

Chrysalis

The Journal of Transgressive Gender Identities

Vol. 2 No. 5, Fall 1997 / Winter 1998

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Never doubt that a small group of thoughtful, committed citizens can change the world; Indeed, it is the only thing that ever has.

— Margaret Mead



This issue.....

Intersex Awakening

Chrysalis

The Journal of Transgressive Gender Identities



The theme of this special issue of Chrysalis is intersexuality

Cheryl Chase and Martha Coventry are the guest editors of this special issue of Chrysalis. Cheryl selected and edited the text, and Martha edited the photos. Contributors include Cheryl and Martha, Tamara Alexander, Max Beck, Raphael Carter, D. Cameron, Brynn Craffey, Derick, Dr. Alice Dreger, Annie Green, Morgan Holmes, Dr. Suzanne Kessler, Jeff McClintock, Angela Moreno, Sven Nicholson, Kira Triea, and Heidi Walcutt.

The cover photo was taken in October, 1996 in Boston, when activists from Hermaphrodites with Attitude picketed the American Academy of Pediatrics. It is generally considered to be the first intersex political action ever (see also the article by Morgan Holmes beginning on page 7).

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Upcoming in Chrysalis:

Number 13 (Vol. 2, No. 6)

Transexual Conspiracies
Real & Imagined

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Mission: Chrysalis is dedicated to the in-depth exploration of gender issues. Our focus will be on topics which have been ignored or only lightly touched upon in other forums. Our treatments will be intelligent and balanced.

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Intersexed people have until recently been without a voice. Things changed four years ago, when Cheryl Chase founded the Intersex Society of North America and its witty and oft irreverent newsletter, *Hermaphrodites With Attitude*. This issue of *Chrysalis*, which is edited by Cheryl and Martha Coventry, both of whom are intersexed, reflects the groundbreaking work of ISNA.

— Dallas

We are thrilled that Dallas has given us this opportunity to present to *Chrysalis* readers these writings about the lived experience and the history of intersexuality.

Intersexuality refers to having a body whose sex differentiation is atypical. It is a matter of being different. There are dozens of reasons why a person may be born intersexed, but its major import is the same for each of us: We are different. Although difference is not an illness or a medical condition, *sexual* difference has been treated as illness since the middle part of the nineteenth century. Medical historian Alice Dreger relates, in “Doctors Containing Hermaphrodites: The Victorian Legacy,” just how Medicine turned its gaze on intersexed people in the latter part of the 1800s, and how that legacy is visible in

modern day medical treatment of intersexuality.

During the early twentieth century, medicine developed technologies, both surgical and hormonal, to alter the body’s sexual characteristics. In the late fifties and sixties, treatment protocols were established. The birth of an intersexed child was labeled a “psychosocial emergency” — but one which was and continues to be addressed by surgeons and endocrinologists, not psychiatrists or sociologists!

Current medical thinking holds that having a body which is visibly different from most males and most females is incompatible with quality of life. Intersexed children will be rejected by their parents, stigmatized by their peers, and as adults be unacceptable as intimate partners — doomed to live without love. The medical solution is to erase the evidence of intersexuality from the child’s body, and then to deep-six that history of difference by treating it as shamefully unspeakable.

The effect of these protocols was to render intersexuals and intersexuality invisible. No medical follow-up was performed, and we certainly did not publicly identify ourselves. Most doctors assumed that we had all successfully blended into the woodwork, and were now living our lives no differently from men or women.

That is not the reality. Many of us treated for intersexuality as infants or children have been terribly hurt by the treatment. Genital surgery has damaged or destroyed our sexual and urinary function, as related by several contributors to this issue. Medical attempts to eliminate difference have failed to do so — plastic surgery does not produce genitals that “pass,” and for many of us, our sexual difference looms large in our psychic make-up. In the effort to transform “different” into “normal,” medical and surgical intervention succeeds only in compounding the suffering of a child who will always feel different anyway.

The first large group of people treated in this way has only recently reached an age at which we have been able to gather enough material resources and practical skills to begin to heal. Medical treatment, by rendering our intersexuality unspeakable, delayed rather than facilitated our healing. The first step was to find each other, so that we could begin to tell our stories, to overcome our shame. We learned that

our secret worry — that perhaps others had benefited from this treatment, perhaps we were the only one abused and damaged in this way — was not true.

As intersexuals have come together — through the Intersex Society of North America (US, Canada, New Zealand), the Androgen Insensitivity Support Group (UK, US, Canada, Germany, Netherlands, Australia), Hijra Nippon (Japan), the Workgroup on Violence in Pediatrics and Gynecology (Germany) — we have heard the same stories over and over again.

Hearing these common histories has given us the determination to speak out publicly and to prevent infants being born every day — about one in two thousand — from being hurt in the ways that we have been hurt. The stories you will read in this issue are an important part of that effort.

Until we found each other through support groups, the only images we had of intersexuality were horrible photos in medical books: children standing naked in front of a wall marked out in centimeters; tight

closeups of infant genitals with surgeon's fingers spreading the parts; surgical illustrations of clitorises being removed, of Frankenstein techniques for making penises more cosmetically acceptable. And all with the eyes blacked out.

When we first came together, we were still too filled with shame to allow our pictures to be published, or in many cases even our real names. Now, we are finding our pride and finding the strength to show our faces. With special assistance from Dallas, we have complemented this issue with a gallery of pictures of us. Pictures of our childhoods, of our lives today, and of the joyful changes that breaking silence has made possible for us. These pictures are our gift to ourselves and to our intersexual brothers/sisters and their parents who have not yet begun their healing journey. And to the world, to declare that we exist, we are human, we are everywhere among you.

— Cheryl Chase

— Martha Coventry

Guest Editors

Ode to a Life

Heidi Walcutt

A little child was born today,
whether it's a boy or a girl was hard to say.
The poor, innocent mother they quickly sedated,
While the doctors and nurses stood around and debated.

One doctor said "The penis is too small,
this will never, never do at all."
Another spoke up "No, the clit is too large,
we need a specialist who can come in and take
charge."

So the call went out across the land,
and when a group of specialists was at hand,
A series of tests was the first thing they did,
the result of these, from the parents they hid.

When all of the testing and probing was done,
the doctors said "We can never tell them of their son."
So the parents were never told of their little boy child,
who by a miracle of nature was born to be wild.

So they sliced and they diced, a new woman to make.
"To hell with the consequences, we'll fix nature's mistake!"

Counseling next became their obsession,
they hounded and pounded into the child their lesson.
"You are a girl, there's no doubt of that,
trust what we tell you, a fact is a fact."

So she lived in the shadows, without any life,
she was constantly battered by emotional strife.
Never voicing her fears, her hopes or her doubts,

until she found ISNA and let it all out.

What dream?

Angela Moreno

look at the child with the dream in her eyes
holding it deep inside her — s. mclachlan

dream what dream?

the shame-crazed fantasy?

the gut-wrenching, teeth-spewing nightmare?

no dream

no more

can't afford it

turn it off

the desire

no desire heat tensing thighs rising

none of it

you can't anymore

nothing but a crusty blanket of

dried blood

where they cut you

go ahead feel it

that unfamiliar

nothingness

where pulp and lust used to thrive

Intersex Resource Guide

Up-to-date information is always available at ISNA's web site

Intersex Society of North America (ISNA)

P.O. Box 31791
San Francisco, CA 94131
info@isna.org
<http://www.isna.org>

ISNA-Canada

Box 1976
Hamilton, Ontario
K0M 1S0 CANADA

The Intersex Society of North America is a peer support and advocacy group operated by and for intersexuals and publisher of the newsletter *Hermaphrodites with Attitude*. ISNA has affiliates in Canada and New Zealand.

HELP (Hermaphrodite Education and Listening Post)

P.O. Box 26292
Jacksonville, FL 32226
<http://users.southeast.net/~help/>
help@southeast.net

Founded by a mother frustrated with the isolation and lack of available information, HELP is a support group for parents, family, friends, and persons affected by sex differentiation disorders, and a source of needed medical information, literature, and personal experiences.

AIS (Androgen Insensitivity Syndrome) Support Group US

4203 Genessee #103-436
San Diego, CA 92117-4950
aissg@aol.com; <http://www.medhelp.org/www/aid>

AIS Support Group Canada

P.O. Box 425
Postal Station C
1117 Queen Street West
Toronto Ontario
M6J 3P5 CANADA

The UK-based AIS Support Group provides support to AIS women, their parents, relatives, and partners. It publishes a newsletter three times a year, holds semi-annual meetings, and offers a variety of publications relevant to AIS. There are chapters in UK, Netherlands, Germany, and Australia.

Genital Mutilation Survivors' Support Network (GMSSN)

c/o Heike Susanne Spreitzer, M.A.
Steinstr. 13a
51 143 Kölnm GERMANY

Boedeker_Spreitzer_GbR@t-online.de

http://home.tonline.de/home/Boedeker_Spreitzer_GbR/is_homep.htm

"We are a peer support, education, and advocacy group founded and operated by and for genitally mutilated intersexuals and women. We feel that extreme damage has been done to us in forcing us to conform to sociocultural ideas which have virtually nothing to do with the physiological realities of experiencing life as female, male, or intersex persons."

Workgroup on Violence in Pediatrics and Gynecology

Brigit Reiter
Brandstrasse 30
Bremen 28 215
GERMANY
aggpg@t-online.de

PESFIS, formerly Hijra Nippon

Suita Yubinkyoku Todome
Honami cho 4-1 Suita shi
Osake T564
JAPAN
+81 080-09-52750

An activist and peer support group for Japanese intersexuals. They speak Japanese only!

Ambiguous Genitalia Support Network

P.O. Box 313
Clements, CA 95227

A parents support group. Introduces parents for pen-pal support.

K.S. & Associates

P.O. Box 119
Roseville, CA 95661-0119
ks47xxy@ix.netcom.com
<http://www.genetic.org/>

A support group for families and men with Klinefelter syndrome. Produces a newsletter called *Equal Exchange*, holds support group meetings and a national convention. Note, though, that the KS&A board "chooses not to actively address the gender issue."

CAHN (Congenital Adrenal Hyperplasia Network)

c/o 4182 Mississippi Street
San Diego, CA 92104

A support group founded by a woman with CAH.

Is Growing up in Silence Better Than Growing up Different?

by Morgan Holmes

In May, 1996, plastic surgeons at New York City's Mount Sinai Hospital held a symposium which included a half day on genital surgery for intersexed infants. ISNA offered to put on a "Patients' Panel" for the symposium. This offer was rejected. In spite of this, three ISNA members traveled to New York and presented their stories in a room adjacent to the surgeons' symposium. This is the talk given there by ISNA-Canada's Morgan Holmes. The surgeons said afterwards that nothing ISNA members said had changed their minds about any aspect of their treatment of intersexed infants.

