**PASSING BODIES: ARE INTERSEXUALS QUEER?**

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In this essay I attempt to answer two related questions:

1. Is intersexuality a queer identity?
2. Compared to other queer identities, are passing and outing fundamentally different for intersexuals?

My answer to the first question is a qualified “yes,” my answer to the second question will be a qualified “no.” My argument proceeds as follows: I present two reasons to think that intersexuality is *not* a queer identity, and two reasons to think that passing and outing *are* fundamentally different for intersexuals. I then examine each of these four reasons and show that they are not compelling reasons.

1. **Is Intersexuality A Queer Identity?**

Any answer to this question has to offer or refer to a definition of queerness. The definition I adopt in this essay is “queer” as referring to sexual practices, behaviors, or appearances which challenge the norms of gender dichotomy, i.e., the assumption that there are sexual practices, behaviors, and appearances which are suitable only for males or for females, respectively. We may suggest that engaging in queer practices and appearances is a necessary condition for queerness, but not a sufficient one, since the queer person, in addition to engaging in queer practices and appearances, also has to *identify* as queer. Section 2.1 of this essay will be devoted to dispelling this suggestion.

 We may also suggest that intersexuals challenge the norms of sex dichotomy, but not the norms of gender dichotomy, and are thus not queer. I discuss this suggestion in Section 1.2 and 2.2. For the purpose of this essay, I will take for granted that there are queer *identities*—that is to say that I will take for granted that queerness does not *merely* denote an anti-essentialist rejection of stable categories of sex, gender, and sexuality. If the latter were the case, then queer identities would seem to be by definition impossible.

* 1. **LGBTQ-I**

Suppose that identifying as queer was a necessary condition for having a queer identity. In this case, the question whether intersexuality is a queer identity could easily be answered by asking intersexuals whether they identify as queer. The answer to this question would probably be “no,” or, more likely, silence. The number of organized intersexuals in the United States, Canada, Great Britain, Australia, Germany, and other European countries ranges in the hundreds.[[1]](#footnote-1) These organized intersexuals represent only a fraction of all intersexed persons. Even according to conservative estimates of the frequency of intersex births—0.2 % of all live births[[2]](#footnote-2)—the number of all intersexuals in *each* of the aforementioned countries would exceed five thousand persons.[[3]](#footnote-3) Furthermore, organized intersexuals may not identify as queer, or they may only identify as queer insofar as they are also gay, lesbian, or transgendered. The vast majority of intersexuals is silent in public, while the “out” minority is divided on questions of identity and political allegiances.

 Unlike the groups contained in the LGBT movement, intersexuals have no developed queer community. In some places, the LGBT movement has included intersex issues on their agenda—as evidenced by the expansion of the acronym to LGBTI or LGBTQI—and intersex activists may benefit from established connections between the LGBT movement and policy-makers.[[4]](#footnote-4) But some intersexuals reject all connections with the LGBT movement. Hence, if we understood “queer” to mean “identifying as queer” and “belonging to a developed queer community,” intersexuality would obviously not be a queer identity.

* 1. **Intersexuality as Medical Category**

Intersexuals may not challenge the norms of gender dichotomy, but they obviously challenge the norms of sex dichotomy, since intersexuality is defined as the presence of both “male” and “female” sexual features in one individual.[[5]](#footnote-5) The term covers a wide range of conditions, with external phenotypes ranging from the clearly female to the clearly male. Since intersex conditions encompass such a variety of phenotypes and since they generate different medical needs (and some generate none at all) it may seem misleading to subsume all of them under the label intersexuality.[[6]](#footnote-6)

In 2006, the American and European endocrinological societies adopted the new term Disorders of Sexual Development (DSD) as a replacement for the previous terms “intersexuality” and “hermaphroditism.” Those in the medical community argued that DSD would be a neutral, descriptive term, less stigmatizing than the previous labels. The switch from intersex to DSD was welcomed, for instance, by parents who want their intersexed children to be treated as normal boys and girls. Since the term “intersex” may be taken to connote a third gender and/or an atypical sexuality—a connotation which has been welcomed by some intersex activists, primarily those associated with LGBT activism and/or queer scholarship—parents are predictably not inclined to accept such a label for their children.[[7]](#footnote-7)

However, some intersex activists continued to use the old term, and they criticized the use of DSD, since it continues to label intersexuality as a disorder. These activists understandably worry that speaking of disorders of sexual development will merely perpetuate the pathologization of intersex bodies and intersex lives and undermine the single most important goal of intersex activism: to protect intersexed persons—and in particular intersexed infants and children—from unwanted and harmful medical interventions.

