



AIS SUPPORT GROUP AUSTRALIA

Support for people and families with intersex conditions.

<http://www.vicnet.net.au/~aissg>

aissg@iprimus.com.au

DOES *RE: KEVIN* RE-DEFINE THE MEANING OF INTERSEX TO INCLUDE TRANSSEXUALISM?

By Andie Hider - Medical Liaison Officer, AIS Support Group Australia

ABSTRACT

The *Re: Kevin* legal decisions, both before Chisholm J of the Family Court of Australia at NSW and the Full Court, established the right of a person with transsexualism to have their marriage legally recognised under Australian Law. Whilst the intent of the findings and the reasons for them are clear, matters considered obiter have been widely cited by certain interested parties as proof that transsexualism is an intersex condition such as Androgen Insensitivity Syndrome. In particular Ms Rachael Wallbank, counsel for “Kevin and Jennifer”, has publicly stated that she considers the *Re: Kevin* finding established that transsexualism is an intersex condition, despite opposition from the intersex community. It is the intent of this paper to examine the findings of the *Re: Kevin* case and certain evidence put before the Family Court of Australia in light of beliefs of the wider medical and scientific communities as well as some background issues pertinent to proper weighting of the findings of the Court.

HISTORY

“Intersex” is a term first used by the American medical profession to more accurately describe a group of conditions once referred to as hermaphroditism or pseudohermaphroditism. Aside from being medically inaccurate when describing the aetiology of the majority of cases of intersex conditions, the term hermaphrodite had been historically used (and miss-used by makers of pornography) to describe a person possessed of complete sets of male and female external and internal reproductive organs leading to misconceptions about the medical realities of the conditions. Using strict medical definitions, a hermaphrodite is a person with both ovarian and testicular tissue, either in separate gonads in the same person or both gonads as mixed tissue. Psychologist John Money, who studied intersex conditions extensively, used the term intersex to describe his patients and widespread adoption of the term by other medical professionals is associated with almost universal adoption of his surgery based treatment paradigm.

People with intersex conditions initially rejected use of the term intersex to describe them because as a medical term it defined them according to their medical condition rather than as an individual with issues unique to them as a person. Persistence with use of the term intersex by the medical profession, led some groups to a failed attempt to positively re-claim the term hermaphrodite. During the late 1980s and early 1990s, intersex advocacy and support groups like the Intersex Society of North America began to accept use of the medical term intersex to describe people with these conditions. Along with wider public activity to increase awareness about intersex conditions, the term began to be

used positively in much the same way as the Gay and Lesbian communities have re-claimed previously negatively used terms like “Queer” and “Dyke”.

In Australia the term intersex has only relatively recently been used in the public domain to describe a community rather than a group of specific medical conditions. The willingness of a few individuals with intersex conditions to speak publicly of their experiences has led to the term intersex having an understood specific meaning rather than people with intersex conditions being considered under the collective “transgender” description. Worldwide publicity surrounding the exposure of the failure of one of John Money’s most widely reported cases, arguably the single case upon which his entire treatment paradigm was finally cemented as acceptable standard practice in the eyes of the wider medical profession, led to a media “feeding frenzy” to write about intersex conditions and the controversial practices used by the wider medical profession to treat people with the conditions. Public support for people with intersex conditions belied expectations of many medical professionals that the “general public” would never accept the birth of infants who did not neatly fit into the generally accepted sex categories of male and female.

Tony Briffa, first Secretary and then President of the Androgen Insensitivity Syndrome Support Group Australia (AISSGA), was widely interviewed by television, radio and print media raising substantially the public profile of people with intersex conditions and is largely responsible for the positive public profile intersex conditions currently enjoy in Australia. His experiences, whilst not typical of the majority of people with intersex conditions, describe some of the worst outcomes possible from well intentioned but misguided medical intervention standardised as a result of John Money’s assertions.