I want, first and most importantly, to express my deep gratitude to our supporters, Dr. William Byne and Dr. Suzanne Kessler, who helped to make this talk possible. I also want to take the opportunity to thank ISNA president and founder Cheryl Chase, who opened the door for intersexed persons to come together and provide each other with a sense of belonging in the world.

There are few moments in life that were as important as the one when I first spoke to Cheryl. I was twenty-four years old, and for seventeen years I had been keeping significant facts about myself hidden from everyone I knew — even from my most intimate partners. I was in the final stages of writing my master's thesis on the political and cultural demands being both met and reinforced in Western medicine's traditional mode of providing a surgical "miracle cure" for intersexed features. I had only just begun, because of Dr. Anne Fausto-Sterling's influential article "The Five Sexes," to tell people about my own history, but these were very "safe" people — my academic advisors, professionals who were used to dealing with topics about sexuality. But I still wasn't talking to my family about my past and I had certainly never spoken to another human being that I knew to be like me. I had grown

up thinking that the reason they had cut my clitoris off when I was seven years old was that I was the only one in the world like me.

I hadn't smoked since a terrible bout of the flu when I was twenty-two, but I smoked during that phone conversation. Suddenly my pain had a mirror image, and as much as I had known, in theory, that removing the erotogenic tissue of kids was at best an inadequate solution, I had never felt how right I was except through my own pain. Now I heard it in someone else, too. But more than that, I heard and felt the anger, which like mine, tried to understand why we had been forced to pay with an ounce of flesh for the failure of our parents and their friends and relations to love us unconditionally.

Without meaning to sound arrogant, I would like to draw your attention to my intelligence; it is not a recent development in my life. I did not start out a fool. One of the few positive things my early childhood medical files attest to is the early indication of high intelligence and an ability to express myself with exceptional clarity. That intelligence was not respected.

I remember quite clearly what my body was like before the surgery performed in 1974 by Dr. Robert Jeffs at The Hospital for Sick Children. I have a tactile memory of how the clitoris felt between my fingers. I have absolutely no recollection of it causing me either pain or consternation. My pediatrician, however, told my father that my clitoris, because it could become erect, would make it uncomfortable to wear anything with an inseam, and he told my father that surgery would relieve the increasing trauma I was having about my body.

Well, by the physician's logic, all penises should be removed at birth, and if my father had thought about it, he would have known that erections are not so much of an interference in his life that he would choose to have his penis removed. Furthermore, if anyone had thought to ask me why I was feeling traumatized, I would have been able to tell them that the reason I didn't want to see the doctor was that I was tired of being trotted out for pelvic exams, of being referred from one doctor to the next as a fine example of how they could detect such an interesting

case. But I didn't tell — I was taught that children are to be seen and not heard and that you do not give an opinion unless you have been asked. Since then, I have decided that my opinion should be heard, regardless of whether or not it has been solicited.

As a premature baby, I had spent my whole life being examined by doctors who were, no doubt, very interested to see how the progesterones my mother was given would affect my body. And I had come to an age where I could protest, or at least cry when yet another man would want to pry my legs apart and stick his fingers up my vagina. What I am saying is that my medical "care-givers" failed to respect my autonomy or my intelligence when they assumed that because I was a child they could do whatever they wanted as long as my father provided his consent. And when I began to balk, instead of questioning their own treatment of me, they blamed my body and they cut it up.

They told my father I would be perfectly normal. They told my father that my problems would be solved. They told my father I would grow up to have a normal sexuality. Perhaps they didn't realize it, but all these things were lies. Before the surgery, I never gave a thought to my body. You may say that I just don't remember, but I have an exceptional memory. I remember. I know that nobody told me what I was going into the hospital for; they only told me that I might have a catheter. Nobody asked me how I felt, nobody explained to me what made me so interesting. And they certainly didn't tell me they were going to amputate my clitoris. Indeed, it's not even what they told my father.

No, they gave it a much more benign name: "clitoral recession." And they didn't explain to him that it didn't mean that they would just be "backing it up a little," which, until a year ago is what he thought had been done. But those were the days before you had to get "informed consent" — all you had to get was consent.

So I went into the hospital and I waited for six days while they buccal smeared me for the umpteenth time, and they did blood tests and urine samples and they punched a hole of skin out of my arm. Now that was a very painful

procedure. I remember that the man who did it told me that he didn't have very many friends. And he also told me that they were going to grow some of my skin in a dish so that if I needed some skin later they would have it. Another lie. The skin sample was used for my karyotype analysis. And I had no idea what he meant about me needing it later. I remember thinking to myself, "For what?" But children don't get to ask the questions, or if we do, nobody thinks we are entitled to true answers.

When they were prepping me for surgery I still had no idea what was going to be done. When I woke up I was covered in orange paint from my navel to my knees on my inner thighs. And hurt! Very few people in this room have ever had their genitals sliced off. You can't imagine how much it hurts to pee afterwards. And it hurts for a long time. However, nobody thought about my pain except to assume there wouldn't be any: obviously the thing about the inseam was considered all fixed because my "Welcome Home" photos show me dressed in yellow wool pants — the early 1970s kind with the inseam that always seemed to cut too high.

It wasn't until the iodine-paint was gone and the hurt subsided that I realized that I no longer had what I had had before. And that was the first time I realized I had been so ugly that they had had to change me. I remember clearly, standing in the bathroom at school, having just suffered through a horrible stinging pee, wanting to ask my friend Ijoma Ross if this had ever been done to her but thinking to myself that I shouldn't ask her. It occurred to me that my classmates didn't disappear for two weeks and come back to school unable to sit still because the inseam of their pants was rubbing against a fresh scar that burned and itched. I never spoke to anyone about it.

Yet it's amazing how many of my father's friends and relations seem to know all about it. I may not have been able to talk, but obviously other people were not so affected.

Years went by. I was a young adolescent. I learned in Health Ed class that a clitoris is a little button about the size of a pea. I didn't think I had one. I tried to find it, but I couldn't find anything like that. At the apex of my labia, I

found only the apex... and it seemed no different from the rest of the tissue there, soft, indistinct. I began to feel like a real freak. The thought of having anyone come near me terrified me. I was afraid that people would find me repulsive and so, when my peers were going on dates, to dances, having sex, being intimate with others, I removed myself. At my first visit to the gynecologist, I was told I had venereal warts — pretty interesting considering that I was terrified to even hold hands with anyone — and the gynecologist refused to believe that I had never been sexually active. I was referred to a pediatric gynecologist at Sick Children's Hospital. I explained to the doctor that I couldn't possibly have warts and I told her why I wouldn't let anyone near me. She assured me that I wasn't a freak, that the surgeons had done a "very nice job" and that I would be sexually normal when I grew up. What she didn't realize was that I was already growing up, but I was far from sexually normal. It is not normal for a 15-year-old girl to be afraid of relationships because she is afraid of being "discovered" as a fake.

A few years later, I made a decision not to have a relationship with a woman. It was a decision I made several times. By then I was having sex with men, but it wasn't "normal." I was having sex with men instead of with women because I realized that if the male surgeons had decided what a "normal vulva" looked like, then I could probably fool these boys with what I had come to call my "designer cunt." But the women. Well, I didn't think they'd be fooled. I thought they would know that I had been "fixed," that I had a "fake one." This was the sexual normalcy they promised my father. But, hey, I was sleeping with men — that is all it takes to be normal, so I guess they were right. Never mind that I didn't enjoy it. Never mind that I did it only because I was afraid that the women I loved wouldn't love me back. Never mind that I wasted my time in fear of being found out.

Skip ahead a few years of very bad sex and living in a closet. Go to university, read the Herculine Barbin story. I was twenty-two years old. I was living with the man I am now married to. I sat him down and told him that this book

we were reading had a lot to do with me. He didn't run away, he told me I looked perfectly normal to him, but I couldn't shake the feeling that I was a monster. Skip ahead another two years. I was twenty-four, and I decided that I was going to prove my place as a "true" woman by having a child.

Shortly before my twenty-fifth birthday, my son was born. And then it all unraveled. Anne Fausto-Sterling's article "The Five Sexes" came out, and I realized that Herculine Barbin and I hadn't been the only two monsters in history. I did some quick arithmetic and realized that there were thousands of people like me and I decided I was going to find them. I realized that I had never been a monster. I mourned for the lost potential. I am still mourning for what I could have done with my body but can't. I still mourn for all the years I spent in silence, for all the loves I denied myself, and for the ways of loving that were physically, literally, removed from me.

What I know now is that I was fine until I was sent to that surgery room. I know that I never doubted myself before then. And if you think that is because I was too young to be sexual, think again; I've already told you that I remember how that clitoris felt between my fingers. My father, pressured by several medical experts, "consented" to a surgery that promised to make me sexually normal. What it actually did was change a perfectly healthy seven-year old girl into a woman who feared her own body and her past and who hated herself for being different. The cure taught me how to hate and fear. But that is what perfectly normal sexuality is all about — the hate and fear that is heterosexism and homophobia. And I ate it for fourteen years and vomited it up for another three after that.

For me the issue is not, primarily, whether or not we can develop a surgery that will not damage orgasmic function — of course, if we are going to perform phalloclit modifications they should not impede the function of that organ. But for me, the primary issue is that parents and surgeons are not entitled to attempt to dictate what sexual normalcy is. It is clear that the promise made to my father was not that I would be sexually happy — it was that I would be normal. I hope you will see that forc-

ing a body to look typical is not the same as making a person feel normal and, in fact, as I believe my case shows, it may actually produce the opposite effect, making a person feel completely abnormal. It is not my personal opinion that genital surgeries should never be carried out on intersexed persons. It is my position that any surgery whose justification is cosmetic and/or the promise of sexual normalcy should be withheld until the person has reached an age to make that decision for him/herself.

Parents and doctors must give up ownership of the sexual future of minors. Children are no longer the property of their parents; we are not chattel. Our sexualities do not belong to the medical profession. It may be that if surgery had not happened when I was young I would have still chosen it. It is equally possible that I would have chosen to keep my big clitoris; the women I know who escaped surgery are quite grateful to have their big clits. That decision should have been mine to make. Without retaining that decision as my personal right, all other aspects of my sexual health have been severely limited.

The medical profession can't give back what was taken from me. But it can listen to me. I was asked to address you today from my heart, at an informal level, not primarily as an academic, but as a person who has lived through the nightmare of early childhood surgery. But I want to remind my audience that I am an academic, that I do hold a graduate degree in this area of research, and that I am a doctoral candidate specializing in this field. As a medical anthropologist with an interdisciplinary viewing lens incorporating bioethics, I have a growing body of data that indicates that early childhood surgeries cannot protect children from suicidal feelings or attempts and, in fact, they may instigate them. And my data show that regardless of the measured nerve response of "corrected" genitalia, promises of sexual normalcy are not being met. The promise is not for the medical profession to make. "Sexual normalcy" is up to each individual to create for him/herself.