But even so, we may suggest that the almost exclusive focus of intersex activism on medical (mal)practice is precisely what sets intersexuality apart from other queer identities. Intersexuals want to be treated with dignity and respect by the medical community and by other human beings, and perhaps the way to achieve this goal is to view intersexuality as a strictly medical category, with no social and political implications. The idea is that if health care professionals treated only the medical issues in intersex conditions—and refrained from trying to address broader psycho-social issues through corrective surgery—intersexuality would become less stigmatized. Conversely, we may suggest that it is precisely the notion of intersexuality as a third gender or a third sex that contributes to the social stigma.

In support of this view, we may adduce the fact that many intersex support groups are organized around specific conditions—Congenital Adrenal Hyperplasia (CAH), Androgen Insensitivity Syndrome (AIS), Turner’s syndrome, Klinefelter’s syndrome—and not around intersexuality as a category.

* 1. **Intersex Passing—Invisible Differences**

The term “passing” has the connotation of a deliberate attempt to be perceived as something one is not, often in order to gain social or financial benefits or to avoid physical or psychological harm. In racist circumstances, a non-white person may have a strong incentive to pass as white. In homophobic circumstances, a queer person may have a strong incentive to pass as straight. But this notion of passing as a deliberate denial of one’s identity presumes that one has a *social choice*: You can decide to either pass and hide your “true identity”—or you can be “out.” Though the choice is not attractive, a black person in racist circumstances may choose not to pass; and a queer person may choose to be open about their sexuality even in homophobic circumstances.

 Now we may suggest that in the case of intersexuals, passing is not a social choice, but a social reality that is reinforced by surgical and pharmaceutical means. Like, say, a learning disability, intersexuality is, in most situations, an invisible difference. The anatomical features which distinguish intersexed persons from others—enlarged clitorises, micropenises, sparse or lacking pubic hair, narrow or absent vaginal canals—are usually hidden beneath clothes. The only persons who will usually notice these features are parents, lovers, and doctors. (And the stigma attached to intersexuality may indeed make it impossible for the intersexed person to reveal her/himself to a potential lover or a doctor.)

 But regarding her/his public appearance, the intersexed person will pass by default. Not just will her/his unique anatomical features go unnoticed, s/he will automatically be seen as male or female, i.e., as *someone with an unambiguous bodily identity*. This type of passing requires little or no effort, and it would be wrong to understand it as the success of a deliberate attempt of the intersexed person to conceal her identity. Passing is effortless for the intersexed person because of the deeply gendered way in which we perceive other people. Whether we see them on the street, hear their voice, or smell their perfume, we immediately and invariably categorize other human beings as either male or female based on these impressions.

 It irks us when we cannot figure someone’s gender immediately. But even in such cases, we assume that if we knew *all the facts* about that person’s body—e.g., if we could see beneath their clothes—we would know what their sex is, and by implication, what their gender is. Thus, because of the default epistemic assumption that human beings have anatomically standard bodies, intersexed persons have no choice but to be perceived as either male or female.

 But intersexuality is not merely invisible within the male/female dichotomy; it is also invisible within the queer/straight dichotomy. Queer people—homosexuals in particular—have developed strategies to make their queerness visible by publicly challenging gender roles. This can be done through haircuts and hairstyles, clothing styles, accessories (or lack thereof), make-up (or lack thereof). However, if an intersexed person employed these strategies, this would not be perceived as a statement about her bodily identity. For instance, if a lesbian, intersexed, female-identifying person wears a short and practical haircut, baggy jeans and “male” shirts, and sneakers or boots, this would be perceived as a statement about *her sexuality and her gender role*, but not about her bodily status. The notion that there may be queer bodies underneath queer clothes is not part of our standard epistemic repertoire.

