servs. Auth. v. Union of India, Writ Petition (Civil) No. 400 of 2012, slip op. at ¶59 (India Sup. Ct. Apr. 15, 2014), available at http://supremecourtofindia.nic.in/outtoday/wc40012.pdf (in recognizing that transgender individuals have a constitutional right to self-identify and present as female, male, or a “third gender,” the India Supreme Court held as follows: “Both gender and biological attributes constitute distinct components of sex. Biological characteristics, of course, include genitals, chromosomes and secondary sexual features, but gender attributes include one’s self image, the deep psychological or emotional sense of sexual identity and character. The discrimination on the ground of ‘sex’ under Articles 15 and 16 [of the Constitution of India], therefore, includes discrimination on the ground of gender identity. The expression ‘sex’ used in Articles 15 and 16 is not just limited to biological sex of male or female, but intended to include people who consider themselves to be neither male or female.”); New S. Wales Registrar of Births, Deaths & Marriages v. Norrie, No. S273/2013, [2014] HCA 11, slip op. at ¶¶35, 37 (Austl. High Ct. Apr. 2, 2014), available at www.austlii.edu.au/cgi-bin/download.cgi/cgi-bin/download.au/cases/cth/HCA/2014/11.rtf (the Australia High Court held that the New South Wales Registrar of Births, Deaths and Marriages should have recorded respondent’s sex as “non-specific” given that respondent submitted evidence that her sex was ambiguous and the fact that “not everyone is male or female;” that is, “‘the sex of a person is not . . . in every case unequivocally male or female.’”); Richards v. U.S. Tennis Ass’n, 400 N.Y.S.2d 267, 272 (Sup. Ct. 1977) (in a disability and sex discrimination case under New York’s Human Rights Law, the court accepted the opinion of the expert who testified on behalf of Renée Richards that she was a woman, regardless of her chromosomes, because “Dr. Richards is a female, i.e., external genitalia and somatic characteristics are that of a female; her internal sex is that of a female who has been hysterectomized and ovarioctomized; Dr. Richards is psychologically a woman; endocrinologically female; somatically (muscular tone, height, weight, breasts, physique) Dr. Richards is female and her muscular and fat composition has been transformed to that of a female; socially Dr. Richards is female; Dr. Richards’ gonadal status is that of an ovarioctomized female.’”); Kosilek v. Maloney, 221 F. Supp. 2d 156, 163 (D. Mass. 2002) (in a case involving medical treatment for a prisoner with a GID, the court noted that “[t]he consensus of medical professionals is that transsexualism is biological and innate. It is not a freely chosen ‘sexual preference’ or produced by an individual’s life experience.”); Doe v. Regional Sch. Unit 26, 86 A.3d 600, 2014 ME 11, 2014 WL 325906 (Me. 2014), rev’g sub nom. Doe v. Clenchy, No. CV-09-201 (Me. Super. Ct. Nov. 20, 2012) (in reversing trial court ruling that that “sex” was limited to “biological sex” and that a grammar school child who was born male was not entitled to used the sex-segregated restroom that corresponded to her female gender identity, the Maine Supreme Judicial Court held that the child was entitled to used the girls’ restroom.
Perhaps the greatest irony in this discussion is that the “traditional,” at-birth indicator of sex—does the newborn have a clitoris or penis?—may well be the least important indicator, whereas gender identity may be the most important. As Dr. Milton Diamond, a leading expert on the development of both DSDs and gender dysphoria and now retired professor of anatomy and reproductive biology at the John A. Burns School of Medicine at the University of Hawai‘i, has noted:

The insignificance of the penis in fostering a feeling of masculinity is probably most strongly indicated by female-to-male ... transsexuals. Female individuals born with XX chromosomes, ovaries and a vagina, and no obvious male physical characteristics, nevertheless, see themselves as males and undergo psychiatric counseling, hormonal treatment and surgery to foster a male

based on her gender identity); Davidson v. Aetna Life & Cas. Ins. Co., 420 N.Y.S.2d 450 (Sup. Ct. 1979) (in holding that sex reassignment surgery is not cosmetic, the court accepted the medical testimony that ‘’Transsexualism used to be attributed entirely to psychological disturbance. More current theories suggest that an inconsistency in the so-called psychosexual brain center causes gender to be perceived as opposite to the morphology of the sexual apparatus. These theories postulate a brain center that is a dimorphic structure and passes through periods of differentiation analogous to those of the genitalia. In transsexualism, there is a flip-over; the result is differentiation of the psychosexual center opposite to that of the genital apparatus and sex chromosomes.’’); Doe v. McConn, 489 F. Supp. 76, 78 (S.D. Tex. 1980) (in holding that a Houston ordinance that makes it unlawful for a person to appear in public ‘’with the designed intent to disguise his or her true sex as that of the opposite sex’’ is unconstitutional as applied to individuals undergoing treatment for a GID, the court found that ‘’most, if not all, specialists in gender identity are agreed that the transsexual condition establishes itself very early, before the child is capable of elective choice in the matter, probably in the first two years of life; some say even earlier, before birth during the fetal period. These findings indicate that the transsexual has not made a choice to be as he is, but rather that the choice has been made for him through many causes preceding and beyond his control. Consequently, it has been found that attempts to treat the true adult transsexual psychotherapeutically have consistently met with failure.’’); Mathis v. Fountain-Fort Carson Sch. Dist. 8, No. P20130034X, at 6 ( Colo. Div. Civ. Rts. June 17, 2013), available at www.transgenderlegal.org/media/uploads/doc_529.pdf (medical ‘’research demonstrates that sex assignments given at birth do not accurately reflect the sex of a child’’); O’Donnabhain v. Commissioner of Internal Revenue, 134 T.C. No. 4, 2010 WL 364206, at *21 & n.49, Tax Ct. Rep. (CCH) 58,122 (2010), available at www.ustaxcourt.gov/InOpHistoric/ODonnabhain.TC.WPD.pdf (in holding that hormone therapy and sex reassignment surgery are not cosmetic surgery for purposes of the Internal Revenue Code, the Tax Court noted that the highest courts in two states and the Seventh Circuit Court of Appeals agree that ‘’in the case of severe GID, sex reassignment surgery is the only known effective treatment,’’ and, quoting Judge Posner, in Maggett v. Hanks, 131 F.3d 670, 671 (7th Cir. 1997), added, ‘’The cure for the male transsexual consists not of psychiatric treatment designed to make the patient content with his biological sexual identity—that doesn’t work—but of estrogen therapy’’ and genital reconstructive surgery); U.S. Steel LLC, 116 LA 861 (Petersen, 2001) (rejecting employer’s argument that employee’s medically necessary, gender-affirming surgery was elective, cosmetic surgery and thus not covered under employer’s sickness and accident benefit plan); Fields v. Smith, 653 F.3d 550, 556 (7th Cir. 2011), cert. denied, 566 U.S. ___, 132 S. Ct. 1810 (2012) (in striking down a Wisconsin statute that prohibited prisons from providing transgender inmates with hormone therapy or sex reassignment surgery, the court compared the denial of such medically necessary treatment to the treatment of cancer without medically necessary surgery); Kosilek v. Spencer, 889 F. Supp. 2d 190, 197, 232 (D. Mass. 2012), aff’d, 740 F.3d 733 (1st Cir. 2013), reh’g en banc granted and majority and dissenting appellate opinions withdrawn by Order of Court, No. 12-2194 (1st Cir. Feb. 12, 2014) (setting hearing en banc for May 8, 2014) (noting that sex reassignment surgery is not cosmetic).
appearance and life. While they aspire to masculinity and typically undergo surgical breast and uterus removal and other reconstructive surgeries, it is estimated that in about half of such cases phalloplasty is not pursued. For these persons satisfying their brain’s dictates to live and interact as a man in society as such is more important than satisfying some of society’s myths that a phallus is needed to document masculinity. In contrast, male-to-female transsexuals, despite having a penis, feel a negative or no attachment to a penis and do not see it as part of their identity. It is not the presence or absence of a penis but the sex of the brain—how it has developed—that determines how one comes to identify as male or female and how one wants to live.252

This conclusion carries over to the employment setting, where “[d]iscrimination stems from a reliance on immaterial outward appearances that stereotype an individual with imagined, usually undesirable, characteristics thought to be common to members of the group that shares these superficial traits. It results in a stubborn refusal to judge a person on his [or her] merits as a human being.”253 As L. Camille Hébert, a professor at the Moritz College of Law at The Ohio State University, has observed,

Although biological sex might be thought to be determined by chromosomes, internal sex organs, and external genitals, employers do not commonly engage in discrimination on the basis of these characteristics. Employers do not generally require tests of or have access to information about chromosomes before making employment decisions. Nor do employers conduct examinations of internal or external genitalia before engaging in sex discrimination. Instead, employers make assumptions and decisions about sex based on an employee’s gender presentation or, perhaps, secondary sex characteristics.254

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This reasoning also applies to competition sports involving elite athletes, where athletes who are perceived as not feminine enough are subjected to “whisper campaigns” that may lead to invasive and humiliating gender testing.\textsuperscript{255}

Additional support for a broad definition of sex comes from dictionaries, which also offer evidence that “sex” is not just black and white. The leading dictionaries in print at the time of the enactment of the Civil Rights Act of 1964 consistently defined sex along the lines of including “not only ‘one of the two divisions of organic esp. human beings respectively designated male or female’—which arguably means biological sex—but also ‘the sum of the morphological, physiological, and behavioral peculiarities of living beings that subserves biparental reproduction’—which would seem to include aspects of sex that are not strictly biological, including behavioral aspects of sex,” such as gender identity.\textsuperscript{256} Indeed, even Title VII goes beyond external genitalia, in that discrimination based on “sex” is statutorily defined to include discrimination based on “pregnancy, childbirth, or related medical conditions.”\textsuperscript{257}

As discussed in Section III.C.3.a. supra, one of Senator Armstrong’s concerns regarding the inclusion of the mental conditions that he wanted to exclude from the ADA—such as GIDs (including transsexualism)—was that the definition of “disability” was very broad and vague, in contrast to the categories of people protected by Title VII:


\textsuperscript{257} 42 U.S.C. §2000e(k).
We have said that it is and shall be against the law for a person to discriminate in employment, promotion, public accommodation, and so on because of race, religion, and sex.

These are easily discernible factual situations. A person is or is not a man or a woman. A person is or is not a Catholic, a Jew, a Mormon, whatever, a Baptist, a Presbyterian. That is something we can readily determine. A person either is or is not Irish, Italian, and so on.258

As the discussion in this subsection has shown, concepts such as color, race, and sex are not cut-and-dried. Each is a continuum and needs to be understood as such.

People pick their religions and can change their faiths if they are moved to do so. Discrimination against people because they changed their religions would be protected by Title VII.259 In contrast, as the medical discussion in this chapter clearly demonstrates, gender identity is not something that can be changed on a whim or even with concerted effort. Today, accepted medical practice is not to try to change the mind, but to adjust a hormonal imbalance and/or the anatomy. If Senator Armstrong is willing to accept individuals’ affirmations of their religion at face value, and because we allow employees to self-identify their race for employment purposes, then we should similarly accept personal affirmations of one’s sex or gender.

In the near future, more courts will need to address, and accept, the fact that sex is not a binary concept. As the Colorado Division of Civil Rights noted in 2013, “[g]iven the evolving research into the development of transgender persons, compartmentalizing a child as a boy or a girl solely based on their visible anatomy, is a simplistic approach to a difficult and complex issue.”260 The evolving medical understanding of the mosaic, non-binary nature of sex,261 coupled with the social reality that gender diversity/nonconformity is here to stay,262 likely will require courts eventually to

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259 Schroer III, 577 F. Supp. 2d 293, 306, 104 FEP 628 (D.D.C. 2008) (in holding that discriminating against an employee going through a gender affirmation is discrimination based on sex, the court explained the following: “Imagine that an employee is fired because she converts from Christianity to Judaism. Imagine too that her employer testifies that he harbors no bias toward either Christians or Jews but only ‘converts.’ That would be a clear case of discrimination ‘because of religion.’ No court would take seriously the notion that ‘converts’ are not covered by the statute. Discrimination ‘because of religion’ easily encompasses discrimination because of a change of religion.”); Macy v. Holder, 2012 WL 1435995, at *11 (EEOC Apr. 20, 2012) (EEOC agreed with the reasoning in Schroer III; cf. Millett v. Lutco, Inc., 2001 WL 1602800, at *5, 23 Mass. Discr. L. Rep. 231 (Comm’n Ag. Discr. Oct. 10, 2001) (in holding that discriminating against a transsexual is discrimination based on sex in violation of Massachusetts’ fair employment practices law, the Massachusetts Commission Against Discrimination noted that “if an individual who had changed religion, and as a result was subjected to disparate treatment filed a complaint with this commission, it would not be an appropriate defense to claim that the employee was subjected to the treatment because of the change in religion, as opposed to the membership in the new religion.”).
261 See also Section III.G.2.b.viii. infra.
262 See Chapter 2 (The Transformative Power of Words), Section IV., and Chapters 43 (Portraits of Gender in Today’s Workplace) and 44 (A Millennial Moment: Understanding Twenty-First Century LGBT Workers and Their Allies).
hold that discrimination because of sex is not merely discrimination against females when compared to males, or vice versa, but rather discrimination against one representation of gender as compared to other representations of gender on a gender continuum. As will be discussed in the next subsection, there is a growing understanding and acceptance of some individuals being neither male nor female, sometimes referred to as a third sex. Beyond that,

[a]s a generation of transsexual, transgender, and gender nonconforming individuals has come of age[,] . . . they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex). Other individuals affirm their unique gender identity and no longer consider themselves either male or female. Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender.263

When the ability to medically transform one’s physical body to better match one’s gender identity became a medical possibility for some people, the medical profession generally focused on ensuring that a transitioning person could fully assimilate into the gender role and expression corresponding to either a normative female or a normative male. As knowledge about the meaning of gender and sex has evolved, the treatment goals have also evolved:

Such “invisibility” . . . is not currently a desired outcome for many transgender individuals and other gender variant adults. As transgender people and groups have become more visible in society, and have gained a measure of relative acceptance, the possibility of a transgender identity as such, rather than as a transitional stage within a male-female divided social system, has become a more realistic option . . . . [While s]ome individuals do hope to fully assimilate as women or as men . . . , others find authenticity in presenting a blend of gendered characteristics, or of fully transitioning gender while continuing to value the earlier life experience in the other gender role, such as by maintaining interests and activities developed during the pre-transition years.264


3. Differences in Sex Development

Judge Robertson’s recognition of the similarities between GIDs and intersex conditions, particularly in terms of them both being continua, was noted in the preceding subsection. To help readers better appreciate the importance of this connection, this section provides a brief overview of intersex conditions.

“Intersex” is a “spectrum of conditions involving anomalies of the sex chromosomes, gonads, reproductive ducts, and/or genitalia. The most traditional definition of intersex refers to individuals born with . . . genitalia that are not clearly male or female. A person may have elements of both male and female anatomy, have different internal organs and external organs, or have anatomy that is inconsistent with chromosomal sex.” It is estimated that various categories of intersex births occur in 1 to 2 percent of all births. Because there is an ongoing debate regarding whether to refer to an individual with such a condition as having an “intersex condition” or a “disorder of protocol for gender transition, and transgender persons must find a way to utilize transitional options to find what is best for them. It is incorrect to assume that there is a uniform measure of a completed transition. They may opt for hormone treatment only, for partial surgery, or for a combination. They may want to live in the role of the other sex or may occupy a gender-ambiguous or gender-neutral position in between the two sexes. They may refer to themselves as men or women, as trans-men or women, or simply as transgender people. Especially among the younger generation, transgender individuals may also refer to themselves as gender queer in an attempt to avoid being categorized in accordance with the prevailing gender binary.”; WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 9 (7th ver. 2011), reprinted in 13 INT’L J. TRANSGENDERISM 165, 171 (2011), available at www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf.

For a further discussion relating to intersexuality, see Professor Greenberg’s essay in Chapter 46 (Interacting in the Workplace With Individuals Who Have an Intersex Condition). The Fenway Glossary uses “genitalia” to refer to both internal reproductive organs and external genital organs. Accord STEDMAN’S MEDICAL DICTIONARY 1099 (25th ed. Illustrated 1990) (definition of “organa genitalia”).

See Julie A. Greenberg, Health Care Issues Affecting People with an Intersex Condition or DSD: Sex or Disability Discrimination?, 45 LOY. L.A. L. REV. 849, 854–55 (2012), available at http://digitalcommons.lmu.edu/llr/vol45/iss3/5/ (medical literature indicates that 1 to 2% of the population has a DSD); DAVID L. ROWLAND & LUCA INCROCCI, HANDBOOK OF SEXUAL AND GENDER IDENTITY DISORDERS 349 (2008) (DSDs affect 1% of the population); Melanie Blackless et al., How Sexually Dimorphic Are We? Review and Synthesis, 12 AM. J. HUM. BIOLOGY 151, 161, 163 (2000), available at http://dx.doi.org/10.1002/(SICI)1520-6300(200003/04)12:2<151::AID-AJHB1>3.0.CO;2-F (depending on the definition of DSD, the percentage is between 0.228 and 2.27%; “[D]evelopmental biology suggests that a belief in absolute sexual dimorphism is wrong. . . . It seems likely that changing cultural norms concerning sex roles and gender-related behaviors may encourage a willingness to engage in . . . a reexamination” of that belief.”); ANNE FAUSTO-Sterling, SEXING THE BODY 51–53 (2000) (1.7%); but see Leonard Sax, How Common Is Intersex? A Response to Anne Fausto-Sterling, 39 J. SEX RES. 174–78 (2002), available at http://dx.doi.org/10.1080/00224490209552139 (asserting that the 1.7% figure should be 0.018% when certain conditions the author does not consider as DSDs are removed). Depending on the individual with a DSD, the conditions that Dr. Sax excludes from the definition of intersex likely would qualify as disabilities under the ADA and Rehabilitation Act.
sex development,” in this chapter a more neutral term—“differences in sex development” (DSD)—is often used.269

Individuals with a DSD or other medical conditions have been subject to discrimination and public humiliation, particularly in the sports arena. For example, María José Martínez-Patiño, one of Spain’s top female hurdlers, was disqualified from international track and field competitions for an extended period of time because she was born with a DSD. She has fully developed breasts and a vagina, feminine pelvic and shoulder structures, an XY chromosomal pair, no ovaries or uterus, and testes hidden in her labia. Although she produces testosterone, it has no effect on her body because she has androgen insensitivity syndrome. Until the first time she was disqualified, as a result of a smear of her buccal mucosa270 the day before one of her competitions, she never had a reason not to think she was female. As Martínez-Patiño explained it in the medical journal The Lancet, “When I was conceived, my tissues never heard the hormonal messages to become male.”271 After three years of study—and public humiliation—Martínez-Patiño was permitted to resume running as a woman in international events.

269See Milton Diamond, Developmental, Sexual and Reproductive Neuroendocrinology: Historical, Clinical and Ethical Considerations, 32 Frontiers in Neuroendocrinology 255, 256 nn.1, 15 (2011), available at http://dx.doi.org/10.1080/00224490209552139 (the term “differences in sex development” avoids stigma or negativism; also noting that the use of the term “disorder” in GID is equally inappropriate); Milton Diamond & Hazel Beh, Variations of Sex Development Instead of Disorders of Sex Development, Archives Disease Childhood (July 27, 2006 e-letter), available at http://adc.bmj.com/content/91/7/554/reply and www.hawaii.edu/PCSS/biblio/articles/2005to2009/2006-variations.html (in suggesting that “variations” would be preferable to “disorders,” the authors observed that “[i]t is undeniable that medical labels have a power that transcends medical treatment. Those who influence how medicine classifies individuals must be sensitive to the potential transformative power of the labels they assign. Medical labeling affects social and legal order. But most importantly, labeling affects individuals. While medicine from time to time may reconsider terminology, the labels assigned to persons born today with sexual characteristics outside statistical norms can become static symbols of their inferiority that they might shoulder for a lifetime.”); Advocates for Informed Choice, Why Does [Advocates for Informed Choice] Use the Terms “Intersex” and “DSD”? (2012), available at http://aiclegal.org/who-we-are/faqs (“The language we use is important, and has consequences. Identity is a very personal matter; no one can tell another how to identify him- or herself.”); Maria José Martinez-Patino et al., An Approach to the Biological, Historical and Psychological Repercussions of Gender Verification in Top Level Competitions, 5 J. Hum. Sport & Exercise 307, 309 (2010), available at www.jhse.ua.es/index.php/jhse/article/view/151/245 (stating that disorders of sex development is “a more sensitive term” than intersex); Children’s Hospital Boston, Disorders of Sexual Differentiation (Sept. 2013), available at www.childrenshospital.org/health-topics/conditions/disorders-of-sexual-differentiation (Children’s Hospital in Boston uses the terminology “disorder of sexual differentiation”).

270“The buccal mucosa is the lining of the cheeks and the back of the lips, inside the mouth where they touch the teeth.” Cedars-Sinai, Buccal Mucosa Cancer (2013), available at www.cedars-sinai.edu/Patients/Health-Conditions/Buccal-Mucosa-Cancer.aspx.

Polish sprinter Ewa Klobukowska was one of the first international athletes disqualified from sports competition because testing revealed that she had a DSD condition and, thus, she was deemed a male. Klobukowska “was ruled ineligible after sex testing determined she had ‘ambiguous genitalia’—although not ambiguous enough to prevent her from giving birth to a child some time later.”

In August 2009, Caster Semenya won the women’s 800 meters at the world track and field championships in Berlin. Her victory was put on hold for eleven months while the International Association of Athletics Federations (IAAF) debated whether Semenya is a man or a woman. At the time, Alice Domurat Dreger, a professor of medical humanities and bioethics at the Feinberg School of Medicine at Northwestern University, said the doctors would examine Semenya’s genes, gonads, genitalia, hormone levels, and medical history. Dreger added: “But at the end of the day, they are going to have to make a social decision on what counts as male and female, and they will wrap it up as if it is simply a scientific decision. And the science actually tells us sex is messy. Or as I like to say, ‘Humans like categories neat, but nature is a slob.’”

In the preceding subsection, reference was made to surgeries designed to “fix” the sex of babies born with DSD conditions. After surgery, these babies are raised in accordance with the gender assigned as a result of the surgery. Many times, the children are not informed of their condition or the surgery until they are in their teens or later. Not surprisingly, some of these children will eventually initiate gender changes, although the frequency varies considerably with the particular DSD condition—from zero to two thirds of the individuals. This is yet another demonstration of the

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273 Christopher Clarey, Gender Test After a Gold-Medal Finish, N.Y. TIMES (Aug. 19, 2009), available at www.nytimes.com/2009/08/20/sports/20runner.html. It took the International Association of Athletics Federations (IAAF) 11 months to finally decide that Semenya met the IAAF’s definition of who qualifies as a woman. According to the IAAF, which admitted that Semenya’s medical confidentiality had been violated, she would undergo “‘very, very comprehensive’” testing—visual evaluation; chromosome testing; gynecological investigation; “‘all manner of things, organs, X-rays, scans.’” Id. See Lindsay Rovegno & Julie Foudy, Professor: Sports Need Gender Policies, ESPN OUTSIDE THE LINES (Nov. 8, 2010), available at http://sports.espnc.com/espn/otl/news/story?id=5649091.

From published reports, it is not clear whether Semenya has a DSD. She won a silver medal at the 2012 London Olympics. Semenya’s treatment by the IAAF and gender testing generally are critically examined in Katrina Karkazis et al., Out of Bounds? A Critique of the New Policies on Hyperandrogenism in Elite Female Athletes, 12 AM. J. BIOETHICS 3 (2012), available at www.tandfonline.com/doi/abs/10.1080/15265161.2012.680533.

overriding importance of gender identity in comparison to internal and external phenotypic sex.

Many unexpected—and sometimes unexplainable—things happen in nature, none of which should result in individuals being deemed or treated as “abnormal” or “immoral” or being discriminated against. For example, twins have been born with different skin colors.\textsuperscript{275} Some variations from the norm are cherished, such as Olympic champion Michael Phelps’ atypical physical appearance.\textsuperscript{276} As the preceding discussion demonstrates, people are born with variations from the “norm,” sometimes unfortunately referred to as “birth defects.” For women such as Martínez-Patiño, Klobukowska, and Semenya, they themselves, their families, and their doctors had always assumed they were female. It was only as the result of intrusive, humiliating testing, in connection with their participation in sports, that their gender was questioned. The invalidity of these testing protocols is clearly explained by Professor Greenberg:

A binary sex paradigm does not reflect reality. Instead, sex and gender range across a spectrum. Male and female occupy the two ends of the poles, and a number of intersexed conditions exist between the two poles. Millions of individuals are intersexed and have some sexual characteristics that are typically associated with males and some sexual characteristics that are typically associated with females.

Although the American legal system blindly clings to a binary sex and gender paradigm, anthropologists who have studied other societies have found cultures that reject binary sex and gender systems. These societies formally recognize that more than two sexes and/or two genders exist.

For instance, in several villages in the Dominican Republic, a significant number of children who are chromosomally XY and who develop embryonic testes have external female genitalia at birth and therefore are raised as girls. At puberty, their testes descend, their voices deepen, and their clitorises transform into penises. Anthropologists have reported that the villagers have special terms for these individuals. They are called “guevodoche (balls at twelve)” or “machihembra (male female).” An intersexual condition of the same biological origin exists among several people in Papua, New Guinea. The term used to describe these children is kwolu-aatmwol (hermaphrodite), which signifies that at puberty the child will turn more into a man than a woman. These children are treated as a third sex.

Many Native American cultures recognize a third gender. These individuals are called \textit{two-spirit} (formerly known as \textit{berdache}) and enjoy a special status in their society. They function as neither male nor female.

\textsuperscript{275}British Twins Have Different Skin Color: In a Rare Occurrence, Boys Inherited Different Genetic Codes from Mother, ASSOCIATED PRESS (Oct. 27, 2006), available at www.msnbc.msn.com/id/15447465/wid/11915773?GT1=8618.

\textsuperscript{276}See Michael Phelps Bio, NBC 2008 Beijing Olympics (2008), available at www.2008.nbcolympics.com/athletes/athlete=2/bio/index.html (“Physical advantage. At first glance, Phelps might look like a typical swimmer. But several of his physical characteristics seem genetically tailored for swimming. His 6-foot-7-inch wingspan is three inches longer than his height, providing him with unusual reach. His torso is long compared to his legs, enabling him to ride high on the water. And his flexible ankles, combined with size-14 feet, allow for a powerful kick.”).
This third sex/gender status is also recognized in India where intersexed or transgendered people are called hijras. Hijras are considered neither male nor female but contain elements of both. 277

Some light does shine brightly at the end of the tunnel. In July 2012, Semenya was selected to carry the flag of South Africa during the opening ceremonies of the 2012 London Olympics. 278

4. Gender Identity Disorders Resulting From Physical Impairments

Based on the foregoing discussion, it is easy to understand that some people are born with chromosomal pairs that are not the norm of XX for female and XY for male, and some individuals may have “ambiguous” genitalia. This is because there are test results that clearly show the variations from the “normative” female or male.

However, when it comes to gender identity, currently there are no physical test results that individuals with gender dysphoria can point to in order to definitively support the deep, innate feelings they have that their physical bodies and their brains have different genders. According to the Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health:

The predominating biological theory suggests that a neurohormonal disturbance takes place in the brain during embryological development. While the genitalia of the human embryo become differentiated as male or female during the 12th week of fetal development, the gender identity portion of the brain differentiates around the 16th week. If there is a hormonal imbalance during this four-week period, gender identity may not develop along the same lines as the genitalia. It is hypothesized that the state of the mother’s overall physical and mental health during pregnancy could cause such an imbalance. Severe emotional trauma or other stress or the ingestion of certain prescription or illegal drugs during pregnancy could interfere with fetal brain chemistry. 279

In other words, as a medical treatise explains, there is a growing understanding as follows:

- Genetic and hormonal factors contribute to both the sex of the individual and his or her gender identity.

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278 Semenya to Carry South Africa’s Flag at Olympics, Associated Press (July 18, 2012), available at www.nytimes.com/2012/07/19/sports/olympics/caster-semenya-to-carry-south-africas-flag-at-olympics.html. One of the three other athletes considered for the honor was sprinter Oscar Pistorius, the “Blade Runner,” whose legs were amputated when he was an infant. Id.

• Before the seventh week of embryonic age, human embryos are bipotential [(for male or female development)]\(^{[280]}\) at all levels of sexual differentiation.

• Lack of androgen in a male fetus or, conversely, the presence of androgen in a female fetus, will result in disparity between genetic and phenotypic sex.

• Androgens, partly through conversion to estradiol, are responsible for masculinizing the brain and inducing the neural circuits of masculine behavior.\(^{281}\)

Current medical studies continue to point in the direction of hormonal and genetic causes for the in utero development of gender dysphoria,\(^{282}\)

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\(^{280}\) The medical treatise further raises the question of whether “bipotential” should be replaced with “multipotential,” an additional indication that the medical community is beginning to see gender as not just a binary phenomenon. David L. Rowland & Luca Incrocci, Handbook of Sexual and Gender Identity Disorders 332 (2008).

\(^{281}\) Id. at 349. See also Milton Diamond, Biased-Interaction Theory of Psychosexual Development: “How Does One Know if One is Male or Female?,” 55 Sex Roles 589, 593 (2006), available at http://dx.doi.org/10.1007/s11199-006-9115-y or www.hawaii.edu/PCSS/biblio/articles/2005to2009/2006-biased-interaction.html (“[t]here now is an extensive review of transsexual development that documents its biological underpinning” arising prenatally out of both genetics and hormones).