I believe the medical profession really does want our lives to be better. Please listen to us as we tell you how to meet that goal. CQ

Raphael Carter lives in Minneapolis, Minnesota, and is the author of *The Fortunate Fall*, a science fiction novel published by Tor Books. The title is a pun on the Merck Manual, which is used by physicians to diagnose a variety of disorders.

The Murk Manual

How to Understand Medical Writing on Intersex

by Raphael Carter

ambiguous genitalia: Genitalia that refuse to declare their sex to doctors — no doubt on the principle that under interrogation by the enemy you should give only name, rank, and serial number.

androgen: *Andro* = male; *gen* = making. Androgens are administered to infants to prevent their becoming androgynes. See *testosterone*.

androgen insensitivity: The condition of infants who callously refuse to respond to testosterone treatment; the cause of many an endocrinologist's hurt feelings.

circumcision: A mass-market edition of intersex surgery, priced for the common man. The reasons for circumcision are too numerous to treat here, but T.V.N. Persaud of the University of Manitoba recites one ingenious opinion: "Some conditions, such as phimosis, often lead to circumcision at a later age that could have been prevented if it had been performed earlier." Physicians thus exhibit the same prescience as the Monopods in C. S. Lewis' *The Chronicles of Narnia*, who boiled potatoes before planting them in order to save doing it when they were dug up.

clitoral recession: See *female genital mutilation*. Despite Webster's false cognate, "recession" is derived from "rescision," the noun form of the verb "rescind." Endocrinologists, like certain Congressmen, like to rescind budgets they feel are too large, even when this means cutting off essential services.

clitoromegaly: *Micropenis* in the female. A longer definition would be superfluous, since this condition is apt to be cut off before the patient can pronounce it.

cryptorchidism: A condition in which the testes (*-orchid*) are hidden (*crypto-*). Hidden from whom? Obviously, from the doctors. Cryptorchidism is thus practiced by those discriminating infants who do not wish to put pearls before swine.

distress: A condition produced in parents when their intersexed children go unutilized.

estrogen: 1. A character in Samuel Beckett's *Waiting for Godot*, who was just pining away for a doctor to come change his sex. 2. A character in Ursula Le Guin's *The Left Hand of Darkness*, who bloody well wasn't.

female: 1. A male intersexual when the endocrinologist is through with him. 2. A female intersexual whom the

urologist has not seen yet.

female genital mutilation (FGM):

The scarring or removal of the clitoris, performed by witch doctors and condemned by all right-thinking people. If the clitoris is a bit larger than average, however, the mutilation is performed by accredited surgeons and covered by all major insurance plans.

formerly intersexed: A term used by specialists to refer to any intersexual old enough to talk back. Such a person has no right to speak for intersexed infants; let the infants speak for themselves.

gynecomastia: Enlargement of the breasts in a patient whom we have decided to call male. In a patient whom we have decided to call female, the same trait is called "excellent breast development."

hypertrophy: Literally, too much meat. How much is too much? More, madam, than your sister has; less, sir, than you will have when we are through.

hypogonadotropic hypogonadism: A condition in which the gonads are small owing to a lack of the chemical signals that activate them. To be distinguished from hypergonadotropic hypogonadism, in which the gonads are small owing to an excess of the chemical signals that activate them. The progress of medical science makes possible these ingenious explanations of formerly murky phenomena.

hypospadias: A condition in which the meatus of the penis exits elsewhere than the tip. The etymology of this term is worthy of great meditation: *hypo* = "too little"; *spadix* is the Latin for sword. If only the infant's sword were larger, he would be able to fight off the surgeon.

idiopathic: Found in solitude. A condition that boors never allow to persist in women or in symptoms. Contrary to previous report, idiopathy does not mean "stupid medicine," there being no need of a special term to identify that thriving Science.

Klinefelter's Syndrome: One of that large class of syndromes named for people who did not have the syndromes. Even Lou Gehrig's Disease has been renamed for some doctor who probably couldn't even hold a bat.

lusus naturae: A freak of nature. It may at first surprise the reader that this term is not applied to people who cut up perfectly healthy genitals; but while that behavior is certainly freak-

ish, nature has nothing to do with it.

male: See *female*. Whatever you may say of medical Fascism, it does make the males run on time.

micropenis: *Clitoromegaly* in the male. Cutting off the micropenis and rearing the child as female is a common way of producing a satisfactory psychological adjustment; "For it's a fact the whole world knows, that Pobbles are happier without their toes" (Edward Lear).

presenting: Having. As in, "The infant presented a hypospadiac micropenis" (said by doctors) or "The jogger presented a large wallet" (said by muggers).

primary hypogonadism: Primary hypogonadism reduces the body's sex hormones due to undeveloped testes or ovaries; see *micropenis*, which it sometimes causes. It is not clear to the compiler of this Manual why some doctors feel that primary hypogonadism should be followed by a genital election.

post-operative transsexual A person who has decided for him- or herself to get surgical sex reassignment. A therapist's certificate is necessary. Those who decide on SRS for others are called *specialists*; surprisingly, no psychological examination is required.

pseudohermaphrodite: *Pseudo* means "false"; a pseudohermaphrodite is one whose falsely ambiguous genitals cruelly mislead the doctor into hopes of publication. So, at least, says pseudoscience.

res ipsa loquitur: Legal, not medical. Latin: "the thing speaks for itself." A sponge left in a patient's body speaks for itself, and is well paid to do so; but for the sex organ removed from the body, nobody will speak.

rights: Wrongs. In medical literature, the "rights" of the intersexed refer exclusively to their right to be modified, never to any right to remain as they are. For example, one text calls for hypospadias to be "corrected" even when it is purely cosmetic, on the grounds that "by the age of five every boy has the right to be a 'pointer' and not a 'setter'."

determination: 1. (when used by intersexuals and their parents) Divining which sex a child is. *Determine:* to find out by investigation. 2. (when used in medical journals) Deciding which sex a child shall be. *Terminate:* to put an end to the matter.

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In Amerika They Call Us Hermaphrodites

by Angela Moreno

*Doctors have come from distant cities
just to see me — stand over my bed
disbelieving what they're seeing
they say I must be one of the wonders
of God's own creation*

— Natalie Merchant (from the song "Wonder," on her album *Tiger Lily*)

There was never any reason to suspect anything strange. I appeared female when I was born in 1972, and I was assigned and raised as a girl.

When I was twelve, I started to notice that my clitoris (that wonderful location of pleasure for which I had no name but to which I had grown quite attached) had grown more prominent. At least, that's how I perceived it. I can't remember whether I thought anything about it; I just remember that I began to notice it. I'm sure that it was at least three months after I had taken note that my mother caught a glimpse of me as I bathed one day after returning from the dance studio. She tried very hard not to let on how alarmed she was, but of course a twelve-year-old girlchild just senses these things. When the pediatrician examined me the next day she was also obviously alarmed. She referred me to a female pediatric endocrinologist at the University of Illinois Medical School.

Exactly one month later, I was admitted to Children's Memorial Hospital in Chicago for surgery. They told me a little bit about the part where they were going to "remove my ovaries" because they suspected cancer or something like that. They didn't mention the part

where they were going to slice off my clitoris. All of it. I guess the doctors assumed I was as horrified by my out-sized clit as they were, and there was no need to discuss it with me. After a week's recovery in the hospital, we all went home and barely ever spoke of it again.

As for the assertion that doctors now consistently provide sophisticated counseling for the intersexed child and family, my experience does not reflect that good intention. First of all, my doctors made a traumatizing hospitalization even more traumatizing by putting me on show for parades of earnest young residents with "you're-a-freak-but-we're-compassionate" grins on their faces. This, all without nurses or my parents anywhere around. Second, I know now from my parents that the pediatric endocrinologists repeatedly advised them that I did not need to know the truth. They told my parents some horror story about a girl like me who had peeked at her file once while the doctor was out of the room and then killed herself. My mother asked the doctors specifically if they thought I would benefit from any type of counseling. They discouraged her from pursuing it. That's what passed for emotional support among the Children's Memorial Hospital intersex specialist team in Chicago in 1985.

I'm now twenty-four. I've spent the last ten years in a haze of disordered eating and occasional depression. My struggle with bulimia has been an all-consuming although mostly secret part of my life, and I now believe it represents my attempts to express the fear, shame, rage,

and intense body-hatred that I have felt as a result of the — until now — unspeakable assault that I experienced under the guise of medical treatment.

I do have some clitoral sensation. I sometimes masturbate and I do have an experience which I call orgasm — some faint muscular contractions. But response is unreliable, and nothing like the tremendous sensitivity and wonderful juicy orgasms I had before the clitoral surgery. I would say that the clitoral recession and vaginoplasty decreased my responsiveness by a factor of five or ten.

Four months ago, I finally got some of my medical records from Children's Memorial Hospital in Chicago. They are shocking. The surgeon who removed my clitoris summarized the outcome as "tolerated well."

I hadn't made much sense of these records until a recent visit to my gynecologist at Barnes Hospital in St. Louis. I was referred to her three years ago by the University of Illinois pediatric endocrinologist to determine whether I would "need" the vaginoplasty. This was all news to me, as I had never been informed that I would ever need more surgery. As it turned out, my gynecologist concluded that I had a sufficient vagina and she recommended only pressure dilation.

Anyway, just about a month ago I visited the gynecologist for my routine annual physical — she's the only doctor I ever see. This time, when she asked what kinds of questions I had, I pulled out my records and asked her to review them with me. She actually spent over an hour with me explaining some of my records

to me. One phrase that stuck in my head was "Androgen Insensitivity Syndrome." I left that day still in a fog, but a little more confident that at least someone had taken my questions seriously.

Then, just under a week ago, I received a package by mail from a friend in whom I had confided some very sketchy details about my surgery. Natalie Angier's article about ISNA (*Intersexual Healing*, *New York Times Week in Review Section*, Sunday, February 4, 1996 — Ed.) and the Winter 95-96 issue of ISNA's newsletter *Hermaphrodites with Attitude* had crossed her desk, and she realized that this might be related to my situation. In fact, she was absolutely right. I couldn't believe it as I sat there reading stories that I could have written.

After reading these articles and others that I located at the ISNA website, I now suspect that I have Partial Androgen Insensitivity Syndrome. The medical team lied to me about removing my ovaries; they actually removed my testes. I know from my records that I have a 46 XY karyotype.