We also need to consider the following factor that contributes to the invisibility of intersexuality: Public silence and ignorance. Intersexuality has only just begun to enter the media, entertainment, and higher education curricula as a topic worthy of discussion.[[8]](#footnote-8) Compared to other queer identities, the public knows even less about intersexuality than about homo- and bisexuality, transgendered people, and genderqueer behavior—and there are certainly fewer persons lobbying on behalf of intersexed persons.

Thus, given the near-complete invisibility of intersexuality, we may suggest that passing for intersexuals takes on a fundamentally different significance. But of course, despite this invisibility, there is always the option of being an out intersexual by explicitly and publicly labeling oneself—and we need to ask whether this process also has a different meaning for intersexuals.

* 1. **Intersex Outing—Confronting Medical Trauma**

Given that passing is effortless for most intersexed persons, and that few people would ever get to see the anatomical features in virtue of which the intersexual person differs from others, it is curious that it would ever be considered a necessity to alter or eradicate these features. And yet for the past half century, a medical treatment protocol has been in place which treats cases of intersexuality as a medical emergency and which regards cosmetic surgery on intersexed genitals as imperative, precisely because of the cases in which intersexed persons would be forced to reveal their identity. The need for cosmetic surgery is justified by an appeal to precisely those cases in which an intersexed person would be forced to reveal her/his differences—sexual relationships, and other contexts in which nudity in front of others is acceptable and expected (locker rooms, public urinals).

Both medical normalizing procedures and the practice of assigning a “gender of rearing” to intersexed infants at or shortly after birth are supposed to enable them to fit more smoothly into a deeply gendered world. They are tools supposed to *enable passing* as someone with an unambiguous sexual identity. But the medical tools in this repertoire have consistently failed[[9]](#footnote-9) to achieve the desired results, creating more harm than good. Cosmetic genital surgeries on intersexed persons frequently result in extensive scarring and significantly decrease or destroy the capacity to feel sexual pleasure. Despite these surgeries, the anatomical differences of the intersexed person may still be obvious to a future sexual partner—assuming the partner is reasonably perceptive—and the intersexed person may feel abnormal *precisely because* s/he has been subjected to normalizing procedures and to medical scrutiny. Even patients who do not report negative results from cosmetic surgeries often complain that the pervasive secrecy surrounding their condition and humiliating treatment from health care professionals greatly contribute to shame and stigma.[[10]](#footnote-10)

 Unsurprisingly, the main focus of intersex activism has been on altering medical practice, and on helping intersexuals to come to terms with their experiences with the medical community. The major value of being out and organized for intersexuals is to find others who have had similar experiences and to overcome medical trauma (and share resources needed to address one’s medical needs and get access to one’s full medical records). And thus, we might suggest that outing in the case of intersexed persons is closer to “outing” oneself—i.e., coming to terms with one’s experiences as—a victim of sexual violence than it is to outing oneself—i.e., embracing one’s identity as—a member of a sexual minority.

1. **Intersexuality is a Queer Identity**

Let us turn now to the reasons for the view that intersexuality is a queer identity—framed as responses to the observations I offered in the first part of this essay.

* 1. **Queer Bodies**

I want to suggest that intersex bodies are queer in virtue of their very existence. These queer bodies challenge the norms of gender dichotomy in at least two ways: They undermine the idea that sex, as opposed to gender, is unambiguous and fixed. Intersex bodies are proof that the concept of sex is as flexible as the concept of gender. Decades of medical research attempting to define the true source of the sex dichotomy have left us with the sobering conclusion that there is no single source. Neither the gonads, nor the chromosomes, nor hormones can be singled out as unique markers of sexual identity.[[11]](#footnote-11) There is no strict sex dichotomy; rather, bodies can be arranged on a continuum, ranging from the clearly male to the clearly female.

 Secondly, intersex bodies undermine the norms of standard heterosexual sex. Many of these bodies are judged to be incapable of being sexually active and the possessors of these bodies are judged to be incapable of having sexual relations—despite the fact that these bodies are perfectly capable of giving and receiving sexual pleasure as they are. If we define sex as penile-vaginal contact and penetration, then, yes, some intersex bodies will not be capable of having sex. But there is no good reason why we should define sex in this narrow way. *At least* oral sex, anal sex, and mutual masturbation are all “real” sex; and perhaps the actual reason for deeming intersex bodies unfit to engage in sexual relations is the implicit delegitimization of “queer” sex, e.g., sex involving clitorises big enough to penetrate a vagina or penises not big enough to penetrate, and sex focusing on the use on mouths, hands, and anuses.