Intersex as a set of conditions, have been extensively studied using both human and animal research models. This research has largely been focussed on proving or disproving John Money’s theory of gender neutrality and the likely interaction of sex hormones in the process of forming gender identity, particularly the role of testosterone. Work with higher order mammals has tended to suggest that gender identity is formed pre-term and efforts to castrate male animals at birth in order to change later behaviours have failed. Male-typical behaviours can be induced in chromosomally female animal research subjects by subjecting developing foetuses to high doses of testosterone. Interestingly, this behavioural research is supported in human research models, chromosomally female children exposed to high doses of testosterone as a result of a condition called Congenital Adrenal Hyperplasia display behaviours that would be described by most as male-typical. Conversely, chromosomally male children born with Complete Androgen Insensitivity Syndrome and a complete lack of response to testosterone appear and behave as other girls and individuals with Partial Androgen Insensitivity Syndrome and therefore some response to testosterone may identify as either male or female.

The increase of scientific and medical interest in genetics, has led many researchers to detailed study of the genetic basis of intersex conditions. Importantly Australian genetics researchers discovered and described some of the most important genetic sex differentiation processes with the assistance of research subjects with intersex conditions. The clear link between identified monogenic (single gene) and polygenic (multi gene) developmental precursors of intersex conditions and the ultimate expression of these as physical variations has provided the genetic research community with the ability to map little understood genetics expression human processes. The roles of genes such as SRY, WNT4 and AR gene modifications have been extensively mapped and described.

Finding a cause for Transsexualism has also generated intense interest in some scientific and medical quarters. Suspicion that there may be a hormonal or genetic cause for transsexualism is widespread

amongst specialists who treat transsexuals as well as researchers interested in the sex differentiation process. Early attempts at discovering some tangible physical or biological evidence produced no reliable determinants, however, later research that established physical differences in certain brain nuclei in male and female brains was applied to the brains of transsexuals with promising results. What is clear is that there is a physical difference between the brain of a male to female transsexual in this area of the brain and a “normal” male brain structure, the size of the nuclei being closer to a normal female brain structure. What is not clear is how this change occurs or what causal or effective interrelationship it has with transsexualism as a condition or with gender identity in general and there has also been no research to establish if such a relationship exists with female to male transsexuals. Interestingly, later research has established that the differentiation process of this part of the brain takes place later than originally thought and begins in the late teens to early twenties as the physical difference has not been noted in children.

There have also been attempts to locate a genetic cause of transsexualism. As one researcher pointed out though, this is like looking for the proverbial needle in a haystack. One barrier to obtaining funding for this research has been anecdotal evidence that transsexualism does not manifest in all identical twins. This tends to preclude genetic determinism as the sole cause, but it may be that someone can be genetically predisposed to transsexualism as with other conditions that still require environmental conditions for the condition to manifest.

POLITICAL AND LOBBYING ISSUES

Wide public support for and interest in people with intersex conditions did not go unnoticed by other groups. Particularly a small but very vocal group of transsexuals began to claim that transsexualism was an intersex condition based on the physical “brain sex” differences noted by some researchers. Their view met strong opposition from groups that represented people with intersex conditions.

The argument adopted by certain members of the transsexual community was that an incongruence between the physical brain structure of male to female transsexuals and the otherwise observably “normal” male bodies they possessed, was a biological incongruence and therefore deserving of being described as an intersex condition. This argument is opposed by intersex support and advocacy groups on the basis that the similarities quoted by some transsexuals, that there were related gender identity issues, were analogous to only some of the experiences of a very small minority of people with intersex conditions whereas incongruence between self identified gender and physical appearance was the principal defining feature of all cases of medically diagnosed transsexualism. For people with intersex conditions, the physical manifestation of the condition has direct effects on sexual function, reproductive ability and hormonal response, matters not of concern to transsexuals.