I am horrified by what has been done to me and by the conspiracy of silence and lies. I am filled with grief and rage, but also relief finally to believe that maybe I am not the only one. My doctor told me more than once that I wasn't the only one, but I never got to meet any of them. I'm full of anticipation, fear, and craziness at the thought that, through ISNA, I may finally be able to speak with and meet others who share these experiences. CQ

My Beautiful Clitoris by Annie Green

Thirty-two years have passed since my clitoris was taken from me. Though I was too young to be able now to recall the event, I feel that I will be grieving the loss for the rest of my life. Every day my thoughts touch on what it would be like, what it would feel like, what it would look like, if this had not happened to me. I have only one connection to the clitoris that I was born with: a pathologist's report on the bit of tissue the surgeons sent him for analysis:

The specimen consists of a soft pinkish piece of tissue measuring 2.8 cm in length and approximately 1 cm in average outside diameter. The distal 1.2 cm. of the specimen is covered with wrinkled, pinkish tissue resembling prepuce. Section shows the specimen to consist of 2 soft, pinkish-white, somewhat shiny, half cylinders, each outlined by a thin rim of shiny whitish tissue and entire complex is covered by a thin rim of soft, shiny, pink tissue.

It sounds beautiful, doesn't it? I imagine it, my clitoris, lying in the cold metal specimen tray. I can't help but think how sad — such an alive, vascular, beautiful, sensitive organ, removed from the warm body of this precious child. My body. How tragic that this little child would grow into a sexual being who will never know orgasm. How heartbreaking that so many years of this child's life would be filled with anguish, confusion, and shame.

I am so glad to have found ISNA. Sometimes, I think it saved my life. I wouldn't have known otherwise what to do with all this. Before ISNA, I, like others I have now come to know, believed I was alone — the only one in the world to have been treated this way.

*We are pleased to be able to present this rare interview with the controversial researcher Dr. Arika Aiert, author of *Sex and Gender: An Epidemiological Perspective*. Interviewer Shelly Primrose from "Not Exactly Out" magazine spoke to Dr. Aiert recently at Dr. Aiert's sparsely furnished home in Hampden, Maryland.*

Interview with Dr. Arika Aiert

by Kira Triea

*I*nterviewer: What causes sex?

Dr. Aiert: Well, soft pink lighting, a glass of wine, "If You Don't Know Me By Now" on the CD, and a nice butch friend who doesn't think I'm a Feminist Traitor because I wear dresses and heels. That usually does it. 'Course, that's just me.

Interviewer: Oops... I meant what determines sex?

Dr. Aiert: Oh! Surgeons determine sex.

Interviewer: In what way?

Dr. Aiert: Well, let me try and explain it to you with an analogy. It's kind of like fishing. When a doctor "hooks a big one," so to speak, he keeps it as a good "viable" fish. But if he hooks a little one, he doesn't throw it back, he makes it into a girl fish. Surgeons feel that fish with small penises will be very unhappy, but if they are just girls, then it doesn't matter so everything will be OK. So, being a girl fish is not as great as being one of the "real guy fish," but it sure beats being such a miserable creature as a "guy fish with a little weeny."

Interviewer: Let me get this right...

Dr. Aiert: Ok, XX babies with clits that are "too big" have them removed. Doctors don't like large clits— they find them upsetting. XY

babies with penises that are “too small” have them removed, too. Surgeons find them equally if not more upsetting. That way, everyone in the world will be walking around with either a nice manly penis, one that a surgeon

Interviewer: “Er ... um ...”

Dr. Aiert: “Yes, more er-umming indeed. The answer is that we don’t know what is “too big” or “too small” or how the child feels about it or how they

[Dr. Aiert takes a mini-maglight out of her shoulder holster, lets 3 cm. protrude from her fist.]

Dr. Aiert: “Is this a penis or a clit?”

Interviewer: “A penis.”

Dr. Aiert: “On a girl child, too?”

Interviewer: “Er ... um ...”

would be proud to display, or they have nothing that even *resembles* a penis at all — *but* they have a vagina and will be able to make their boyfriends happy, so everything works out fine for everyone. Surgeons are quite proud of their vagina-making skills. But what we have in reality is a plague of mutilation, an epidemic. If these guys were doing this stuff to adults they’d have every cop in the nation looking for them.

Interviewer: Er... “too big,” “too small”?

Dr. Aiert: Yes. Kind of a gray area, right? In fact, it’s just one vast soupy Sargasso Sea of gray area with no land in sight, a sort of Primordial Plain of Murk and Confusion. *[Dr. Aiert takes a mini-maglight out of her shoulder holster, lets 3 cm. protrude from her fist.]*

Dr. Aiert: “Is this a penis or a clit?”

Interviewer: “A penis.”

Dr. Aiert: “On a girl child, too?”

Interviewer: “Er... um.”

Dr. Aiert: “Exactly — er um” *[Exposes 1 cm. of maglight]* “How about this?”

Interviewer: “For a boy or a girl?”

Dr. Aiert: “Does it matter?”

are going to feel about it later. But surgeons are manly men of action who like to *fix* things and that’s exactly what happens. Lots of things get fixed.

Interviewer: Does this approach ever work?

Dr. Aiert: Not one damn bit that we can ascertain! If it has, we have never had anyone come forward and tell us about it. What we do have is more and more people coming forward who are hopping mad and out for blood, or tragically damaged from having had body parts removed and altered as infants and teens, people who have spent their teenaged years as the subjects of medical experimentation, purposefully kept isolated from each other by the Medical Industrial Complex. It’s not pretty.

Interviewer: Why don’t surgeons just talk to their ex-patients?

Dr. Aiert: They are very busy. Plus, they are quite important and ex-patients may bring back troubling thoughts. In general, they seem to want to avoid any upsetting confrontations with patients who are potentially unstable. Also, they are cowards who do not seek or face the truth.

Interviewer: Isn’t that a bit harsh?

Dr. Aiert: No, not at all. Harsh is having every bit of feeling tissue removed

from your clitoral area at 18 months old area because it was “too big.” Harsh is having vaginoplasty at 14 years old, then a week later being strapped down to a table with your legs apart and a speculum stuck in you so that a dozen people can take a look and comment.

Interviewer: What is the solution, then?

Dr. Aiert: **Surgery and hormone therapy should only be consensual and informed.** Kids know what sex they are if they are just left to work it out and feel loved and safe enough to talk to their parents about it. Intersexed children raised fairly neutrally could easily decide at puberty what sex they would be, or if they wanted to remain intersexed. Medical complications should be handled with love and honesty. Intersexed children *are* special, so they should be made to feel that way, instead of like freaks or worse. Actually, it is really so simple.

Interviewer: What causes gender?

Dr. Aiert: Clothes. Yes, gender is mainly brought about by clothes. If someone has a really confused wardrobe — strapless dresses, high heels, alongside a pinstripe power suit or lumberjack shirts, it’s a sure sign that they may be confused about gender. Once you are one with your wardrobe, your gender worries are over. Another cause of gender are the sexual positions. Lots of sex has a “top” and a “bottom,” so we have a male gender person on top and a female gender person on the bottom. It works out that way almost every time! Take lesbians, for instance, who can make love sideways to mutual satisfaction. With no top or bottom, there is no gender, and many lesbians are quite unconcerned about gender. It is my theory that if we all had sex, say, by hanging vertically and rubbing our interesting parts together, the whole gender thing would just sort of fade away.

Interviewer: Where are you off to next?

Dr. Aiert: Actually I’m beginning a new book on lesbian sexuality and I’m going down to Lynn’s place to do some research. Care to join me? CQ

Doctors Containing Hermaphrodites The Victorian Legacy

by Alice Dreger

Michigan State University

In the early 1880s, a French woman, identified in medical records only as Sophie V., went to a local surgical clinic seeking advice and help. At the age of 42, Sophie had now been married two months to her first husband, but for all their trying he could not “accomplish the conjugal act” with her; he just could not seem to penetrate her vagina. The attending physician, identified in the record as Professor Michaux, examined Sophie’s genitals and quickly discovered the “problem”: Sophie V. was a man, no matter what she had been led to believe all of her life. She had a “penis” five centimeters long, albeit lacking the urinary-tract opening in the usual place. Her “labia” contained at least one testicle. And, Michaux noted, of course her husband couldn’t get his penis into her vagina, because she didn’t really have one!

Sophie understandably thought Michaux was either cruel or crazy. True, there had been some question about Sophie’s sex when she was born, and her parents had taken her to a medical man when she was but a few weeks old. As the medical journals records, at that time “the man of the art did not find the thing sufficiently clear, and he asked the parents to return later with the child.” Sophie’s parents did not, though, because they feared the man might operate on their child and accidentally hurt or even kill her. Instead they just decided Sophie must be a girl, and so she was raised. When she was in her early 20s, Sophie developed what she thought was a hernia, and she wore bandages to support it from that time forward. This “hernia”

was, according to Michaux, the descended testicle. Now she was married to a man, one who wanted to penetrate her in a particular way but couldn't seem to do so because Sophie lacked the parts. What to do?

The answer to the medical man Michaux was simple: Sophie had testicles and a penis; she was a man; she was therefore not really married (no matter what she thought) because no marriage between two men was a true or legal marriage. She — or rather *he* — should have his civil status formally changed to male and start acting his “true” sex. Sophie was a man.

The answer to Sophie was equally simple: She felt like a woman, she dressed like a woman, she had always been a woman. She was married to a man whom she loved and who loved her. The doctor was either crazy, or wrong, or confused, or at least not worth listening to. Sophie had no interest in becoming a man. Sophie was a woman.

Sophie V. had the sort of anatomy that in her day qualified her to be labeled in the medical literature a “hermaphrodite.” This is still a common use of the term in our vernacular, although medical experts have grown much more specific with regard to distinguishing one kind of “ambiguous” genitalia or “intersex” from another (more on that later). Sophie’s genitals did not look much like your supposedly-standard male or female type, but more like something in between, or something fairly different, and this was what, in the nineteenth century, generally made one a “hermaphrodite.” In Sophie’s time, the word “hermaphrodite” was sometimes also used to refer to people who today would likely be classified as transvestites, transsexuals, homosexuals, feminists, bearded women, and so on. But when identities got sorted out in the way they did in the nineteenth century, “hermaphrodite” came to refer fairly specifically to people born with unusual genitalia.

Most people labeled male have one penis each, a scrotum, two descended testicles, a prostate, no vagina, penile erections and ejaculations, and so on. Most labeled female have

one clitoris each, a vagina, two ovaries in the abdomen, no testicles, erections (in this case of the clitoris), a period of life in which they menstruate, and so on. But human anatomy is amazingly variable, intentionally and unintentionally. A fair number of babies are born with internal and/or external organs that don’t fit the “most” description of malehood or femalehood. How many is hard to say. Such statistics depend on definition (what is a standard penis? or an acceptable vagina? what should be counted as intersexual, or ambiguous?), on examination techniques and standards, on record-keeping and reporting of statistics, on frequency of variations within a given sample, and so on. But I think we can say with confidence that at least one in every two or three thousand births results in a question about the sex of the child. Add that up and it comes to thousands of cases per year in the US alone.