 But what are we to make of the fact that many intersexual do not identify as queer and would not want their bodies regarded as queer? I suggest in response here that many intersexuals realize, even when they are not fully informed about their condition, that they are different from the norm—and they are reminded of that fact by medical attention and medical interventions which may in fact contribute to their uneasiness about asserting their differences. Conversely, as we will see below, medical attempts to normalize intersex bodies only make sense in a social and cultural context in which these bodies are regarded as queer. As Katrina Karkazis puts it: “[The] whole reason intersex even exists as a category is because these bodies violate *cultural* rules about gender.”[[12]](#footnote-12)

* 1. **Just A Medical Issue?**

The main focus of intersex activism has been on the medical (mis)treatment of intersexuals. It might thus seem obvious that intersex “identity” is a localized phenomenon, defined and limited by medical practice. However, this medical practice—and especially the treatment protocol which has been in place in the “Western” countries for the past decades—cannot be understood without reference to the broader cultural context.

 Cosmetic normalizing procedures on intersexuals are not a medical necessity; and the birth of an intersexed infant is treated as a “psycho-social emergency” but it is rarely a real medical emergency. The reason newborn intersexed infants have been rushed off to the neonate ICU is often not because they need immediate intensive care, but because the doctors want to win time to determine the chromosomal, gonadal, and anatomic status of the child—and thus conjecture its likely future gender.[[13]](#footnote-13)

 The standard medical practice which favored early surgical intervention is based on the idea that a person with ambiguous genitals—and by implication, an ambiguous sexual and bodily identity—will not be able to function in a deeply gendered society. Doctors invoke the prospect that the intersexed child will be mocked by peers for her/his appearance, that s/he will be unable to find sexual partners, and that s/he will suffer from simply being different. The doctors’ opinion on these matters is informed *by cultural norms*, not by medical norms—cultural norms that determine what constitutes an “acceptable appearance” in the locker room, the public urinal, or in the bedroom.

 The way in which sexual function was determined in the treatment of intersexuals is a point in case. Sexual function meant not the capacity to give and receive pleasure through genital contact (or manual-genital contact or oral-genital contact, for that matter). Sexual function was defined by the ability to penetrate or be penetrated—which is why, according to the standard treatment protocol, very small penises and very narrow and/or short vaginas were unacceptable. The same logic ruled out large clitorises, since the ability to penetrate and be penetrated in one body was also unacceptable.[[14]](#footnote-14)

 Certainly the doctors did not have malicious intentions in acting on these cultural norms; they wanted to ensure that their patients could live satisfying lives. But the fact that these intentions were informed by *cultural norms* matters, since it means that medical (mis)treatment of intersexuals is *not* a localized phenomenon.

* 1. **Queer Invisibilities**

I suggested above that intersexuality is invisible in a standard heterosexual context as well as in a queer context. But the same is true for other queer identities. A lesbian, post-transition male-to-female transsexual may be read as nothing but a lesbian woman (while running the risk of being shunned by the lesbian community if she discloses her transition). A femme lesbian may be ignored by her “own” community, and regarded as unquestionably straight by everyone else.[[15]](#footnote-15)

 On the other end of the spectrum, “queer” looks and “queer” behavior are easily misconstrued as indicating a stable same-sex desire: a young man wearing mascara in public may be read as “effeminate, and therefore gay.” Young women with “butch” looks will likely be read as lesbian. Since the gay-straight-continuum represents stable sexual desires and sexual practices, and not bodily differences and fluctuating desires and identifications, it is ill-suited to represent intersexuals, transsexuals, genderqueers, and bisexuals. And transsexuals and bisexuals in particular have complained about their under- and misrepresentation in the LGBT movement. (We should note another related point here: The fact that there is a tension between organized intersexuals and the LGBT movement—and between transsexuals/transgendered persons and intersexuals in particular[[16]](#footnote-16)—does not imply that intersexuals are not queer.)

The presumed invisibility of intersexuals in a queer context is not a reason to single out intersexuality as a non-queer identity—for if this reasoning applied here, then it may also apply in the case of trans- and bisexuals, but both identities are commonly regarded as queer.