Interestingly the transsexual community had made no attempt to make claims that transsexualism is an intersex condition until after the public profile of intersex conditions was raised and the intersex community began to achieve widespread support. One founding member of a group purporting to represent people with transsexualism made the comment that it was politically expedient for transsexuals to align themselves with the intersex community. A NSW based group claiming to represent both people with intersex conditions and transsexuals despite the fact that all established intersex groups have opposed representation by them, published a media statement seeking support for rights specific to the needs of transsexuals with no benefit for people with intersex conditions,

exclusively citing the experiences of people with intersex conditions to support their claims. With a publicly displayed motive centred on political expedience rather than medical or scientific reality, intersex support and advocacy groups expressed outrage at obvious attempts to use the experiences of a marginalised group only recently able to gain recognition in their own right, to further the cause of a group whose experiences and issues were completely different. When confronted about the misuse of the experiences of people with intersex conditions in this way the groups concerned made no apology for their actions.

Medical specialists who routinely treat patients with intersex conditions and who provide support for parents of infants and children with the conditions have also expressed disagreement with the classification of transsexualism as an intersex condition. Confusion created in the minds of parents when misinformation about the conditions is espoused by transsexual groups, makes the job of medical professionals and intersex support and advocacy groups far more difficult than it should be and does nothing to ease parental concerns.

RE: KEVIN

Intersex advocacy and support groups have never opposed the view that there is very likely a biological cause for transsexualism. Members of the AISSGA have assisted people with transsexualism by referral to appropriate medical professionals, serving on committees of groups dedicated to assisting transgender and transsexual persons and generally supporting the efforts of transgender and transsexual groups efforts to obtain important rights. Mr Tony Briffa of the AISSGA even went so far as to provide an affidavit for the *Re: Kevin* case supporting the efforts of “Kevin and Jennifer” to have their marriage recognised by demonstrating that the medical profession may record a sex at birth on a birth certificate regardless of biological sex determinants, something that was noted in the original judgment.

Despite claims to the contrary by some transsexuals, there is no specific statement made by Chisholm J or the Full Court in *Re: Kevin* “that transsexualism is an intersex condition” or “transsexualism should be included in the concept of intersex”, the Judges at all times stopping short of making any such direct statement. All references to intersex conditions made in the judgment by the Judges concerned relate to the views that former distinctions between transsexualism and intersex conditions solely on the basis that transsexualism is a psychiatric condition and intersex a biological condition are not valid and that for the purposes of Australian Law the two should be treated equally.

The only time that direct statements are made that transsexualism is an intersex condition are by Ms Wallbank in her submissions to the Court, including her statement that all of the experts who provided affidavits for the hearing believed transsexualism is an intersex condition and her use of the phrase “transsexualism and other intersex conditions”. Whilst this belief on behalf of the expert witnesses was noted by all of the Justices concerned, nowhere did they reiterate it as their own or the Courts’ belief. It is not a valid argument to state that by omission of opposing statements during Ms Wallbank’s submission the Judges agreed transsexualism is an intersex condition.

Both Chisholm J and the Full Court are very careful not to rely on the biological “brain sex” argument to support their findings, rather is it considered obiter. Both findings refer to the *probable* biological basis of transsexualism but note that this is by no means an established medical or scientific fact. The

judgment was made on the basis of human rights and the legal definition of the word “man” for the purposes of marriage, not on biological grounds.

On the subject of the experts used in the *Re: Kevin* case, Ms Wallbank has submitted that the Attorney General was variously unable to or incapable of adducing evidence that contradicted the views of the experts whose evidence she led in the case. This is a highly specialised field of expertise and Ms Wallbank was in the position of having personal experience and contacts that would field a number of contacts for experts that would support her views on the subject matter. The AISSGA has in a very short period of time amassed statements from many more internationally respected and published experts in the fields of endocrinology, psychiatry, molecular biology, psychophysiology and genetics who have worked with both transsexual and intersex patients, who disagree with the assertion that transsexualism is an intersex condition and who state that transsexualism has yet to be proven to have a biological basis. This is not intended to make the point that Ms Wallbank experts opinions were wrong or not soundly based, but rather that one of the fundamental principles of science is the respect for alternate points of views and the views of the experts in *Re: Kevin* were only one half of the story. Had the Attorney General had access to the same expertise as the AISSGA, the outcome of discussion about the biological basis of transsexualism might have been different.