\(^{282}\) See Eileen Luders et al., Increased Cortical Thickness in Male-to-Female Transsexualism, 2 J. Behav. & Brain Sci. 357, 360 (2012), available at http://dx.doi.org/10.4236/jbbs.2012.23040 (Conclusion: “Gender identity is a central and fundamental human characteristic that can influence people’s well-being…. [T]he current study provides evidence that brain anatomy is associated with gender identity, where measures in [male-to-female] transsexuals appear to be shifted away from gender-congruent men.” (footnote omitted)); Gunter Heylens et al., Gender Identity Disorder in Twins: A Review of the Case Report Literature, 9 J. Sex. Med. 751 (2012), available at http://dx.doi.org/10.1111/j.1743-6109.2011.02567.x (abstract: “These findings suggest a role for genetic factors in the development of GID.”); Milton Diamond, Transsexuality Among Twins: Identity Concordance, Transition, Rearing, and Orientation, 14 Int’l J. Transgenderism 24 (2013), available at http://dx.doi.org/10.1080/15532739.2013.750222 and www.hawaii.edu/PCSS/biblio/articles/2010to2014/2013-transsexuality.html (abstract: “The responses of our twins relative to their rearing, along with our findings regarding some of their experiences during childhood and adolescence show their [gender] identity was much more influenced by their genetics than their rearing.”); Ai-Min Bao & Dick F. Swaab, Sexual Differentiation of the Human Brain: Relation to Gender Identity, Sexual Orientation and Neuropsychiatric Disorders, 32 Frontiers in Neuroendocrinology 214–26 (2011), available at http://dx.doi.org/10.1016/j.yfrne.2011.02.007 (abstract: “During the intrauterine period a testosterone surge masculinizes the fetal brain, whereas the absence of such a surge results in a feminine brain. As sexual differentiation of the brain takes place at a much later stage in development than sexual differentiation of the genitals, these two processes can be influenced independently of each other. Sex differences in cognition, gender identity …, sexual orientation …, and the risks of developing neuropsychiatric disorders are programmed into our brain during early development. There is no evidence that one’s postnatal social environment plays a crucial role in gender identity or sexual orientation.”); Alicia Garcia-Falgueras & Dick F. Swaab, Sexual Hormones and the Brain: An Essential Alliance for Sexual Identity and Sexual Orientation, 17 Pediatric Neuroendocrinology 22–35 (2010), available at http://dx.doi.org/10.1159/000262525 (abstract: “The fetal brain develops during the intrauterine period in the male direction through a direct action of testosterone on the developing nerve cells, or in the female direction through the absence of this hormone surge. In this way, our gender identity (the conviction of belonging to the male or female gender) and sexual orientation are programmed or organized into our brain structures when we are still in the womb. However, since sexual differentiation of the genitals takes place in the first two months of pregnancy and sexual differentiation of the brain starts in the second half of pregnancy, these two processes can be influenced independently, which may result in extreme cases in transsexuality. This also means that in the event of
ambiguous sex at birth, the degree of masculinization of the genitals may not reflect the degree of masculinization of the brain. There is no indication that social environment after birth has an effect on gender identity or sexual orientation.”); Ivanka Savic et al., *Sex Differences in the Human Brain, Their Underpinnings and Implications*, Chapter 4—Sexual Differentiation of the Human Brain in Relation to Gender Identity and Sexual Orientation, 186 PROGRESS IN BRAIN RESEARCH 41–62 (2010), available at http://dx.doi.org/10.1016/B978-0-444-53630-3.00004-X (same); Lauren Hare et al., *Androgen Receptor Repeat Length Polymorphism Associated with Male-to-Female Transsexualism*, 65 BIOLOGICAL PSYCHIATRY 93, 95 (2009), available at www.biologicalpsychiatryjournal.com/article/S0006-3223(08)01087-1 (“There is a likely genetic component to transsexualism, and genes involved in sex steroidogenesis are good candidates…. [A] decrease in testosterone levels in the brain during development might result in incomplete masculinization of the brain …, resulting in a more feminized brain and a female gender identity.”); Louann Brizendine, *The Female Brain*, inside front book jacket (2006) (“Every brain begins as a female brain. It only becomes male eight weeks after conception, when excess testosterone shrinks the communication center, reduces the hearing cortex, and makes the part of the brain that processes sex twice as large.”); Paul-Martin Holterhus et al., *Disorders of Sex Development Expose Transcriptional Autonomy of Genetic Sex and Androgen-Programmed Hormonal Sex in Human Blood Leukocytes*, 10 BMC GENOMICS 292, 292 (2009), available at http://dx.doi.org/10.1186/1471-2164-10-292 or www.ncbi.nlm.nih.gov/pmc/articles/PMC2713997/pdf/1471-2164-10-292.pdf (conclusion: “A significant fraction of gene expression differences between males and females in the human appears to have its roots in early embryogenesis and is not only caused by sex chromosomes but also by long-term sex-specific hormonal programming due to presence or absence of androgen during the time of external genital masculinization. Genetic sex and the androgen milieu during embryonic development may therefore independently modulate functional traits, phenotype and diseases associated with male or female gender as well as with DSD conditions.”); Giuseppina Rametti et al., *White Matter Microstructure in Female to Male Transsexuals Before Cross-Sex Hormonal Treatment. A Diffusion Tensor Imaging Study*, 45 J. PSYCHIATRIC RES. 199–204 (2010), available at http://dx.doi.org/10.1016/j.jpsychires.2010.05.006 (abstract: “Some gray and white matter regions of the brain are sexually dimorphic….” Our results show that the white matter microstructure pattern in untreated [female to male] transsexuals is closer to the pattern of subjects who share their gender identity (males) than those who share their biological sex (females). Our results provide evidence for an inherent difference in the brain structure of [female to male] transsexuals.”); Giuseppina Rametti et al., *The Microstructure of White Matter in Male to Female Transsexuals Before Cross-Sex Hormonal Treatment. A DTI Study*, 45 J. PSYCHIATRIC RES. 949–54 (2011), available at http://dx.doi.org/10.1016/j.jpsychires.2010.11.007 (abstract: “Our results show that the white matter microstructure pattern in untreated [male to female] transsexuals falls halfway between the pattern of male and female controls. The nature of these differences suggests that some fasciculi do not complete the masculinization process in [male to female] transsexuals during brain development.”); Edwina Sutton et al., *Identification of SOX3 As an XX Male Sex Reversal Gene in Mice and Humans*, 121 J. CLINICAL INVESTIGATION 328, 328, 332 (2011), available at http://dx.doi.org/10.1172/JCI42580 or www.jci.org/articles/view/42580/pdf (“Sex in mammals is genetically determined and is defined at the cellular level by the sex chromosome complement (XY males and XX females) and at the phenotypic level by the development of gender-specific anatomy, physiology, and behavior…. Although female development has traditionally been considered by some to be a ‘default’ pathway, it is now clear that sexual fate is determined by a balance of opposing signals within the gonad, in which [the Y-linked testis-determining gene] Sry exerts a dominant masculinizing influence…. Through characterization of a unique transgenic mouse line, we show that ectopic expression of [gene] Sox3 in uncommitted XX gonads is sufficient to divert the program of ovarian development toward testis formation, leading to XX males. Our data indicate that Sox3 functions as a molecular switch, activating the testis differentiation pathway via a mechanism that is functionally analogous to Sry. Furthermore, we provide the first evidence to our knowledge that SOX3 gain of function in humans can also lead to complete XX male sex reversal.”); Lindsay R. Chura et al., *Organizational Effects of Fetal Testosterone on Human Corpus Callosum Size and Asymmetry*, 35 PSYCHONEUROENDOCRINOLOGY 122, 122 (2010), available at http://dx.doi.org/10.1016/j.psyneuen.2009.09.009 and http://docs.autismresearchcentre.com/papers/2009_Chura_etal_OrgEffectsOfFT_Psychoendocrinology.pdf (summary: “Previous theory and research in animals has identified the critical role that fetal testosterone (FT) plays in organizing sexually dimorphic brain development…. We suggest that this possible
which is consistent with the fact that such causes also play a role in DSD conditions.\textsuperscript{283} When there is a hormonal imbalance in utero, it is possible that an individual’s physical anatomy may develop as if a male, while the brain develops as if a female, or vice versa. This outcome is confirmed by the ongoing medical ethics debate over whether it is appropriate to treat fetuses with the off-label use of the drug dexamethasone in pregnant women at risk of carrying a female fetus with congenital adrenal hyperplasia (CAH). CAH is a genetic condition of the adrenal glands, which causes the glands to produce inadequate amounts of the hormones cortisol and aldosterone. As a result, a person’s body produces too much androgen, which increases the degree of virilization (i.e., the development of masculine traits) in both females and males with CAH.\textsuperscript{284} “The prenatal administration of dexamethasone, a potent synthetic steroid of the glucocorticoid class, cannot prevent an affected child from being born with CAH. The intervention is aimed instead at causing CAH-affected female fetuses to develop in a more female-typical fashion than they otherwise might. Androgens contribute to sex differentiation, including in the brain and genitals; relatively low prenatal levels ordinarily result in a more female-typical development; relatively high levels usually result in male-typical development…. Prenatal dexamethasone is meant to engineer the CAH-affected female fetus’s hormonal system to be typically female.”\textsuperscript{285}


In explaining why “transsexuals are intersexed in their brains,” Dr. Diamond points to the impact of hormones on brain development:

Prenatal programming and biasing work through alterations of the nervous system; thus can be said to reflect brain sex. During prenatal development the nervous system, the brain in particular, is programmed along a track that is usually concomitant with the development of other sex appropriate structures like genitals and reproductive organs. The brain, however, as in other [i]ntersex conditions, can develop along one sex/gender path while other organs develop along another. Put simply, the brain can develop as male while other parts of the body develop as female. Further, it is important to recall that the developing nervous system controlling gender-linked behaviors is more sensitive to certain stimuli than are the tissues forming genitals and thus can be modified while the genitals are not.\(^{286}\)

Sigmund Freud, who was a neurologist and renowned for his theories of psychosexual development, understood that “sexual conduct has its roots

\(^{286}\)Milton Diamond, Biased-Interaction Theory of Psychosexual Development: “How Does One Know if One is Male or Female?,” 55 Sex Roles 589, 597 n.14 (2006), available at http://dx.doi.org/10.1007/s11199-006-9115-y or www.hawaii.edu/PCSS/biblio/articles/2005to2009/2006-biased-interaction.html. See Schroer I, 424 F. Supp. 2d 203, 213 n.5, 97 FEP 1506 (D.D.C. 2006) (“If, as some believe, sexual identity is produced in significant part by hormonal influences on the developing brain in utero, this would place transsexuals on a continuum with other intersex conditions . . . , in which the various components that produce sexual identity and anatomical sex do not align.”); In re Heilig, 816 A.2d 68, 73, 77, 78 (Md. 2003) (in holding that the courts have jurisdiction to order a change of gender on a birth certificate, the court observed that “[t]here is a recognized medical viewpoint that gender is not determined by any single criterion, but that . . . seven factors may be relevant”; that the recent “studies imply that transsexualism may be more similar to other physiological conditions of sexual ambiguity, such as androgen insensitivity syndrome, than to purely psychological disorders”; and that “[b]ecause transsexualism is universally recognized as inherent, rather than chosen, psychotherapy will never succeed in ‘curing’ the patient.”); Harry Benjamin, The Transsexual Phenomenon 5 (Symposium 1999) (1966), available at http://web.archive.org/web/20130323091015/http://tgmeds.org.uk/downs/phenomenon.pdf (“Intersexes exist, in body as well as in mind.”); but see Heino F.L. Meyer-Bahlburg, Transsexualism (“Gender Identity Disorder”)—A CNS-Limited Form of Intersexuality?, 707 Advanced Experimental Med. & Biol. 75, 75, 77 (2011), available at http://dx.doi.org/10.1007/978-1-4419-8002-1_17 (although “persons with early-onset GID have much in common with individuals with somatic intersexuality” in “terms of behavioral or psychological presentation,” “the emerging data are interesting, but at this time insufficient to constitute a firm basis for a theory of GID as a form of [central nervous system]-limited Intersexuality.”). Professor Meyer-Bahlburg was a member of the American Psychiatric Association’s working group that drafted the DSM’s current gender dysphoria diagnosis and, not surprisingly, his view was adopted in the final commentary to the DSM-5. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 457 (5th ed. 2013) (although there may be a genetic contribution to gender dysphoria, there is insufficient evidence “to label gender dysphoria . . . as a form of intersexuality limited to the central nervous system.”). Professor Diamond agrees with Professor Meyer-Bahlburg that there is a need for additional studies to replicate earlier results, but notes that “no studies have been reported that counter [the earlier] reports, and my prediction is that the findings will be reproduced and transsexualism will eventually be seen as an intersex variation due to brain (nervous system) intersexuality.” Milton Diamond, Transsexuality Among Twins: Identity Concordance, Transition, Rearing, and Orientation, 14 Int’l J. Transgenderism 24, 35 (2013), available at http://dx.doi.org/10.1080/15532739.2013.750222 and www.hawaii.edu/PCSS/biblio/articles/2010to2014/2013-transsexuality.html.
deep in the physical structure of the brain, to which brain chemistry may have to be added.”287

In sum, current research is tending to show that GIDs (including transsexuality) or gender dysphoria is just one of a number of physical (not psychiatric) medical conditions that the medical community is still struggling to fully understand.288 Other conditions whose causes are not yet fully understood include, for example, polycystic ovary syndrome,289 cerebral palsy,290 fibromyalgia,291 strabismus,292 dyslexia,293 and stuttering.294 Indeed, at one time, stuttering was believed to be the result of a mental condition, but today the medical community believes that is rarely the case.295 GIDs are similar to these and other medical conditions, such as microvascular angina, for which a patient may have symptoms, but medical tests do not reveal an underlying cause, yet accepted nonpsychiatric treatment resolves the pain.296 Each of these conditions arises from a physical impairment arising from unclear origins.

288Jennifer L. Levi and Bennett H. Klein, Pursuing Protection for Transgender People through Disability Laws, in Paisley Currah, Richard M. Juang, & Shannon Price Minter, TRANSGENDER RIGHTS 81 (2006) (“Recent studies suggest that being transgender has a physiological, not a psychological, etiology.”).
290“Cerebral palsy (CP) is a broad term used to describe a group of chronic ‘palsies’—disorders that impair control of movement—due to damage to the developing brain. . . . Much remains unknown about the disorder’s causes.” WebMD, Understanding Cerebral Palsy—The Basics (Mar. 21, 2013), available at www.webmd.com/brain/understanding-cerebral-palsy-basic-information.
291“Fibromyalgia is a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues. . . . Doctors don’t know what causes fibromyalgia, but it most likely involves a variety of factors working together.” Mayo Clinic, Fibromyalgia (Jan. 22, 2011), available at www.mayoclinic.com/health/fibromyalgia/DS00079.
293“Dyslexia is a learning problem that makes it hard to read, write, and spell. It occurs because the brain jumbles or mixes up letters and words. . . . Experts don’t know for sure what causes dyslexia.” WebMD, Dyslexia—Overview (June 4, 2010), available at http://children.webmd.com/child/dyslexia-overview.
294“Stuttering—also called stammering—is a speech disorder that involves repeating or prolonging a word, syllable or phrase, or stopping during speech and making no sound for certain syllables. . . . Researchers are still studying the underlying causes of stuttering.” Mayo Clinic, Stuttering (Sept. 8, 2011), available at www.mayoclinic.com/health/stuttering/DS01027.
295Id.
296Id.
The medical treatments (e.g., hormones and surgery) for GIDs have been highly successful, which is strong evidence that GIDs (including transsexuality), although not yet fully understood from an etiology perspective, result from one or more physiological conditions, and are not sexual perversions as Senators Armstrong and Helms painted them in 1989; that gender dysphoria can be resolved with nonpsychiatric treatments; and that a person’s sex or gender is not simply an issue of genitals and chromosomes, but involves a multitude of factors, not the least of which is the individual’s gender identity. Indeed, gender identity may well be the most important factor because, as psychiatrist and urologist William Reiner has observed:

In the end it is only the children themselves who can and must identify who and what they are. It is for us as clinicians and researchers to listen and to learn. Clinical decisions must ultimately be based not on anatomical predictions, nor on the “correctness” of sexual function, for this is neither a question of morality nor of social consequence, but on that path most appropriate to the likeliest psychosexual developmental pattern of the child. In other words, the organ that appears to be critical to psychosexual development and adaptation is not the external genitalia, but the brain.

A growing body of medical evidence suggests that gender dysphoria may have a basis in a physical impairment resulting from genetics and/or in utero exposure of the fetus to the “wrong” hormones during the development of the brain, such that the anatomic physical body and the brain develop in different gender paths. In addition, a physical impairment may exist subsequent to birth to the extent the person is born with an anatomic physical body and hormone output that do not match the individual’s gender identity or the sex of the individual’s brain. As a result of one or both of these impairments, some individuals may develop gender dysphoria. In such situations, the prerequisite for a disability claim under the ADA and the Rehabilitation Act have been met—a GID resulting from a physical impairment. Although the precise causes of many medical conditions are

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298 See Milton Diamond, Biased-Interaction Theory of Psychosexual Development: “How Does One Know if One Is Male or Female?”, 55 Sex Roles 589, 596 n.13 (2006), available at http://dx.doi.org/10.1007/s11199-006-9115-y or www.hawaii.edu/PCSS/biblio/articles/2005to2009/2006-biased-interaction.html (“It is not the presence or absence of a penis but the sex of the brain—how it has developed—that determines how one comes to identify as male or female and how one wants to live.”).

299 See Kosilek v. Maloney, 221 F. Supp. 2d 156, 163 (D. Mass. 2002) (“The consensus of medical professionals is that transsexualism is biological and innate. It is not a freely chosen
not known, this does not warrant denying persons with these conditions the benefits of the ADA or the Rehabilitation Act. As the Massachusetts Superior Court observed when it declined to engraft onto the commonwealth’s ADA-like, three-pronged definition of “disability” the federal exclusion of GIDs not resulting from physical impairments, “In light of the remarkable growth in our understanding of the role of genetics in producing what were previously thought to be psychological disorders, this Court cannot eliminate the possibility that all or some gender identity disorders result ‘from physical impairments’ in an individual’s genome.”

Perhaps the most compelling confirmation of this conclusion is the 2013 edition of the American Psychiatric Association’s DSM-5, which was published in 2013. As discussed in Section III.G.2.b.viii. infra, in the DSM-5 the term “gender identity disorder” has been replaced with the less stigmatizing term “gender dysphoria,” and the renamed diagnosis has been placed in its own, highest-level DSM classification (called “gender dysphoria”) in recognition of gender dysphoria’s uniqueness as a medical condition that does not necessarily cause emotional distress and is treated with nonpsychiatric modalities, such as cross-sex hormones, surgery, and/or social and legal transition to the appropriate gender. The drafters of the gender dysphoria diagnosis noted that they chose not to make any decision about categorizing gender dysphoria as either a psychiatric or a nonpsychiatric condition, which is an acknowledgment of the growing body of research discussed above that gender dysphoria may be a medical condition arising from a physical impairment resulting from in utero hormonal and genetic causes and of the need to retain a diagnostic code so that hormonal and surgical treatments remain available to treat the underlying anatomic cause of the gender dysphoria. The DSM-5’s treatment of gender dysphoria is a long-overdue recognition of what Dr. Harry Benjamin observed in his 1966 landmark treatise, The Transsexual Phenomenon: “Psychotherapy with the aim of curing transsexualism, so that the patient will accept himself as a man, it must be repeated here, is a useless undertaking with present available methods.”

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301 Harry Benjamin, The Transsexual Phenomenon 53 (Symposium 1999) (1966), available at http://web.archive.org/web/201302191015/http://tgmeds.org.uk/downs/phenomenon.pdf. See In re Heilig, 816 A.2d 68, 78 (Md. 2003) (in holding that the courts have jurisdiction to order a change of gender on a birth certificate, the court observed that “[b]ecause transsexuality is universally recognized as inherent, rather than chosen, psychotherapy will never succeed in ‘curing’ the patient.”); Kosilek v. Spencer, 740 F.3d 733, 765 (1st Cir. 2013), reh’g en banc granted & majority & dissenting appellate opinions withdrawn by Order of Court, No. 12-2194
5. Gender Identity Disorders Resulting From Physical Impairments Are Disabilities

A GID resulting from a physical impairment can substantially limit a number of major life activities and thus qualifies as a disability under the ADA and the Rehabilitation Act. As explained in Section II.B.4.c. *supra*, major life activities include, but are not limited to, caring for oneself, sleeping, speaking, concentrating, thinking, communicating, interacting with others, and the operation of a major bodily function, including normal cell growth and genitourinary, neurological, brain, endocrine, and reproductive functions. Many of these major life activities can be limited when a person has a GID. For example, the need for regular, ongoing, and sometimes lifelong health care is a significant aspect of caring for oneself.302 Individuals with a GID may need ongoing treatment for, among other things, hormonal imbalance, electrolysis to remove facial hair from a gender-affirmed female’s face, psychotherapy related to conditions such as depression and anxiety that may result from the social stigma and loss of family and employment when an individual comes out as gender affirmed or gender diverse.303 These

(1st Cir. Feb. 12, 2014) (setting hearing en banc for May 8, 2014) (noting that “‘psychotherapy as well as antipsychotics and antidepressants . . . do nothing to treat the underlying [gender identity] disorder’ ” (quoting Fields v. Smith, 653 F.3d 550, 556 (7th Cir. 2011), cert. denied, 566 U.S. ___, 132 S. Ct. 1810 (2012)); O’Donnabhain v. Commissioner of Internal Revenue, 134 T.C. No. 4, 2010 WL 364206, at *21 n.49, Tax Ct. Rep. (CCH) 58,122 (2010), available at www.ustaxcourt.gov/InOpHistoric/ODonnabhain.TC.WPD.pdf (in holding that hormone therapy and sex reassignment surgery are not cosmetic surgery for purposes of the Internal Revenue Code, the Tax Court quoted Judge Posner, in *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997): “‘The cure for the male transsexual consists not of psychiatric treatment designed to make the patient content with his biological sexual identity—that doesn’t work—but of estrogen therapy’ ” and genital reconstruction surgery.); U.S. Steel LLC, 116 LA 861 (Petersen, 2001) (rejecting employer’s argument that employee’s medically necessary, gender-affirming surgery was elective, cosmetic surgery and thus not covered under employer’s sickness and accident benefit plan); Doe v. McConn, 489 F. Supp. 76, 78 (S.D. Tex. 1980) (in holding that a Houston ordinance that makes it unlawful for a person to appear in public “with the designed intent to disguise his or her true sex as that of the opposite sex” is unconstitutional as applied to individuals undergoing treatment for a GID, the court found that “[m]ost, if not all, specialists in gender identity are agreed that the transsexual condition establishes itself very early, before the child is capable of elective choice in the matter, probably in the first two years of life; some say even earlier, before birth during the fetal period. These findings indicate that the transsexual has not made a choice to be as he is, but rather that the choice has been made for him through many causes preceding and beyond his control. Consequently, it has been found that attempts to treat the true adult transsexual psychotherapeutically have consistently met with failure.”); Kosilek, 221 F. Supp. 2d at 163 (in a case involving medical treatment for a prisoner with a GID, the court noted that “[t]he consensus of medical professionals is that transsexualism is biological and innate. It is not a freely chosen ‘sexual preference’ or produced by an individual’s life experience.”).


303 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 453, 814–15 (5th ed. 2013) (the *DSM-5* added the concept of a “posttransition specifier” to reflect that individuals who previously had gender dysphoria may still require lifelong continuing medical treatment procedures (e.g., hormones) that serve to support their gender affirmations); *Pursuing Protection for Transgender People*, at 85. The posttransition-specifier
treatments can ameliorate or resolve the GID. Without treatment, a person’s physical and psychological health would be adversely affected in a significant way. The need for continuing medical care, including, for example, the need to take daily medications, has been held to substantially limit an individual in the major life activity of caring for oneself. Persons with a GID do not have “normal” cell and body development. As explained in Section III.E. supra, these individuals appear to follow a different path of development in utero than the norm, with their physical bodies and brains developing in different gender directions.

Persons with a GID are likely to have a number of other major life activities substantially limited:

- Individuals with a GID are often treated with hormone therapies, to replace the hormones their bodies have failed to produce, and

concept is explained in the commentary of the American Psychiatric Association’s working group that drafted the DSM-5’s gender dysphoria diagnosis. The American Psychiatric Association has removed from public view the extensive supporting rationales for the changes to the DSM that had appeared at www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=482. As of December 2013, that web page was still accessible via the Wayback Machine at http://archive.org/web/web.php.

Pursuing Protection for Transgender People, at 86.

See, e.g., Hernandez v. Prudential Ins. Co. of Am., 977 F. Supp 1160, 1165 (M.D. Fla. 1997) (“The fact that [an employee with HIV] will need continual medical care demonstrates that he cannot care for himself.”); United States v. Happy Time Day Care Ctr., 6 F. Supp. 2d 1073, 1081 (W.D. Wis. 1998) (ADA public accommodation case, where the court found that a suppressed immune system resulting from HIV can substantially limit a person’s ability to care for oneself, and also seemed to suggest that scheduling doctors’ appointments or managing the logistics of a daily pill regimen might substantially limit the ability of an adult to care for oneself); Peters v. Baldwin Union Free Sch. Dist., 320 F.3d 164, 165, 168–69, 13 AD 1793 (2d Cir. 2003) (in a case involving the Rehabilitation Act and New York’s Human Rights Law, the court noted the following: “A mental illness that impels one to suicide can be viewed as a paradigmatic instance of inability to care for oneself. It therefore constitutes a protected disability under the Rehabilitation Act.”); Lie v. Sky Publ’g Corp., 2002 WL 31492397, at *6, 15 Mass. L. Rep. 412 (Super. Ct. Oct. 7, 2002) (under Massachusetts’ fair employment practices law, in a case involving GID, the court observed that “the need for ongoing medical care in the form of psychotherapy and hormone treatments may qualify as a substantial limitation on its own”); Commission on Human Rights & Opportunities ex rel. Peterson v. City of Hartford, 2010 WL 4612700, at *12, 50 Conn. L. Rep. 750 (Super. Ct. Oct. 27, 2010), rev’d 2008 WL 5455392 (Conn. Comm’n Hum. Rts. & Opp. Nov. 14, 2008), rev’d on other grounds, 50 A.3d 917, 115 FEP 1686 (Conn. App. Ct.), certification denied, 55 A.3d 570 (Conn. 2012) (under Connecticut’s Fair Employment Practices Act, in a case involving GID, the court held plaintiff had a chronic physical disability because, for the rest of her life, she would be on medication (hormones) and under the care of a physician); Doe v. U.S. Postal Serv., 1985 WL 9446, at *2–3 & n.2, 37 FEP 1867 (D.D.C. 1985) (in a pre-ADA Rehabilitation Act case, the court allowed a discrimination claim based on transsexualism to proceed in view of the regulations that defined major life activities to include caring for one’s self and working. The court disagreed with the employer’s contention that because a transsexual’s condition may be alleviated through the use of hormones and gender reassignment surgery, plaintiff’s impairment is merely ‘short term’ and therefore not covered by the Rehabilitation Act.”); but see Fishbaugh v. Brevard County Sheriff’s Dep’t, FCHR Order No. 04-103 ( Fla. Comm’n Hum. Rel. Aug. 20, 2004), available at http://fchr.state.fl.us/fchr/complaints_1/final_orders/final_orders_2004/fchr_order_no_04_103, aff’d in part, rev’d in part on other grounds, 2003 WL 22813121 (Fla. Div. Admin. Hrgs. Nov. 21, 2003) (terminated employee, who was not restricted in working, failed to show under Florida’s Civil Rights Act of 1992 that lifelong hormone treatments and medical monitoring substantially limited her in a major life activity).
other medical procedures. Hormones regulate a number of bodily functions, including body temperature, eating, mood, sexual desire, and sleeping.306 These therapies may also increase the risks for certain other medical conditions.307 “[T]he non-ameliorative effects of mitigating measures, such as negative side effects of medication or burdens associated with following a particular treatment regimen, may be considered when determining whether an individual’s impairment substantially limits a major life activity.”308 In addition, surgery and hormone therapy may have physical and psychological side effects that themselves constitute disabilities.309

- Individuals with a GID may have secondary psychiatric conditions, such as anxiety, depression, and severe stress, that can substantially limit an individual’s brain function and the ability to care for oneself, concentrate, interact with others, learn, sleep, and think.310 These

306 Pursuing Protection for Transgender People, at 85–86.
307 Pursuing Protection for Transgender People, at 86. See Evanthia Diamanti-Kandarakis et al., Endocrine-Disrupting Chemicals: An Endocrine Society Scientific Statement, 30 Endocrine Rev. 293–42 (2009), available at http://edrv.endojournals.org/cgi/reprint/30/4/293 and www.endocrine.org/-/media/endosociety/Files/Publications/Scientific%20Statements/EDC_Scientific_Statement.pdf (see Figure 1, which shows hormone-sensitive physiological systems, “including brain and hypothalamic neuroendocrine systems; pituitary; thyroid; cardiovascular system; mammary gland; adipose tissue; pancreas; ovary and uterus in females; and testes and prostate in males.”); Mayo Clinic, Hormone Therapy: Is It Right for You? (Oct. 25, 2012), available at www.mayoclinic.com/health/hormone-therapy/WO00046 (estrogen replacement treatment can increase the risk of serious health conditions, including blood clots, breast cancer, heart disease, and stroke); Katrina Karkazis et al., Out of Bounds? A Critique of the New Policies on Hyperandrogenism in Elite Female Athletes, 12 Am. J. Bioethics 3, 12 (2012), available at www.tandfonline.com/doi/abs/10.1080/15265161.2012.680533 (“anti-androgens used to treat hyperandrogenism can have sequelae . . . such as diuretic effects that cause excessive thirst, urination, and electrolyte imbalances; disruption of carbohydrate metabolism (e.g., glucose intolerance, insulin resistance); headache; fatigue; nausea; and liver toxicity”).
308 29 C.F.R. §1630.2(j)(4)(ii).
309 Jette v. Honey Farms Mini Mkt., 2001 WL 1602799, at *3 n.4, 23 Mass. Discr. L. Rep. 229 (Comm’n Ag. Discr. Oct. 10, 2001) (noting that “a complainant who has undergone surgery or hormone therapy may be able to establish physical or psychological side effects that rise to the level of a disability”; also holding that discrimination against individuals because of their transsexuality is discrimination on the basis of sex and disability under Massachusetts’ ADA-like, definition of “disability”). See Section III.F. infra.
are the types of secondary psychiatric conditions that the DSM has consistently cited as examples of the emotional distress that people with gender dysphoria may have (see Section III.G.2.b. infra).