* 1. **Queerness as Resistance**

I suggested above that intersex outing may be closer to “outing” oneself as a victim of sexual violence than to outing oneself as a member of a sexual minority (and embracing this identity). Intersexuals are not (yet) celebrating their identity as a group; instead, they give each other support to cope with and overcome their medical histories.[[17]](#footnote-17) Certainly there is a difference between support groups with just a few dozen members and large LGBT organizations able to mobilize thousands for parades and demonstrations.

 We should not forget, however, that other queer movements were born out of resistance to violence and pathologization. Since the invention of the term “homosexuality,” same-sex desire was regarded as a disorder, and it is still regarded by some as a curable illness. Transsexuality is listed under “gender identity disorder” in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), and homosexuality was listed as a disorder in the DSM until 1973 (“ego-dystonic homosexuality” was only removed from the DSM in 1987). Homosexual persons, or persons merely suspected of being homosexual were in the past subjected to drastic medical interventions: clitorectomies for lesbian women, chemical castration for gay men (the most prominent member of the latter group was probably Alan Turing). In the case of homosexuals in particular, pathologization and medical malpractice obviously seems to be just one aspect of general societal disapproval and oppression. We count list here countless other instances of violence against and shunning and silencing of queer people: school bullying, homophobic slurs, assaults, “corrective rapes,” and so forth.

 And thus being out for queer people is not merely celebrating one’s identity and becoming part of a community, it is also a way of resisting societal oppression. In the case of white, middle- or upper-class queers in affluent countries, it may not feel that way anymore—but we should not forget that in many other contexts, being out or being outed as queer can be dangerous and even life-threatening.

 Yet once again, we could suggest that the situation for intersexuals is different, since they are “merely” resisting the medical establishment. But this suggestion overlooks the fact that the medical reaction to intersexuality is informed by the judgment that intersexed genitals are socially unacceptable—and that the particular social unacceptability of intersexed genitals fits into the broader social unacceptability of queerness, broadly construed. A recent example for a potential intersection of the medical treatment of intersexuals and societal shunning of queer sexuality is the dexamethasone controversy: Dexamethasone—or “dex” for short—is a drug that is thought to reduce the virilizing effects of elevated testosterone levels in female fetuses with CAH when given to the pregnant mothers. Since some studies have associated the elevated testosterone levels in CAH girls and women with an increased incidence of homosexual desire, critics have branded this as of now still experimental treatment as a prevention not just of intersexuality but of homosexuality as well.[[18]](#footnote-18)

 Generally speaking, the attempt to eradicate the signs of intersexuality by surgical and pharmaceutical means would not make sense without a social and cultural context in which intersexed bodies are deemed freakish (and in which, indeed, the existence of intersexed bodies is denied—most people do not know about the appearances or the frequency of intersexuality). Hence intersex activism is not merely opposition to a specific medical practice; it is opposition to societal conditions which make the medical practice in question possible and intelligible in the first place.

1. **Conclusion**

There are good reasons why intersexuals are hesitant about associating with the LGBT movement and about claiming concepts such as “queer”: They fear appropriation and misrepresentation of their concerns from a larger, established community, and they fear that by using the vocabulary of non-standard sexuality, they would make themselves vulnerable to further stigmatization and pathologization.

 I have suggested here that these fears are understandable, but ultimately not compelling. It seems to me that the stigmatization and pathologization of intersexuals and their bodies can be overcome only if intersexuals are able to reclaim their differences and thus their “queerness.” Despite the slowly growing influence of intersex organizations, the obstacles to this process of reclaiming are extremely daunting. Intersexuality is still subject to pervasive stigmatization, shaming, and secrecy; intersex activists are still being branded as radicals, especially by the medical community. The intersex movement, even though it is very small, is already experiencing internal strife about issues such as early gender assignment and its association with the LGBT movement.

 It is difficult to make conjectures about the future of intersex movement, since it is so young and so small. It may dissipate or disappear, or it may grow into a stronger community over time. If the latter happens, then intersexuality could develop into a stable, socially represented identity. But for now, intersexuals and the queer identities represented in the LGBT movement at least have the same general goal: to reduce discrimination and violence against and increase acceptance of non-standard, i.e., non-heteronormative, sexual identities and sexual practices. And this, I think, should count for something.