So unusual sexual anatomy is not really all that unusual, not nearly as unusual as most people assume. Until graduate school, I had never known about it, and I meet people all the time who have never heard of it until they met me and asked me what I research. Even people who were born “intersexed” may not know of the phenomenon, since they are often never told the diagnoses written in their medical records. But people in the medical profession know it isn’t too rare. Doctors are trained to be on the lookout for intersexuality, and it is standard material in all medical genetics, gynecology, and urology textbooks. Medical students in the course of their education all learn about “intersexuality,” and most gynecologists I talk to eagerly tell me about a number of cases they’ve personally seen. Today almost every major hospital has a standard protocol for what to do when a child is born whose sex is confusing or suspicious.

Intersexuality is even becoming more visible in pop culture. The recent movie “Flirting with Disaster” featured a bisexual (interesting choice) who was born with a hypospadiac penis, that is, an organ like Sophie’s that looks like a penis but doesn’t have the pee-hole in the usual place; a recent episode of the television drama “Chicago Hope”

included a story of a baby born genetically male but with an unacceptably small penis. (The doctors in that story decided, as is generally the case in the US today, a boy with a wee penis is no boy and so the child should be made — hormonally, surgically, and socially — a girl.) As possibilities for sex/gender identities expand and become inhabited by more and more people, interest in intersexuality grows.

I am a social historian of science and medicine, and I became interested in the scientific and medical treatment of hermaphrodites because so much literature has been written lately on the social construction of gender, but I wanted to know how “sex” (“male” and “female” anatomy and physiology) came to be thought of the way it is today. After all, although we often act as if it is, “sex” is *not* a completely self-evident thing. We say a hermaphrodite is a person with unusual sexual anatomy, but when you come right down to it, what *is* sexual anatomy? What do you count, and how do you count it? Do you have to have a penis to be a male? If so, what size, and when do you have to have it — at birth? At the moment in question? Do you have to — or have to be able to or have been able to — become pregnant to be a female? Or is it just those XX and XY chromosomes? If so, are women with XY chromosomal bases not women, even though they are born with female-looking genitalia and develop like most females at puberty? (This is the case in people with an XY-chromosomal basis and a condition now described as androgen-insensitivity syndrome, or AIS.) Is it the case that those of us who don’t know if we are XX or XY don’t know our sex?

As the Olympic Committee — which keeps trying to figure out who should count as a male athlete and who a female — has discovered the hard way, none of these possible sex signifiers alone really suffices to capture the usual way we think about sex, even if we claim they are the ultimate, true, sexual signifiers, because there will always be people we are willing to count as male or female who don’t fit any given definition. Do we then use a sort of “Cosmo

Continued on P. 19



Most people today who come upon the 1888 photograph of renowned gynecologist Fancourt Barnes's "living specimen" are taken aback. But, at least at first, it is not the unusual genital conformation that strikes them. Rather, it is the whole scene — the hermaphrodite lying prone, his/her face in a blur, the hand of a man reaching in and holding up the phallus — that make many current-day viewers' mouths drop open. Yet this picture is not very unusual for photographs of hermaphrodites in the late nineteenth century. In such pictures, the faces of hermaphrodites were often revealed, intentionally or unintentionally. And photographs of hermaphrodites at this time also tended, like the one under consideration here, to be somewhat murky... While today we see very few doctors' hands in anatomical illustrations, they are all over photographs and drawings of hermaphrodites from the late-nineteenth and early-twentieth centuries.

In a way, the reaching-hand-motif — tunning as it is to late-twentieth century eyes — serves to remind us of two things. First, it reminds us that at least two persons squeeze into the frame of study, namely the

hermaphrodite and the medical/scientific observer. However, as is so well represented in the photograph of Barnes's specimen, while the hermaphrodite's ambiguous anatomy and the role of the biomedical observer come relatively easily into focus, the identity and the mind of the hermaphrodite (represented in Barnes' portrait by the blurry face) do not. Second, the hand-motif serves to remind us that the meaning and representation of anatomy is always culture-specific. In present-day anatomy texts, it seems that the anatomist, the "hand," disappears — that the portrait is self-evident — and that is why the reaching-hand-motif of the past strikes us now as so surprising. But in a way, present-day texts are much more deceptive than the graphic pictures of a century ago. The old illustrations, in which the examiners' hands figure prominently, never allow us to forget that there is a "hand" guiding any given image. Today, with the hands invisible, we cannot see that the grip is still tight.

From Alice Dreger, "But My Good Woman, You Are a Man!: Hermaphrodites and the Medical Invention of Sex," forthcoming from Harvard University Press, 1998.



This person, photographed at age 21, was first considered to be a girl. She had been engaged, but was left by her fiancé when she told him that she could never have children. "R.X. never had the menses nor menstrual molimina, nor any sexual sentiments whatsoever; she did not masturbate. Lately she has shown for the first time a sexual appetite for men. She absolutely wants to be married to a man... This young woman came to me and asked me to operate on her in order to make it possible for her to marry. Then her father came to me and asked me to do what his daughter wanted. When I told him it was impossible, that an operation would change nothing, that his daughter was a malformed man, and, that even if his daughter did marry, the marriage would not last long, he answered by saying he would find in the countryside a son-in-law who would not discover anything abnormal about the girl!" There were doubts at the birth of R.X., but the local midwife recommended raising the child as a girl, and now the father, who thought his daughter was a boy, regretted that he did not follow his own opinion.



Fig. 1

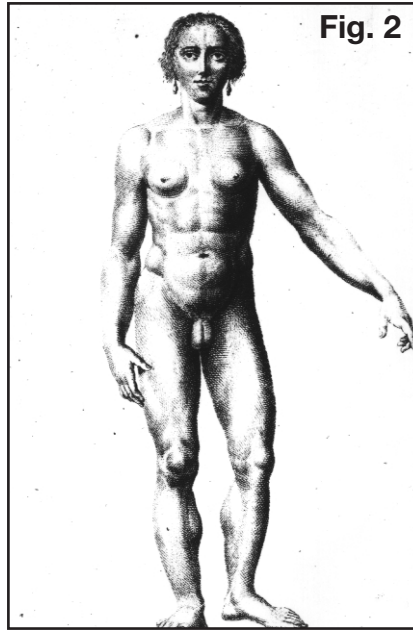


Fig. 2

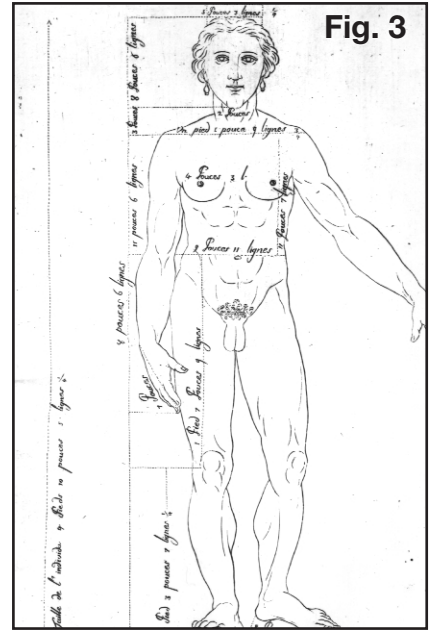


Fig. 3

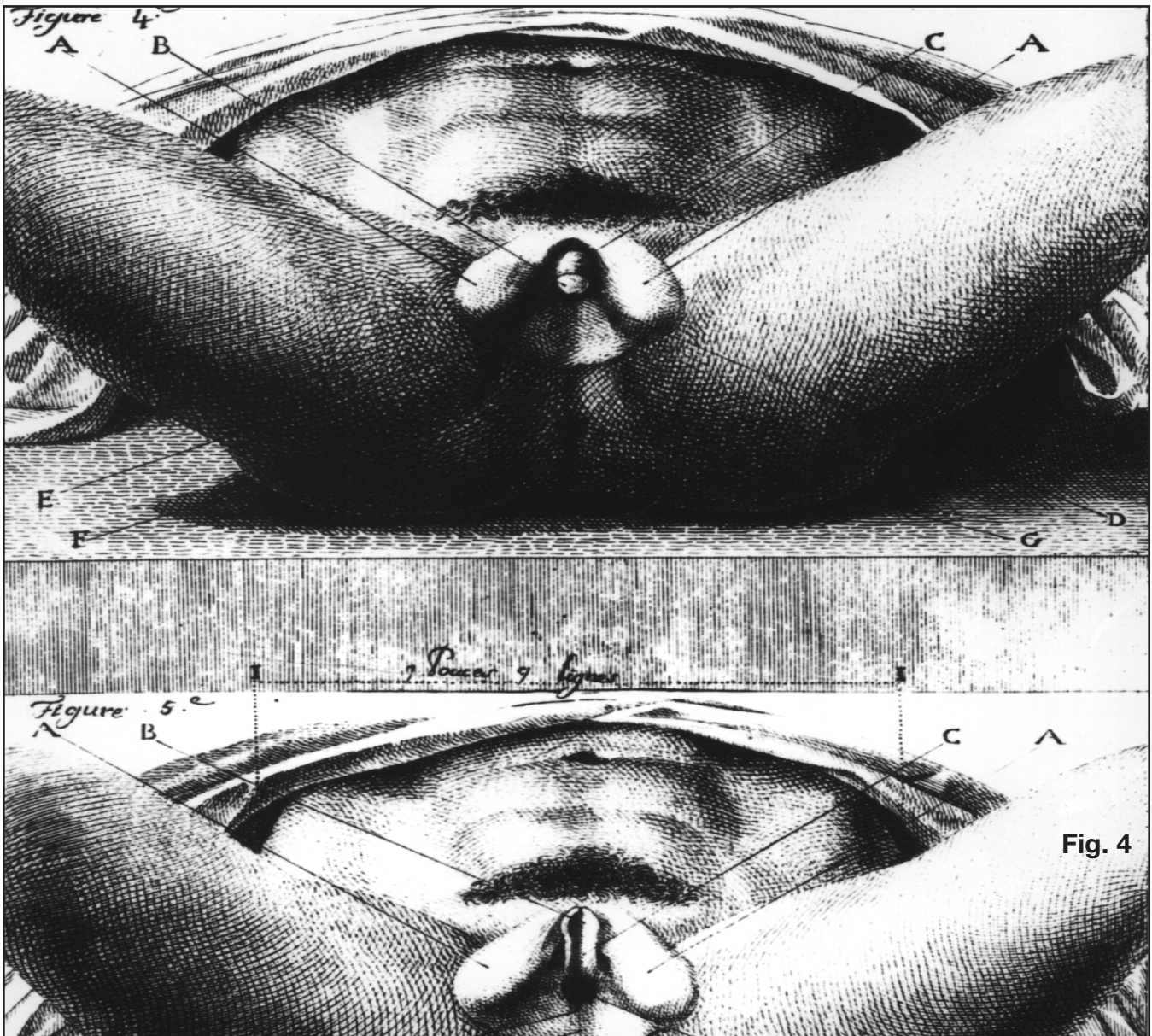


Fig. 4

These figures are from a 1802 article published in Milan. Foroni, an Italian peasant woman, was going to be married to a man when some questions were raised about her sex. Three doctors came in from the big city to check her out and they decided she was a man.