- A GID may interfere with a gender-affirmed woman’s ability to interact with others and communicate as a result of the GID itself and/or the adverse effects of testosterone on her vocal chords311 and physical appearance, thereby resulting in a lower-pitched voice and a potentially more masculine-looking body, which will, at times, single her out as being different from other women.312 Gender-specific socialization skills are most easily achieved at a young age, as part of the growing up process among peers of the same gender. When children with gender dysphoria are deprived of the opportunity to fully socialize with children of the same gender identity, their socialization skills are impaired, which likely will carry over to later life.313 The DSM has consistently noted that gender dysphoria can cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (see Section III.G.2.b. infra).314

- Because many individuals with a GID are born with reproductive organs that do not match their brain gender, they do not have the ability to reproduce in the same manner as persons whose physical bodies and brain gender are in alignment. For example, a gender-affirmed

311 See the discussion in Chapter 31 (Names, Gender Markers, Pronouns, and Telephone Etiquette) regarding the impact of hormones on vocal cords.

312 Electro-Craft Corp., 1988 WL 1091932, at *4 (in a case under New Hampshire’s Law Against Discrimination, the court noted that “transsexuals frequently experience marked impairment of [the major life activities of] social and occupational functioning”); see McAlindin, 192 F.3d at 1233–35 (ADA employment case involving anxiety disorder that limited employee’s ability to interact with others, which is a major life activity).


314 See Enriquez v. West Jersey Health Sys., 777 A.2d 365, 376, 86 FEP 197, 11 AD 1810 (N.J. Super. Ct. App. Div.), certification denied, 785 A.2d 439 (N.J. 2001) (in holding that gender dysphoria can constitute a disability under New Jersey’s Law Against Discrimination, the court commented, “With regard to gender dysphoria specifically, [the DSM-IV] notes that the ‘disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.’ Transsexualism can be accompanied by a profound sense of loathing for an individual’s primary and secondary sexual characteristics, which is overwhelming and unalterable.”).
woman will not be able to become pregnant and give birth. Although persons with a GID may have reproductive organs that function normally in terms of and in congruence with their physical sex, the fact that their physical ability to reproduce is not impaired does not mean they are not substantially impaired in reproduction from a social standpoint. This situation was recognized as a disability by the Supreme Court in *Bragdon v. Abbott*, where the Court observed that “[r]eproduction and the sexual dynamics surrounding it are central to the life process itself.” Moreover, individuals with a GID who have genital surgery to relieve their gender dysphoria may be rendered sterile and, thus, no longer have the ability to reproduce and may have significantly impaired their ability to engage in intimate relationships. Medically induced impotence can substantially limit the major life activity of sexual relations.

**F. Other Conditions That Individuals With Gender Identity Disorders Have, Have Had, or Are Regarded As Having Are Protected by the Americans With Disabilities Act and the Rehabilitation Act**

Individuals with a GID, whether or not resulting from physical impairments, may have other disabilities that are protected by the ADA and the Rehabilitation Act. As Senator Harkin made clear during the discussion of the amendment that added the sexual behavior disorders exclusion to the ADA, “this amendment is narrowly focused. That is, if a person exhibits only a sexual behavior disorder, that person is not a disabled person under this act and cannot bring a cause of action for discrimination based on that disorder. Of course, this provision cannot be used as a pretext for discrimination based on other disabilities.”

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315 524 U.S. 624, 8 AD 239 (1998) (ADA public accommodation case). This aspect of the *Bragdon* decision is discussed in Section II.B.4.b. *supra*.

316 524 U.S. at 638. In *Bragdon*, although the plaintiff was fully capable of becoming pregnant and giving birth, she was still found to be substantially limited in her ability to reproduce and to bear children because her asymptomatic HIV infection imposed a significant risk of transmitting the infection to both her sexual partner and newborn. According to the Court, the definition of “disability” did not turn on the fact that the plaintiff made a “personal choice” not to reproduce. *Id.* at 641; *cf. id.* at 660–61 (Rehnquist, C.J., dissenting) (“voluntary choices” not to engage in sexual intercourse, give birth, and raise a child are not impairments that substantially limit a person’s major life activities).

317 McAlindin v. County of San Diego, 192 F.3d 1226, 1233–35, 9 AD 1217, 10 AD 252 (9th Cir. 1999) (ADA employment case involving impotence arising from the use of prescribed medications, where the Ninth Circuit noted that “sexuality is important in how we define ourselves and how we are perceived by others and is a fundamental part of how we bond in intimate relationships.”).


319 As discussed in Section II.C.3. *supra*, in the context of the legislative debates over the ADA, although homosexuality is excluded from the ADA, if LGB individuals have HIV or AIDS, then they are covered. *See, e.g.*, 135 CONG. REC. S10,767–772 (daily ed. Sept. 7, 1989)
As discussed earlier, the medical community is beginning to treat gender dysphoria as a physical condition with possible secondary psychiatric overlays, such as depression and anxiety. Coming out as gender affirmed, gender diverse, or as having a sexual orientation other than heterosexual can be very stressful. People risk losing their families, including spouses and children, their jobs, their homes, everything they cherish to live as their true selves. Individuals going through other life-changing events, such as divorces and catastrophic illnesses, may face similar challenges. These challenges often lead to depression, anxiety, and other non-GID psychiatric conditions. Adverse actions by employers premised on actual or perceived depression or anxiety would be actionable under the ADA and the Rehabilitation Act.

A 2012 study found that individuals with gender dysphoria have psychological distress not from the dysphoria but from the stigma they confront from society at large. This is not surprising given that children who are gender diverse are subjected to elevated levels of exposure to physical, psychological, and sexual abuse. “Being transgender is a quintessentially

(Senators Harkin and Kennedy made it very clear that although gays, lesbians, bisexuals, and illegal drug users are not protected by the ADA, they would be protected if they have AIDS or HIV). Accord Foley v. Runyon, 1995 WL 384447 (EEOC June 23, 1995) (claim that employee was perceived as having AIDS is cognizable under the Rehabilitation Act because it is not a disability claim based on his homosexuality).

Conditions such as a depression, anxiety, and panic disorders qualify as disabilities. See, e.g., Peters v. Baldwin Union Free Sch. Dist., 320 F.3d 164, 165, 168–69,13 AD 1793 (2d Cir. 2003) (Rehabilitation Act claim; “A mental illness that impels one to suicide can be viewed as a paradigmatic instance of incapacity to care for oneself.”); Mattice v. Memorial Hosp. of S. Bend, Inc., 249 F.3d 682, 684–86, 11 AD 1339 (7th Cir. 2001) (ADA claim; depression and panic disorder); and Quiles-Quiles v. Henderson, 439 F.3d 1, 4–8, 17 AD 1089 (1st Cir. 2006) (Rehabilitation Act claim; anxiety and depression). The 2013 edition of the DSM recognizes anxiety and depression as separate, comorbid conditions that an individual with gender dysphoria may have. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 458–59 (5th ed. 2013).

See Myers v. Cuyahoga Cnty., 182 F. App’x 510, 98 FEP 959, 18 AD 354 (6th Cir.), cert. denied, 549 U.S. 965 (2006) (summary judgment against a transsexual social worker on her ADA claim upheld because she failed to present any evidence that her adjustment disorder—which was diagnosed by the employer’s doctor—limited, let alone substantially limited, her in any major life activities); cf. Barnes v. City of Cincinnati, 401 F.3d 729, 95 FEP 994 (6th Cir.), cert. denied, 546 U.S. 1003, 96 FEP 1440 (2005) (in upholding a jury verdict in a Title VII sex-stereotyping case in favor of a transsexual police officer who was living off-duty as a woman, had a French manicure, had arched eyebrows, and on occasion came to work with makeup, the court noted that his supervisors’ unusually intensive oversight of him because of his gender nonconformity caused him significant stress); Smith v. City of Jacksonville Corr. Inst., 1991 WL 833882, at ¶¶27, 52 (Fla. Div. Admin. Hrgs. Oct. 2, 1991), aff’d in part, rev’d in part on other grounds, FCHR Order No. 92-023 (Fla. Comm’n Hum. Rel. June 10, 1992), available at http://www.doah.state.fl.us/ROS/1998/88005451%20ATAFO.pdf (in a case decided under the Florida Human Rights Act, the hearing officer held that a terminated employee was a person with a disability, observing that her “transsexualism caused ongoing suicidal ideation, [depression,] situational alcohol abuse, and poor health due to bleeding ulcers. By any view, these symptoms interfered with Petitioner’s full and normal use of her mental and physical faculties and limited Petitioner’s major life activities, i.e. life and health.”).

The stigmatic condition that has engendered fear and discomfort in others wholly separate and apart from the effect that being transgender has on any one person’s life.” The 2011 Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder observed that “[a]dults with gender identity concerns have also often experienced stigmatization or victimization related to gender variant appearance or behavior, or on the basis of actual or presumed sexual orientation…. In fact, some authors have concluded that such stigmatization largely accounts for mental illness among individuals with GID.” As a result of the stigma, referred to as “gender-related abuse” or “interpersonal abuse,” those authors found that more than 50 percent of gender-affirmed women have had lifetime major depression (which is almost three times higher than the national average) and lifetime suicide ideation (more than three times higher than the national average); 35 percent plan their suicides (ten times higher than the national average); and nearly 30 percent actually attempt suicide (seven times higher than the national average). The 2013 edition of the DSM recognized this, observing that “[g]ender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity [such as anxiety and depressive disorders], school dropout, and economic marginalization, including unemployment.”

easily fit. Many not only experience an inner sense of not belonging but also harassment and discrimination, including verbal and physical abuse and reduced access to education, employment, housing, medical care, and other social services. A disproportionate number of violent and sometimes lethal acts are directed against transgender and other gender-variant people.”)


American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 458 (5th ed. 2013) (DSM-5). The DSM-5 is discussed in Section III.G.2.b.viii. infra.
stress, anxiety, depression, and/or suicidality, arising from the abuse—and not from the gender dysphoria—are protected disabilities under the ADA and the Rehabilitation Act.327

Likewise, if an employer thinks an LGBT employee is a psychiatrically disturbed person, wrongly perceiving the individual to be, for example, bipolar or schizophrenic, and terminates the employee based on the mistaken diagnosis, then the employee should be able to seek redress under the ADA for “regarded as” discrimination.328 Many adult, gender-affirmed patients have been misdiagnosed as being bipolar. Bipolar disorder “is associated with mood swings that range from the lows of depression to the highs of mania. When you become depressed, you may feel sad or hopeless and lose interest or pleasure in most activities. When your mood shifts in the other direction, you may feel euphoric and full of energy.”329 Consider, for example, adults who have been depressed for most of their lives as a result of their gender dysphoria and then learn that, despite religious and social upbringing that led them (and others) to believe they were abnormal, freakish people, they have a medical condition that can be treated with hormones and surgery. A common reaction is to feel relieved, indeed euphoric, that they really are not social outcasts and can live openly as their true selves with some basic, nonpsychiatric medical treatment. A psychiatrist—or employer—not familiar with gender identity issues and the advances in medical knowledge might well misperceive these individuals as being bipolar. If an employer takes adverse action based on the misdiagnosis or simply the belief that an employee is bipolar (or schizophrenic, delusional, etc.), then it likely will violate the ADA, the Rehabilitation Act, and/or similar state laws.

G. Arguments for Expanding the Coverage of the Americans with Disabilities Act and the Rehabilitation Act to Include All Gender Identity Disorders (Including Transsexualism) and Transvestism

1. Introduction

As explained in the preceding sections, the ADA and the Rehabilitation Act protect individuals with a GID from discrimination on the basis of either their GID (when it results from a physical impairment) or other disabilities

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327 See Peters v. Baldwin Union Free Sch. Dist., 320 F.3d 164, 165, 168–69, 13 AD 1793 (2d Cir. 2003) (in a case under the Rehabilitation Act and New York’s Human Rights Law, the Second Circuit also noted that “[a] mental illness that impels one to suicide can be viewed as a paradigmatic instance of inability to care for oneself. It therefore constitutes a protected disability under the Rehabilitation Act”).

328 Cf. Foley v. Runyon, 1995 WL 384447 (EEOC June 23, 1995) (EEOC held that a claim that employee was perceived as having AIDS is cognizable under the Rehabilitation Act as it is not a disability claim based on his homosexuality). See Section II.B.5. supra relating to “regarded as” discrimination claims, and Section III.G.2.c.iii. infra discussing state law cases applying the “regarded as” prong to individuals with gender dysphoria.

they have that are indisputably covered by these laws (e.g., depression or cancer). Because the medical science with respect to the etiology of GIDs is not yet fully understood (which, as explained previously, is the case with many other medical conditions that courts have no difficulty in accepting as disabling), it is worthwhile to consider arguments in favor of giving these federal laws a broader interpretation, such that all cases of GIDs (including transsexualism), whether or not arising from physical impairments, are treated as protected disabilities. This section of the chapter sets forth two such arguments.

First, as described previously in this chapter, as a result of the hidebound views of two U.S. senators and the lack of understanding of the American Psychiatric Association’s DSM by other members of Congress, both GIDs not resulting from physical impairments and transsexualism were inappropriately classified in the ADA and the Rehabilitation Act as “sexual behavior disorders,” which are excluded from both laws. In view of this clearly erroneous classification, courts should not bar disability claims by individuals who have GIDs not resulting from physical impairments or transsexualism, as those conditions are defined in the DSM-III-R (1987), by (1) limiting the sexual behavior disorders exclusion to just those conditions that the DSM-III-R actually recognized as sexual behavior disorders—referred to as “paraphilias” in the DSM-III-R—at the time the exclusion was enacted in 1990; (2) striking the exclusion of GIDs not resulting from physical impairments and transsexualism, as having been erroneously included among the sexual behavior disorders; or (3) finding that “gender dysphoria,” as currently defined by the medical community, is not within the scope of either law’s sexual behavior disorders exclusion. In the 2013 edition of the DSM (DSM-5), the GID (including transsexualism) diagnosis was replaced with the new diagnosis, “gender dysphoria.”

Second, the exclusion of individuals with GIDs not resulting from physical impairments, transsexualism, or transvestism, as well as transvestites, violates their rights to equal protection of the laws and thus should not be enforced. Acceptance of this second argument would help protect individuals who are gender diverse but wrongly regarded as having the psychiatric condition transvestism (which was replaced with the revised diagnosis “transvestic disorder” in the DSM-5).

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330 As discussed in Section III.E. supra, a growing body of medical evidence suggests that GIDs (including transsexualism) have a biological or physical origin. As discussed in this section, the DSM has long recognized that labeling conditions as mental disorders does not imply that the conditions are unrelated to biological or physical factors or processes. Thus, the ADA likely created, and the Rehabilitation Act likely reinforced, a false dichotomy between GIDs not resulting from physical impairments on the one hand, and GIDs resulting from physical impairments on the other.

331 The legislative history of the “LGBT exclusions,” including particularly the morality-based comments of Senators Armstrong and Helms, is discussed in Section III.C.3. supra. As discussed in Section II.C.3–4. supra, similar comments were made by legislators in the context of how HIV and AIDS would be treated under the ADA.
2. The Argument That Gender Identity Disorders (Including Transsexualism) Were Not Sexual Behavior Disorders When the Americans with Disabilities Act was Enacted and Still Are Not Sexual Behavior Disorders

a. Introduction

The exclusion of both GIDs not resulting from physical impairments and transsexualism from the ADA and Rehabilitation Act’s definition of “disability” was based on the misunderstanding that they were “sexual behavior disorders,” and thus, as discussed in Section III.C.3.a. supra, were not worthy of protection because of their “moral content.” The reality, however, is that ever since GIDs, including transsexualism, were added to the DSM-III in 1980, they have been grouped in the DSM separately from the paraphilias, which are the DSM’s equivalent of sexual behavior disorders. In addition, when the ADA’s sexual behavior disorders exclusion was enacted in 1990, the DSM-III-R, which was published in 1987, was the version that was the basis for the legislative debates in Congress. In the DSM-III-R, GIDs (including transsexualism) were reclassified from “psychosexual disorders” (which were divided into four classes—GIDs, paraphilias, psychosexual dysfunctions, and other psychosexual disorders) to “disorders usually first evident in infancy, childhood, or adolescence,” a classification hardly suggestive of any type of sexual behavior disorder. To show that GIDs (including transsexualism) have never been categorized as sexual behavior disorders, the following discussion traces the evolution of the DSM’s inclusion of homosexuality, GIDs, and paraphilias, and the reason for their inclusion in and, in the case of homosexuality, its subsequent removal from, the DSM.

In view of the discussion in this section, courts should construe the sexual behavior disorders exclusion in the ADA and the Rehabilitation Act as being limited to the paraphilias actually set forth in the DSM and not extending to GIDs not resulting from physical impairments and transsexualism, which are clearly misclassified as sexual behavior disorders. Alternatively, the court should strike the inclusion of GIDs not resulting from physical impairments and transsexualism, as having been erroneously included among the sexual behavior disorders. Should a court be disinclined to alter the language of either law, then it should find that “gender dysphoria,” the new DSM-5 diagnosis, is not within the scope of either law’s sexual behavior disorders exclusion.

Cf. United States v. Happy Time Day Care Ctr., 6 F. Supp. 2d 1073, 1080 (W.D. Wis. 1998) (in an ADA public accommodation case where the court found that a suppressed immune system resulting from HIV can substantially limit a person’s ability to care for oneself, the court declined to consider whether procreation was a major life activity for a three-year-old child because “there is something inherently illogical about inquiring whether an individual’s ability to perform a particular activity is substantially limited . . . when . . . this individual is incapable of engaging in that activity in the first place”).
b. The Diagnostic and Statistical Manual of Mental Disorders and the LGBT Exclusions

(i.) Introduction

A brief history of the inclusion of homosexuality and GIDs (including transsexualism) in the eight iterations of the DSM helps illuminate the reactionary views of two U.S. senators who persuaded their colleagues to include GIDs in the ADA’s listing of excluded sexual behavior disorders. A discussion of the DSM, and the politics within the psychiatric community related to it, is bound to cause significant controversy, especially when it comes to sexual orientation, gender identity, and gender expression. To minimize the risk of being drawn into that morass, this section draws on an article written by Jack Drescher, a psychiatrist who was a member of the working group that drafted the revised diagnoses that are included in the DSM-5’s three new, highest-level classifications—gender dysphoria, sexual dysfunctions, and paraphilic disorders. As will be seen, Drescher’s article, Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual, discusses how the DSM has been used to medically stigmatize a socially disliked group of individuals (i.e., LGBT people), how the removal of homosexuality partially removed that stigma, and the debate over whether GIDs or gender dysphoria belongs in the DSM.

With respect to sexual orientation, Drescher explains that the adverse social attitudes toward homosexuality arose out of religious teachings. Civil law followed, with enactment of homophobic laws, such as those criminalizing sodomy in most of the United States. Psychiatric diagnoses were used to replace religious and supernatural explanations for unacceptable social behaviors, such that “many ‘sins’ would eventually come to be classified as ‘illnesses’: demonic possession redefined as insanity, drunkenness as alcoholism, and sodomy as an illness called homosexuality.” Drescher points to a 19th-century diagnosis as a classic example of using psychiatry as a form of social control: drapetomania, a “disorder of slaves who have a tendency to run away from their owner due to an inborn propensity for

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334 Id. at 432, 440, 447.

335 Id. at 432, 440, 443, 447. For an extensive discussion of the use of religion and laws to socially stigmatize groups of people with legitimate medical conditions, such as cancer, cholera, epilepsy, HIV or AIDS, leprosy, mental illnesses, and tuberculosis, because of fears, myths, and ignorance, see Adrienne L. Hiegel, Sexual Exclusions: The Americans with Disabilities Act as a Moral Code, 94 Colum. L. Rev. 1451, 1452–66 (1994).

336 Queer Diagnoses, at 440.
Once homosexuality was removed from the *DSM* in 1973, “unprecedented social acceptance of gay men and women gradually ensued,” including the 2003 U.S. Supreme Court decision, in *Lawrence v. Texas*, which struck down sodomy laws.

With respect to gender-affirmed and gender-diverse individuals, Drescher notes that religious teachings did not approve of cross-dressing or transsexualism. Most people have assumed that transgender individuals are homosexuals, and early psychiatrists conflated the two concepts. Indeed, transgender people are often seen as the “most subversive” segment of the LGBT movement. They have a longer history of civil rights activism than gays and lesbians, and were active participants in the New York City Stonewall Riots, which were a defining moment in the LGBT movement.

Gender-affirmed and gender-diverse people challenge most societies’ gender beliefs, which draw on strict conformance to a male/female gender binary and touch nearly all aspects of daily life. To enforce this binary approach to gender, most cultures require that all newborns be designated male or female.

Although many physicians and psychiatrists initially opposed hormone and surgical treatments for individuals with a GID, because they felt these individuals were neurotic or psychotic, over time the medical profession came to recognize that such treatments were the proper remedy for many indivi-

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338 *539 U.S. 558 (2003).*

339 *Queer Diagnoses,* at 443.

340 *Queer Diagnoses,* at 430, 436, 440, 443, 447.


342 *Id.* at 434, 442–43, 446. According to Kara Suffredini, “It is notable that the primary actors in the Stonewall Riots were transgendered. This fact testifies to an initial connection between transgenders and gays at the inception of the visible gay and lesbian civil rights movement. However, the discussion of this historic connection is noticeably absent from much of the discussion about, and between, the transgender and gay civil rights movements today.” *Kara S. Suffredini, Which Bodies Count When They Are Bashed?: An Argument for the Inclusion of Transgendered Individuals in the Hate Crimes Prevention Act of 1999, 20 B.C. THIRD WORLD L.J.* 447, 448–49 (2000), available at http://lawdigitalcommons.bc.edu/twlj/vol20/iss2/6 (footnotes omitted). See also Professor Susan Marine’s essay in Chapter 44 (A Millennial Moment: Understanding Twenty-First Century LGBT Workers and Their Allies).

343 *Queer Diagnoses,* at 430. See Glenn v. Brumby, 663 F.3d 1312, 1316, 113 FEP 1543 (11th Cir. 2011) (“a person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes”). The *Glenn* decision is discussed further in Chapters 6 (Glenn v. Brumby: Forty Years After Grossman), 14 (Title VII of the Civil Rights Act of 1964), and 15 (Federal Equal Protection).

344 *Queer Diagnoses,* at 431. Drescher notes how in Iran, where homosexuality is illegal, gender-affirmation surgeries flourish to enforce the country’s strict binary gender and religious beliefs. *Id.* at 431. Iran’s approach to transsexualism is also discussed in Rev. Jean Southard’s essay in Chapter 45 (Faith Communities and Justice for Lesbian, Gay, Bisexual, and Transgender Individuals).
als, as psychotherapy did not resolve their gender dysphoria. The late Harry Benjamin, the physician who perhaps had the most positive impact on the proper hormonal and surgical treatment of gender-affirmed individuals, "believed that the transsexual suffers from a biological disorder, that his brain was probably ‘feminized’ in utero” and eschewed “any psychological explanation.” As Drescher explains, the 1980 addition of transsexualism to the DSM (in the DSM-III) was based on the research and clinical contributions of four leading medical doctors, including Benjamin, who “took issue with the prevailing psychiatric view of their time that dismissed the existence of transgender subjectivities as a unique psychological phenomenon in its own right. The pioneering activities of these men—creating gender clinics and providing medical and surgical treatment to trans individuals—ultimately led to the new diagnosis in the DSM. They also changed professional and eventually public attitudes toward sex reassignment.”

It is important to note that GIDs (including transsexualism) were added to the DSM to facilitate the availability of medical treatment, such as hormones and surgeries, and insurance coverage for patients. The addition of GIDs to the DSM in 1980 afforded an oppressed group access to nonpsychiatric medical treatments that would not have otherwise been available and protected medical doctors from the potential for lawsuits from patients who might have “postoperative regrets” by having psychiatrists rule out comorbid pathologies, such as delusion. The addition of GIDs to the DSM also provided transsexuals the opportunity to come out and be visible, thereby educating the medical community, whose view of transgender people improved significantly as a result. However, the inclusion of GIDs (including transsexualism) in the DSM carried with it a significant

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346 Queer Diagnoses, at 437–40. See also Section III.E.4. supra.

347 The international Standards of Care that are used to treat the medical aspects of GIDs were previously named after Benjamin. See Harry Benjamin STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS (6th ed. 2001). In 2011, the standards were revised and renamed the “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.” World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (7th ver. 2011), reprinted in 13 INT’L J. TRANSGENDERISM 165 (2011), available at www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf.


349 Queer Diagnoses, at 437.

350 Id. at 441, 446, 449–50.

351 Id. at 441–42, 446, 449–50.


353 Queer Diagnoses, at 442–44.
downside, which would become evident a decade later in the exclusion of GIDs not resulting from physical impairments and transsexualism from the protections afforded by the ADA and the Rehabilitation Act: “Psychiatric classification can initially increase public empathy for people who are seen as suffering from a ‘disease’ and can even enable oppressed groups to be treated more humanely, but classification comes at the cost of reinforcing the belief that certain behaviors are deviant, subnormal, or pathological, and therefore less deserving of genuinely equal rights.”354

Today, the medical community resolves the gender dysphoria that some people experience as a result of the disconnect between their brains and their physical bodies by recognizing that the individuals with a GID are normal but simply may need to have their physical bodies, not their minds, modified.355 Thus, although treatment options are still needed for some people, it is suggested that the condition be coded as a medical, not psychiatric, diagnosis, no different from other surgical procedures that resolve other physical “abnormalities,” such as a cleft lip and palate, that can cause psychiatric overlays.356

Although pockets of resistance to transgender individuals still exist—such as from people who rally against same-sex marriage (for example, because a person who is married and goes through a gender affirmation is in a same-sex marriage357) or who oppose laws that protect individuals from discrimination based on gender identity or expression (for example, by

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354Id. at 444, 447 (quoting Margaret Nichols, Dreger on the Bailey Controversy: Lost in the Drama, Missing the Big Picture, 37 ARCHIVES SEXUAL BEHAV. 476, 476 (2008), available at http://dx.doi.org/10.1007/s10508-008-9329-x (internal quotation marks omitted)). Accord Milton Diamond & Hazel Beh, Variations of Sex Development Instead of Disorders of Sex Development, ARCHIVES DISEASE CHILDHOOD (July 27, 2006 e-letter), available at http://adc.bmj.com/content/91/7/554/reply and www.hawaii.edu/PCSS/biblio/articles/2005to2009/2006-variations.html (“It is undeniable that medical labels have a power that transcends medical treatment. Those who influence how medicine classifies individuals must be sensitive to the potential transformative power of the labels they assign. Medical labeling affects social and legal order. But most importantly, labeling affects individuals. While medicine from time to time may reconsider terminology, the labels assigned to persons born today with sexual characteristics outside statistical norms can become static symbols of their inferiority that they might shoulder for a lifetime.”).

355See id. at 445–46; HARRY BENJAMIN, THE TRANSEXUAL PHENOMENON 53, 89 (Symposium 1999) (1966), available at http://web.archive.org/web/20130223091015/http://tgmeds.org.uk/downs/phenomenon.pdf (“Psychotherapy with the aim of curing transsexualism, so that the patient will accept himself as a man, it must be repeated here, is a useless undertaking.”); National Association of Social Workers, Statement on Gender Identity Disorder and the DSM (May 18, 2010), available at www.socialworkers.org/diversity/new/lgbtq/51810.asp (GID and gender dysphoria “should be viewed and approached from the perspective of a medical model rather than that of a mental health model…. More appropriate is a medical diagnosis and support for mental health and life coping issues related to the diagnosis.”); Kosilek v. Spencer, 740 F.3d 733, 765 (1st Cir. 2013), reh’g en banc granted and majority and dissenting appellate opinions withdrawn by Order of Court, No. 12-2194 (1st Cir. Feb. 12, 2014) (setting hearing en banc for May 8, 2014) (noting that “psychotherapy as well as antipsychotics and antidepressants … do nothing to treat the underlying [gender identity] disorder” (quoting Fields v. Smith, 653 F.3d 550, 556 (7th Cir. 2011), cert. denied, 566 U.S. ___, 132 S. Ct. 1810 (2012)));

356See Queer Diagnoses, at 445–46, 453.

357See Chapter 37 (Employee Benefit Issues), Section III.E.2.e.
making the disproven argument that allowing gender-affirmed women to use women’s restrooms will result in an onslaught of sexual assaults of women and girls\(^{358}\)—the reality is that the “trans train” has already left the station, in terms of both medical and social acceptance.\(^{359}\) As was the case with gays and lesbians in the 1970s and 1980s, gender-affirmed or gender-diverse individuals are now being accepted by mainstream society at what seems to be a far faster rate of acceptance than earlier with gays and lesbians.\(^{360}\) Much has changed since the early 1970s, when Paula Grossman came out as a transgender schoolteacher and unsuccessfully litigated for her right to continue teaching.\(^{361}\) Within the first 14 years of the third millennium, just a few of the significant indicators of this change are as follows:

- the exponential presence in grammar and high schools of transgender students, teachers, and parents;\(^{362}\)
- the attendance of transgender men at the remaining “Seven Sisters” women’s colleges;\(^{363}\)
- the election and appointment of openly gender-affirmed or gender-diverse people to public positions;\(^{364}\)

\(^{358}\) See Chapters 36 (Gender-Segregated Facilities) and 42 (The “Bathroom Bill” Security Concerns Debunked). These types of appeals to fear have been referred to as “dog whistle politics.” See Ian Haney López, *Dog Whistle Politics: How Coded Racial Appeals Have Reinvented Racism and Wrecked the Middle Class* (2014).