1. The reasons for the small number of organized intersexuals could be a) ignorance of the existence of support groups or b) ignorance of the intersex condition. It was part of the old treatment protocol to keep the condition secret from the patient, so that even adult patients were lied to about the nature of their condition. For instance, adult patients with Complete or Partial Androgen Insensitivity Sydrome (PAIS or CAIS) have been told that their “ovaries”—which were in fact testes—had to be removed because they had not developed properly; see, for instance, Sherri G. Morris, “Twisted Lies—My Journey in an Imperfect Body,” in *Surgically Shaping Children*, ed. Erik Parens (Johns Hopkins University Press: Baltimore 2006), pp. 3-12. [↑](#footnote-ref-1)
2. There are different opinions in the medical community about which conditions should be included in the term, and about how common (or rare) these conditions are. Anne Fausto-Sterling has estimated that more than 1.5% of all live births are intersex, assuming a very large figure for cases of late-onset Congenital Adrenal Hyperplasia (LOCAH); this figure, as well as Fausto-Sterling’s definition of intersex, have been challenged. See Fausto-Sterling, *Sexing the Body*, p. 53 (Basic Books: New York 2000); for a challenge to Fausto-Sterling’s numbers see Leonard Sax, “How Common Is Intersex? A Response to Anne Fausto-Sterling” in *The Journal of Sex Research* 39/3 (August 2002), pp. 174-8. Sax wants to restrict the term “intersex” to cases “in which chromosomal sex is inconsistent with phenotypic sex, or in which the phenotype is not classifiable as either male or female,” excluding conditions such as LOCAH, Klinefelter’s syndrome (an additional X-chromosome in 47, XXY males), and Turner’s syndrome (a missing second X-chromosome in 45, X females). Under Sax’s narrow definition of “true intersexuality” the frequency of intersex births drops to less than 0.02%. If we discount Fausto-Sterling’s high number for LOCAH, and take her remaining number as representative, we arrive at a rate of 0,2%. [↑](#footnote-ref-2)
3. A medical study conducted in Germany in 2006/7 about the long-terms effects of medical and surgical treatment for intersexuals had 69 participants; see Richter-Appelt et al.: “Sexual Quality of Life in Individuals with 47,XY Disorders of Sex Development” in *Journal of Sexual Medicine*, first published online 6 January 2010. It is up to date one of the most comprehensive studies of its kind, and the majority of its participants were recruited through support groups. However, if we assume an intersex birth rate of 0.2% in a population of over 80 million, Germany’s intersex population would exceed 16,000 persons, meaning that well under 1% of all German intersexuals participated in this study and/or are active in support groups. [↑](#footnote-ref-3)
4. Stephanie Turner, in her article “Intersex Identities—Locating New Intersections of Sex and Gender,” in *Gender and Society* 13 (1999), pp.457-479, even argues that intersex activism is deeply indebted to the LGBT movement. [↑](#footnote-ref-4)
5. These anatomical features can be the chromosomes (i.e., the presence of more than one chromosome set in one body, e.g., 45X/46XY), the gonads (i.e., the presence of both ovarian and testicular tissue, or underdeveloped “streak” tissue), or the genitalia (i.e., the presence of enlarged clitorises, so-called micropenises, fused labiae, empty scrotal sacks, short and/or narrow vaginas). [↑](#footnote-ref-5)
6. In other words, the term “intersexuality” may be as misleading as the term “hermaphrodite” which conjures up images of mythical beings with fully formed sets of male and female genitals. In a similar vein, “intersexuality” may be taken to imply the presence of clearly ambiguous genitals—which need not be the case. [↑](#footnote-ref-6)
7. See the epilogue of Elizabeth Reis, *Bodies in Doubt – An American History of Intersex* (Johns Hopkins University Press: Baltimore 2009), here especially pp. 154-158. [↑](#footnote-ref-7)
8. Intersexual characters were featured on the popular TV shows *House, M.D.* and *Grey’s Anatomy*; and in the area of professional sports, the topic came into sharp focus when Caster Semenya, a South African middle distance runner, was accused of being a “hermaphrodite” after her resounding victory in the women’s 800 meters at the Athletics World Championship 2009 in Berlin. [↑](#footnote-ref-8)
9. My use of the word “consistently” may be challenged on the grounds that we have very little data about the long-term effects of medical interventions on intersexed children and adolescents. The lack of data is, in fact, deplorable, given that we are considering the effects of invasive surgeries which have often happened without the informed consent by the intersexed child/adolescent and her/his parents. However, the evidence that is available points strongly to the conclusion that medical interventions during infancy—often surrounded by increased secrecy and shame—do not yield medically satisfactory results and have devastating long-term effects on the psychological well-being of the children who undergo them. [↑](#footnote-ref-9)
10. The types of surgeries which have been most vocally challenged by intersex activists are partial or complete amputations of the clitoris (clitorectomy), reconstructive surgeries to create or dilate the vagina in intersexed infants (vaginoplasty), and surgeries to reroute the urethra to the tip of the penis in persons with hypospadias, a condition in which the urethra does not end at the tip of the penis, but along its shaft or at its base.