Figure 1: Shows Foroni clothed. She is posed classically, her whole person is shown, but note how thickly her finger and arms are drawn. Who knows what the sketcher knew and wanted to show?

Figure 2: Shows Foroni now naked (except for earrings) and standing — in a neo-Grecian pose, incidentally, like a classical statue. Again, a whole person — still kind of idealized, but all there, looking slightly away, pointing at something (the “truth?”).

Figure 3: We see the move in this picture towards quantifying the body. A two-dimensional representation of Foroni — no shading, just her outline. Almost like she is a chalk drawing on the sidewalk. Now the idea is to look at the proportions of the body — the ratio of the proportion of the neck to the umbilicus vs. the proportion of the leg to the whole body, etc. A very 18th, early-19th century idea — actually dates back farther. Da Vinci has that famous picture of the man inscribed inside a circle — he’s holding his arms up and his legs are sort of spread, and he fits perfectly in the circle. That was meant to show proportion. This is in that same tradition, but here being taken very seriously as a forensic tool in search for “true sex” — women and men were supposed to have different bodily proportions. So this quantifying would presumably reveal the truth.

The other important thing about this picture is that, at this time, the *whole body* still matters—the whole body will reveal the “true sex” — sex is spread out all over the body. Little by little, there will be more and more focus on the genitals, and then on the gonads, and then on the chromosomes, and sex will still wash over the body, but it will reside chiefly in its interior realm.

Figure 4: The wave of the future. In this collection, 3 of the 5 pictures (*Figs 1-3*) are of a whole body. Only two images (*Fig. 4*) are of the genitals. Later that ratio will be turned upside down — fewer and fewer pictures of the whole body, more and more of the genitals. (This might have to do with respecting the patient’s privacy, but it is hard to know.) Note how, compared to the later hands-in-genitals pictures (*see the photo on p. 17 – Ed.*), these relatively early pictures do *not* show a hand in the genitals even though, in the bottom image, it is clear someone pushed up the phallus so that its underside and the vagina could be shown.

Continued from P. 16

girl” test and say that, if you have, say, “five of the following” traits, you count? Perhaps such an additive system would work. But then one would still have to decide what to add. What size would a phallus have to be to count as a clitoris or a penis? Would one have to wait until puberty to see what happens with the breasts, the body hair distribution, and so on? More to the point, what would count as sexual anatomy in such an additive system? If in Sophie’s time, as was the case, most women had long hair, should head hair have counted as part of the sexual anatomy? (English doctors said it should, and French doctors it shouldn’t.) And if, as Darwin claimed, the females of most human races were fairer-skinned than the males of their races, should skin color count towards sexual anatomy? But, wait, we wouldn’t count those anymore. Well, then, is the question of what counts as “sexual” specific to time, place, culture? That, too, seems strange — most people want to say some parts always counted and always will count for malehood and femalehood, that there is a single “real” maleness and femaleness, even if we can’t fit everyone into that definition.

What I find is that it is those tense and tentative definitions of “real sex” which reveal so much about how we think about and limit sex, and, much more frighteningly, it is those definitions to which people like Sophie, the fictional baby on Chicago Hope, and real children born today are subjected. When I started this research, I assumed it would tell us good things for people who believe in the goals of radical feminism and the queer rights movements. It has. It has told us that, like gender, sex and sexuality are concepts which are in very important ways historically developed and culture-specific. But it also tells us some frightening things about what happens to intersexuality and people born intersexed. This history matters more than I ever thought it would, in some ways more than I wish it would, for I wish things looked pretty good compared to the way things used to be, and I don’t find that to be the case.

For the last several years, I have been working on a large study of the biomedical treatment of human hermaphroditism in the late-nineteenth and early-twentieth centuries. I am currently writing a book on the subject, and in the space here can only touch on some of the larger points. What makes the period I study so interesting is that it was a time when much was in flux. Scientists and medical doctors did not yet hold the sort of phenomenal cultural authority they would come to hold in the mid-twentieth century. Theories of sex, embryology, evolution, and so on were in periods of intense debate and development. And finally, this was a time when dominant sex roles were being increasingly challenged, with vigor as never before, especially by feminists and homosexuals. What a time to be a medical man faced with a person like Sophie! Increasingly it was specifically the medical man who would be faced with such people, for in the nineteenth century as never before, the sexual anatomy of the masses — like all other aspects of human sexuality — became the purview of the medical profession.

What I find in my research is basically this: Increasingly as the nineteenth-century and then the twentieth-century progressed, medical and scientific men did all they could, conceptually and practically, to limit each and every body to a single sex. In the nineteenth-century it wasn’t enough to just pick; the sex assigned had to be what they called the “true sex” of the body. Every body was assumed likely to have a single true sex, male or female, a true sex that could be masked by ambiguous anatomy or “strange” behavior, but unmasked by the able medical man.

And, as experts reminded their sometimes-provincial colleagues, it was up to the medical man to make sure everyone was sorted and sorted right. Otherwise one might end up with “perverse” cases like Sophie’s, where men unknowingly engaged in sexual relations with other men, or cases like Herculine Barbin’s, in which a masked man “accidentally” penetrated the sanctuaries of women and... well, penetrated the sanctuaries of women.

The clinical problem was how to figure out what each person’s true sex

was. The combinations could be quite confusing — breasts on men, beards on women, genitals that seemed to be a little of both or a lot of neither. Medical men fretted over cases in which so many traits seemed to contradict the “sex” of other traits, traits including voice pitch, genitalia, hair distribution, fingernail quality, breast development, angle of the knees, quality of the gaze, sorts of desires. In fact, even though they never doubted that there were two, and only two, distinct human sexes, medical men of the nineteenth century had a devil of a time agreeing what sex was, or more specifically, on what should count as the necessary or sufficient signs of sex. Yet they were, as a group, increasingly reluctant to allow that any body could be a true hermaphrodite — a person truly both male and female — and doctors grew increasingly interested in keeping every body sorted lest sexual havoc ensue. It was bad enough that people like Oscar Wilde and Susan B. Anthony questioned social borders; the last thing the social body needed was doubts about the anatomical borders on which the social borders had been constructed!

The logical solution was the one chosen by biomedical experts: pick a single binary trait which could be used to sort otherwise ambiguous bodies. In the 1890s, a consensus emerged, according to which “true sex” would be signified by the gonadal tissue, that is, ovarian or testicular tissue. Does Sophie look confusing? Well, the rule went, if she has testicles, she is simply a man; if ovaries, a woman. This seemed like a good solution.

Why the gonads? After all, why not pick something more readily accessible, like breasts, or facial hair? The gonads made a good signifier in part because they were binary and doctors wanted to envision sex as binary. Gonadal tissue postnatally tends to be pretty easily identified as ovarian or testicular in nature. (An awful lot of men have breasts and a sizable number of women have mustaches.) Besides, it seemed like the gonads *were* the key to sexual identity; after all, what is a man but a person who can impregnate via his sperm, and what is a woman but a person who can produce ova and thus

be impregnated? Even if not *all* men and women were fertile or active in these ways, it seemed like a logical definition, especially at a time when men and women were almost universally in scientific and popular texts described as mere manifestations of their reproductive roles. Late-nineteenth century biomedicine was also very focused on tissues as key (especially in research on disease), so it seemed logical to assume that the tissues held the answers in this case. Finally, there were growing hints that gonads produced some sort of “internal secretions” (what would later come to be known as hormones) which in turn played important roles in sexual development.

Still, with all these good reasons to pick the gonads as signifiers, the chief impetus to pick a *single* signifier was the practical messiness of sex — the blending of and disagreements over the plethora of “sex” traits. Almost every body had either ovarian or testicular tissue, and almost none had both or neither. This meant almost everyone could have a single true sex. Additionally, while it was agreed by most doctors then and now that some people really do have both ovarian and testicular tissue, in the 1890s, clinical techniques did not allow for the required microscopic diagnosis of living true hermaphrodites, so the threat of true hermaphroditism was satisfactorily subdued. At least everyone living would seem only to have one true sex which they could be advised to heed.

This, then, was the gonadal definition of true sex, the definition that has stuck in the technical literature all the way up until today. As was developed in the nineteenth century, the medical classification system for intersexuality now divides us all up into five basic types: males have testicular tissue and are “unambiguous”; females have ovarian tissue and are “unambiguous”; “ambiguous” people with testicular tissue are called male pseudo-hermaphrodites; “ambiguous” people with ovarian tissue are called female pseudo-hermaphrodites; and those rare people with ovarian and testicular tissue are called true hermaphrodites. These are what Anne Fausto-Sterling helpfully abbreviates as males, females, merms,

ferms, and herms. She also suggests we accept and broadcast this five-sex system of classification.

So, are all people like Sophie now assigned a sex identity according to their gonadal tissue? Well, no. After all, what the heck is one supposed to do with a true hermaphrodite, or a woman with testicles, if you want to assign everybody according to gonads and still maintain the “old-fashioned” ideas of sex? This very real problem emerged in the early twentieth century because of the development of new diagnostic techniques, namely laparotomies (exploratory surgery) and biopsies (sampling of tissue without removing the whole organ). Now a doctor *could* diagnose a living true hermaphrodite, but the legal and social system wasn’t ready to handle it.

And, even if you could figure out a way to cope with true hermaphrodites — and those were pretty rare and so not *too* threatening to the system — it was becoming clear that a relatively frequent condition existed in which a patient could look, sound, act, and feel for all the world like a female but would have testes! This is the condition now known as androgen insensitivity syndrome (AIS) or testicular-feminization syndrome. We understand this as a case in which a genetically-male individual has testes which produce testosterone but her/his body can’t “read” that testosterone (the receptors are lacking). AIS individuals are often classic Western womanly beauties with a female vulva, long limbs, hairless bodies and faces, rounded hips and breasts, “feminine” voices. (There is a rumor that many women high-fashion models are actually AIS “males,” a claim which, whether or not true, I enjoy suggesting to my undergraduates who belong to the more sexist and heterosexist fraternities and sororities.) While the explanation for AIS remained elusive in the early twentieth century, the phenomenon was well documented, and diagnostic techniques now allowed easy identification of such cases. Were these people to be assigned male because they had testes? What would stop other “women” from claiming they were really men and demanding such “male” rights as the vote? The gonadal definition

seemed now, in practice, completely unacceptable, even if in theory it allowed easy sorting.