\(^{359}\) With respect to social acceptance, see the essays in Parts II (Personal Essays: Walk in Our Shoes) and VIII (LGBT People in the Context of Culture, Religion, and Society).

\(^{360}\) As of April 2014, 18 states, the District of Columbia, and Puerto Rico have laws that prohibit discrimination based on gender identity or expression. With one exception (Minnesota in 1993), all those laws were enacted and/or went into effect in the 14-year period from 2001 to 2014. Those same jurisdictions, as well as three other states, bar sexual orientation discrimination. See Chapter 20 (Survey of State Laws Regarding Gender Identity and Sexual Orientation Discrimination in the Workplace). Prior to 2001, it took 23 years (1977 to 1999) before just 11 states (including Minnesota) and the District of Columbia had enacted their sexual orientation laws, and an additional 14 years (2000 to 2013) to pass sexual orientation laws in the remaining 10 states and Puerto Rico.

\(^{361}\) Grossman is the subject of Scott Keeler’s and Richard Schachter’s essays, respectively, in Chapters 4 (The Shattering of Illusion: The Case of Paula Grossman, Pioneering Transgender Plaintiff) and 5 (Why the Fuss? My Best Grammar School Teacher Was Fired Simply Because She Was a “Transsexual”). In contrast to Grossman, Vandy Beth Glenn, who wrote the essay in Chapter 6 (*Glenn v. Brumby: Forty Years After Grossman*), was successful in her litigation. Their litigations are further discussed in Chapters 14 (Title VII of the Civil Rights Act of 1964) and 39 (Law and Culture in the Making of *Macy v. Holder*).

\(^{362}\) See, e.g., *Queer Diagnoses*, at 453.


• the very positive coverage of gender-affirmed and gender-diverse individuals by the media\textsuperscript{365} and in movies featuring highly respected actors and actresses;\textsuperscript{366}
• the change in religious attitudes;\textsuperscript{367}
• the very open support of transgender health issues by leading medical organizations, including the American Academy of Nursing, American College of Nurse-Midwives, the American College of Obstetricians and Gynecologists, the American Medical Association (AMA), the American Psychiatric Association, the American Psychological Association, and the World Professional Association for Transgender Health;\textsuperscript{368}
• the recognition by the U.S. Tax Court and other tribunals, the Internal Revenue Service, and health insurance companies that gender-affirming medical procedures are neither cosmetic nor experimental and are, in fact, medically necessary;\textsuperscript{369}
• the support of bar associations, such as the American Bar Association, which has urged federal, state, and local governments to enact legislation prohibiting discrimination on the basis of actual or perceived gender identity or expression, in employment, housing, and public accommodations;\textsuperscript{370} and

while presenting as a man and 18 years later was reelected when presenting as a woman but still using his male name and masculine pronouns to refer to himself). To read Rasmussen's bio in his own words, see Stu Rasmussen for Mayor of Silverton, available at www.sturasmussen.com/about.htm.


\textsuperscript{366} See, e.g., the following films: Soldier’s Girl (2003) (true-life story of the murder of soldier Barry Winchell because of his relationship with a transgender woman); Normal (2003) (Tom Wilkinson portrayed the husband beginning a gender affirmation and Jessica Lange portrayed the wife); Transamerica (2005) (Felicity Huffman portrayed the transgender woman); and Dallas Buyers Club (2013) (Jared Leto received the Best Actor in a Supporting Role Oscar\textsuperscript{®} for his portrayal of a transgender woman). See also Boys Don’t Cry (1999) (true-life story of the murder of Brandon Teena, a transgender man; Hilary Swank received the Best Actress Oscar\textsuperscript{®} for her portrayal of Teena).

\textsuperscript{367} See Rev. Jean Southard’s essay in Chapter 45 (Faith Communities and Justice for LGBT Individuals). See also Queer Diagnoses, at 447.

\textsuperscript{368} See Chapter 37 (Employee Benefit Issues), Section III.G.

\textsuperscript{369} See Chapter 37, Section III.H.

\textsuperscript{370} American Bar Association, House of Delegates Resolution 122B (Aug. 2006), available at www.abanet.org/leadership/2006/annual/dailyjournal/hundredtwentytwob.doc. See also Catherine Reuben’s essay in Chapter 13 (Why I Support Transgender Rights: An Employer-Side Lawyer’s Story), which discusses the support of the Massachusetts Bar Association and the
the application of Title VII and the Equal Protection Clause to protect
gender-affirmed and gender-diverse individuals and the enactment
of state and local laws prohibiting discrimination based on gender
identity and expression.

The history of the inclusion of homosexuality, GIDs (including trans-
sexualism), and transvestism in the eight iterations of the DSM is set out in
the following discussion. At the end of this chapter are six diagrams that
will allow readers to graphically see the evolution of the DSM.

(ii.) The Diagnostic and Statistical Manual [of] Mental
Disorders, First Edition (1952): Homosexuality and
Transvestism

The first edition of the DSM, commonly referred to as the DSM-I, in-
cluded the disorder “sexual deviation,” which was one of several “sociopathic
personality disturbances” (SPDs). Sexual deviation was “reserved for
deviant sexuality which is not symptomatic of more extensive syndromes,
such as schizophrenic and obsessional reactions. The term include[d] most
of the cases formerly classed as ‘psychopathic personality with pathologic
sexuality.’ The diagnosis . . . specify[ed] the type of the pathologic behavior,
such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism
(including rape, sexual assault, [and] mutilation).” Individuals with SPDs
were “ill primarily in terms of society and of conformity with the prevailing
cultural milieu.” The words “gender” and “paraphilias” do not appear in
the DSM-I. For a graphic depiction of the DSM-I’s diagnostic classifications,
see Exhibit 16.1 at the end of this chapter.

(iii.) The Diagnostic and Statistical Manual of Mental
and Transvestism

In the second edition of the DSM, commonly referred to as the DSM-II,
the diagnosis “sexual deviation,” which was reclassified as one of several
“nonpsychotic mental disorders,” was used

for individuals whose sexual interests are directed primarily toward objects
other than people of the opposite sex, toward sexual acts not usually associated

371 See Chapters 6 (Glenn v. Brumby: Forty Years After Grossman), 14 (Title VII of the
Civil Rights Act of 1964), 15 (Federal Equal Protection), and 39 (Law and Culture in the Mak-
ing of Macy v. Holder).
372 See Chapter 20 (Survey of State Laws Regarding Gender Identity and Sexual Orienta-
tion Discrimination in the Workplace).
373 AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL [OF] MENTAL
Queer Diagnoses, at 434.
374 DSM-I, at 38–39.
375 Id. at 38.
with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them.376

Exhibitionism, masochism, and voyeurism were added to homosexuality, transvestism, fetishism, pedophilia, and sadism.377 These eight terms were not defined in the DSM-II. In addition, the words “gender” and “paraphilias” do not appear in the DSM-II. For a graphic depiction of the DSM-II’s diagnostic classifications, see Exhibit 16.2 at the end of this chapter.


As a result of changing approaches to psychiatry, a changing of the guard within the American Psychiatric Association, and increased gay and lesbian activism arising from the 1969 Stonewall Riots, the Board of Trustees of the American Psychiatric Association voted in 1973 to remove homosexuality as a diagnosis from the DSM.378 Commencing with the seventh printing of the DSM-II, referred to herein as the DSM-II-R,379 the caption “homosexuality” was replaced with “sexual orientation disturbance” (SOD) and the following explanation was added:

This [diagnosis] is for individuals whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation. This diagnostic category is distinguished from homosexuality, which by itself does not constitute a psychiatric disorder. Homosexuality per se is one form of sexual behavior, and with other forms of sexual behavior which are not by themselves psychiatric disorders, are not listed in this nomenclature.380

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377 DSM-II, at 44.
378 Queer Diagnoses, at 434.
379 The revision of the DSM-II was not officially retitled the “DSM-II-R.”
The other “nonpsychotic mental disorders,” including transvestism, remained unchanged. No other changes to the *DSM* were made in 1973. For a graphic depiction of the *DSM-II-R*’s diagnostic classifications, see Exhibit 16.2 at the end of this chapter.

(v.) *The Diagnostic and Statistical Manual of Mental Disorders, Third Edition (1980): Ego-Dystonic Homosexuality, Transvestism, and Gender Identity Disorders (Including Transsexualism)*

In the third edition of the *DSM*, commonly referred to as the *DSM-III*, SOD was replaced with “ego-dystonic homosexuality” (EDH), which was placed within the new diagnostic class of “psychosexual disorders,” which also included new groupings called “psychosexual dysfunctions” (e.g., “inhibited sexual excitement” (such as erectile dysfunction), “inhibited orgasm,” and “premature ejaculation”), “paraphilias” (including transvestism, exhibitionism, fetishism, pedophilia, sexual masochism and sadism, voyeurism, and the newly added disorder zoophilia), and “gender identity disorders” (including transsexualism). EDH involved “a desire to acquire or increase heterosexual arousal, so that heterosexual relationships can be initiated or maintained, and a sustained pattern of overt homosexual arousal that . . . has been unwanted and a persistent source of distress.” Distress or confusion relating to one’s sexual orientation was also associated with two new diagnoses—“identity disorder” (within the diagnostic class for “disorders usually first evident in infancy, childhood, or adolescence”) and “psychosexual disorder not elsewhere classified.” SOD and its replacement EDH were retained in the *DSM* as a result of political compromises, despite the fact that “neither diagnosis met the definition of a disorder in the new nosology.” For a graphic depiction of the *DSM-III*’s diagnostic classifications, see Exhibit 16.3 at the end of this chapter.

For the first time, the *DSM* included a definition of “transvestism,” the “essential feature [of which] is recurrent and persistent cross-dressing by a heterosexual male that during at least the initial phase of the illness is for the purpose of sexual excitement. Interference with the cross-dressing results in intense frustration. This diagnosis is not made in those rare instances

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381 *American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders* 18, 261–83 (3d ed. 1980) (*DSM-III*). Copyright © 1980 American Psychiatric Association. See *Queer Diagnoses*, at 435. “Zoophilia” was the diagnosis for individuals who repeatedly fantasized about or engaged in sexual activity with animals as their “preferred or exclusive method of achieving sexual excitement.” *Id.* at 270.

382 *DSM-III*, at 281.

383 *Id.* at 65–67, 282–83.

384 *Queer Diagnoses*, at 435. For a condition to be included in the *DSM-III*, it had to cause “a painful symptom (distress) or impairment in one or more important areas of functioning (disability).” *DSM-III*, at 6. Mere expression of personal differences with respect to accepted social norms was not enough to label someone with a mental disorder. *DSM-III*, at 6.
in which the disturbance has evolved into Transsexualism.”385 This edition of the DSM noted that female impersonators did not necessarily have transvestism.386

The DSM-III introduced the concept of “gender identity disorder,” which was defined as

an incongruence between anatomic sex and gender identity. Gender identity is the sense of knowing to which sex one belongs, that is, the awareness that ‘I am a male,’ or ‘I am a female.’ Gender identity is the private experience of gender role, and gender role is the public expression of gender identity. Gender role can be defined as everything that one says and does, including sexual arousal, to indicate to others or to the self the degree to which one is male or female.387

Three different diagnoses for GIDs were created: one for children (GIDC), one for adolescents and adults (transsexualism), and a third one for conditions that did not fit the diagnostic criteria of the first two (atypical GID).388 To qualify as transsexualism, five criteria had to be satisfied: “A. [s]ense of discomfort and inappropriateness about one’s anatomic sex[;] B. [w]ish to be rid of one’s own genitals and to live as a member of the other sex[;] C. [t]he disturbance has been continuous . . . for at least two years[;] D. [a]bsence of physical intersex or genetic abnormality[; and] E. [n]ot due to another mental disorder . . . .”389 Individuals may be markedly impaired in social and occupational functioning as a result of both the GID and associated psychopathology, such as anxiety and depression.390 Depression is common and can lead to suicide attempts.391

According to the DSM-III, because sex reassignment surgery was then a relatively recent development, the efficacy of surgery in resolving transsexualism was deemed unknown.392 In contrast, according to the AMA Committee on Human Sexuality, “Psychotherapy for adult transsexuals has been largely ineffective and surgical reassignment of the sex is frequently employed.”393 As explained below, with the publication of the DSM-5 in 2013 the American Psychiatric Association came to agree with the AMA and Dr. Benjamin, who was at the forefront of the modern treatment of individuals with gender dysphoria, that the preferred and effective treatment for GIDs is medical, not psychiatric.394

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385DSM-III, at 269 (emphasis added).
387Id. at 261.
388Id. at 261–66. See Queer Diagnoses, at 437, 439.
389DSM-III, at 263–64.
390Id. at 262–63.
392Id. at 262.
393American Medical Association, Human Sexuality 136 (Committee on Human Sexuality 1972). The AMA further explained that transsexuals cross dress not for sexual reasons but to achieve harmony with their gender identity (sense of masculinity or femininity). Id. at 24, 136.
Beginning with the DSM-III, the DSM became “agnostic” with respect to the biological or physical factors or processes underlying the disorders included in the DSM.\textsuperscript{395} Although this may have been a useful development for the psychiatrists using the DSM,\textsuperscript{396} it could lead a casual reader, such as a U.S. senator, to wrongly conclude that most, if not all, psychiatric conditions are purely mental and, as such, psychosexual disorders are volitional problems reflective of weak morals.\textsuperscript{397}

As explained in Section III.G.2.b. supra, GIDs were added to the DSM to facilitate the availability of medical treatment, such as hormones and surgeries, and insurance coverage for patients, and to protect medical doctors from the potential for lawsuits, from patients who might have “postoperative regrets,” by having psychiatrists rule out comorbid pathologies, such as delusion. The DSM-III expressly noted that persons with a GID are not delusional.\textsuperscript{398} Retrospective studies have demonstrated that postoperative regret is extremely rare and, to the extent that there has been regret, it usually related to issues such as surgical complications and failure of families and friends to be supportive.\textsuperscript{399} These studies further validate that hormonal and surgical treatments are highly effective in resolving gender dysphoria.\textsuperscript{400}

phenomenon.pdf (although psychotherapy “is a useless undertaking” in resolving gender dysphoria, a preoperative psychiatric evaluation is useful to ensure the “emotional stability” of the patient and rule out psychosis); accord Kosilek v. Spencer, 740 F.3d 733, 765 (1st Cir. 2013), reh’g en banc granted and majority and dissenting appellate opinions withdrawn by Order of Court, No. 12-2194 (1st Cir. Feb. 12, 2014) (setting hearing en banc for May 8, 2014) (noting that “psychotherapy as well as antipsychotics and antidepressants . . . do nothing to treat the underlying [gender identity] disorder” (quoting Fields v. Smith, 653 F.3d 550, 556 (7th Cir. 2011), cert. denied, 566 U.S. ___, 132 S. Ct. 1810 (2012))).

\textsuperscript{395}Kenneth J. Zucker, Reports from the DSM-V Work Group on Sexual and Gender Identity Disorders, 39 Archives Sexual Behav. 217 (2010), available at http://dx.doi.org/10.1007/s10508-009-9548-9. The introduction to the DSM-III noted that different disorders may overlap and that for most disorders included in the DSM-III, their etiologies are unknown. DSM-III, at 6.

\textsuperscript{396}American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 7 (3d ed. 1980) (DSM-III) (“inclusion of etiological theories would be an obstacle to use of the manual by clinicians of varying theoretical orientations”).

\textsuperscript{397}The legislative history of the “LGBT exclusions,” including particularly the morality-based comments of Senators Armstrong and Helms, is discussed in Section III.C.3. supra. As discussed in Section II.C.3.–4. supra, similar comments were made by legislators in the context of how HIV and AIDS would be treated under the ADA.

\textsuperscript{398}DSM-III, at 263. See Benjamin, at 53, 60, 89 (although psychotherapy “is a useless undertaking” in resolving gender dysphoria, a preoperative psychiatric evaluation is useful to ensure the “emotional stability” of the patient and rule out psychosis).


In the revised third edition of the DSM, commonly referred to as the DSM-III-R, EDH, the final, significant remnant of the American Psychiatric Association’s treatment of nonheterosexual conduct as a pathological disorder, was removed. Distress related to one’s sexual orientation was still associated with two possible diagnoses—“identity disorder” (within the diagnostic class for “disorders usually first evident in infancy, childhood, or adolescence,” which also included GIDs) and “sexual disorder not otherwise specified” (within the new “sexual disorders” class, which included separate groupings for paraphilias, such as the renamed “transvestic fetishism,” and “sexual dysfunctions,” which included “sexual arousal disorders” (e.g., erectile dysfunction) and “orgasm disorders” (e.g., premature ejaculation)).

For a graphic depiction of the DSM-III-R’s diagnostic classifications, see Exhibit 16.4 at the end of this chapter.

The sexual disorder transvestic fetishism pertained to a heterosexual male with “recurrent, intense, sexual urges and sexually arousing fantasies, of at least six months’ duration, involving cross-dressing. The person has acted on these urges, or is markedly distressed by them. Usually the person keeps a collection of women’s clothes that he intermittently uses to cross-dress when alone. While cross-dressed, he usually masturbates and imagines other [males] being attracted to him as a woman in his female attire.” The other paraphilias with their own individual diagnoses—exhibitionism, fetishism, pedophilia, sexual masochism and sadism, and voyeurism—were carried forward into the DSM-III-R, although zoophilia was replaced with frotteurism.

GIDs were moved from psychosexual disorders to “disorders usually first evident in infancy, childhood, or adolescence,” an acknowledgment that in the “vast majority of cases the onset of [GID] can be traced back to childhood,” before puberty and sexual arousal issues. The DSM-III-R
removed the reference to “sexual arousal” and the suggestion that transsexualism is not associated with a physical intersex or genetic abnormality. The diagnostic criteria for transsexualism, which was the GID diagnosis for adolescents and adults, were revised to require “A. [p]ersistent discomfort and sense of inappropriateness about one’s assigned sex[;] B. [p]ersistent preoccupation for at least two years with getting rid of one’s primary and secondary sex characteristics and acquiring the sex characteristics of the other sex[; and] C. [t]he person has reached puberty.”406 In addition to the three types of GIDs identified in the DSM-III (GIDC, transsexualism in adolescents and adults, and a renamed GID not otherwise specified (GIDNOS)), the DSM-III-R added a fourth diagnosis called “GID of adolescence or adulthood, nontranssexual type” (GIDAANT), which was indicated for individuals who displayed “persistent or recurrent discomfort and sense of inappropriateness about one’s assigned sex, and persistent or recurrent cross-dressing in the role of the other sex, either in fantasy or in actuality, in a person who has reached puberty. This disorder differed from Transvestic Fetishism in that the cross-dressing is not for the purpose of sexual excitement; it differed from Transsexualism in that there is no persistent preoccupation (for at least two years) with getting rid of one’s primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.”407

The DSM-III-R continued to note that individuals may be markedly impaired in social and occupational functioning as a result of both the GID and associated psychopathology, such as anxiety and depression.408 The DSM-III-R estimated that one in 30,000 anatomical males and one in 100,000 anatomical females have the condition.409 Other studies suggest that there is a significantly larger population of gender-affirmed people, such as one in 12,900 anatomical males and one in 33,800 anatomical females; one in 2,900 anatomical males and one in 8,300 anatomical females; and one in 500 males.410 When compared to other “birth defects,” such as anencephalus

407 Id. at 76. See Queer Diagnoses, at 437.
408 DSM-III-R, at 74–75.
409 Id. at 75.
The introduction to the *DSM-III-R* observed that labeling conditions as mental disorders does not imply that the conditions are unrelated to biological or physical factors or processes. The introduction also noted that different disorders may overlap and the etiologies of most of the *DSM-III-R*’s disorders are unknown.

(vii.) *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994) and the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (2000): Transvestic Fetishism and Gender Identity Disorders*

The fourth edition of the *DSM* (commonly referred to as the *DSM-IV*) introduced, and the fourth edition, text revision (commonly referred to as the *DSM-IV-TR*) continued, a new diagnostic class—“sexual and gender identity disorders”—which included three subclasses: “sexual dysfunctions” (e.g., sexual desire and arousal disorders), paraphilias (including transvestic fetishism), and GIDs. For a graphic depiction of the *DSM-IV* and the *DSM-IV-TR*’s diagnostic classifications, see Exhibit 16.5 at the end of this chapter.

The *DSM-IV* and the *DSM-IV-TR*’s descriptions of the sexual disorder transvestic fetishism are significantly similar to each other and with the description in the *DSM-III-R*, though the *DSM-IV* and the *DSM-IV-TR* included a specifier for those heterosexual males with transvestic fetishism who have persistent discomfort with their gender role or identity that is insufficient for a diagnosis of a GID. The sexual disorders exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism and sadism, and voyeurism were also carried forward into the *DSM-IV* and the *DSM-IV-TR*.

As was the case with the *DSM-III-R*, GIDs remained distinct from sexual disorders. However, in contrast to the *DSM-III-R*, the two categories of GIDs—GIDC and transsexualism—were combined into one overarching
GID diagnosis, and the GIDAANT diagnosis was eliminated. GIDNOS was carried forward. Distress relating to one’s sexual orientation was again associated with two possible diagnoses—“identity problem” (within the diagnosis class for “other conditions that may be a focus of clinical attention”) and “sexual disorder not otherwise specified” (which was oddly placed as an orphan into the GIDs grouping because it did not fit within the criteria for any specific sexual disorders). The term “transsexualism” was removed from the textual discussion of the GIDs, perhaps in recognition of the pejorative meanings the term had acquired.

In the DSM-IV and the DSM-IV-TR, the revised basic diagnosis for GID in children, adolescents, and adults required that a person have a “strong and persistent cross-gender identification” and a “persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex” that “causes clinically significant distress or impairment in social, occupational, or other important areas of functioning,” but “is not concurrent with a physical intersex condition.” Individuals with intersex conditions who have gender dysphoria were diagnosed with GIDNOS.

When homosexuality was removed from the DSM in 1973, the published supporting rationale stated the following:

For a mental or psychiatric condition to be considered a psychiatric disorder, it must either regularly cause subjective distress, or regularly be associated with some generalized impairment in social effectiveness or functioning. With the exception of homosexuality (and perhaps some of the other sexual deviations when in mild form, such as voyeurism), all of the other mental disorders in [the] DSM-II fulfill either of these two criteria…. Clearly homosexuality, per se, does not meet the requirements for a psychiatric disorder since, as noted above, many homosexuals are quite satisfied with their sexual orientation and demonstrate no generalized impairment in social effectiveness or functioning.

The only way that homosexuality could therefore be considered a psychiatric disorder would be the criteria of failure to function heterosexually, which is considered optimal in our society and by many members of our profession. However, if failure to function optimally in some important area of life as judged by either society or the profession is sufficient to indicate the presence of a psychiatric disorder, then we will have to add to our nomenclature the following conditions: celibacy (failure to function optimally sexually), revolutionary behavior (irrational defiance of social norms), religious fanaticism (dogmatic and rigid adherence to religious doctrine), racism (irrational hatred

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420 See Fenway Health, Glossary of Gender and Transgender Terms 15 (rev. Jan. 2010), available at www.fenwayhealth.org/site/DocServer/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms_fi.pdf?docID=7081 (“The term ‘transsexual’ is hotly debated, and it is not certain whether people will use or reject this term. For some, it is disliked in the same way ‘homosexual’ has become disfavored. Many people find both transsexual and homosexual pejorative. ‘Transsexual’ is considered by some to be a misnomer inasmuch as the underlying medical condition is related to gender identity and not sexuality.”).
421 DSM-IV, at 537–38; DSM-IV-TR, at 581.
422 DSM-IV, at 538; DSM-IV-TR, at 582.
of certain groups), vegetarianism (unnatural avoidance of carnivorous behavior), and male chauvinism (irrational belief in the inferiority of women).\footnote{423}

If homosexuality per se does not meet the criteria for a psychiatric disorder, what is it? Descriptively, it is one form of sexual behavior. Our profession need not now agree on its origin, significance, and value for human happiness when we acknowledge that by itself it does not meet the requirements for a psychiatric disorder.\footnote{424}

This analysis is equally applicable to gender-diverse people who are not distressed by their bodies but express their gender identity in a way that does not correspond to the socially expected gender binary. As Drescher explains, “transgender” is used “by a variety of people who, in their own ways, transgressed usual sex and gender expectations.”\footnote{425} The term refers to a sense of persistent identification with, and expression of, gender-coded behaviors not typically associated with one’s sex at birth, and which were reducible neither to erotic gratification, nor psychopathological paraphilia, nor physiological disorder or malady. The self-applied term was meant to convey the sense that one could live non-pathologically in a social gender not typically associated with one’s biological sex, as well as the sense that a single individual should be free to combine elements of different gender styles and presentations, or different sex/gender combinations.\footnote{426}

The \textit{DSM-IV} and the \textit{DSM-IV-TR} acknowledged this by adding commentary that made it clear that merely being nonconforming to stereotypical gender role behavior is not a disorder.\footnote{427} Rather, the GID diagnosis was reserved for “a profound disturbance of the individual’s sense of identity with regard to maleness or feminality.”\footnote{428}

The \textit{DSM-IV-TR} added definitions of certain terms:

\textit{Gender identity} refers to an individual’s self-perception as male or female. The term \textit{gender dysphoria} denotes strong and persistent feelings of discomfort with one’s assigned sex, the desire to possess the body of the other sex, and the desire to be regarded by others as a member of the other sex. The terms \textit{gender identity} and \textit{gender dysphoria} should be distinguished from the term \textit{sexual orientation}, which refers to erotic attraction to males, females, or both.\footnote{429}

\footnote{423}The concept of nonpsychopathic deviance from social, religious, and sexual norms not being a mental disorder was highlighted in introductions to both the \textit{DSM-III} and the \textit{DSM-III-R}. \textit{DSM-III}, at 6; \textit{DSM-III-R}, at xxii.


\footnote{428}\textit{DSM-IV}, at 536; \textit{DSM-IV-TR}, at 580.

\footnote{429}\textit{DSM-IV-TR}, at 535.
The introductions to the *DSM-IV* and the *DSM-IV-TR* observed that although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders*, the term *mental disorder* unfortunately implies a distinction between “mental” disorders and “physical” disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much “physical” in “mental” disorders and much “mental” in “physical” disorders.\(^\text{430}\)

The introductions also warned that “there are significant risks that diagnostic information will be misused or misunderstood” and could result in “ungrounded speculation about mental disorders” if the “pertinent clinical and research literature” is not reviewed.\(^\text{431}\)

(viii.) *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (2013): Transvestic Disorder and Gender Dysphoria

In the fifth edition of the *DSM*, commonly referred to as the *DSM-5*, GID is renamed “gender dysphoria.”\(^\text{432}\) In the *DSM-5*, sexual dysfunctions, paraphilic disorders (formerly paraphilias), and gender dysphoria are completely divorced from each other, and each one is now in its own, separate, highest-level diagnostic class. By placing gender dysphoria in its own class, the American Psychiatric Association has endeavored to destigmatize the condition and has minimized the risk that the *DSM* will be used to misclassify gender dysphoria as a sexual behavior disorder. The GIDNOS diagnosis was replaced with two diagnosis—Other Specified Gender Dysphoria and Unspecified Gender Dysphoria—for situations where the symptoms “do not meet the full criteria for gender dysphoria.”\(^\text{433}\) For a graphic depiction of the *DSM-5*’s diagnostic classifications, see Exhibit 16.6 at the end of this chapter.

Transvestic fetishism was renamed “transvestic disorder.”\(^\text{434}\) The most significant change in the criteria for this diagnosis is that it is no longer expressly limited to heterosexuals or males.

Distress relating to one’s sexual orientation took yet another step out of the *DSM*. The *DSM-5* expressly states that “identity problems” faced by adolescents and young adults, such as “conflicts about sexual orientation,” are not mental disorders.\(^\text{435}\) In the section of the *DSM-5* pertaining to conditions that may be a focus of clinical attention, “sex counseling” is listed

\(^{430}\) *DSM-IV*, at xxi; *DSM-IV-TR*, at xxx.

\(^{431}\) *DSM-IV*, at xxxii–xxiv; *DSM-IV-TR*, at xxxii–xxxiii.


\(^{433}\) *DSM-5*, at 459.

\(^{434}\) Id. at 702–04.

\(^{435}\) Id. at 665–66.
for individuals seeking counseling relating to issues such as sex education and sexual orientation.  

Before being published in final form, two drafts of the DSM-5 were released for public comment. The February 2010 draft renamed GID “gender incongruence” because this new term better reflected the incongruence between the identity people experience or express and how they are expected to live based on the gender assigned to them at birth. The revision also eliminated the stigmatizing concept of “disorder” with respect to this diagnosis, shifted the discussion from “sex” to “gender,” eliminated the intersex exclusion, reflected that gender dysphoria can be eliminated by transitioning and living in the gender that matches an individual’s gender identity, and noted the growing understanding that gender is not simply a question of being either male or female but rather is a continuum.

The May 2011 draft of the DSM-5 made several additional changes. First, gender incongruence was replaced with “gender dysphoria,” in recognition of the latter term’s common usage within and outside the medical community. A “B” criterion was inserted, to reflect that the diagnosis is reserved for “clinically significant distress or impairment in social, occupational, or other important areas of functioning.” The commentary accompanying the draft noted gender dysphoria’s uniqueness as a psychiatric diagnosis because it does not necessarily cause emotional distress and is treated with nonpsychiatric modalities (i.e., hormones, surgery, and/or legal and social transition). Nonetheless, an individual may have a significant emotional problem, such as depression or anxiety, as a result of other causes, such as social stigma, difficulty in obtaining appropriate medical care, employment discrimination, and rejection by family and friends. Third, a “posttransition” specifier

[436] Id. at 725.

[437] The American Psychiatric Association has removed from public view the draft versions of the DSM-5 gender dysphoria diagnostic class and criteria [hereinafter the DSM-5 Draft], along with the extensive supporting commentary (which was set forth under the “Rationale” tab) for the changes to the DSM, that had appeared at www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=482. As of December 2013, that web page was still accessible via the Wayback Machine at http://archive.org/web/web.php.