It is also interesting to note that in comparing the experiences of people with intersex conditions and people with transsexualism, the Family Court was making a judgment that had the potential to legally affect people with intersex conditions. No witnesses were called to represent the experiences or views of people with intersex conditions and the views of the intersex community were effectively represented solely through the experiences of transsexuals who were seeking a particular outcome. Because of this cases cited by Ms Wallbank relating to the experiences of people with intersex conditions were the exception rather than the rule when considering the experiences of the majority of people living with the conditions. The reality is that the majority of issues faced by people with intersex conditions are in no way similar to people with transsexualism and therefore would not support Ms Wallbank’s submissions to the Court. Any comparisons of the issues faced by people with intersex conditions and those with transsexualism made by the Family Court should be very carefully weighted against the circumstances in which they were made. Even had the Family Court directly stated a belief that transsexualism was an intersex condition, it would only be on the basis of their perception of a few experiences of a minority within the intersex community, not the experiences of the majority. Representation of the experiences of the intersex community in this way not only has theoretical risks, but as a result of the *Re: Kevin* case Ms Wallbank submitted evidence to the Court and subsequently the Full Court that was quite incorrect and has the potential to damage efforts by the intersex community to gain important rights.

THE DANGERS OF REPRESENTATION BY OTHER GROUPS:

During *Re: Kevin*, Reference was made to the UK High Court case of *Bellinger* for which Louis Gooren (one of Ms Wallbank experts for *Re: Kevin*) provided expert evidence as follows:

“Some intersex conditions are such that they can not even be determined at birth and are only discovered much later at puberty. As such some of our fellow human beings live (unbeknown to all but their medical practitioner) their lives as women but with a male-type XY chromosomal pattern or testis and vice versa.”

Gooren's statement was provided in support of the fact that transsexualism can only be diagnosed later in life, rather than at birth, and to demonstrate similarities between transsexualism and some intersex cases. The statement is quite misleading in content as any specialist in intersex conditions will attest. All intersex conditions can be diagnosed at birth providing correct diagnostic procedures are undertaken. In the case of a girl with Complete AIS or the Boy with CAH as described by Mr Gooren, a simple Karyotype test conducted at birth will determine that their chromosome pattern is atypical for a child of that physical sex. There is no diagnostic test for transsexualism at birth so as a direct comparison the example fails. What Mr Gooren should have stated is that sometimes intersex conditions are not obvious *visually* but as with other genetic conditions often a simple test will establish their presence.

In *Re: Kevin* to support arguments that gender identity is not able to be established at birth, Ms Wallbank submitted to Chisholm J and the Full Court in that it was accepted medical practice where sexual ambiguity is present at birth, to delay any surgery until such time as a child is old enough to display their obvious or preferred gender identity. Ms Wallbank has also quoted in a paper presented to the NSW Neglected Communities Forum titled citing expert evidence adduced in *Re: Kevin*, the following:

"In Australia and elsewhere, when the sexually differentiated features of an individual's body (and in particular the genitalia) are incongruous, or fail to provide a clear indication of the individual's sex the individual is said to be ("intersex", "intersexual" or "intersexed"). It is now accepted 'best medical practice' that where this condition is detected at or near birth then the assignment of that individual's legal sex should be postponed until, or such assignment takes place on a provisional basis only to be later affirmed or reversed in the basis of, the disclosure or affirmation by the individual of the individual's innate or brain sex;"

Ms Wallbank assertions are, quite simply, untrue. This position statement does not represent "accepted 'best medical practice'" anywhere in Australia or, with very few exceptions, anywhere else in the world. Furthermore, to put such evidence before the Family Court of Australia, the very Court the AISSGA has submitted should be responsible for regulating such surgeries in Australia, is potentially very damaging to the attainment of the most fundamental of all human rights for people with intersex conditions, the rights of self determination and physical integrity. Had Ms Wallbank sought full advice from an appropriate range of specialists that treat patients with intersex conditions on a regular basis she would have soon discovered that this information was not correct. One of the experts from whom she presented evidence to the Family Court, was Professor Milton Diamond. Professor Diamond on a recent trip to Australia, spent much time in meetings and giving presentations opposing the practice of surgically reinforcing the gender of infants with intersex conditions shortly after birth as is currently standard medical practice in paediatric hospitals in Australia.