Many intersexed persons who were subjected to clitorectomies have reported a partial or complete loss of sexual sensation. Vaginoplasties in infants frequently result in extensive scarring (stenosis)—sometimes the scar tissue is so thick that it can close up the newly created/dilated vagina, and generally, the scar tissue tends to make sexual intercourse very painful. (The high frequency of stenosis in infant vaginoplasties is the main reason why the American Association of Pediatrics recommended a moratorium on these surgeries in the 2006 DSD consensus statement.) Hypospadias surgeries also appear to have a very low success rate. Often patients undergo multiple surgeries, because scar tissue blocks the rerouted urethra, or they suffer from severe, recurring, and painful inflammations. The scarring on the penis can be so extensive and disfiguring that these patients have been informally referred to by doctors as “hypospadias cripples.” The “success” of hypospadias surgeries may require frequent catheterization for the rest of the patient’s life just to keep the rerouted urethra open.

For personal accounts of the long-term effects of early corrective surgery, see, for instance, the stories assembled in Alice Dreger (ed.): *Intersex in the Age of Ethics* (University Publishing Group: Hagerstown, MD 1999). [↑](#footnote-ref-10)
11. See, for instance, the historical account of the attempt to determine the “true sex” of “hermaphrodites and to find the true source of sex dichotomy in Anne Fausto-Sterling: *Sexing the Body* (Basic Books, New York 2000). [↑](#footnote-ref-11)
12. Katrina Karkazis: *Fixing Sex—Intersex, Medical Authority, and Lived Exprerience* (Duke University Press: Durham, NC and London 2008), p. 5. [↑](#footnote-ref-12)
13. Cf. Karkazis: *Fixing Sex*, pp. 6-8. [↑](#footnote-ref-13)
14. Interestingly, this notion of sexual function did not extend to the preservation of fertility. In some cases, doctors removed fully functional gonads which would have been able to produce sperm or ova, respectively. On the medical definition of “sexual function,” see Karkazis: *Fixing Sex*, p. 100-101. [↑](#footnote-ref-14)
15. On this problem, see the contribution by Alice MacLachlan and Susanne Sreedhar to this volume. [↑](#footnote-ref-15)
16. See Raven Kaldera: “Dangerous Intersections—Intersex and Transgender Differences,” published on his website at http://www.ravenkaldera.org/intersection/DangerousIntersections.html (accessed 15 July 2011). [↑](#footnote-ref-16)
17. Sharon Preves, in her study *Intersex and Identity—The Contested Self* (Rutgers University Press: New Brunswick, NJ and London 2003), suggested that there is an emerging intersex pride (see Chapter 5). However, this pride can certainly not compare in magnitude and expression with the established gay and lesbian communities. [↑](#footnote-ref-17)
18. For a recent journalistic account of the controversy, see Cheryl Wetzstein, “Critics of Doctor Deplore ‘Cure’ for Lesbianism in Utero—Lack of Formal Study Faulted,” in *The Washington Times*, 7 July 2010, online at http://www.washingtontimes.com/news/2010/jul/7/critics-of-doctor-deplore-cure-for-lesbianism-in-u/?page=1 (accessed 15 July 2011). [↑](#footnote-ref-18)