[440] DSM-5 Draft (under the “Proposed Revision” tab).

[441] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 452 (5th ed. 2013) (DSM-5) (the quoted language is from the final text of the DSM-5).

[442] DSM-5 Draft (under the “Rationale” tab).

was added, to account for the fact that a gender-affirmed person who had gender dysphoria generally does not have the dysphoria after transition but still may have a continuing need for medical assistance (such as hormone treatment or intermittent psychotherapy because of negative social reaction to the transition).\textsuperscript{445} The specifier expressly confirms that surgery is not required for an individual to transition.\textsuperscript{446} These changes were designed to ensure that mere gender variance is not diagnosed as gender dysphoria and that the redefinition of this condition does not result in jeopardizing either insurance coverage or treatment access for patients.\textsuperscript{447}

The final version of the \textit{DSM-5} includes the core changes proposed by the drafters.\textsuperscript{448} The commentary accompanying the final version does not expressly mention the uniqueness of the gender dysphoria diagnosis as had the earlier draft commentary.\textsuperscript{449} Nonetheless, the revised diagnostic criteria and final commentary make clear that hormones, surgery, and/or legal and social transition are the accepted pathways to eliminating the dysphoria, and that surgery is not required in order to fully transition. The final commentary reintroduced the term “transsexual” in the \textit{DSM}—to denote those transgender individuals who seek or who have undergone a social transition from one gender to another\textsuperscript{450}—despite the fact that many medical practitioners have moved away from using that term. It is important to note that the final commentary reaffirms that gender-variant behavior and living outside the binary of male/female is not pathological (although it can lead to “high levels of stigmatization, discrimination, and victimization”) and that a person can successfully go through a gender affirmation without having

\textsuperscript{445}\textit{DSM-5 Draft} (under the “Rationale” tab).
\textsuperscript{446}\textit{Id}. (under the “Proposed Revision” tab).
\textsuperscript{447}\textit{Id}. (under the “Proposed Revision” and “Rationale” tabs).
\textsuperscript{448}\textsc{American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders} 451–59, 814–15 (5th ed. 2013) (\textit{DSM-5}); see Jack Drescher, \textit{Controversies in Gender Diagnoses}, 1 LGBT Health 1, 3 (2013), available at http://online.liebertpub.com/doi/pdf/10.1089/lgbt.2013.1500 (highlighting the changes proposed by the working group that were adopted in the final version of the \textit{DSM-5}).
\textsuperscript{449}In articles that they have written, members of the working group that drafted the \textit{DSM-5} have referred to gender dysphoria as the “unique” psychiatric diagnosis that it is treated with nonpsychiatric modalities. See Drescher, at 1, 3 (noting that gender incongruence is a “unique medical condition”); Heino F.L. Meyer-Bahlburg, \textit{From Mental Disorder to Iatrogenic Hypogonadism: Dilemmas in Conceptualizing Gender Identity Variants as Psychiatric Conditions}, 39 Archives Sexual Behav. 461, 469, 471 (2010), available at http://dx.doi.org/10.1007/s10508-009-9532-4 (nothing that GID is a “unique” psychiatric diagnosis, “in that it is based on an incongruence between the assigned gender (usually based on the genital appearance) and the experienced gender, and the most successful intervention to date for adults in terms of patient satisfaction appears to be hormonal and surgical body modification.”); \textit{see also} National Association of Social Workers, Statement on Gender Identity Disorder and the \textit{DSM} (May 18, 2010), available at www.socialworkers.org/diversity/new/lgbtq/51810.asp (GID and gender dysphoria “should be viewed and approached from the perspective of a medical model rather than that of a mental health model. . . . More appropriate is a medical diagnosis and support for mental health and life coping issues related to the diagnosis.”).
\textsuperscript{450}\textit{DSM-5}, at 451, 830.
gender dysphoria or any medical intervention. As a result, the DSM-5 has replaced the phraseology “the other sex” with “the other gender” or “some alternative gender.”

The final commentary notes that cross-gender behaviors normally commence between ages two and four, and the feeling of dysphoria becomes more common as children approach puberty, with growing apprehension of the adverse effects of puberty on their bodies. The commentary also concedes that the DSM-IV failed to fully recognize that the boundaries between disorders are more porous than originally believed and that there is a “growing inability to integrate [the] DSM disorders with the results of genetic studies and other scientific findings.”

The DSM-5 provides two similar sets of revised diagnostic criteria for gender dysphoria in children and in adolescents and adults, with slight differences to reflect age-appropriate differences in the indicators of the gender dysphoria. In the case of adolescents and adults, the criteria are (a) “[a] marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration,” and (b) “[t]he condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.”

The drafters of the revised gender dysphoria diagnosis had noted that they chose not to make any decision about categorizing gender dysphoria as either a psychiatric or a nonpsychiatric condition. This is a further reflection of the growing body of research that gender dysphoria may be a medical condition arising from a physical impairment resulting from in utero hormonal and genetic causes; of the need to retain a diagnostic code so that hormonal and surgical treatments remain available to treat the underlying anatomical cause of the gender dysphoria; and of gender dysphoria’s unique position as a condition that is treated with hormones, surgery, and/or social and legal transition to the gender that accords with a person’s gender identity.

The DSM-5’s treatment of gender dysphoria is a long overdue recognition of what Dr. Benjamin observed nearly 50 years earlier in his classic

451 Id. at 14, 451, 453–54, 458, 814.
452 Id. at 452–53, 814.
454 Id. at 5–6, 10.
455 Id. at 452–53.
456 DSM-5 Draft (under the “Rationale” tab); Mark Moran, New Gender Dysphoria Criteria Replace GID, 48 PSYCHIATRIC NEWS 9 (Apr. 5, 2013), available at http://psychnews.psychiatryonline.org/data/Journals/PN/926751/psychnews_48_7_full_issue.pdf (the DSM-5 working group “decided the access-to-care issue was very important,” Drescher told Psychiatric News. “If you take out the diagnosis, you don’t have a code for treatment.”); Jack Drescher, Controversies in Gender Diagnoses, 1 LGBT HEALTH 1, 2–3 (2013), available at http://online.liebertpub.com/doi/pdf/10.1089/lgbt.2013.1500 (explaining how the DSM-5 attempts to balance the need to reduce the stigma associated with the diagnosis of gender dysphoria with the need to retain the diagnosis to maintain access to care).
457 DSM-5 Draft (under the “Rationale” tab); accord Drescher, at 3 (noting that gender incongruence is a “unique medical condition”). Columbia University Medical Center Professor
treatise, The Transsexual Phenomenon: “Psychotherapy with the aim of curing transsexualism, so that the patient will accept himself as a man, it must be repeated here, is a useless undertaking with present available methods.”458 Or as professional golfer Mianne Bagger has put it, “People need to understand that we are actually females with a physical problem, and not males with a psychological problem. We were born this way.”459

In July 2012, the American Psychiatric Association officially endorsed medical and surgical treatment for transgender and gender-variant individuals and opposed discrimination against such individuals.460 In particular, the Association acknowledged that individuals with gender dysphoria “can

Heino F.L. Meyer-Bahlburg reviewed various theories relating to the development of “gender identity variants,” including

[a] number of recent findings suggest that GID may perhaps be understood in part as a [central nervous system (CNS)]-limited form of DSD or intersexuality, without involvement of the reproductive tract.

It is also conceivable that there may be genetically based systemic sex-hormone abnormalities that do not cause abnormalities of the reproductive anatomy, but nevertheless influence brain and behavior. . . . Such genetic mechanisms may underlie the demonstration of substantial heritability of gender-related behavior in general and GID in particular in child and adolescent twin samples. . . . The absence of genital abnormalities in such cases suggests dose specificity or tissue specificity of the androgen receptor deficit, or timing effects, the latter because it has long been demonstrated in animal research that the sexual differentiation of the brain during a hormone-sensitive prenatal or perinatal period can be modified independently of the (earlier) sexual differentiation of the reproductive tract. . . .

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At the very least, GID is an unusual psychiatric category, in that it is based on an incongruence between the assigned gender (usually based on the genital appearance) and the experienced gender, and the most successful intervention to date for adults in terms of patient satisfaction appears to be hormonal and surgical body modification.

Heino F.L. Meyer-Bahlburg, From Mental Disorder to Iatrogenic Hypogonadism: Dilemmas in Conceptualizing Gender Identity Variants as Psychiatric Conditions, 39 Archives Sexual Behav. 461, 465–66, 469 (2010), available at http://dx.doi.org/10.1007/s10508-009-9532-4. See also National Association of Social Workers, Statement on Gender Identity Disorder and the DSM (May 18, 2010), available at www.socialworkers.org/diversity/new/lgbtq/51810.asp (GID and gender dysphoria “should be viewed and approached from the perspective of a medical model rather than that of a mental health model. . . . More appropriate is a medical diagnosis and support for mental health and life coping issues related to the diagnosis.”).


benefit greatly from medical and surgical gender transition treatments” and 
that health insurance plans should cover “gender transition treatments,” 
which the Association said are medically necessary. The Association 
recognized that “the presence of the GID diagnosis in the DSM has not 
served its intended purpose of creating greater access to care—one of the 
major arguments for diagnostic retention.”

Further, the American Psychiatric Association stated that transgender 
and gender-variant people are not impaired in their “judgment, stability, 
reliability, or general social or vocational capabilities” and should not be 
forced to use inappropriate gender-segregated facilities. The Association 
noted that these individuals wrongly “face significant discrimination, 
predjudice and hatred and the potential for victimization from violent hate 
crimes.” The Association failed to note that its inclusion of GIDs in the 
DSM fostered some of this discrimination, prejudice, and hatred, as is clearly 
reflected in both the LGBT exclusions in the ADA and Rehabilitation Act 
and the congressional debate leading up to the enactment of the ADA. In 
announcing the completion of the DSM-5, the Association made it clear 
that a diagnosis of gender dysphoria should neither be used to stigmatize 
people nor “be used against them in social, occupational, or legal areas.”

The addition of GIDs to the DSM in 1980 facilitated the availability 
of some medical treatment and insurance coverage for patients and pro-
vided medical doctors assurances that the patients did not have comorbid 
conditions, such as delusions. 466 Their removal from the DSM might have 
the reverse consequence. 467 Although acknowledging that removing GIDs 
from the psychiatric realm likely would have a significant stigma-reducing 
effect, Drescher reluctantly favored keeping gender dysphoria in the

461 American Psychiatric Association, Position Statement on Access to Care for Transgender and Gender Variant Individuals, at 1–2.
462 Id. at 2.
463 American Psychiatric Association, Position Statement on Discrimination Against Transgender and Gender Variant Individuals, at 1.
464 Id. at 2.
467 Queer Diagnoses, at 446, 448–50, 454.
468 See also National Association of Social Workers, Statement on Gender Identity Disorder and the DSM (May 18, 2010), available at www.socialworkers.org/diversity/new/lgbtq/51810.asp (in support of its argument that GIDs, gender incongruence, and gender dysphoria should not be in the DSM, the National Committee on Lesbian, Gay, Bisexual, and Transgender Issues of the National Association of Social Workers has stated: “Continuing to include the diagnoses in the DSM contributes to the sustained oppression of a marginalized group. In fact, doing so has a particularly potent and pernicious effect given the esteemed and authoritative nature of the DSM, and its pervasive use.”).
DSM-5 to ensure nonpsychiatric medical treatment and insurance coverage will remain available to anatomically dysphoric transgender individuals.\textsuperscript{469} The American Psychiatric Association agreed with his balancing of the costs and benefits.\textsuperscript{470}

c. The Clear Majority of Cases Decided Under State Laws Support the Proposition That Gender-Affirmed Individuals Should Be Protected From Disability Discrimination

Courts addressing the use of the ADA and the Rehabilitation Act to provide protection to gender-affirmed people should consider the fact that a clear majority of the tribunals applying state laws barring employment discrimination based on disability and that have no LGBT exclusions have interpreted those laws to afford protection to gender-affirmed individuals. These decisions reflect the careful analysis of the tribunals that have determined, based on medical evidence and not prejudice, that gender dysphoria is a legitimate medical condition worthy of protection under disability law. With one exception, the cases in the minority imported the federal sexual behavior disorders exclusions into state law.\textsuperscript{471}

(i.) Decisions Favorable to Gender-Affirmed Individuals

The laws in the following jurisdictions, which have antidiscrimination statutes that do not expressly exclude GIDs (including transsexualism), have been interpreted to protect people with gender dysphoria:

- **Connecticut**: The Connecticut Fair Employment Practices Act provides that a person has a “mental disability” if the individual has a record of, or is regarded as having, one or more mental disorders as defined in the most recent edition of the DSM.\textsuperscript{472} A person is “physically disabled” if the individual “has any chronic physical handicap, infirmity or impairment, whether congenital or resulting from bodily injury, organic processes or changes or from illness, including, but not limited to, epilepsy, deafness or hearing impairment or reliance on a wheelchair or other remedial appliance or device.”\textsuperscript{473} In Conway v. City of Hartford,\textsuperscript{474} the Connecticut Superior Court held that

\textsuperscript{469} *Queer Diagnoses*, at 446–48, 453–55.

\textsuperscript{470} See Mark Moran, *New Gender Dysphoria Criteria Replace GID*, 48 *Psychiatric News* 9 (Apr. 5, 2013), available at http://psychnews.psychiatryonline.org/data/Journals/PN/926751/psychnews_48_7_full_issue.pdf (the DSM-5 working group “decided the access-to-care issue was very important,’ Drescher told *Psychiatric News*. ‘If you take out the diagnosis, you don’t have a code for treatment.’”); Jack Drescher, *Controversies in Gender Diagnoses*, 1 *LGGBT Health* 1, 2–3 (2013), available at http://online.liebertpub.com/doi/pdf/10.1089/lgbt.2013.1500 (explaining how the DSM-5 attempts to balance the need to reduce the stigma associated with the diagnosis of gender dysphoria with the need to retain the diagnosis to maintain access to care).

\textsuperscript{471} As explained in Section III.G.2.c.ii. *infra*, the one case that did not follow the ADA’s sexual behaviors disorder exclusion was decided under Iowa law before the passage of the ADA.

\textsuperscript{472} **Conn. Gen. Stat.** §46a-51(20).

\textsuperscript{473} Id. §46a-51(15).

(1) Transsexualism or gender dysphoria is not a physical disability in view of the exclusion of transsexualism from both the ADA and the Rehabilitation Act and the adverse court decisions under the state laws of Iowa and Pennsylvania (discussed below), (2) gender dysphoria is a mental disability because it is recognized as such in the DSM, and (3) a transsexual cannot bring a sex discrimination claim under Connecticut law in view of the then-weight of authority that transsexuals are not protected by Title VII and other states’ prohibitions against sex discrimination.\textsuperscript{475}

Thereafter, in \textit{Declaratory Ruling on Behalf of John/Jane Doe},\textsuperscript{476} the Connecticut Commission on Human Rights and Opportunities expressly rejected the Conway ruling with respect to sex discrimination, finding it was no longer persuasive in view of post–\textit{Price Waterhouse v. Hopkins}\textsuperscript{477} case law under Title VII, and left open the issue with respect to physical and/or mental disability discrimination. Then, in \textit{Commission on Human Rights & Opportunities ex rel Peterson v. City of Hartford},\textsuperscript{478} the Superior Court revisited and rejected its Conway holding that transsexualism is not a physical disability. The court noted that “[a]ttitudes change and the law reflects this.”\textsuperscript{479} The court held that the plaintiff had a chronic physical disability because, for the rest of her life, she would be on medication (hormones) and under the care of a physician.\textsuperscript{480} Finally, the court held that one of the hearing officer’s rationales for ruling against the plaintiff—he could not detect a physical disability by observing her throughout the hearing—was irrelevant, as “numerous chronic medical illnesses are not observable.”\textsuperscript{481}

- \textit{Florida: In Smith v. City of Jacksonville Correctional Institution},\textsuperscript{482} after the employer learned that the plaintiff was a transsexual, it fired her, despite the facts that she had an unblemished employment record; she was highly successful at her job; and male and female corrections officers wore unisex uniforms, had common restroom

\textsuperscript{475}See also Commission on Human Rights & Opportunities ex rel. Dwyer v. Yale Univ., 2005 WL 5746424 (Conn. Comm’n Hum. Rts. & Opp. Nov. 29, 2005) (holding that an employee with a GID has a mental disability).


\textsuperscript{477}490 U.S. 228, 49 FEP 954 (1989).


\textsuperscript{479}2010 WL 4612700, at *12.

\textsuperscript{480}Id.

\textsuperscript{481}Id. at *13.

facilities, patrolled all parts of the institution (including bathing areas), and had direct contact with both male and female prisoners. Applying an ADA-like, three-pronged definition of “disability,” the Florida Division of Administrative Hearings determined that the employee had suicidal ideations, bleeding ulcers, and depression and abused alcohol as a result of her gender dysphoria; that gender dysphoria is a disability because of the substantial limitations on the major life activities of life and health; and that the employer discriminated against the plaintiff based on the attitudes, conjecture, and fear relating to her disability (and thus the plaintiff was regarded as disabled) and by failing to make any attempt to reasonably accommodate the plaintiff’s recognized medical condition.\footnote{Smith, 1991 WL 833882, at ¶¶52–53.}

The hearing officer observed:

60. There was no indication that the City attempted in any way to determine whether it really needed to terminate Smith. It simply terminated her out of hand after learning she was a transsexual. There was no checking, testing, or verification of any kind. Smith was given no chance to see if she could perform effectively. There was no inquiry, investigation, or interviewing to ascertain whether she would be rejected by coemployees, inmates, or other persons.

61. There was no attempt to become informed or educated in any way about transsexuality. There was no checking or inquiry to determine whether other transsexuals had successfully managed to preserve working relationships upon coming into the open. The City instead made a snap decision based on the personal predilections and perspectives of the Directors who met with Smith, without any effort then or later to assess the validity of their assumptions.

65. More important, even if the City had met its burden of showing an adverse reaction to Smith’s transsexuality, it does not follow that the reaction would be entitled to the dignity of a [bona fide occupational qualification]. Any adverse reaction to Smith solely because of her transsexuality would have been sheer prejudice. The very purpose of the Human Rights Act is to provide protection against that kind of intolerance. Smith’s condition was wholly involuntary. There was nothing illegal, immoral, wrong, or bad about it. It was entirely personal to her and was harmful to no one else. She was as undeservedly afflicted as someone born with a physical deformity. Her condition accordingly was no less entitled to protection than any of the other protected conditions or status categories of the Human Rights Act.

66. As the Supreme Court stated in School Board of Nassau County \textit{v. Arline}, 480 U.S. 273, 284 (1987), the basic purpose of laws against handicap discrimination is “to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others.” The Supreme Court went on to point out in \textit{Arline} that laws against handicap discrimination have been “carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically
sound judgments.” 480 U.S. at 285. The Supreme Court additionally pointed out that “society’s accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment.” 480 U.S. at 284.484

The Florida Commission on Human Relations (FCHR) affirmed the hearing officer’s decision.485

The Smith case involved the Florida Human Rights Act of 1977, which was superseded by the Florida Civil Rights Act of 1992 (FCRA), and a plaintiff who had gender reassignment surgery after her employment was terminated. In Fishbaugh v. Brevard County Sheriff’s Department,486 the FCHR had to determine whether the FCRA should be construed consistent with the 1990 ADA and 1992 Rehabilitation Act exclusion of transsexualism. Fishbaugh involved a deputy sheriff who had disclosed her transgender status before applying for her job, had sex reassignment surgery several years earlier, had successfully completed preemployment medical and psychological testing, was hired, and claimed she was terminated about eight months later because of her GID. The FCHR agreed with the administrative law judge’s importation into the FCRA the federal exclusion of transsexualism, and further determined that although the plaintiff had had many of the same impairments as did Smith, after her surgery the plaintiff did not and, thus, she failed to satisfy the FCRA’s ADA-like, three-pronged definition of “disability.”487 Three months after the Fishbaugh decision, the FCHR, in Shepley v. Lazy Days RV Center,488 which involved a transsexual

484 Id. at ¶¶60–61, 65–66.
487 The administrative law judge’s decision found that before, but not after, her surgery, Fishbaugh had “severe anxiety, depression, and distress based on her lifelong gender dysphoria” and that after her surgery she “must continue to undergo hormone treatments and medical monitoring for the rest of her life … [and] is unable to bear or produce children.” Fishbaugh v. Brevard County Sheriff’s Dep’t, 2003 WL 22813121, at *2 (Fla. Div. Admin. Hrgs. Nov. 21, 2003), aff’d in part, rev’d in part on other grounds, FCHR Order No. 04-103 (Fla. Comm’n Hum. Rel. Aug. 20, 2004). The FCHR held that Fishbaugh, who was not restricted in working, failed to show that lifelong hormone treatments and medical monitoring substantially limited her in a major life activity. Fishbaugh v. Brevard Cnty. Sheriff’s Dep’t, FCHR Order No. 04-103 (Fla. Comm’n Hum. Rel. Aug. 20, 2004). The FCHR did not discuss the “record of disability” prong of the definition of a disability.
who had not yet had any surgery, again held that transsexualism is not a protected disability under the FCRA, limiting Smith in view of the fact that the current plaintiff failed to show that she had any other disabilities or was perceived as disabled. By limiting, instead of overruling, Smith, the FCHR recognized that employer adverse action based on other disabilities arising out of gender dysphoria, such as the major depression, severe stress, and severe bleeding ulcers that plaintiff Smith had, is actionable even though the other disabilities are associated with transsexualism.489

- **Illinois:** In Evans v. Hamburger Hamlet,490 an employee who was diagnosed with gender dysphoria and was presenting as a woman outside of work was told by her boss to cut her hair, which she kept pulled back in the manner that female food servers kept their hair. Her request for a reasonable accommodation for her disability was denied and she was terminated for a number of reasons, including that she did not fit the restaurant’s “image.” The Chicago Commission on Human Relations held that the employee stated a claim for disability discrimination under the Chicago Human Rights Ordinance, which does not require that a disability substantially limit a major life activity, noting that the DSM-III recognized gender dysphoria as a psychological disorder. The tribunal declined to follow the ADA and Rehabilitation Act transsexualism exclusion. A year later, in a case involving the same parties, the Illinois Human Rights Commission (IHRC) addressed the same issue under the Illinois Human Rights Act (IHRA). The Illinois Department of Human Rights (IDHR) had determined that transsexualism is not a protected disability. On appeal, the IHRC reversed and remanded for an evidentiary hearing regarding whether the employee’s transsexualism rose to the level of a disability as defined in the joint rules of the IHRC and the IDHR.491 The IHRC rejected incorporation of the ADA’s transsexualism exclusion into the IHRA.


• Massachusetts: In Lie v. Sky Publishing Corp., the employer refused to accommodate, and then terminated, an employee diagnosed with a GID who was under medical care and who had requested to be allowed to wear traditionally female attire to work. Despite knowing about her gender dysphoria, in court papers the employer repeatedly referred to the employee as a “cross-dresser” and “transvestite,” which the court pointed out were inaccurate characterizations. Applying the Massachusetts ADA-like, three-pronged definition of “disability,” the Massachusetts Superior Court denied the employer’s motion for summary judgment on the disability claims, finding that plaintiff alleged sufficient facts to establish that her GID substantially limited her in the major life activities of caring for herself, relating to others, and working, and that the employer regarded her as disabled. The court followed the lead of the Massachusetts Commission Against Discrimination (MCAD), which, in Jette v. Honey Farms Mini Market, held that failure to allow a person diagnosed with transsexuality to wear feminine clothing and use a female name can constitute disability discrimination. The court held that the employer was not entitled to summary judgment on its defense that accommodating the plaintiff dressing as a woman would be an undue hardship for the employer. Both Lie and Jette declined to incorporate into Massachusetts law the ADA’s transsexualism and GIDs exclusions, and both rejected the reasoning of an earlier superior court decision to the contrary. The Lie court

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494 See also Doe v. Yunits, 2001 WL 664947, 15 Mass. L. Rep. 278 (Super. Ct. Feb. 26, 2001), where the court allowed a student with a GID, who was barred from junior high school because she wore female clothing, to proceed with a disability discrimination claim under the Declaration of Rights of the Massachusetts Constitution, which also has an ADA-like, three-pronged definition of “disability.” The court declined to adopt the Rehabilitation Act’s exclusion of GIDs not resulting from physical impairments. In an earlier decision in the case, where the court preliminarily enjoined the school from prohibiting the plaintiff from wearing any clothing that other students (male or female) are allowed to wear, the court held that plaintiff did not have a likelihood of success on her disability discrimination claim in view of the federal exclusion of transvestism and transsexualism. In denying relief from the preliminary injunction, the appellate court did not address the disability discrimination claim. See Doe v. Yunits, 2000 WL 33162199 (Mass. Super. Ct. Oct. 11, 2000), aff’d sub nom. Doe v. Brockton Sch. Comm., 2000 WL 33342399 (Mass. App. Ct. Nov. 30, 2000) (extensive recitation of the facts that supported the court’s issuance of a preliminary injunction).
496 Lie, 2002 WL 31492397, at *6 (finding it “more compelling … that this state’s legislature has never seen fit to” to amend state law to include the ADA exclusions and rejecting LaFleur’s dicta as inconsistent with the “full [MCAD] decision holding transsexualism is a protected handicap”); Jette, 2001 WL 1602799, at *1–3 (MCAD rejected LaFleur’s dicta and observed that when the prohibition against handicap discrimination was added to Massachusetts’
also observed that “[i]t cannot be gainsaid that transsexuals have a classically stigmatizing condition that sometimes elicits reactions based solely on prejudices, stereotypes, or unfounded fear.”

- **New Hampshire:** In *Doe v. Electro-Craft Corp.*, the New Hampshire Superior Court held that discharging an employee because she was a transsexual who had gender reassignment surgery is actionable under the state’s Law Against Discrimination, which has an ADA-like, three-pronged definition of “disability,” finding that GID and coexisting depression can substantially limit the major life activities of social and occupational functioning, caring for oneself, personal safety, and preserving one’s life.

- **New Jersey:** In *Enriquez v. West Jersey Health Systems*, the New Jersey Superior Court, Appellate Division, held that gender dysphoria could constitute a disability under the state’s Law Against Discrimination (NJLAD), which does not require that a disability substantially limit a major life activity. The court observed that “gender dysphoria is a recognized mental or psychological disability that can be demonstrated psychologically by accepted clinical diagnostic techniques”; gender dysphoria “does not cause violations of the law as does exhibitionism”; and discrimination is not acceptable simply because the plaintiff is “a member of a very small minority whose condition remains incomprehensible to most individuals.”

In reaching this result, the court relied on the *DSM-IV*:

antidiscrimination law, the legislature modeled the state’s definition of “handicap” on the definition in the federal Rehabilitation Act but declined to adopt the federal Act’s transsexualism exclusion).

497 Lie v. Sky Publ’g Corp., 2002 WL 31492397, at *7, 15 Mass. L. Rep. 412 (Super. Ct. Oct. 7, 2002). *Accord Doe v. Yunits*, 2001 WL 664947, at *5 (“persons who were previously thought to be eccentric or iconoclastic (or worse) and who were vilified by many people in our society may turn out to have physical or mental impairments that grant them protection from discrimination. Stated differently, the traits that made them misunderstood and despised may make them persons enjoying special protection under our law.”); *Jette*, 2001 WL 1602799, at *3 (the state’s prohibition against disability discrimination is “designed to protect [qualified] individuals who are substantially impaired in a major life activity ‘from deprivations based on prejudices, stereotypes, or unfounded fear’ ”).


501 777 A.2d at 372, 376. *See also M. T. v. J. T.*, 355 A.2d 204, 211 (N.J. Super. Ct. App. Div.), *certification denied*, 364 A.2d 1076 (N.J. 1976) (in holding that a transsexual woman’s marriage to a man was legal, the court observed the following: “In so ruling we do no more than give legal effect to a Fait accompli, based upon medical judgment and action which are
The DSM-IV ... notes that each recognized disorder contained within the manual “is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.” With regard to gender dysphoria specifically, the manual notes that the “disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.” Transsexualism can be accompanied by a profound sense of loathing for an individual’s primary and secondary sexual characteristics, which is overwhelming and unalterable.502

The court declined to import into the NJLAD the ADA's sexual behavior disorder exclusions.503

- **New York:** In *Doe v. Bell*,504 the New York Supreme Court, which is a trial court in New York, held that GID is a disability under the state’s Human Rights Law (NYHRL), which does not require that a disability substantially limit a major life activity, and, as a reasonable accommodation, New York City was required to allow a teenager with a GID to wear dresses in an all-male congregate foster care facility. The facility director’s failure to accept that the teenager had been diagnosed as having a GID was evident in his apparent refusal to refer to her with feminine pronouns.505 In rejecting the facility’s argument that allowing the teenager to wear a dress would “threaten the safety and security of the institution,” the court quoted from the U.S. Supreme Court’s *Arline* decision: “‘Allowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of § 504 [of the federal Rehabilitation Act], which is to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others.’”506 The court further held that the City could not meet its reasonable accommodation obligation by placing her in a shelter designed just for LGBT youth. Rejecting this separate-but-equal defense, the court observed that the “obligation to act in a nondiscriminatory fashion is not satisfied merely by providing a small number of facilities at which children with GID are assured nondiscriminatory treatment. At each and every facility run and

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502 *Enriquez,* 777 A.2d at 376 (citations omitted) (also allowing plaintiff to proceed under the NJLAD with a sex discrimination claim based on gender stereotyping and adverse treatment resulting from her gender transition).
503 *Id.* at 375.
505 See *id.* at 849.
506 *Id.* at 855 (quoting School Bd. of Nassau Cnty. v. Arline, 480 U.S. 273, 284, 43 FEP 81, 1 AD 1026 (1987)).
operated by the [City], it must comply with the [NYHRL’s] mandate to provide reasonable accommodations to persons with disabilities.”