And so there began in medical practice a retreat to the external genitalia. We often think of the emergence of the concept of gender identity as a twentieth-century step toward liberation, away from traditional sex roles, and indeed it was in the realms of gay rights and feminism. Freeing “gender” from “sex” meant freeing oneself from claims that traditional sex roles emerged from an indelible biological reality. But in medical treatments of intersexuality, ironically, the concept of gender identity (an identity beyond anatomical sex) emerged specifically so that traditional social concepts of sex and sex roles *could remain undisturbed* by messy bodies. In *theory* doctors retained the gonadal definition of sex with five categories (male, female, merm, ferm, and herm), but in *practice* such a definition would have required a new social category of a third sex (for true hermaphrodites) as well as the labeling of very womanly AIS patients as men. This would have meant some rather profound social disarray or at least some important changes. So in *practice* doctors increasingly decided to assign a *gender* identity to each patient — strictly boy/man or girl/woman — according to what a person’s social role already was or was likely to be given that person’s appearance. The earliest suggestion I have found that doctors make practical “gender” assignments was in 1916. In the text the author, an English surgeon, suggested that such a clinical solution would ensure that pretty girls could still get married even if their sex was technically confused or confusing. The desire for social stability, combined with the exigencies of new diagnostic technologies, drove medical men in this direction.

So today, theoretically at least, women have the same rights as men, and being gay or lesbian is supposed to be acceptable to medical professionals. One might expect to find a greater tolerance, then, of ambiguous sex, since we tolerate more “ambiguous” gender roles. Alas, such is not the case. Today, as Suzanne Kessler has documented in her 1990 article in *Signs*, ambiguous

babies are typically sorted early into girls and boys in this way: Genetic and gonadal males with small or otherwise-unacceptable (and unbuildable) penises are made into girls, for a “satisfactory” penis is considered the *sine-qua-non* of boyhood. Babies born with workable female reproductive systems are made into more-convincing girls, even if that means destruction of the clitoris-penis and other parts. Doctors seem to think very little of deciding a child will be put on hormone therapy for the rest of

Doctors tell themselves and us that they do these sex-assignments and sex-therapies for the sake of the individual patients, and they must believe this in order to do what they do. But if we look at the effects, we must wonder. Is there good evidence that, from a medical point of view, the time to treat cases of genital ambiguity is pre-puberty?

his/her life.

“Normal” has two basic meanings. In one sense “normal” is used to describe the average or typical. But in another it is used to speak to an ideal, a perfect sample. The word was first used mathematically to describe a kind of angle, namely a right angle (ninety-degrees), and we see even in that term — right — those two meanings, one descriptive (as in ninety-degrees) and one prescriptive (as in correct). So too we have the “most” definition of sex as given above — most people labeled female have labia minora and majora, a clitoris, etc. — and that is a definition of normal sex in the first sense, that is, in the sense of typical sex. But, as in so many areas of cosmetic surgery, the definition slips from the descriptive norm (what is average) to the prescriptive (what is ideal, what must be), and massive amounts of medical treatment are brought to bear to attempt to make acceptable-looking girls and boys out of “unacceptable” children.

This was already starting to hap-

pen in the late nineteenth century. For instance, surgeons, particularly in France, worked to develop techniques to remake hypospadiac penises so that patients with the condition could pee standing up. In a case very similar to Sophie’s, a French surgeon offered to make his patient a more workable vagina. (The surgeon was soundly reprimanded by colleagues who accused him of contributing to a “perverse” situation, namely a marriage between two “men.”) There are two differences today: Today the surgeries attempted are far more ambitious, and they are typically performed on babies or children. The logic is that any child left to grow with ambiguous genitalia will suffer irreparable psychological harm. This sort of extraordinary surgery is known in medicine and history of medicine as “heroic” surgery; this refers to attempts to perform — against the odds — the seemingly impossible. When the surgery doesn’t work — when it results in scar tissue, dysfunction, disfigurement — that in a way seems OK, because it was, to start with “heroic” in its aim.

But is this heroic? Doctors tell themselves and us that they do these sex-assignments and sex-therapies for the sake of the individual patients, and they must believe this in order to do what they do. But if we look at the effects, we must wonder. Is there good evidence that, from a medical point of view, the time to treat cases of genital ambiguity is pre-puberty? Or does this often result in sexual and urinary dysfunction and disfigurement? Is it true that no one could psychologically survive a big clitoris, a bifid scrotum, a hypospadiac penis? Are the genitals shaped by the scalpel necessarily less traumatic than those shaped in the womb?

Given the apparent lack of follow-up studies to show whether these surgeries work most of the time, physically and psychologically, and given the tragic stories of many medically reshaped hermaphrodites, one must wonder if this is “heroic” or just misguided, even heady. Any reasonable person who takes a close look at the literature cannot but conclude that the current treatment of intersexuality has far more to do with

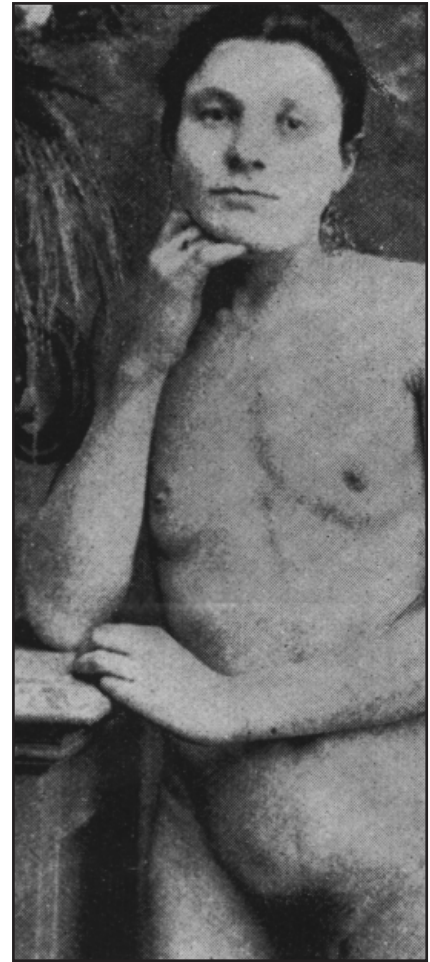
social needs regarding sex borders than the child's or even the family's needs. If the patient and family were the chief concern, adequate follow-up studies would be done, peer-support groups established and made known, and regular psychological counseling offered. I strongly suspect, also, that the ethos of surgery forces this sort of treatment — an ethos which dictates the surgeon must always recommend surgery and must always attempt the difficult or impossible, indeed the most “cutting edge” — pun painfully intended — solution. (There is a saying in medicine about the three basic rules: If it works, keep doing it. If it doesn't work, stop doing it. And never go to a surgeon unless you want surgery.)

If I look back in history, to times we tend to consider less liberal, less accepting of difference, I find that in fact hundreds of hermaphrodites like Sophie survived. Yes, some were traumatized, some ostracized, some confused. But we see also people who just went on, who didn't much care, who found lovers and friends and lives as they were. There is, for instance, the tale of the French peasant vineyard-worker and his bearded wife, a wife whose beard did not bother her husband; the story goes that they each shaved once a week for mass, and no one really questioned her beard since vineyard-workers were known to be particularly strong and virile. How varied are the stories! It pains me to no end to see, repeatedly, the story of Herculine Barbin, a nineteenth-century French hermaphrodite, used to make the claim that all hermaphrodites left alone would

kill themselves as Barbin did. Barbin was in fact not left alone — her sex was re-assigned to male, perhaps as she wanted and perhaps not. No better is it for us to claim she killed herself because of the reassignment. Why Barbin did commit suicide will never be known for sure. But we can see that, before the days of early diagnosis and early treatment, many hermaphrodites survived, had lovers — just lived.

So too were the approaches of the doctors remarkably varied before the time when medical training became standardized and hermaphroditism experts and protocols emerged to rule the day. How many definitions of sex there were, how many opinions of how to settle questions of sex. Perhaps this did not make things any easier on any individual patient, but it shows to us the faint signs, like faded cave paintings, of all the roads not taken, all the roads we could go back and try to take.

And so I find myself wondering if we can start to change the definition of heroic medicine, away from one which regards as heroism extraordinary attempts to shape the identity of a baby (or anyone else) according to the received limits of acceptable identities, and towards one which regards as heroism the willingness to question medical tradition, to question colleagues' judgments. I dare to envision a new road taken, a road of honesty about intersexuality, a road along which we find the active encouragement of acceptance of anatomical diversity, a road towards a world of medicine in which the patient's wishes are at least seriously



The posing of this person leaning against a mantle with flowers in the background seems to accentuate the exoticism of hermaphrodites. All we know about this figure is that s/he is a case of “peno-scrotal hypospadias with a small uro-genital sinus... The general aspect and the breasts are feminine.”

“Historians — since we care about dates — have a habit of putting the birth dates and death dates of various important figures after the first introduction of their names. For example, ‘Jane Smith (1874-1920) was well known for her use of split infinitives.’ When I was working on my book, I instinctively stuck in the birth and death dates after the introduction of each of the important doctors who treated hermaphrodites. One day I realized I should do the same thing for the particularly famous hermaphrodites whom I was introducing — Herculine Barbin, Marie-Madeleine Lefort — and wham! Suddenly they came to life as people who had been born and who had died — they were historical figures. Until that time they must have occupied in my mind the same sort of position they did in most of the medical folklore — unusual characters who pop in and out with mythical, often tragicomic lives. Now they were real. They had achieved a parallel existence with the doctors. They had finally been awarded the great historical parenthetical tombstone they had earned.”

— Alice Dreger

Power, Orgasm And the Psychohormonal Research Unit

by Kira Triea

I've wondered why researchers at Johns Hopkins were so concerned with the genitals of a barely teenaged hermaphrodite from a family of absolutely no standing or financial resources. My experience at the PRU [Psychohormonal Research Unit] leads me to believe that a need to express and preserve androcentric control is at the root of the medical industrial complex's fascination with my (our) genitals. The amount of medical resources which were brought to bear against a fourteen-year-old intersexed kid are pretty amazing, considering that life-saving surgery and treatments are routinely denied people at Hopkins. Why all the unsolicited attention?

Doctors act as enforcers of genital and behavioral conformity for the Penis Club. As high priests of the biological technocracy, and as privileged possessors of "secret" knowledge, they wield their power to ensure that only owners of a medically approved, "viable" penis are granted membership in the Penis Club. All others are by default granted membership in the Vagina Club. The penis does need to be "viable" as its purpose is not seen as being for pleasurable gratification, but as the mechanism by which members of the Vagina Club are penetrated. Intersexed neonates who have no clearly defined membership qualifications for either club are modified at Hopkins to become members of the Vagina Club. The fact that I was older meant that they couldn't dismiss my interests in the matter as casually as they do with neonates. The fact that I was already verbal required them to tread with a little more care in their quest to neutralize my hermaphrodite genitals.