Examples such as these demonstrate the damage that can be caused to communities when their experiences are used by others or their "interests" are represented by people not qualified to do so and are yet more examples of reasons why groups or people who represent the interests of transsexuals should not represent people with intersex conditions. Both examples are obvious in their intent and may have been made with the best intentions of obtaining rights for people with transsexualism, but their end result is to lead to misunderstanding about the realities of intersex conditions. The only way to truly represent the intersex community is to have lived the experiences associated with intersex conditions, either as a person with the conditions or the parent of a child with an intersex condition. Ms Wallbank

continued reference to “transsexualism and other intersex conditions” is quite dangerous as it implies a familiarity with the experiences of the intersex community she just does not possess.

OTHER MATTERS:

Ms Wallbank asserted in her “Neglected communities” paper that the decision to undergo affirmation processes such as surgery and hormonal intervention makes a person transsexual, rather than transgender, and therefore within the “concept of intersex”. It is interesting that she should make this position statement, presumably on behalf of the transsexual community, for a number of reasons. First and foremost I personally think this definition, if accepted, will create a new underclass from the ranks of transsexual people who do not undergo sex affirmation procedures due to familial or societal pressures or are medically incapable of doing so. A person who is incapable of undertaking sex affirmation procedures for various reasons and who endures extreme emotional pain as a result, should not be further singled out if this form of diversity is not embraced but rather suffered under an environment of mere tolerance. I have transgender (the term they use to describe themselves) friends and associates and would not like to see them supported any less because they are not prepared to permanently alter their bodies to fit a new set of societal “standards”. Secondly accepting for the point of discussion the biological basis of transsexualism, one must also accept that other forms of sexual diversity could be biological variations of human sexual development and therefore deserving of being classified as biological as transsexualism. It could be then argued that people who “identify” as transgender have a less “severe” form of transsexualism because, like transsexualism, they display no external physical manifestation of the condition but have a gender identity that is different to their physical self. Finally, it is the view the intersex community that surgeries on infants without their consent or surgery that has no genuine therapeutic value should not be undertaken and that the reason many adults feel it necessary to undertake genital surgery is because of societal pressure to conform. Interesting then that Ms Wallbank should argue the defining feature of a person truly having transsexualism as a biological condition and therefore fitting within, as she referred to it, “the concept of intersex”, should be their choice to undertake irreversible procedures.

On the biological basis of transsexualism, many claims have been made that the biological basis of transsexualism has been proven and is widely accepted in medicine. Ethically responsible clinics that treat transsexualism in children will not allow surgery on a child even with parental consent. Were transsexualism biological proven and widely medically accepted as claimed, surgery on minors would be allowed with parental consent as it is on infants with intersex conditions. The AISSGA assisted in a case where a leading clinic that treats transsexual patients, recently reviewed their age of consent for surgery from 21 to 18 years to assist a transsexual patient who clearly had met all requirements for surgery. They felt that to keep her “marking time” for another three years was quite unconscionable, but lowering the age of consent to 18 years is still a long way from allowing surgery on minors. It is true that some evidence provides a strong reason to believe there is a biological basis for transsexualism, even though the cause or reason for the condition has yet to be conclusively proven. It is also true that many medical professionals and others accept that it is highly likely there is a biological basis for the condition something that I personally, as do many others in the AISSGA, also believe. There is still, however, a long way to go before it is proven or widely accepted to the extent some claim.

Having a probable biological basis for transsexualism accepted at law is a considerable advantage for groups seeking to obtain vital rights. Having this accepted at law for the purposes of marriage on the

balance of probabilities is not a statement of general or scientific proof of the biological basis of the condition for any other reason though and certainly does not make transsexualism an intersex condition.