In Richards v. U.S. Tennis Association, the court held that “the requirement of defendants that [Renée Richards] pass the Barr body [sex-chromatin] test in order to be eligible to participate in the women’s singles of the U.S. Open is grossly unfair, discriminatory and inequitable, and violative of her rights under the [NYHRL],” which bars employment discrimination on the basis of disability and sex. The court added, “[w]hen an individual such as plaintiff, a successful physician, a husband and father, finds it necessary for his own mental sanity to undergo a sex reassignment, the unfounded fears and misconceptions of defendants must give way to the overwhelming medical evidence that this person is now female.”

• Washington: In Doe v. Boeing Co., the Washington Supreme Court upheld the termination of an employee with gender dysphoria in view of the state’s Law Against Discrimination (WLAD). At the time, the WLAD did not contain a definition of “disability,” but the Washington State Human Rights Commission had promulgated a “circular,” “problematic” definition of “disability” that “requires factual findings of both (1) the presence of an abnormal condition, and (2) employer discrimination against the plaintiff because of that condition.” The court held that although gender dysphoria “is a medically cognizable and diagnosable condition [which causes] great mental and emotional agony” and, thus, an “abnormal condition,” the plaintiff failed to prove that she was discriminated against based on her gender dysphoria because the employer’s dress code provided enough accommodation of her need to dress femininely.

Thirteen years later, the state Supreme Court decided to reject the circular definition of “disability” and in its place adopted the ADA’s definition of “disability.” Nothing in the opinion indicated whether the court also intended to incorporate any or all of the ADA’s disability exclusions into the WLAD. Less than a year later, in 2007, the Washington State Legislature rejected the Court’s adoption of the ADA’s definition as it determined that the federal definition was too narrow. It adopted a new, broader definition and none of the

509 Id. at 272–73.
510 Id. at 272.
511 846 P.2d 531, 2 AD 548 (Wash. 1993).
513 Id. at 536.
ADA’s exclusions. There have been no reported decisions pertaining to the application of that definition to gender dysphoria.

(ii.) Decisions Adverse to Gender-Affirmed Individuals

The laws in the following jurisdictions, which have fair employment practices statutes that do not expressly exclude GIDs (including transsexualism), have been interpreted to not protect people with gender dysphoria:

516Several states and Puerto Rico include LGBT-related exclusions in their fair employment practices laws or regulations and/or some other laws:

Hawaii: Although the Hawaii Employment Practices Act (HEPA) is silent on the issue, the regulations issued by the Hawaii Civil Rights Commission have excluded from the definition of “disability” the same LGBT exclusions as the ADA. HAW. ADMIN. RULES §12-46-182. The impact of these exclusions is minimized by the fact that the HEPA prohibits discrimination based on sexual orientation and gender identity or expression.

Idaho: The Idaho fair employment practices act does not have any expressed LGBT-related exclusions in its definition of “disability.” IDAHODE §67-5902(15). However, the Idaho Human Rights Commission’s regulations provide that “[t]he prohibition of discrimination on the basis of disability … will be construed in compliance with the Americans with Disabilities Act, as amended, 42 USC 1201 et seq. and federal regulations at 29 C.F.R. Part 1630.” IDAHODE ADMIN. CODE §45.01.01(101). Several Idaho statutes pertaining to children expressly exclude transsexualism, transvestism, and other sexual behavior disorders, as well as sexual preference or orientation, from their definitions of “disability.” See IDAHODE §§16-1501(2)(b) (Adoption of Children), 16-1602(15) (Child Protective Act), 16-2002(17) (Termination of Parent and Child Relationship), and 32-717(4)(b) (Divorce Actions—Custody of Children).

Indiana: The Indiana Civil Rights Law (ICRL) has three different definitions of “disability.” In the chapter pertaining to employment discrimination against persons with disabilities, the definition of “disability” includes the same LGBT-related exclusions as are in the ADA. IND. CODE ANN. §22-9-5-6(d)(3). The general definition section of the ICRL, which applies to employment, housing, and public accommodations, has a very short definition of “disability” that contains no expressed LGBT-related exclusions. IND. CODE ANN. §22-9-1-3(r). Similarly, the short definition of “disability” in the chapter of the ICRL pertaining to equal housing for persons with disabilities has no expressed LGBT-related exclusions. IND. CODE ANN. §22-9-6-1.

Iowa: The Iowa Civil Rights Act of 1965 (ICRA) does not have any expressed LGBT-related exclusions in its definition of “disability,” although, as discussed in the main text of this subsection, the Iowa Supreme Court has held that transsexualism is not a disability under the ICRA. IOWADE §216.2(5); SOMMERS V. IOWA CIVIL RIGHTS COMMISSION, 337 N.W.2d 470, 476–77, 47 FEP 1217, 1 AD 442 (Iowa 1983). An Iowa law relating to economic development has had since 1994 the same LGBT-related exclusions in its definition of “disability” as are in the ADA, in the context of “targeted small businesses.” See IOWADE §15.102(12)(b)(1). In addition, another Iowa law, enacted in 1994 and repealed in 2006, relating to personal assistance services programs for individuals with disabilities, had an identical set of LGBT-related exclusions. See IOWADE §225C.46(1)(a)(2) (2005; repealed 2006). In 2007, the IRCA was amended to expressly prohibit discrimination based on gender identity and sexual orientation.

Kentucky: The Kentucky Civil Rights Act’s (KCRA) definition of “disability” provides that “persons excluded from coverage by the [federal ADA] shall be excluded from” the KCRA. KY. REV. STAT. ANN. §344.010(4). See also KY. REV. STAT. ANN. §344.030(1).

Louisiana: The Louisiana Human Rights Act (LHRA), which applies to public accommodations and applied to employment until 1997, includes the same LGBT-related exclusions as are in the ADA. LA. REV. STAT. ANN. §51.2232(11)(b). In contrast, the Louisiana Employment Discrimination Law (LEDL), enacted in 1997, does not contain any expressed LGBT-related exclusions in its definitions of “disability” or “impairment.” LA. REV. STAT. ANN. §23.322(3), (6). Courts have not applied the remaining provisions of the older LHRA to actions commenced under the LEDL. See, e.g., LOWRY V. DRESSER, Inc., 893 So.2d 966, 967–68 (La. Ct. App. 2005), writ denied, 922 So.2d 1157 (La. 2006) (in an age discrimination case, the court—citing other
cases on point—declined to import into the LEDL the antiretaliation provision of the LHRA); Glover v. Smith, 478 F. App’x 236, 242–44 (5th Cir. 2012) (following Lowry in a case involving alleged retaliation for complaining about race discrimination).

**Maine:** The Maine Human Rights Act (MHRA) expressly excludes, among others, the following conditions as “disabilities”: bisexuality, heterosexuality, homosexuality, gender identity or expression, and sexual behavior disorders. Me. Rev. Stat. Ann. tit. 5, §§4553(9-C), 4553-A(3)(B). Although gender identity or expression and sexual orientation are not disabilities, they are protected classes under the MHRA and, pursuant to regulations of the Maine Human Rights Commission, an employer must “make reasonable accommodations in rules, policies, practices, or services that apply directly or indirectly to gender identity or gender expression, unless [doing so] would impose an undue hardship.” 94-348-3 Me. Code R. §3.12(F).

The exclusion relating to sexual orientation and gender identity or expression appears to be in recognition of the fact that sexual orientation and gender identity or expression are normal conditions and, thus, are not disabilities. However, this should not mean that a person who has been diagnosed with the medical condition gender dysphoria or GID cannot be considered as having a disability under the MHRA.

**Nebraska:** The Nebraska Fair Employment Practice Act’s definition of a “physical or mental impairment” contains the same LGBT-related exclusions as are in the ADA. Neb. Rev. Stat. §48-1102(9).**

**Ohio:** The Ohio Civil Rights Act’s definition of “disability” contains the same LGBT-related exclusions as are in the ADA. Ohio Rev. Code Ann. §4112.01(A)(16)(b).


**Oregon:** The Oregon fair employment practices act expressly excludes, among others, the following conditions as “disabilities” or “impairments”: homosexuality, bisexuality, transvestism, and other sexual behavior disorders. Or. Rev. Stat. §659A.130. Under the Oregon law, transsexualism and gender identity disorders not resulting from physical impairments can be disabilities. Or. Admin. R. 839-006-0206(8). The Oregon law prohibits discrimination based on sexual orientation and gender identity or expression.

**Puerto Rico:** Puerto Rico’s Act 44, which prohibits discrimination based on disabilities in the workplace, excludes from its definition of “disability” homosexuals, bisexuals, transvestites, transsexuals, and “persons with sexual identity disorders which are not the result of physical disabilities.” 1 P.R. Laws Ann. §§501(f)(1)–(2). The impact of these exclusions is minimized by the fact that Act 44 prohibits discrimination based on gender identity or sexual orientation.

**South Carolina:** The South Carolina Human Affairs Law expressly provides that the term “‘disability’ must be interpreted in a manner consistent with federal regulations promulgated pursuant to the” ADA. S.C. Code Ann. §1-13-30(n).

**Texas:** The Texas fair employment practices act does not have any expressed LGBT-related exclusions in its definition of “disability.” Tex. Lab. Code §21.002(6). In contrast, the Texas Fair Housing Act excludes from its definition of “disability” both sexual orientation and transvestites. Tex. Pr. Code §301.003(6).

**Virginia:** The Virginians with Disabilities Act, which applies to employment, public accommodations, housing, and other areas, does not have any expressed LGBT-related exclusions in its definitions of “disability,” “mental impairment,” and “physical impairment.” Va. Code Ann. §§1.5-40.1. The Virginia Human Rights Act, which also applies to employment, public accommodations, housing, and other areas, does not define the term “disability” or provide an express remedy for disability discrimination. Va. Code Ann. §§2-2.3900 et seq. In contrast, the Virginia Fair Housing Law excludes from its definition of “handicap” transvestites. Va. Code Ann. §§36-96.11.

**West Virginia:** The West Virginia Human Rights Commission’s regulations under the West Virginia Human Rights Act expressly exclude transvestism, transsexualism, and gender identity disorders not resulting from physical impairments from the definition of a “mental impairment.” W.Va. Admin. Code §77-1-2.3.1.

See Chapter 20 (Survey of State Laws Regarding Gender Identity and Sexual Orientation Discrimination in the Workplace) for a discussion of these jurisdictions’ laws.
• Florida: As explained in Section III.G.2.c.i. supra, the FCHR, in Fishbaugh\textsuperscript{517} and Shepley,\textsuperscript{518} retreated from its earlier view that GID is a protected disability in view of the FCHR’s decision to follow the ADA lockstep, including importation of the ADA exclusion of transsexualism. However, the FCHR did not foreclose the right of a person with gender dysphoria to pursue disability claims with respect to disabling conditions arising out of the dysphoria, such as depression and bleeding ulcers.

• Iowa: In 1983, in Sommers v. Iowa Civil Rights Commission,\textsuperscript{519} the Iowa Supreme Court held that transsexualism is neither a physical nor a mental disability under the Iowa Civil Rights Act (ICRA), which has an ADA-like, three-pronged definition of “disability,” because the medical condition neither involves an abnormal or unhealthy body nor has the “inherent propensity” to limit major life activities.\textsuperscript{520} Twenty-five years later, the Iowa legislature amended the ICRA to expressly bar discrimination based on gender identity and sexual orientation.\textsuperscript{521} Courts and agencies in a majority of other states have expressly rejected the per se exclusion approach of Sommers.\textsuperscript{522}
Pennsylvania: In Dobre v. National Railroad Passenger Corp., a federal district court engrafted onto the Pennsylvania Human Relations Act's (PHRA) definition of "disability," which is modeled on the Rehabilitation Act, the subsequently enacted Rehabilitation Act exclusion of transsexualism. Dobre was followed by the Pennsylvania Commonwealth Court, which is one of the state's two intermediate appellate courts, with two judges dissenting, in Holt v. Northwest Pennsylvania Training Partnership Consortium, Inc. Each court also determined that the plaintiff failed to allege that transsexualism limited her in a major life activity and, thus, she failed to prove she had a disability.

The Pennsylvania Human Relations Commission (PHRC), in its January 2011 amicus brief in Stacy v. LSI Corp., advised the federal district court for the eastern district of Pennsylvania that both Dobre and Holt wrongly interpreted the PHRA. The PHRC explained that Pennsylvania enacted the PHRA's definition of "disability" in 1991, after the ADA was enacted. The legislature was aware of the various ADA exclusions from the definition of "disability" and elected to adopt just one of those exclusion (relating to the current illegal use of drugs). As such, the PHRA does not include a sexual behavior disorders exclusion, and the PHRC interprets the PHRA to prohibit discrimination based on a GID that otherwise meets the PHRA's ADA-like, three-pronged definition of "disability." The district court did not address this issue in its opinion granting the defendants' motion for summary judgment because the court determined that the plaintiff's termination during a large-scale reduction-in-force was based on a legitimate, nondiscriminatory reason.

North Carolina: In Arledge v. Peoples Services, the North Carolina General Court of Justice, Superior Court Division, held that North Carolina does not recognize a disability public policy exception to at-will termination in the case of a transsexual who was expressly terminated because of "customer relation concerns." In reaching this result, the court noted that "North Carolina courts 'look to federal decisions for guidance in establishing evidentiary standards and

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850 F. Supp. at 288–90.
Dobre, 850 F. Supp. at 289; Holt, 694 A.2d at 1139.
principles of law to be applied in discrimination cases’” and cited the ADA’s transsexualism exclusion in dismissing the plaintiff’s disability claim.532

(iii.) The Law Pertaining to “Regarded As” Claims Favors Gender-Affirmed Individuals

Individuals with gender dysphoria have had significant success in making “regarded as” claims of disability discrimination under state laws.533 Although Sommers and Dobre declined to allow “regarded as” claims of disability discrimination with respect to transsexualism under Iowa and Pennsylvania law,534 tribunals in Connecticut, Florida, Massachusetts, New Jersey, New York, and Washington have declined to follow their lead.535 Such claims should be successful inasmuch as “[b]eing transgender is a

532Id. at *2.
533See Section II.B.5. supra for an overview of “regarded as” disability claims under the ADA.
quintessentially stigmatic condition that has engendered fear and discomfort in others wholly separate and apart from the effect that being transgender has on any one person’s life. Transgender people are often substantially limited not as any inherent result of the condition but as a result of the negative attitudes of others,” which is precisely what the “regarded as” prong of the definition of “disability” is designed to protect against.  

**d. Conclusion**

As explained in Section III.C.3.a. *supra*, in the discussion of the legislative history of the LGBT exclusions, Senators Armstrong and Helms focused on excluding from the ADA’s protection those workers with the *DSM-III-R* disorders they felt were an affront to the “moral standards” of employers. Senator Armstrong’s long list of disfavored mental disorders included “**SEXUAL DISORDERS: TRANSVESTISM AND TRANSSEXUALISM.**” Senator Harkin, the chief sponsor of the bill, stated that the compromise he struck with Senator Armstrong was “narrowly focused. That is, if a person exhibits only a *sexual behavior disorder*, that person is not a disabled person under this act and cannot bring a cause of action for discrimination based on that disorder.” The architects of the compromise admitted that they did not understand the medical conditions that they were agreeing to exclude. Senator Harkin freely conceded that he was “not familiar with these disorders,” and Senator Armstrong commented that he was “simply not learned enough or well enough informed to suggest an amendment” to eliminate the disorders he felt were morally objectionable. They were both correct about their lack of knowledge in this area, which confirmed the caveat in the *DSM-III-R* that “the proper use of [the *DSM-III-R*’s diagnostic] criteria requires specialized clinical training that provides both a body of knowledge and clinical skills.”

In fact, GIDs, including transsexualism, were not listed as “sexual disorders” or “sexual behavior disorders” in the *DSM-III-R*, the version of the

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**Notes:**


539 Id. at S10,753.

540 Id. at S10,753, 10,772.

541 AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* xxix. (3d ed. rev. 1987) (*DSM-III-R*). See also id. at xxvi. The introductions to the *DSM-IV* and *DSM-IV-TR* warn that “there are significant risks that diagnostic information will be misused or misunderstood” and could result in “ungrounded speculation about mental disorders” if the “pertinent clinical and research literature” is not reviewed. AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* xxiii–xxiv (4th ed. 1994); AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* xxxii–xxxiii (4th ed. text rev. 2000).
DSM the senators were relying on. Rather, as explained earlier and clearly shown in Exhibit 16.4, they were classified within “disorders usually first evident in infancy, childhood, or adolescence,” an acknowledgment that gender dysphoria normally develops well before puberty and sexual arousal issues.542 Interestingly, when it came to excluding from the ADA conditions that the DSM-III-R actually included as “sexual disorders,” the compromise Senators Armstrong and Harkin reached included only the paraphilias and none of the sexual dysfunctions, such as hypoactive sexual desire disorder, male erectile disorder, inhibited orgasm, and premature ejaculation.543 These sexual performance conditions were not raised as a concern by Senators Armstrong and Helms.544

After the disability exclusions were agreed to by the Senate but before he abstained from the vote the same evening to approve the Senate version of the ADA bill, Senator Warren Rudman (R-N.H.) commented that “we are talking about behavior that is immoral, improper, or illegal and which individuals are engaging in of their own volition, admittedly for reasons we do not fully understand.”545 His comments are inapplicable to GIDs (including transsexualism)—as clearly shown in both the medical and legal discussions in Section III.E. supra, there is nothing immoral, improper, illegal, or volitional about GIDs.546 Excluding GIDs (including transsexualism) from

542DSM-III-R, at 71–78; cf. United States v. Happy Time Day Care Ctr., 6 F. Supp. 2d 1073, 1080 (W.D. Wis. 1998) (in an ADA public accommodation case, where the court found that a suppressed immune system resulting from HIV can substantially limit a person’s ability to care for oneself, the court declined to consider whether procreation was a major life activity for a three-year-old child because “there is something inherently illogical about inquiring whether an individual’s ability to perform a particular activity is substantially limited . . . when . . . this individual is incapable of engaging in that activity in the first place”).

543DSM-III-R, at 290–96; see also Exhibit 16.4.


546See, e.g., In re Heilig, 816 A.2d 68, 78 (Md. 2003) (“[b]ecause transsexualism is universally recognized as inherent, rather than chosen, psychotherapy will never succeed in ‘curing’ the patient”); Kosilek v. Maloney, 221 F. Supp. 2d 156, 163 (D. Mass. 2002) (“The consensus of medical professionals is that transsexualism is biological and innate. It is not a freely chosen ‘sexual preference’ or produced by an individual’s life experience.”); Doe v. McConn, 489 F. Supp. 76, 78 (S.D. Tex. 1980) (“Most, if not all, specialists in gender identity are agreed that the transsexual condition establishes itself very early, before the child is capable of elective choice in the matter, probably in the first two years of life; some say even earlier, before birth during the fetal period. These findings indicate that the transsexual has not made a choice to be as he is, but rather that the choice has been made for him through many causes preceding and beyond his control.”); Enriquez v. West Jersey Health Sys., 777 A.2d 365, 376, 372, 86 FEP 197, 11 AD 1810 (N.J. Super. Ct. App. Div.), certification denied, 785 A.2d 439 (N.J. 2001) (gender dysphoria “does not cause violations of the law as does exhibitionism”; and discrimination is not acceptable simply because the plaintiff is “a member of a very small minority whose condition remains incomprehensible to most individuals.”).
the ADA violated the fundamental purpose of the ADA, as summarized by Senator Harkin on the evening the exclusion was agreed to: “The point of the bill is to start breaking down those barriers of fear and prejudice and unfounded fears, to get past that point so that people begin to look at people based on their abilities, not first looking at their disability.”

Overcoming ignorance was a common theme throughout the debate that day. See the following examples:

[Senator Harkin:] For people with disabilities, the ADA sends a clear message that they are entitled to be treated with dignity and respect and that they can and will be judged as individuals on the basis of their abilities; not on the basis of ignorance, irrational fears, or patronizing attitudes.

[Senator David Durenberger (R-Minn.):] But this bill is not only about making those of us without disabilities aware and accountable for our actions toward persons with disabilities. This bill is about changing the lives of persons with disabilities. It is about opening opportunities for persons with disabilities by removing the shades that those of us without disabilities wear mostly out of ignorance. It is a statement of our social values.

[Senator Pete Domenici:] [T]he time has come when they deserve an unbiased evaluation of their capability based upon the disease rather than some subjective disability attached to just the use of the name.

[Senator Joe Biden (D-Del.):] We can no longer afford to lose the input of millions of disabled persons because of unthinking or ignorant prejudice.

[Senator Jim Jeffords (R-Vt.):] By living and working alongside of disabled Americans in ever-increasing numbers, I hope the prejudices will fade and disappear.

[Senator Paul Simon (D-Ill.):] It is time to ensure a guarantee of nondiscrimination for [those] who must overcome not just a disabling condition, but the superstition, fear and prejudice that accompanies it… Part of the problem lies in ignorance.

The overarching goal of eliminating unfounded prejudice and ignorance is also reflected by the fact that “[i]n passing the original ADA, Congress relied extensively on the reasoning of School Board of Nassau County v. Arline.” In Arline, the Supreme Court explained that “the basic purpose” of the Rehabilitation Act “is to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others,” that “Congress acknowledged that society’s accumulated myths and fears about disability and disease are as handicapping as are the physical
limitations that flow from actual impairment,” and that the Rehabilitation Act is “carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments.” When it passed the ADAAA, Congress expressly reaffirmed its commitment to Arline’s broad view of the ADA.

As noted in Section III.G.2.c.iii. supra, “[b]eing transgender is a quintessentially stigmatic condition that has engendered fear and discomfort in others wholly separate and apart from the effect that being transgender has on any one person’s life.” By wrongly excluding GIDs not resulting from physical impairments and transsexualism from the ADA and the Rehabilitation Act, Congress exacerbated the stigma individuals with gender dysphoria confront. As the 2011 Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder observed, “Adults with gender identity concerns have also often experienced stigmatization or victimization related to gender variant appearance or behavior, or on the basis of actual or presumed sexual orientation…. In fact, some authors have concluded that such stigmatization largely accounts for mental illness among individuals with GID.” The 2013 edition of the DSM recognizes this as well, observing that “[g]ender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity [(such as anxiety and depressive disorders)], school dropout, and economic marginalization, including unemployment.”

The discussion in this section clearly shows that, as a result of a moral crusade by two senior conservative senators on one evening and in an effort to close the deal that evening on Senate approval of the ADA after a day-long debate that focused mainly on other issues, the members of the Senate simply made no effort to understand that GIDs (including transsexualism) were

555 Arline, 480 U.S. at 284–85.
559 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 458 (5th ed. 2013).
neither “sexual disorders” nor “sexual behavior disorders” (i.e., paraphilias), and, therefore, should not have been included in the ADA’s sexual behavior disorders exclusion. Congress did precisely what it had told the regulated community and the courts not to do—it failed to base its decision on “reasoned and medically sound judgment.”

560 GIDs not resulting from physical impairments and transsexualism are not sexual behavior disorders or of the nature of the illegal activities that the ADA excludes from its reach.

Courts should read these laws as not excluding individuals who have GIDs not resulting from physical impairments and transsexualism by either limiting the sexual behavior disorders exclusion to the paraphilias or striking the erroneously included GIDs not resulting from physical impairments and transsexualism from the exclusion. Alternatively, courts should limit the exclusion to its precise terms and not apply it to the significantly refined and revised medical condition now referred to as “gender dysphoria.”

3. The Argument That the Exclusion of Gender Identity Disorders Not Resulting From Physical Impairments, Transsexualism, and Transvestism From the Americans with Disabilities Act and the Rehabilitation ActViolates Transgender Individuals’ Rights to Equal Protection

a. Introduction

If a court disagrees with the arguments set forth in the preceding subsection that (1) GIDs not resulting from physical impairments and transsexualism should not be treated as falling within the ADA and the Rehabilitation Act’s sexual behavior disorders exclusion and (2) the new diagnosis of gender dysphoria does not fall within the exclusion, then it should rule the exclusion of GIDs not resulting from physical impairments and transsexualism violates the equal protection component of the Due Process Clause of the Fifth Amendment.561 The exclusion is both “irrational and discriminatory.”

560 School Bd. of Nassau Cnty. v. Arline, 480 U.S. 273, 284–85, 43 FEP 81, 1 AD 1026 (1987). As explained in Section II.C.4. supra, because Congress did not have the medical expertise to determine if HIV or AIDS presented a risk of transmission through food handlers, it appropriately delegated to the Secretary of Health and Human Services the authority to determine which infectious or communicable diseases can be so transmitted. Congress could have done likewise with respect to GIDs, but did not. Disability and civil rights groups were insistent on the addition of this delegation provision to the ADA to protect people with HIV or AIDS, but apparently made no attempt, or were not insistent, to have a similar delegation provision added with respect to individuals with a GID. See Chai R. Feldblum, The Federal Gay Rights Bill: From Bella to ENDA, in Creating Change: Sexuality, Public Policy, and Civil Rights 149, 173 (John D’Emilio et. al. eds., 2000).

561 U.S. Const. amend. V, which reads in relevant part: “No person shall be . . . deprived of life, liberty, or property, without due process of law.”

The same equal protection analysis also requires that the exclusion of transvestism be struck from both laws.

Federal equal protection challenges to classifications based on sex, gender, or gender stereotypes are subject to heightened scrutiny. In City of Cleburne v. Cleburne Living Center, the Supreme Court explained the following:

Legislative classifications based on gender ... call for a heightened standard of review. That factor generally provides no sensible ground for differential treatment. “[W]hat differentiates sex from such nonsuspect statuses as intelligence or physical disability ... is that the sex characteristic frequently bears no relation to ability to perform or contribute to society.” ... Rather than resting on meaningful considerations, statutes distributing benefits and burdens between the sexes in different ways very likely reflect outmoded notions of the relative capabilities of men and women. A gender classification fails unless it is substantially related to a sufficiently important governmental interest.

In contrast, the Court explained that classifications involving disability-based classifications are subject to rationality review:

To withstand equal protection review, legislation that distinguishes between [people with intellectual disabilities] and others must be rationally related to a legitimate governmental purpose. This standard, we believe, affords government the latitude necessary both to pursue policies designed to assist [people with intellectual disabilities] in realizing their full potential, and to freely and efficiently engage in activities that burden [these individuals] in what is essentially an incidental manner. The State may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational. Furthermore, some objectives—such as “a bare ... desire to harm a politically unpopular group”—are not legitimate state interests.

In City of Cleburne, the Court held that a city’s zoning ordinance that required a special use permit for a group home for individuals with intellectual disabilities, but not for other multi-dwelling facilities (such as boarding homes, hospitals, nursing homes, and fraternity houses), was unconstitutional as applied to a proposed group home. The Court found that there was no “rational basis for believing that the [proposed] home would pose any special threat to the city’s legitimate interests” and that the permit

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563 As discussed in Section III.C.4.b.–c. supra, the ADA and the Rehabilitation Act have redundant exclusions of transvestism and transvestites. For simplicity purposes, in the remaining discussion in Section III.G.3., the text generally refers just to transvestism. The same equal protection arguments equally apply to the transvestite exclusion.


565 Id. at 440–41 (quoting Frontiero v. Richardson, 411 U.S. 677, 686 (1973) (plurality opinion)). For additional cases, see Chapter 15 (Federal Equal Protection), Section V.

566 City of Cleburne, 473 U.S. at 446–47 (citations omitted). In this quote the term “the mentally retarded” has been replaced with “people with intellectual disabilities” in view of the recognition today that the first term is highly offensive. See 29 C.F.R. §1630.2(h)(2), (j)(3)(iii) (noting that “mental retardation” has been replaced by “intellectual disability”); Special Olympics, R-Word: Spread the Word to End the Word, available at www.r-word.org.
requirement “rest[ed] on an irrational prejudice against” people with intellectual disabilities.\textsuperscript{567} The Court added the following:

But mere negative attitudes, or fear, unsubstantiated by factors which are properly cognizable in a zoning proceeding, are not permissible bases for treating a home for [people with intellectual disabilities] differently from apartment houses, multiple dwellings, and the like. It is plain that the electorate as a whole, whether by referendum or otherwise, could not order city action violative of the Equal Protection Clause, and the City may not avoid the strictures of that Clause by deferring to the wishes or objections of some fraction of the body politic. “Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect.”\textsuperscript{568}

Classifications based on sexual orientation have been reviewed and stricken under both of the preceding tests.\textsuperscript{569} As will be explained in the following discussion, the ADA and Rehabilitation Act’s exclusion of GIDs not resulting from physical impairments, transsexualism, and transvestism violates the equal protection rights of persons diagnosed with one of these conditions or who are wrongly regarded as having such a condition.

b. Applicability of Heightened Scrutiny to Gender and Sexual Minorities

In \textit{Windsor v. United States},\textsuperscript{570} the Second Circuit Court of Appeals struck down Section 3 of the Defense of Marriage Act (DOMA)\textsuperscript{571} as unconstitutional on equal protection grounds. Section 3 provided that for purposes of interpreting the meaning of any federal law or regulation “the word ‘marriage’ means only a legal union between one man and one woman as husband and wife, and the word ‘spouse’ refers only to a person of the opposite sex who is a husband or a wife.”\textsuperscript{572} The Second Circuit determined that homosexuality satisfies the four factors that the Supreme Court has examined in deciding whether a new classification qualifies as a quasi-suspect class entitled to heightened scrutiny: (1) “whether the class has been historically ‘subjected to discrimination’”; (2) “whether the class has a defining characteristic that ‘frequently bears [a] relation to ability to perform or contribute to society’”; (3) “whether the class exhibits ‘obvious, immutable, or distinguishing characteristics that define them as a discrete group’”; and (4) “whether the class is ‘a minority or politically powerless.’”\textsuperscript{573}

As discussed in Chapter 15 (Federal Equal Protection), in 2013, the Supreme

\textsuperscript{567} \textit{City of Cleburne}, 473 U.S. at 448, 450.
\textsuperscript{568} \textit{Id.} at 448 (citations omitted).
\textsuperscript{569} See Chapter 15 (Federal Equal Protection), Section V.
\textsuperscript{570} 699 F.3d 169 (2d Cir. 2012), aff’d, 570 U.S. ___, 133 S. Ct. 2675, 118 FEP 1417 (2013).
\textsuperscript{571} Pub. L. No. 104-199, §3 (Sept. 21, 1996) (codified at 1 U.S.C. §7). The constitutionality of DOMA is discussed in Chapter 15 (Federal Equal Protection), and the pernicious workplace impact of DOMA is discussed in Chapters 18 (Immigration and Lesbian, Gay, Bisexual, and Transgender Employees) and 37 (Employee Benefit Issues).
\textsuperscript{572} 1 U.S.C. §7.
\textsuperscript{573} \textit{Windsor}, 699 F.3d at 181–82.
Court affirmed the Second Circuit’s decision, although the Court saw no need to go through the extensive, four-step analysis that the Second Circuit did, because it was plain to the Court that

[Section 3] violates basic due process and equal protection principles applicable to the Federal Government. . . . The Constitution’s guarantee of equality “must at the very least mean that a bare congressional desire to harm a politically unpopular group cannot” justify disparate treatment of that group. . . . In determining whether a law is motivated by an improper animus or purpose, “‘[d]iscriminations of an unusual character’” especially require careful consideration. . . . DOMA cannot survive under these principles. . . . The avowed purpose and practical effect of [DOMA] are to impose a disadvantage, a separate status, and so a stigma upon all who enter into same-sex marriages made lawful by the unquestioned authority of the States.