It is difficult to justify claiming on one hand that one definition in a dictionary is incorrect whilst others in the same dictionary are correct because much more is understood about transsexualism than once was, when the same can be said of intersex conditions and that this new understanding demonstrates even more markedly the differences between the conditions. On this point, as much of this discussion is medically based, the Oxford *Medical Dictionary* definitions for intersex, transsexual, pseudohermaphroditism and hermaphrodite are as follows:

intersex n. an individual who shows anatomical characteristics of both sexes. See hermaphrodite, pseudohermaphroditism.

transsexualism n. the condition of one who firmly believes that he (or she) belongs to the sex opposite to his (or her) biological gender. The roots of such a belief usually go back to childhood. Children with such beliefs are treated with encouragement to engage in the activities appropriate to their biological sex and to work through their difficulties in psychotherapy. Adults with such beliefs can seldom be persuaded to change them; surgical sex reassignment is sometimes justifiable, to make the externals of the body conform to the individual's view of himself (or herself).

pseudohermaphroditism n. a congenital abnormality in which the external genitalia of a male or female resemble those of the opposite sex; for example, a woman would enlarged labia and a clitoris, resembling a scrotum and penis respectively.

hermaphrodite n. an individual in which both male and female sex organs are present or in which the sex organs contain both ovarian and testicular cells. Human hermaphrodites are very rare.

The Oxford Medical Dictionary clearly links intersex to definitions of conditions displaying variations of internal or external reproductive anatomy and contains an accurate and up to date medical description of hermaphroditism.

I note that Ms Wallbank has taken issue with some of what she referred to as Mr Briffa's definitions. The definitions and points of view put forward by Mr Briffa generally and as expressed in his paper to the "Neglected Communities" forum, except where expressly stated as being his own, are expressed on behalf of and with support of the wider community of people with intersex conditions, their parents and in some cases medical specialists who treat people with intersex conditions. Points of view in this document, except where expressly stated as being my own, are also expressed on behalf of and with support of the wider community of people with intersex conditions, their parents and in some cases medical specialists who treat people with intersex conditions. Committee members of the AISSGA always take great care to consult as widely as possible with members of our own group, members of other intersex support groups, and where appropriate genetics groups such as the Genetic Support Network of Victoria before putting forward opinions on behalf of our members and other interested parties.

CONCLUSIONS

The experiences of all people with intersex conditions are vastly different to the experiences of people with transsexualism and transsexualism is a demonstrably different condition to intersex conditions even were the biological basis of transsexualism proved. Even in cases where a person with an intersex condition later affirms a gender not originally assigned, issues such as childhood surgery, repeated childhood medical examinations, secrecy about the conditions and lack of appropriate explanations about the condition to parents, problems with later surgical outcomes because of earlier interventions, infertility and problems from related medical conditions, make their experiences vastly different to people with transsexualism.

The Family Court of Australia has never directly stated that transsexualism is an intersex condition. The Family Court has found that transsexualism *probably* has a biological basis and that distinguishing between people with intersex conditions and people with transsexualism solely on this basis for legal purposes is no longer valid. Matters to do with the biological basis of transsexualism were considered obiter and were not the basis of or for the judgment, something specifically made clear by the presiding Judges.

Claims that the intersex community have adopted the term intersex and that hermaphrodite is a more appropriate word to describe the conditions are not correct given the origin, history and correct medical definitions associated with the terms.

Transsexualism and intersex conditions have clearly distinct medical and legal needs and the only way to ensure these needs are understood correctly and subsequently met is to have each group appropriately represented to medical and legal communities and Government. The ACT has recently enacted clear and distinct definitions of transsexualism and intersex and these were arrived at by wide and appropriate consultation. The AISSGA hopes that this degree of consultation will extend to other Governments Australia wide resulting in the adoption of legislation to protect our diverse communities that is truly world leading.