. . .

DOMA’s principal effect is to identify a subset of state-sanctioned marriages and make them unequal. The principal purpose is to impose inequality, not for other reasons like governmental efficiency. . . . The differentiation denies the couple, whose moral and sexual choices the Constitution protects, and whose relationship the State has sought to dignify. And it humiliates tens of thousands of children now being raised by same-sex couples. The law in question makes it even more difficult for the children to understand the integrity and closeness of their own family and its concord with other families in their community and in their daily lives.574

Quoting a congressional report, the Court observed that DOMA was intended to express “both moral disapproval of homosexuality, and a moral conviction that heterosexuality better comports with traditional (especially Judeo-Christian) morality.”575 The holding in Windsor in consistent with the Court’s earlier holdings in Lawrence v. Texas576 and Romer v. Evans577 that moral disapproval of a group does not constitute a legitimate governmental interest.578

Under either the Second Circuit or Supreme Court’s approach, it is clear that transgender people should be regarded as a quasi-suspect class, entitled to have legislation directed against them evaluated using heightened scrutiny. Transgender individuals clearly fit within the four factors set forth by the Second Circuit, and Congress singled out in the ADA and

575133 S. Ct. at 2693, 118 FEP at 1425 (internal quotation marks omitted).
576539 U.S. 558 (2003) (invalidating on due process grounds a Texas law that criminalized consensual same-sex sexual conduct).
577517 U.S. 620, 70 FEP 1180 (1996) (invalidating on equal protection grounds a provision of the Colorado Constitution that prohibited all legislative, executive, or judicial action designed to protect homosexual individuals from discrimination).
578Lawrence, 539 U.S. at 577 (“the fact that the governing majority in a State has traditionally viewed a particular practice as immoral is not a sufficient reason for upholding a law prohibiting the practice” (internal quotation marks omitted)); Romer, 517 U.S. at 632–33 (the Court determined that the Colorado constitutional provision it invalidated “seems inexplicable by anything but animus toward the class it affects; it lacks a rational relationship to legitimate state interests. . . . Equal protection of the laws is not achieved through indiscriminate imposition of inequalities.” (internal quotation marks omitted)).
the Rehabilitation Act individuals diagnosed with GIDs not resulting from physical impairments, transsexualism, or transvestism for no reason other than moral disapproval.

(i.) Transgender People Have Faced Historical Discrimination

In *Windsor*, the Second Circuit observed that gays and lesbians have suffered a history of discrimination for at least 90 years. In many peoples’ minds, transgender individuals are merely a subset of the gay and lesbian community, and, as a result, transgender people have suffered the same fate as gays and lesbians. Indeed, transgender individuals have been perceived to be “the most subversive” segment of the LGBT community. Groups opposed to legislation that would protect transgender people regularly refer to such bills as part of the “homosexual agenda.”

In addition, although homosexuality was removed from the American Psychiatric Association’s *DSM*, the stigma toward transgender individuals

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580 *Queer Diagnoses*, at 427, 430, 436, 440 (most people have assumed that transgender individuals are homosexuals, and people, including psychiatrists, have historically conflated sexual orientation and gender identity); *Harry Benjamin, the Transsexual Phenomenon* 43 (Symposium 1999) (1966), available at http://web.archive.org/web/20130323091015/http://tgmeds.org.uk/downs/phenomenon.pdf (“Almost invariably, [transsexualism] is [incorrectly] linked with…transvestism and sometimes also with homosexuality, both giving rise to confusion.”); Millett v. Lutco, Inc., 2001 WL 1602800, at *2 & n.3, 23 Mass. Discr. L. Rep. 231 (Comm’n Ag. Discr. Oct. 10, 2001) (noting that transsexuals are misperceived as gay or lesbian); Blackwell v. U.S. Dept’ of Treasury, 830 F.2d 1183, 44 FEP 1856, 1 AD 1152 (D.C. Cir. 1987) (in a case involving whether transvestism is a disability protected by the Rehabilitation Act, Judge (later Justice) Ginsburg held that “the liability of a government department under the Act should not turn on the level of sophistication or ability … of the particular interviewing officer … [to know] that homosexuality and transvestism are not one and the same”). As explained in Chapter 2 (The Transformative Power of Words), related confusion often results in “gender identity or expression” incorrectly being understood as a subset of “sexual orientation.”


582 See, e.g., Peter Sprigg, *The Obama Administration Promotes the Homosexual Agenda* (Family Research Council June 2012), available at http://downloads.frc.org/EF/EF12G17.pdf (noting that President Obama has appointed a record number of homosexuals, including transgender people, and has prohibited discrimination based on gender identity in federal employment); Concerned Women for America, *Pressing Onward!, FAMILY VOICE* 13 (May–June 2009), available at www.cwfa.org/familyvoice/2009-05/mayjune09.pdf (“[v]irtually every state has dealt with some aspect of the homosexual agenda,” including proposed laws to prohibit discrimination based on gender identity); Traditional Values Coalition, Pelosi Goes Wild Again Over Homosexual Agenda (undated), available at www.traditionalvalues.org/content/action_alerts/30648/Pelosi%20Goes%20Wild%20Again%20Over%20Homosexual%20Agenda (if Congress repeals “Don’t Ask, Don’t Tell,” then military base family housing “will be opened up to ‘gay’ couples and conflicts over spousal benefits for non-married individuals. The legalization of gays, bisexuals, and transgenders in the military will increase pressure to repeal … [DOMA]”).
was further exacerbated by the retention of transvestism in the *DSM* and the addition of GIDs (including transsexualism) to the *DSM*.583 The ADA and Rehabilitation Act’s exclusion of GIDs not resulting from a physical impairment, transsexualism, and transvestism expressly sanctions the continued, blatant discrimination against transgender individuals, including the vast majority of gender-affirmed and gender-diverse persons who do not have any disabilities but who may be regarded as disabled as a result.584 Moreover, because Congress misclassified GIDs not resulting from physical impairments and transsexualism as sexual behavior disorders, judges and employers have been misled into accepting as true something that simply is not true, and opponents of transgender rights have been empowered in their campaign against such individuals by citing the ADA sexual behavior disorders exclusion as evidence that transgender people as a group are not worthy of legal protection.

And, as explained in Chapter 40 (Employment Discrimination Against LGBT People: Existence and Impact), transgender individuals face far worse employment prospects than do gays and lesbians. Moreover, although homophobic jokes are heard less frequently in public today, transphobic jokes continue unabated. Transgender people frequently are subjected to disparaging comments, such as a presidential appointee and an aide to a House member being referred to as “she-males,” a term that even *The Washington Times* used in a 2010 editorial opposing the proposed ENDA.585

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583 The evolution of the inclusion of homosexuality and gender identity disorders in the *DSM* is discussed in Section III.G.2.b. *supra*.

584 See 42 U.S.C. §12101(a)(2) (the ADA states that “Congress finds that . . . historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem”).

(ii.) Transgender People Have the Abilities to Perform or Contribute to Society

The Second Circuit in *Windsor* also found that being gay or lesbian has no impact on a person’s abilities to perform or contribute to society, noting that “[t]he aversion homosexuals experience has nothing to do with aptitude or performance.” As the essays in Part II (Personal Essays: Walk in Our Shoes) of this treatise demonstrate, many individuals who are gender affirmed or gender diverse have successful careers and loving families. Many more would but for the stigma and misunderstanding that many in society have about transgender individuals. The case reporters and this treatise are filled with decisions that show that fully competent and productive employees have been terminated simply because they were transgender, sometimes with the judges expressing their regret that existing law compelled them to uphold the dismissal of the employees’ lawsuits.

As Judge Susan Dlott observed in one of the leading cases involving transgender employment rights under Title VII and the Equal Protection Clause:

“cross-dresser,” “cross-gender,” “transsexual,” and “drag queen” can create a hostile environment; Tates v. Blanas, 2003 WL 23864868, at *8 (E.D. Cal. Mar. 11, 2003) (in holding that transgender prisons were disparately treated compared to nontransgender inmates, the court found, among other things, that the former were derided by being called “‘he/she,’ ‘it,’ ‘faggot,’ ‘bitch,’ ‘queer,’ and ‘homo’”).


*Blackwell* v. U.S. Dep’t of Treasury, 656 F. Supp. 713, 715, 43 FEP 1804, 1 AD 992 (D.D.C. 1986), *aff’d in part and vacated*, 830 F.2d 1183, 44 FEP 1856, 1 AD 1152 (D.C. Cir. 1987) (“While the failure to employ plaintiff is highly reprehensible, plaintiff cannot recover and the complaint must be dismissed. Hopefully wiser heads will correct the underlying injustice.”); *Sommers* v. Iowa Civil Rights Comm’n, 337 N.W.2d 470, 477, 47 FEP 1217, 1 AD 442 (Iowa 1983) (“Although a transsexual may have difficulty in obtaining and retaining employment, the commission could reasonably believe that difficulty is the result of discrimination based on societal beliefs that the transsexual is undesirable, rather than from beliefs that the transsexual is impaired physically or mentally as that term is used in the statute and defined in the rule. While we do not approve of such discrimination, we do not believe it is prohibited by the Iowa Civil Rights Act.”); *Oiler* v. Winn-Dixie La., Inc., 2002 WL 31098541, at *6, 89 FEP 1832 (E.D. La. 2002) (“In holding that defendant’s actions are not proscribed by Title VII, the Court recognizes that many would disagree with the defendant’s decision [to terminate plaintiff] and its rationale. The plaintiff was a long-standing employee of the defendant. He never cross-dressed at work and his crossdressing was not criminal or a threat to public safety. Defendant’s rationale for plaintiff’s discharge may strike many as morally wrong. However, the function of this Court is not to raise the social conscience of defendant’s upper level management, but to construe the law in accordance with proper statutory construction and judicial precedent.”); *In re Grossman*, 384 A.2d 855, 856 (N.J. Super. Ct. App. Div. 1978) (in two consecutive cases involving the same gender-affirmed female plaintiff, the court made clear: “In fairness to Mrs. Grossman, we emphasize that the [Education] Commissioner’s conclusions relate only to her fitness to continue teaching [grammar school students] in the Bernards Township school system. We express no opinion with respect to her fitness to teach elsewhere and under circumstances different from those revealed in the present case.”).
Defendant argues [that] excluding transsexuals as a class is rationally related to the legitimate government interest of promoting only competent and capable police officers. Implicit in this argument is the assumption that any “rare psychiatric disorder” prevents the suffering individual from being a competent and capable police officer. Defendant has come forward with no evidence that supports this assumption generally, nor has it shown that Plaintiff’s transsexuality impeded his performance as sergeant. In fact, when Captain Demasi sent Plaintiff for a psychological evaluation during his probation, Plaintiff was found fit for duty.588

Judge Dlott also noted the following:

The notion that the mere circumstance of Plaintiff being a transsexual who happens to be a relatively non-masculine male deprives Plaintiff of protection under Title VII is patently absurd. In fact, to interpret Title VII as Defendant would have the Court do would, without sufficient justification, violate the Equal Protection Clause.589

(iii.) Transgender People Have Obvious, Immutable, and Distinguishing Characteristics

The Second Circuit in Windsor also found that “homosexuality is a sufficiently discernible characteristic to define a discrete minority class.”590 Transgender individuals are members of a quintessentially discrete minority class. As the Eleventh Circuit observed in 2011 in the equal protection case Glenn v. Brumby,591 “A person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes. ‘[T]he very acts that define transgender people as transgender are those that contradict stereotypes of gender-appropriate appearance and behavior.’”592 They stand out from others because their “appearance, behavior, or other personal characteristics differ from traditional gender norms.”593 In the case of some gender-affirmed people, medical evidence suggests that they have an intersex-like condition that develops in utero594 that is immutable and not “correctable”

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589Id. at *22 n.8 (citing Romer v. Evans, 517 U.S. 620, 70 FEP 1180 (1996)).
590Windsor, 699 F.3d 183. Accord Obergefell v. Wmyslo, 962 F. Supp. 2d 968, 991 (S.D. Ohio 2013) (“Under any definition of immutability, sexual orientation clearly qualifies. There is now broad medical and scientific consensus that sexual orientation is immutable.”).
591663 F.3d 1312, 113 FEP 1543 (11th Cir. 2011).
594See Section III.E. supra.
with psychotherapy. Such immutability supports the conclusion that transgender people belong to a discrete minority class. 596

(iv.) Transgender People Are a Minority and Politically Powerless

Finally, with respect to “whether [homosexuals are] ‘a minority or politically powerless,’” the Second Circuit in Windsor determined that they “are not in a position to adequately protect themselves from the discriminatory wishes of the majoritarian public.” 598 Although the transgender

595 See, e.g., HARRY BENJAMIN, THE TRANSEXUAL PHENOMENON 53 (Symposium 1999) (1966), available at http://web.archive.org/web/20130323091015/http://tgmeds.org.uk/downs/phenomenon.pdf (“Psychotherapy with the aim of curing transsexualism, so that the patient will accept himself as a man, it must be repeated here, is a useless undertaking with present available methods.”); In re Heilig, 816 A.2d 68, 78 (Md. 2003) (“because transsexuality is universally recognized as inherent, rather than chosen, psychotherapy will never succeed in ‘curing’ the patient”); Kosilek v. Maloney, 221 F. Supp. 2d 156, 163 (D. Mass. 2002) (“The consensus of medical professionals is that transsexualism is biological and innate. It is not a freely chosen ‘sexual preference’ or produced by an individual’s life experience.”); Doe v. McConn, 489 F. Supp. 76, 78 (S.D. Tex. 1980) (“Most, if not all, specialists in gender identity are agreed that the transsexual condition establishes itself very early, before the child is capable of elective choice in the matter, probably in the first two years of life; some say even earlier, before birth during the fetal period. These findings indicate that the transsexual has not made a choice to be as he is, but rather that the choice has been made for him through many causes preceding and beyond his control. Consequently, it has been found that attempts to treat the true adult transsexual psychotherapeutically have consistently met with failure.”); Kosilek v. Spencer, 740 F.3d 733, 765 (1st Cir. 2013), reh’g en banc granted and majority and dissenting appellate opinions withdrawn by Order of Court, No. 12-2194 (1st Cir. Feb. 12, 2014) (setting hearing en banc for May 8, 2014) (noting that “psychotherapy as well as antipsychotics and antidepressants … do nothing to treat the underlying [gender identity] disorder” (quoting Fields v. Smith, 653 F.3d 550, 556 (7th Cir. 2011), cert. denied, 566 U.S. ___, 132 S. Ct. 1810 (2012))); O’Donabhin v. Commissioner of Internal Revenue, 2010 WL 364206, at *21 n.49, 134 T.C. No. 4, Tax Ct. Rep. (CCH) 58,122 (2010), available at www.ustaxcourt.gov/InOpHistoric/ODonabhin.TC.WPD.pdf (in holding that hormone therapy and sex reassignment surgery are not cosmetic surgery for purposes of the Internal Revenue Code, the Tax Court quoted Judge Posner, in Maggert v. Hanks, 131 F.3d 670, 671 (7th Cir. 1997): “The cure for the male transsexual consists not of psychiatric treatment designed to make the patient content with his biological sexual identity—that doesn’t work—but of estrogen therapy” and genital reconstruction surgery.); U.S. Steel LLC, 116 LA 861 (Petersen, 2001) (rejecting employer’s argument that employee’s medically necessary, gender-affirming surgery was elective, cosmetic surgery and thus not covered under employer’s sickness and accident benefit plan).


597 Id. at 185. In Griego v. Oliver, 316 P.3d 865 (N.M. Sup. Ct. 2013), the New Mexico Supreme Court applied intermediate scrutiny in holding that New Mexico’s ban on same-sex marriage violated the New Mexico Constitution. With respect to the argument that LGBT individuals are not politically powerless in view of their recent legislative victories, the Court observed the following:

[W]e recognize that [the LGBT community has] had some recent political success regarding legislation prohibiting discrimination against them. However, we also conclude that effective advocacy for the LGBT community is seriously hindered by their continuing need to overcome the already deep-rooted prejudice against their integration into society, which warrants our application of intermediate scrutiny in this case. The political advocacy of the LGBT community continues to be seriously hindered, as evidenced by
wing of the LGBT community may be viewed as its most subversive, it is also the weakest. When it has been politically expedient to do so, decisions have been made to favor the rights of sexual minorities over those of gender minorities. These decisions reflect the relative lack of power transgender individuals have even within the LGBT movement. For example, Professor Ruth Colker, in her discussion of the legislative history of the ADA, notes the following:

In an ideal world, the gay community would have fought [the ADA transvestite and transsexual] exclusions because the manner in which they were excluded was offensive. As written, the ADA lumps gay men, lesbians, and bisexuals with “voyeurs,” as if these groups have something in common. The language concerning transvestites and transsexualism is also extremely derogatory. Transsexual and transvestite individuals are lumped together with individuals who have “sexual behavior disorders.” Certainly, many individuals who are transgendered do not consider themselves to have a “sexual behavior disorder.” Additionally, the Legislation excluded transvestites from coverage twice . . . . That redundancy is itself derogatory because it highlights the legislators’ extreme desire to prevent this group from having legal protection. In sum, the language is deeply insulting . . . . But with the right-wing clamoring about the “sodomy lobby,” there was no room in which to argue that these exclusions were harmful and degrading. The best that the gay rights community was able to achieve was to take “homosexuality” and “bisexuality” out of the sentence that listed “sexual behavior disorders.” This was not much of a victory.599

As discussed in detail in Chapter 19 (The Employment Non-Discrimination Act: Its Scope, History, and Prospects), Section III.C.2., in September 2007 the Human Rights Campaign (HRC), which is the largest and most powerful LGBT advocacy organization on Capitol Hill, stated that it would not support and, in fact, would oppose ENDA if the legislation did not include gender identity as a protected category. However, in November 2007, a little more than a month after a version of ENDA that did not include gender identity had been introduced in the House of Representatives, HRC reneged on its pledge and supported passage of the new version.

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599 Ruth Colker, *Homophobia, AIDS Hysteria, and the Americans with Disabilities Act*, 8 J. GENDER RACE & JUST. 33, 50 (2004), available at http://moritzlaw.osu.edu/sites/colker2/files/2012/12/Homophobia-AIDS-Hysteria.pdf (footnotes omitted). As explained in Section II.C.4. *supra*, because Congress did not have the medical expertise to determine if HIV or AIDS presented a risk of transmission through food handlers, it appropriately delegated to the Secretary of Health and Human Services the authority to determine which infectious or communicable diseases can be so transmitted. Disability and civil rights groups were insistent on the addition of this delegation provision to the ADA to protect people with HIV or AIDS, but apparently made no attempt, or were not insistent, to have a similar delegation provision added with respect to individuals with a GID. See Chai R. Feldblum, *The Federal Gay Rights Bill: From Bella to ENDA*, in *CREATING CHANGE: SEXUALITY, PUBLIC POLICY, AND CIVIL RIGHTS* 149, 173 (John D’Emilio et. al. eds., 2000).
Similarly, at the same time that the last significant remnant of homosexuality was removed from the *DSM*, transvestism was retained and GIDs (including transsexualism) were added. As explained by Dr. Drescher:

Why would the same experts who persuasively and successfully argued for removal of homosexuality from the *DSM-II* advocate for including the GID diagnoses in the *DSM-III*? As the ... history reveals, what seems paradoxical today is the result of decisions made by individuals who lived in a different time with different ideas, different social values regarding gender, and different clinical and social agendas.\(^{600}\)

The American Psychiatric Association has repeatedly spoken out in support of gay civil rights since 1973, yet remained silent on transgender civil rights until 2012, which may be reflective of the fact that it has “hundreds of openly LGB psychiatrists advocating for organizational awareness of LGB rights,” whereas there are “very few visible trans psychiatrists” within the Association.\(^{601}\)

When in 2012 Robert Spitzer, a psychiatrist who played a key role in the removal of homosexuality from, and the addition of GIDs to, the *DSM*, repudiated his views in support of sexual-orientation reparative psychotherapies, some advocates within the transgender community were disappointed that the immediate response from the gay and lesbian community was one of rejoice without any recognition of the harm Spitzer did to transgender individuals. One such advocate, Dr. Kelley Winters, put it this way:

This week, ... journalists turned a blind eye to Dr. Spitzer’s failure to retract a lifetime of trans psychopathologization, stereotyping gender identities and expression that differ from assigned birth roles as mental disease. This omission speaks to the marginal status of trans people within the GLbt rights movement and progressive media, as much as Spitzer’s omission speaks to

\(^{600}\) *Queer Diagnoses*, at 442 (footnote omitted).

\(^{601}\) *Id.* at 448–49. In September 2011, an American Psychiatric Association task force recommended that the Association follow the lead of other medical professional organizations in advocating that treatments for GIDs are medically necessary and should be covered by health insurance. William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder,* 41 Archives Sexual Behav. 759, 768–69, 790–91 (2012), *available at* http://dx.doi.org/10.1007/s10508-012-9975-x and reprinted in 169 Am. J. Psychiatry 875 & data supp. at 9, 30 (2012), *available at* http://ajp.psychiatryonline.org/data/Journals/AJP/24709/appi.ajp.2012.169.8.875.ds001.pdf. The report was made publicly available in June 2012. In July 2012, the Association acted on the task force recommendations by issuing two position statements that (1) support laws protecting the civil rights of “transgender and gender variant individuals”; (2) oppose all discrimination against such individuals in employment and health care; (3) acknowledge that such individuals “can benefit greatly from medical and surgical gender transition treatments”; and (4) support “health insurance coverage for gender transition treatment.” American Psychiatric Association, Position Statement on Discrimination Against Transgender and Gender Variant Individuals (July 2012), *available at* www.psychiatry.org/Files%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2012_TransgenderDiscrimination.pdf; American Psychiatric Association, Position Statement on Access to Care for Transgender and Gender Variant Individuals (July 2012), *available at* www.psychiatry.org/Files%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2012_TransgenderCare.pdf.
trans marginalization by mental health policymakers. Shifting stigma from one oppressed class to a more oppressed class is not real change.\textsuperscript{602}

Likewise, when the U.S. Department of Defense announced in July 2011 that it had finally eliminated its “Don’t Ask, Don’t Tell” (DADT) policy, LGBT advocacy groups understandably cheered, but some of them failed to publicly note at the same time that more work needed to be done inasmuch as an unlegislated version of the DADT policy still applies to transgender service members.\textsuperscript{603} As \textit{U.S. News & World Report} observed in June 2013, when then-Secretary of Defense Leon Panetta spoke at a Department of Defense’s LGBT Pride Month event a year earlier, he said the following:

“As we recognize Pride Month, I want to personally thank all of our gay and lesbian service members, LGBT civilians and their families for their dedicated service to our country,” \ldots He went on to applaud their professionalism and courage, adding “now after repeal, you can be proud of serving your country and be proud of who you are when in uniform.”

Notice the “T” in that acronym only applies to civilians. Panetta’s very particular choice of words highlights an ongoing inconsistency in how the military treats sexuality versus gender identity: Transgendered troops may not serve openly.

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The Pentagon’s Medical Standards for Appointment, Enlistment, or Induction in the Military Services includes among its list of reasons for disqualification “transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.” \textsuperscript{604}

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\textsuperscript{603}See, e.g., HRC Statement on DADT Repeal Certification (Human Rights Campaign July 21, 2011), \textit{available at} www.hrc.org/press-releases/entry/hrc-statement-on-dadt-repeal-certification. The DADT policy is discussed in detail in Chapter 17 (Special Issues Involving Federal Employees, Employees of Federal Contractors, and Members of the Military), Section IV.
\textsuperscript{604}Paul D. Shinkman, “Don’t Ask, Don’t Tell” Still Applies to Transgender Service Members, \textit{U.S. News & World Report} (June 21, 2013), \textit{available at} www.usnews.com/news/articles/2013/06/21/dont-ask-dont-tell-still-applies-to-transgender-service-members. Secretary Panetta’s choice of wording was no accident. Twelve months later, his successor, Chuck Hagel, at a similar event, made the same distinction between LGBT civilians and LG military service members:

Gay and lesbian service members and LGBT civilians are integral to America’s armed forces.\ldots

Our nation has always benefited from the service of gay and lesbian soldiers, sailors, airmen, and Coast Guardsmen, and Marines. Now they can serve openly, with full honor, integrity and respect. This makes our military and our nation stronger, much stronger. The Department of Defense is very proud of its contributions to our nation’s security. We’re very proud of everything the gay and lesbian community have contributed and continue to contribute. With their service, we are moving closer to fulfilling the country’s founding vision, that all of us are created equal.

Additional evidence of the political powerlessness of transgender people is amply illustrated by the way an otherwise “liberal” state reacted to the constitutionally deficient care of a prisoner with gender dysphoria. The editor’s note introducing Thomas Beatie’s essay in Chapter 10 (Beyond Binary) comments on the public outcry in response to a federal judge’s carefully reasoned 2012 decision in *Kosilek v. Spencer*, which held that the Massachusetts Department of Correction (DOC) wrongly denied a transgender woman gender affirmation surgery. Politicians in Massachusetts (and elsewhere) on both sides of the legislative aisle, including both candidates for the U.S. Senate seat formerly held by the late Edward M. Kennedy, denounced the decision. In his opinion, Chief Judge Mark Wolf anticipated the outcry:

As explained in detail in [this] Memorandum, [DOC Commissioner] Dennehy did not decide to deny Kosilek sex reassignment surgery because of a sincere or reasonable concern for security. Rather, she was motivated by her understanding that providing such treatment would provoke public and political controversy, criticism, scorn, and ridicule. She had ample reasons to expect such a reaction. The Lieutenant Governor in whose administration Dennehy served publicly opposed using tax revenues to provide Kosilek sex reassignment surgery. Many members of the state legislature, including one who was close to Dennehy, did the same. In addition, the media regularly ridiculed the idea that a murderer could ever be entitled to such “bizarre” treatment.

Elected officials are entitled to express their views on whether a prisoner should receive sex reassignment surgery. The media has the right to comment critically on the conduct of prison officials and judges as well. Every citizen has a right to criticize public officials, including judges, too.

General Eric Holder comments similarly excluded references to transgender individuals when he discussed the DADT policy:

We can all be proud that, today, those who courageously serve their country in uniform—those who sacrifice so that we can all enjoy the freedoms we cherish—need no longer hide their sexual orientation. With the repeal of the “Don’t Ask, Don’t Tell” law in 2010—an achievement that the Human Rights Campaign helped make possible—we celebrated the beginning of a new era for many brave servicemen and women. And we ensured that, here at home and around the world, lesbian, gay, and bisexual Americans can serve proudly, honestly, and openly—without fear of being fired for who they are.


605 *889 F. Supp. 2d 190 (D. Mass. 2012), aff’d, 740 F.3d 733 (1st Cir. 2013), reh’g en banc granted and majority and dissenting appellate opinions withdrawn by Order of Court, No. 12-2194 (1st Cir. Feb. 12, 2014) (setting hearing en banc for May 8, 2014).

606 See, e.g., Kelly Heard, *Murderer’s Sex Change: Cruel, or Just Unusual?*, UNIV. MIAMI LAW REVIEW BLOG (Sept. 11, 2012), available at http://lawreview.law.miami.edu/murderers-sex-change-cruel-unusual (“Senator Scott Brown referred to the ruling as ‘an outrageous abuse of taxpayer dollars.’ Brown’s opponent and Harvard Law School professor Elizabeth Warren agreed.”); Andrew Cray and Jeff Krehely, *Massachusetts Senate Candidates Fail to Understand Importance of Funding Transgender Health Services*, THINK PROGRESS BLOG (Sept. 10, 2012), available at http://thinkprogress.org/lgbt/2012/09/10/819091/massachusetts-senate-candidates-fail-to-understand-importance-of-funding-transgender-health-services (“there still seems to be question about whether care provided to transgender prisoners is a ‘good use of taxpayer dollars’ (in the words of Massachusetts Democratic Senate candidate Elizabeth Warren) or even whether it is an ‘outrageous abuse’ of state funds (in the words of the sitting senator Warren is challenging, Republican Scott Brown”).)
However, a prison official acts with deliberate indifference and violates the Eighth Amendment if, knowing of a real risk of serious harm, she denies adequate treatment for a serious medical need for a reason that is not rooted in the duties to manage a prison safely and to provide the basic necessities of life in a civilized society for the prisoners in her custody. Denying adequate medical care because of a fear of controversy or criticism from politicians, the press, and the public serves no legitimate penological purpose. It is precisely the type of conduct the Eighth Amendment prohibits.607

Despite Chief Judge Wolf’s ruling and subsequent orders, he was forced to issue a directive in 2013 requiring the DOC Commissioner to file detailed monthly reports, signed under oath, because “the court [was] concerned that the pattern of resistance and delay regarding adequate medical care for transsexual prisoners that the First Circuit found proven in Battista [v. Clarke, 645 F.3d 449, 454–55 (1st Cir. 2011)], and is exemplified by the instant case, may be continuing.”608

Finally, the ADA states that “unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination.”609 By excluding individuals who have or had been diagnosed with GIDs not resulting from physical impairments, transsexualism, or transvestism from the ADA and the Rehabilitation Act, Congress reinforced the minority status of a portion of the transgender community who have or had been diagnosed with one of these conditions, unfortunately and perversely confirming one of Congress’s finding when enacting the ADA: individuals with disabilities “occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally.”610 In addition, transgender individuals who do not have a disability nonetheless may be assumed to be disabled due to the manner in which the ADA and Rehabilitation Act treat GIDs not resulting from a physical impairment, transsexualism, or transvestism and, until 2013, the DSM had treated gender nonconformity.

\[c. \text{ Applicability of Heightened Scrutiny to Gender Stereotypes}\]

Moreover, the singling out of individuals with GIDs not resulting from physical impairments, transsexualism, or transvestism is based on sex stereotyping and results in disparate treatment based on gender, both with respect to transgender people as a group when compared to nontransgender people and with respect to gender-nonconforming men when compared to gender-nonconforming women. Such differential treatment violates these

607 Kosilek, 889 F. Supp. 2d at 203 (citation omitted). See Jennifer Levi, Transgender Exceptionalism Should Not Cloud Legal Analysis, JURIST (Oct. 16, 2012), available at http://jurist.org/hotline/2012/10/jennifer-levi-grs-kosilek.php (observing that Judge Wolf’s “decision is in the finest tradition of civil rights analysis . . . —that constitutional protections must be upheld by our courts regardless of how marginalized or unpopular the person to whom they apply”).


610 Id. §12101(a)(6).
individuals’ rights to equal protection. As explained in Section III.G.3.a. supra, equal protection challenges to classifications based on gender stereotypes or sex are subject to heightened scrutiny. As Professor L. Camille Hébert has observed:

[S]ociety appears to be more tolerant of gender nonconformity of women than men. Even as children, “tomboys”—young girls who act “like boys”—are more accepted than “sissies”—young boys who are considered too effeminate. Societal standards of acceptable dress among children and adults also reflect this uneven approval of gender nonconformity between the sexes. Women can wear what would have once been considered “masculine” clothing—pants, suits, and even ties—without any sanction; indeed, professional women are generally expected to dress in a manner that de-emphasizes their secondary sex characteristics. Men, on the other hand, are generally ridiculed for dressing in a way that is considered traditionally feminine. A man in a dress instantly stands out; only relatively recently have men been able to wear earrings or makeup or carry a purse—a “man bag”—without social disapproval. It is not enough to dismiss these differences as just a matter of social norms; it cannot be an accident that “masculine” dress is acceptable for women, but “feminine” dress is not acceptable for men. Instead, it appears that society is willing to accept a woman who strives to emulate men, while looking with disapproval on a man who demeans himself by “aping” women.

Society’s greater disapproval of gender nonconformity among men also appears to extend to the gender nonconformity evidenced by transsexual and transgendered individuals. Evidence suggests that men in general object to transsexualism more than women do; this may be particularly true with respect to transsexual women. Men who view women as inferior may well find it especially repugnant that transsexual women intentionally and willingly give up the societal advantages that are provided to men by becoming women. Men, even those who do not hold negative views of women, may find it incomprehensible that transsexual women are willing and even eager to give up their penises. And some men may also feel that transsexual men are merely “passing” as men and therefore seeking a status and privileges to which they are not entitled; sometimes these feelings are expressed in the form of sex-based violence and rape.

Similarly, some women may view transsexual women as interlopers and not true women and transsexual men as traitors. The first of these views appears to be reflected in a letter written by a mother responding to her son’s disclosure of her transsexualism:

It is insulting to me, as a woman, that you assume that the outer trappings of femaleness somehow entitle you to all the other baggage that women carry—baggage that can only be acquired by growing up female in a male world. For you to think that donning female attire entitles you to appropriate and fully understand all that being a woman encompasses is unfair to me and to women in general. It denigrates my experience. The way you appear to grasp all this is so male.

It is difficult to understand these reactions as other than gendered or motivated by issues of sex and the proper role and status of the sexes. Many of these reactions are clearly based on gender hostility, such as the mother’s characterization of her son’s behavior as “so male” and the fact that the hostility of men who discover the transsexualism of a drinking buddy is expressed by

611 See generally Chapter 15 (Federal Equal Protection).
rape. And even these reactions that are not based purely on hostility do appear to be motivated by beliefs about sex and gender. Accordingly, it appears that negative views about transsexual and transgendered individuals are related to gender and therefore are motivated, at least in part, because of sex.\textsuperscript{612}

The disparate treatment of transgender individuals based on their gender nonconformity or diversity violates their rights to equal protection. As the Eleventh Circuit held in \textit{Glenn v. Brumby},\textsuperscript{613} “discrimination against a transgender individual because of her gender-nonconformity is sex discrimination, whether it’s described as being on the basis of sex or gender,” and thus violative of the Equal Protection Clause of the Fourteenth Amendment.\textsuperscript{614}

Since its inclusion in the \textit{DSM}, transvestism has been treated as a disorder involving sexual arousal related to cross-dressing. However, many individuals engage in various degrees of “cross-dressing” not for sexual arousal. Rather, the clothing they choose best expresses their gender identity. As Dr. Benjamin observed, “[m]ost writers on the subject refer to transvestism as a sexual deviation, sometimes as a perversion. It is not necessarily either one. It also can be a result of ‘gender discomfort’ and provide a purely emotional relief and enjoyment without conscious sexual stimulation, this usually occurring only in later life.”\textsuperscript{615} To the extent individuals fit the latter category, they should not be categorized as having a transvestic disorder. However, because of the rampant misperception that all “cross-dressers” are “transvestites” (within the meaning of the \textit{DSM}) and men, it is quite likely that they will be perceived as having a mental condition that they do not have, and, therefore, should receive ADA and Rehabilitation Act protection under the “regarded as” prong of the definition of “disability.” To the extent that the ADA and Rehabilitation Act’s exclusion of transvestism would bar such a regarded-as claim because transvestism is not a protected disability, that exclusion deprives the non-sexually driven cross-dressers (or, more generally, gender-diverse people) from equal protection of the laws as they are denied legal relief for being unjustly stigmatized with a mental condition when other individuals who are stigmatized by medical conditions (e.g.,

\textsuperscript{612}L. Camille Hébert, \textit{Transforming Transsexual and Transgender Rights}, 15 Wm. & Mary J. Women & L. 535, 564–67 (2009), available at http://scholarship.law.wm.edu/wmjowl/vol15/iss3/3 (footnotes omitted); See also Milton Diamond, \textit{Biased-Interaction Theory of Psychosexual Development: “How Does One Know if One Is Male or Female?”}, 55 Sex Roles 589, 595 (2006), available at http://dx.doi.org/10.1007/s11199-006-9115-y or www.hawaii.edu/PCSS/biblio/articles/2006to2009/2006-biased-interaction.html (“In our society, however, a male that exhibits feminine behaviors sufficient to be considered a sissy is much less tolerated than a female tomboy and there is a social price to pay for effeminate demonstrations. There can be bodily consequences as well as social ones; many boys are forced to physically fight their peers to defend themselves against taunts and prejudice.”).

\textsuperscript{613}663 F.3d 1312, 113 FEP 1543 (11th Cir. 2011).

bipolar, HIV, or cancer) they don’t have are afforded relief under the ADA and the Rehabilitation Act. Moreover, gender nonconformity with respect to clothing choices is accepted with respect to women, but generally not with respect to men. As a result, the DSM historically singled men out for the transvestism diagnosis. Importing the transvestism diagnosis into the ADA and Rehabilitation Act via the exclusion codifies the social disdain for male gender nonconformity and thus violates equal protection.

d. Applicability of Rationality Review to Disabilities

The ADA and Rehabilitation Act’s treatment of gender-affirmed and gender-diverse people cannot survive under the heightened scrutiny that classifications based on gender or LGBT status are subject to. Moreover, such treatment cannot survive even under the significantly more deferential rationality review applied to classes based on disabilities. As discussed in Section III.C.3.a. supra, the sexual behavior disorders exclusion was added to the ADA legislation at the last moment, around 10:00 p.m., near the end of a 14-hour debate day that the Senate had with respect to the bill. These disorders were among a very long list of conditions—including bipolar disorder, borderline personality disorder, delusional disorder, depressive neurosis, disruptive behavior disorders, phobias, psychotic disorders, and stress disorders—that Senators Armstrong and Helms identified during the debate and wanted to exclude from the ADA. The list also included a number of mental disorders associated with illegal activities. It is quite evident that the proponents of the ADA, to get the bill out of the Senate, agreed to eliminate conditions that pertained to illegal conduct (e.g., kleptomania and pyromania), that were represented to them by Senators Armstrong and Helms as being sexual perversions,617 and/or that simply were not worth fighting for (e.g., compulsive gambling). Most telling were the admissions by Senator Armstrong, the chief proponent of the list, that he was “simply not learned enough or well enough informed to suggest an amendment” to eliminate the disorders he felt were morally objectionable, and Senator Harkin, the chief sponsor of the Senate bill, that he was “not familiar with these disorders.” Most likely, nearly all, if not all, of the senators were not familiar with these “disorders,” especially GIDs, and had no time on

616. Transsexual Phenomenon, at 21 (“Women’s fashions are such as to allow a female transvestite to indulge her wish to wear male attire without being too conspicuous. Her deviation has been considered merely arrogant while male transvestism is to many objectionable because, in their opinion, it humiliates.”). Until the DSM was revised in 2013, its transvestism diagnosis has focused on heterosexual men, reflecting the ingrained societal acceptance of a degree of gender nonconformity by women.


619. Id. at S10,753.
the evening of the debate to educate themselves. The fact that GIDs and transsexualism were listed separately in the ADA suggests that the senators did not even understand that transsexualism was one type of GID.

As explained in Sections III.G.2.b.vi. and III.G.2.d. supra, GIDs (including transsexualism) were not listed as “sexual disorders” or “sexual behavior disorders” in the *DSM-III-R*, the medical reference that was discussed during the floor debate. Rather, they were classified within “disorders usually first evident in infancy, childhood, or adolescence,” an acknowledgment that gender dysphoria normally develops well before puberty and sexual arousal issues. In contrast, when it came to excluding conditions that the *DSM-III-R* actually included as “sexual disorders”—paraphilias and sexual dysfunctions—the compromise Senators Armstrong and Harkin reached included just the paraphilias and none of the sexual dysfunctions, such as hypoactive sexual desire disorder, male erectile disorder, inhibited orgasm, and premature ejaculation. The sexual performance conditions were not raised as a concern by Senators Armstrong and Helms. That senators were unfamiliar with GIDs is not an indictment of them, other than for their failure to investigate before legislating. Rather it is a reflection of the rampant misinformation and social stereotypes that have been imposed on transgender individuals. As explained in the Section III.G.2.d. supra, it was precisely this sort of stereotyping, reliance on prejudice, and failure to take the time to understand a specific medical condition that the ADA was designed to overcome.

Tribunals applying state laws prohibiting disability discriminations have rejected the exclusion of GIDs not resulting from physical impairments and transsexualism as being without any rational basis. For example, in *Doe v. Electro-Craft Corp.*, the New Hampshire Commission on Human Rights (NHCHR) had declined to interpret the disability provision of its state’s Law Against Discrimination to protect a transsexual employee who had undergone gender reassignment surgery. On appeal, the superior court reversed, observing that the NHCHR had no basis for “patently disregard[ing] the definition and description of transsexualism in [the] *DSM-III*” or substituting the NHCHR’s “manifestly unsupported” findings for the medical expertise reflected in the *DSM-III* because “the distinguishing features and characteristics of transsexualism involve complex medical information, as is evident from the *DSM-III*. They are not the sort of generally recognized technical or scientific facts within the [NHCHR’s] specialized knowledge as to which it

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620 Cf. United States v. Happy Time Day Care Ctr., 6 F. Supp. 2d 1073, 1080 (W.D. Wis. 1998) (in an ADA public accommodation case, where the court found that a suppressed immune system resulting from HIV can substantially limit a person’s ability to care for oneself, the court declined to consider whether procreation was a major life activity for a three-year-old child because “there is something inherently illogical about inquiring whether an individual’s ability to perform a particular activity is substantially limited . . . when . . . this individual is incapable of engaging in that activity in the first place”).

could take official notice.” In *Enriquez v. West Jersey Health Systems*, the New Jersey Superior Court, Appellate Division, similarly declined to exclude GIDs from the state’s Law Against Discrimination (NJLAD), even though GIDs not resulting from physical impairments are excluded from the ADA. In holding that taking adverse employment action on the basis of a person’s gender dysphoria and transitioning on the job can constitute both disability and sex discrimination, the court observed that “gender dysphoria is a recognized mental or psychological disability that can be demonstrated psychologically by accepted clinical diagnostic techniques”; gender dysphoria “does not cause violations of the law as does exhibitionism”; and discrimination is not acceptable simply because the plaintiff is “a member of a very small minority whose condition remains incomprehensible to most individuals.” Similarly, in *Richards v. U.S. Tennis Association*, the New York trial court held that barring Renée Richards from “the women’s singles of the U.S. Open is grossly unfair, discriminatory and inequitable, and violative of her rights under the [state’s] Human Rights Law,” and “the unfounded fears and misconceptions of defendants must give way to the overwhelming medical evidence that this person is now female.”

Other state law disability cases, discussed in Section III.G.2.c. supra, demonstrate that numerous tribunals have recognized gender dysphoria as a legitimate medical condition deserving of protection from invidious discrimination. For example, in *Doe v. Yunits*, which involved an interpretation

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622 Id. at *4–5.
624 777 A.2d at 372, 376. See also *M. T. v. J. T.*, 355 A.2d 204, 207, 211 (N.J. Super. Ct. App. Div.), certification denied, 364 A.2d 1076 (N.J. 1976) (in holding that a transsexual woman’s marriage to a man was legal, the court observed: “In so ruling we do no more than give legal effect to a Fait accompli, based upon medical judgment and action which are irreversible. Such recognition will promote the individual’s quest for inner peace and personal happiness, while in no way disquising any societal interest, principle of public order or precept of morality.” The court also quoted approvingly from the trial court’s decision: “It is the opinion of the court that if the psychological choice of a person is medically sound, not a mere whim, and irreversible sex reassignment surgery has been performed, society has no right to prohibit the transsexual from leading a normal life. Are we to look upon this person as an exhibit in a circus side show? What harm has said person done to society? The entire area of transsexualism is repugnant to the nature of many persons within our society. However, this should not govern the legal acceptance of a fact.”); *Poff v. Caro*, 549 A.2d 900, 903 (N.J. Super. Ct. Law Div. 1987) (in a regarded-as case of discrimination in public accommodations based on AIDS under the NJLAD, the court quoted *Andersen v. Exxon*, 446 A.2d 486, 492 n.2, 43 FEP 1763, 1 AD 335 (N.J. 1982): “Prejudice in the sense of a judgment or opinion formed before the facts are known is the fountainhead of discrimination engulfing medical disabilities which prove on examination to be ... nonexistent.”).
626 Id. at 272.
627 Doe v. Yunits, 2001 WL 664947, 15 Mass. L. Rep. 278 (Super. Ct. Feb. 26, 2001) (allowing a student with a GID, who was barred from junior high school because she wore female clothing, to proceed with a disability discrimination claim under the Declaration of Rights of the Massachusetts Constitution, which has an ADA-like, three-pronged definition of “disability”). In an earlier decision in the case, where the court preliminarily enjoined the school from prohibiting plaintiff from wearing any clothing that other students (male or female) are
of the disability article of the Declaration of Rights of the Massachusetts Constitution, the Massachusetts Superior Court explained why it expressly rejected engrafting onto the commonwealth’s ADA-like, three-pronged definition of “disability” the federal exclusion of GIDs not resulting from physical impairments:

Indeed, the better view is that Massachusetts, in contrast with the federal government, chose in Article CXIV to protect all persons who meet the definition of “qualified handicapped individuals” from discrimination in state programs, regardless of the specific nature of their handicap. Massachusetts did not choose to define specifically which handicaps were protected by law. Rather, it simply provided a generic definition of a “qualified handicapped individual” and allowed the courts to determine whether a plaintiff, based on that plaintiff’s specific circumstances and the facts specific to his or her case, met that definition. There is wisdom to such an approach. It recognizes that, as our knowledge of genetics, biology, psychiatry, and neurology develops, individuals who were not previously believed to be physically or mentally impaired may indeed turn out to be so, and may warrant protection from handicap discrimination. It also recognizes that this may mean that persons who were previously thought to be eccentric or iconoclastic (or worse) and who were vilified by many people in our society may turn out to have physical or mental impairments that grant them protection from discrimination. Stated differently, the traits that made them misunderstood and despised may make them persons enjoying special protection under our law.628

The categorizations by Senators Armstrong and Helms of GIDs (including transsexualism) as “sexual behavior disorders” and as conditions worthy of moral condemnation were without foundation and based on ignorance in view of the etiology of GIDs and the usual development of gender dysphoria in childhood (as opposed to later in life as are some behaviors that they deemed “sexual perversions”). The position of these senators was irrational, and runs afool of the Supreme Court’s admonishments in the disability case City of Cleburne that “some objectives—such as ‘a bare ... desire to harm a politically unpopular group’—are not legitimate [governmental] interests.”629 And, as discussed earlier in this section in the context of claims under Title VII and the Equal Protection Clause of the Fourteenth Amendment, Judge Dlott determined that there was no rational basis for the assumption that a “rare psychiatric disorder” such as GID, prevented the plaintiff “from being a competent and capable police officer.”630


e. The Exclusion of Gender Identity Disorders Not Resulting From Physical Impairments, Transsexualism, and Transvestism Does Not Survive Rational or Heightened Scrutiny

It is evident from the preceding discussion that the ADA and Rehabilitation Act’s discriminatory treatment of transgender individuals does not survive either rational or heightened scrutiny. Many of the authorities discussed above clearly demonstrate that there simply is no rational basis for singling out persons who have or had a diagnosis of a GID not resulting from a physical impairment, transsexualism, or transvestism. GIDs (including transsexualism) clearly are not sexual behavior disorders. The transvestism diagnosis has a distinctly discriminatory impact on gender-nonconforming men. The ADA and Rehabilitation Act exclusion of these diagnoses does further harm in that such exclusion reinforces unfounded perceptions about transgender people generally, regardless of whether such individuals have been diagnosed with one of these DSM conditions. If transgender people are wrongly perceived as transsexuals or transvestites, as a result of the ADA and Rehabilitation Act exclusions they are prohibited from seeking relief under those laws for “regarded as” disability discrimination. In effect, both laws simultaneously perpetuate discrimination against the overwhelming majority of the members of the transgender community who have no disability but who may be regarded as disabled because of unfounded fears, prejudice, and stereotypes, and deprive them of the protections of these laws.

As the Supreme Court stated in City of Cleburne, “It is plain that the electorate as a whole, whether by referendum or otherwise, could not order city action violative of the Equal Protection Clause, and the City may not avoid the strictures of that Clause by deferring to the wishes or objections of some fraction of the body politic. ‘Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect.’”631 The Court repeated this admonition in United States v. Windsor632 when it held that “[t]he Constitution’s guarantee of equality ‘must at the very least mean that a bare congressional desire to harm a politically unpopular group cannot’ justify disparate treatment of that group.”633 The actions of two senior U.S. senators imbued the ADA and the Rehabilitation Act with their seeming deep hatred for LGBT people. To close the deal on the ADA, during its one and only day of debate over the ADA and almost at the end of that very long day, the proponents of the ADA agreed to bow to that hatred, thereby depriving transgender individuals of the protections of the ADA and the Rehabilitation Act.

Thus, the ADA and Rehabilitation Act’s exclusion of GIDs not resulting from a physical impairment, transsexualism, and transvestism violates the Equal Protection Clause with respect to both persons who have been

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631 City of Cleburne, 473 U.S. at 448 (citations omitted).
633 133 S. Ct. at 2693, 118 FEP at 1425.
diagnosed with one of these conditions and transgender individuals who have not be so diagnosed but are regarded as having one of these conditions.

f.  \textit{The Removal of Gender Identity Disorders Not Resulting From Physical Impairments, Transsexualism, and Transvestism From the Rehabilitation Act Violated Transgender Individuals' Rights to Equal Protection}

Finally, as explained in Section III.C.2. \textit{supra}, the courts had held that both transsexualism and transvestism were protected disabilities under the Rehabilitation Act. Thereafter, Congress amended the Rehabilitation Act to include the same LGBT exclusions that are contained in the ADA. Thus, as the result of the moral indignation of two legislators, Congress stripped individuals of their protection from discrimination based on actual or perceived GIDs not resulting from a physical impairment, transsexualism, or transvestism. In \textit{Romer v. Evans}, the Supreme Court struck down a Colorado constitutional amendment that both repealed local ordinances that provided protection from sexual orientation discrimination and barred the enactment of such protection at any level of state or local government. The Court found that the amendment’s “sheer breadth is so discontinuous with the reasons offered for it that the amendment seems inexplicable by anything but animus toward the class it affects; it lacks a rational relationship to legitimate state interests.”

Similarly, in \textit{Perry v. Brown}, the Ninth Circuit Court of Appeals held that a California constitutional amendment that withdrew the right of same-sex couples to marry deprived gay men and lesbian women the equal protection of the laws. The court held that “[w]ithdrawing from a disfavored group the right to obtain a designation [of marriage] . . . is different from declining to extend that designation in the first place.” It explained that “[t]he relevant inquiry in \textit{Romer} was not whether the \textit{state of the law} after [Colorado] Amendment 2 was constitutional; there was no doubt that the Fourteenth Amendment did not require antidiscrimination protections to be afforded to gays and lesbians. The question, instead, was whether the \textit{change in the law} that Amendment 2 effected could be justified by some legitimate purpose.” The court held that there was no legitimate justification for taking away the right to marry and found that the inference that the California amendment “was born of disapproval of gays and lesbians is heightened by evidence of the context in which the measure was passed.” The Supreme Court vacated the Ninth Circuit’s decision, finding that the appellants did not have standing to appeal from the trial court’s judgment, and directed the

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Ninth Circuit to dismiss the appeal for lack of jurisdiction. Although the Ninth Circuit’s decision has been vacated, the persuasiveness of its opinion on the merits remains.

As the discussion in this chapter demonstrates, it was the disapproval based on moral grounds of conservative senior Senators Armstrong and Helms that led to the enactment of ADA’s exclusion of GIDs not resulting from a physical impairment, transsexualism, and transvestism, and the codification two years later of that exclusion in the Rehabilitation Act when the latter law was amended to conform to the ADA. Based on *Romer* and *Perry*, the inclusion of this exclusion in the Rehabilitation Act violated “the constitutional conception of ‘equal protection of the laws’ means anything, it must at the very least mean that a bare . . . desire to harm a politically unpopular group cannot constitute a legitimate governmental interest.”

**H. Workplace Impact of the Americans with Disabilities Act or the Rehabilitation Act Applying to Individuals With Gender Dysphoria**

None of the case law under the ADA or the Rehabilitation Act relating to individuals with GIDs has addressed the issue of what accommodations would be reasonable, because the litigation in those cases never reached that stage of analysis. However, many of the state law cases discussed in this chapter provide insights into what would be reasonable. These cases demonstrate that when courts view gender dysphoria through the lens of disability discrimination instead of the prism of sex discrimination, they readily appreciate the need for reasonable accommodations that will allow a person with gender dysphoria to transition on the job or in school in accordance with accepted medical standards. This generally means that an employer should make sure all employees treat a gender-affirmed employee in accordance with the individual’s stated gender identity (e.g., using the correct pronouns when referring to the person) and in a respectful manner, and should permit the individual to follow the normal workplace dress code and use the restrooms that correspond to the individual’s affirmed gender. As explained in Section II.B.7. *supra*, the EEOC has stated that making facilities, including restrooms, accessible is a reasonable accommodation. As discussed in Chapter 36 (Gender-Segregated Facilities), in 2011 the U.S. Office of Personnel Management advised federal agencies that “once

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641 As explained in Section III.C.1. *supra*, the transvestite exclusion had already been added to the Rehabilitation Act in 1988, less than one year after the federal circuit court’s decision in the *Blackwell* litigation (discussed in Section III.C.2.b. *supra*), as a statutory note to the Fair Housing Act, as a result of an amendment sponsored by Senator Helms.
[a transitioning employee] ... has begun living and working full-time in the gender that reflects his or her gender identity, agencies should allow access to restrooms and (if provided to other employees) locker room facilities consistent with his or her gender identity.\textsuperscript{643} Other federal agencies have adopted similar directives.\textsuperscript{644} And, in 2012, the American Psychiatric Association stated that transgender and gender-variant people should not be forced to use inappropriate gender-segregated facilities.\textsuperscript{645}

Accommodating an individual with gender dysphoria is easy to do. Part VII (Workplace Solutions) of this treatise provides extensive guidance and suggestions to help employers seamlessly handle many human resource situations, including requests for accommodations that might arise. It also discusses the case law with respect to restrooms and dress codes in the context of gender-affirmed and gender-diverse persons.


Note: This exhibit should be read in conjunction with the discussion of the history of the DSM that is contained in this chapter.
Exhibit 16.2. Diagnostic Classes in the 1968 and 1973 Editions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-II and DSM-II-R)*

| DSM-II (1968) |
| DSM-II-R (1973) |
| I. Mental Retardation |
| II. Organic Brain Syndromes |
| III. Psychoses Not Attributed to Physical Conditions Listed Previously |
| IV. Neuroses |
| VII. Special Symptoms |
| VIII. Transient Situational Disturbances |
| IX. Behavior Disorders of Childhood and Adolescence |
| X. Conditions Without Manifest Psychiatric Disorder and Non-specific Conditions |
| XI. Non-diagnostic Terms for Administrative Use |

| VI. Psychophysiologic Disorders |

| V. PERSONALITY DISORDERS AND CERTAIN OTHER NONPSYCHOTIC MENTAL DISORDERS |

| [Partial Listing] |
| 305.6 Psychophysiologic Genitourinary Disorder (e.g., dyspareunia and impotence) |

| 302 SEXUAL DEVIATIONS |

| 302.0 HOMOSEXUALITY (1968) |
| 302.0 SEXUAL ORIENTATION DISTURBANCE (1973)† |

| 302.01 Fetishism |
| 302.02 Pedophilia |
| 302.03 TRANSVESTISM |

| 302.04 Exhibitionism |
| 302.05 Voyeurism |
| 302.06 Sadism |
| 302.07 Masochism |

| 302.08 Other Sexual Deviation |
| 302.09 Unspecified Sexual Deviation |

† The 1973 revision made just this one change to the DSM.

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Note: This exhibit should be read in conjunction with the discussion of the history of the DSM that is contained in this chapter.
Exhibit 16.3. Diagnostic Classes in the 1980 Edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*


*Note:* This exhibit should be read in conjunction with the discussion of the history of the DSM that is contained in this chapter.
Exhibit 16.4. Diagnostic Classes in the 1987 Edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*

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*Note:* This exhibit should be read in conjunction with the discussion of the history of the DSM that is contained in this chapter.
Exhibit 16.5. Diagnostic Classes in the 1994 and 2000 Editions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV and DSM-IV-TR)*

**DSM-IV (1994)**


I. Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
   II. Delirium, Dementia, and Amnestic and Other Cognitive Disorders
   III. Mental Disorders Due to a General Medical Condition
   IV. Substance-Related Disorders
   V. Schizophrenia and Other Psychotic Disorders
   VI. Mood Disorders
   VII. Anxiety Disorders
   VIII. Somatoform Disorders
   IX. Factitious Disorders
   X. Dissociative Disorders
   XI. Sexual and Gender Identity Disorders
   XII. Eating Disorders
   XIII. Sleep Disorders
   XIV. Impulse-Control Disorders Not Elsewhere Classified
   XV. Adjustment Disorders
   XVI. Personality Disorders
   XVII. Other Conditions That May Be a Focus of Clinical Attention (including IDENTITY PROBLEM)
   XVIII. Additional Codes

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*American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994); American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (4th ed. text rev. 2000). Copyright © 1994, 2000 American Psychiatric Association. Note: This exhibit should be read in conjunction with the discussion of the history of the DSM that is contained in this chapter.*
Exhibit 16.6. Diagnostic Classes in the 2013 Edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*

- **1. Neurodevelopmental Disorders**
- **2. Schizophrenia Spectrum and Other Psychotic Disorders**
- **3. Bipolar and Related Disorders**
- **4. Depressive Disorders**
- **5. Anxiety Disorders**
- **6. Obsessive-Compulsive and Related Disorders**
- **7. Trauma- and Stressor-Related Disorders**
- **8. Dissociative Disorders**
- **9. Somatic Symptom and Related Disorders**
- **10. Feeding and Eating Disorders**
- **11. Elimination Disorders**
- **12. Sleep-Wake Disorders**
- **15. Disruptive, Impulse-Control, and Conduct Disorders**
- **16. Substance-Related and Addictive Disorders**
- **17. Neurocognitive Disorders**
- **18. Personality Disorders**
- **19. Paraphilic Disorders**
- **20. Other Mental Disorders**
- **21. Medication-Induced Movement Disorders and Other Adverse Effects of Medication**
- **22. Other Conditions That May Be a Focus of Clinical Attention (Including SEX COUNSELING; OTHER PROBLEMS RELATED TO EMPLOYMENT)**

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*Note: This exhibit should be read in conjunction with the discussion of the history of the DSM that is contained in this chapter.*