Hopkins doctors view themselves as compassionate, helpful people who save lives and alleviate suffering. They assumed that since I was raised as a boy, I must want to become a member of the Penis Club. They attempted to utilize technical means to alleviate my suffering as a “defective male.” That was the first gender label that they assigned to me. When I first arrived at the PRU I was evaluated by John Money. He assumed that I had a male gender and, being fourteen years old, knew the “facts of life.” He asked me if I wanted to fuck someone or if I wanted to be fucked by someone else. Since I didn’t completely understand what he was talking about, he showed me a pornographic movie. I first learned the mechanics of penetrative intercourse from this movie, in which a guy with an immense penis had rough, almost violent, penetrative sex with a woman. Money had drawn another blank, as the movie did nothing but frighten me. This technique would probably have worked if I’d been shown a movie which portrayed kissing, hugging and soft affection. But Money and Hopkins do not postulate a soft world. Their world is the hard sex-dipoled landscape of power and domination, peopled with those fortunate denizens who are able to fuck others and those who are equipped only to be fucked.

Like earthlings faced with the arrival of some sensitive and mysterious alien, the PRU psych squads continued their attempts to divine the hermaphrodite creature’s “true sex.” Not having the sensitivity or intelligence to obtain this information by asking, they decided to inject me with testosterone and observe the results. “Put the electrodes here, the hermaphrodite runs over there. Put the electrodes there, the hermaphrodite runs over here.” My reaction to testosterone was considered a litmus test for my eligibility for the Penis Club, and it was a test that I failed completely. At this point they reconsidered their labeling of my gender. Money now decided that I was a “failed male,” i.e. female. My “true sex” had been discovered. Like shards of genetic pottery scattered amid the ruins of my childhood, my femaleness manifested in my desire to keep

my body, my soft skin and shape and voice, as they were. They shifted gears, now they worked to prepare me for initiation into the Vagina Club.

I go blank when people tell me that “in other cultures, intersexed people were respected as Shamans.” This knowledge was of absolutely no value to me at all when I was fourteen and faced with either hormonal mutation and surgery or vaginoplasty. But there must be some truth in it because I can think of no other reason why they would invest so much energy in my genitals. They must have been profoundly awed by my genitals! Since they were different from normal genitals, they must be more powerful! Since I had declined membership (“failed”) as a Penis Club initiate, it was now of paramount importance to make me a member of the Vagina Club as soon as possible. There was no other alternative.

As a member of the Vagina Club I was treated differently at the PRU. Money no longer talked to me of fucking and being fucked. People called me “sweetheart” or “honey,” and tried to talk with me of boyfriends and perhaps even marriage. Money told me a story about another hermaphrodite who had a vaginoplasty and whose boyfriend had even visited her in the hospital. I don’t remember hearing the words “orgasm” or “Lesbian” the entire time I was there, over three years.

I first had an orgasm four years ago, during what I call The Awakening, in which I became fully aware of my life and the implications of being intersexed. I seriously doubt that Dr. Howard Jones, who performed genital

surgery on me, paid any consideration at all to that function. I have no clitoris at all; whatever was there before seems to have been relocated, perhaps entered into the witness protection program and now living in Arizona. Jones seems to have taken care though, to ensure that I was able to be penetrated, as my “vagina” seems to be deep enough to allow for that. Part of my left upper arm was pressed into genital duty here, which bothered me greatly when I came out of surgery. I wish I’d been consulted, or at least informed. Of course, why would I need to be informed? The objective was to make the hermaphrodite fuckable.

I have spent the last twenty-three years crawling free of the wreckage of the impact during puberty of my anatomy and biology with the PRU. In the last four years I have managed to get back some of my carry-on baggage: I have become accepting of my intersexuality, orgasmic and sexual. I am relatively stable, and I am aware of myself as a valuable and unique person, an intersexed person who is feminine. I actually think I’ve done pretty well, considering the technological big guns which were brought to bear on me at the PRU. I’ve come to the conclusion that my genital grigri must be very strong indeed, a mojo so “viable” and enduring that it protected me from the death they envisioned. Perhaps I should follow my clitoris out to Arizona and become the founder of The Church of the Resurrected Climax. I think though, that I will stick around, where me and my Magical Snatch can stir up some really troublesome voodoo. CQ

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Time for a Change

by Heidi Walcutt

I was born in 1961 with a problem of sex differentiation. At the age of three months I was diagnosed as a male pseudo-hermaphrodite at Cincinnati Children's Hospital when they performed an exploratory laparotomy [abdominal surgery]. They found a rudimentary uterus, fallopian tubes, segments of a vas deferens, and gonads. They did a second laparotomy and biopsy at age seven months where they removed what they characterized as "three under-developed testes." The reason for this removal was to prevent a possible malignancy of these organs or perhaps a masculinizing puberty.

In 1966 I underwent plastic surgery at Buffalo Children's Hospital to reduce my enlarged clitoris and open the labial skin. At this time it was discovered that I did not have a vaginal opening, but rather a urethral-sinus cavity [a partially developed vagina that opens into the urethra].

At age ten or eleven I began to receive counseling sessions at Buffalo Children's two or three times a year. In these sessions, I would sit with a psychologist for about an hour and she would talk to me in very general terms about my being different. She told me that I was female, but my ovaries and uterus had been "under-developed," and that I would need to take pills prescribed by doctors if I wanted to have puberty like other girls. I remember sex education classes that start in the fifth grade — you know, the ones where they separate the boys and girls and talk to you about physical changes that will happen to you, but nothing about sex itself. I knew then that what I was hearing didn't apply to me, but I couldn't talk about my difference with anyone — not the teachers, not my parents.

I remember at this time hearing about hermaphrodites in Greek mythology, and I knew that it had something to do with my unnamed condition and my being different. I remembered my amputated penis, and wondered why they had removed it. I knew that my sisters didn't have to go through this surgery when they were young, so it had something to do with that. I didn't have anyone to talk to about the information I was acquiring, so I just locked it away deep in my mind.

Around age fifteen they told me that I would need surgery if I ever wanted to have sexual relations with a man. We discussed this further, but I was very uncomfortable with the idea of further surgical procedures. Having been in and out of the hospital many times as a child, I had the usual fear of needles, doctors, and surgery. In any case, I don't suppose that it is very important now since I am lesbian-identified. If I were even remotely interested in sex with men I might feel differently.

At age seventeen they told me to take birth control pills. This was to keep the hormones balanced in my system. I was told that because of my — still unnamed — “condition,” I was similar to post-menopausal women, and that I might get weak bones if I didn't take the pills. But having suffered the turmoil of a hormonally-induced puberty, and then taking these pills, I felt like I was on an emotional roller coaster: up one day and suicidally depressed the next. The psychologists never discussed this with me, but after a few months I just stopped taking the pills and I haven't taken them ever since. A little risk of weakened bones just doesn't seem worth the pain of being back on that emotional roller coaster.*

I learned about ISNA, purely by chance, at a talk in 1995 by Dr. Anne Fausto-Sterling. Until that time I had never spoken with anyone outside of the medical profession about my intersexuality. In the past I had dealt with my intersexuality by not dealing with it, by simply squashing all my feelings. I kept things to myself. Questions. Problems. Shame.

My mother and I have only now,

over the past year, been able to talk about this openly. I found out from her that after I was delivered they put her out with a sedative and whisked me off to the nursery, where I was given oxygen for the first twenty four hours after birth because I was cyanotic. They also began the standard battery of blood tests, including buccal smears, to determine my genetic sex. These tests came back indicating my genetic sex as being male. When my mother recovered from the sedation, she was not told of my condition. It wasn't until two days after my delivery that she was told about my condition. She was only nineteen, living five hundred miles away from her family and friends, had just gone through childbirth, and was still doped up from the sedative when they broke the “news” about her child's ambiguous genitals. My father was at work and his parents were not there at hospital to be with her either. Their explanation used a lot of medical jargon, and then after confusing her with all of this they asked her if she wanted to see me or not. I guess the doctors believe that a mother who has just given birth would not want to see her child. My mother recalls that when they finally allowed her to see me for the first time, two days after I was born, she felt like she wanted to kidnap me, take me away from the hospital right then and there.

Later that day, when my father was there, they described again my condition and their proposed treatment. By this time the doctors had already decided that I should be assigned female. When they explained this to my parents, they did so in a way that suggested that if I didn't have the recommended surgeries I might die. My parents were given little time to think about what was said, they were pressured into allowing the doctors to go ahead quickly with further examinations and with surgery.

Because of the way I and my family were treated by doctors who are considered to be experts, I am working with ISNA to change the current medical treatment of intersexed conditions. Our stories are slowly becoming known to the general public. We are all around you, but — until now — we have been invisible because we have been silent. It's time for that to change. CQ

** Actually, the risk of osteoporosis for an intersexual whose gonads have been removed by surgeons and who does not take replacement hormones is far more severe than for a post-menopausal woman, because s/he will be without hormones for many more years. Severe osteoporosis is painful and debilitating in the extreme, and should not be lightly dismissed as “weakened bones.” Ed.*



“Daughter of Undetermined Sex,” Nieman Eisman, ca 1920.

"...your clit with its tongue out waiting for my breath."

— Minnie Bruce Pratt

Finding the Words

by Martha Coventry

W

hen I was growing up, and well into adulthood, I used to have a waking nightmare that a squad of men in uniforms would arrive at my door, take me into the night and execute me for not being a real woman. In my mind, they were always justified and I never raised my voice in protest. When my youngest daughter was two and I was 35, I was incapacitated nearly to the point of self-destruction by some unknown shame. I began intensive therapy, desperate to discover why I felt so bad, so tainted, so wrong. One Sunday morning, feeling inches away from disaster, I called my therapist. "I don't know if this is important," I told her, "but I had this operation." There. I had said it out loud, and in that instant a tiny sliver of light appeared.

I knew nothing of what had been done to me when I was six years old. One evening, my mother came into the bathroom where I was playing in the tub. She told me that the next day I would have to go to the hospital for an operation. I remember something rushing out of me at that moment, like wind through a closing door. Did I put my hands down to protect the clit that stuck out innocently from between my labia? Not a word of explanation was ever given for the surgery, and when they cut out my clit, they cut out my tongue. I could not cry out to save myself, and that stifled scream wedged in my throat, blocking my voice. Endless fears about who and what I was took the place of words and they settled like darkness over me.

At age eleven or twelve, I had my first orgasm. Somehow I had brought myself to the edge and I just touched the opening to my vagina and it happened. Shockingly. Perhaps it was this new and powerful experience of pleasure from a place that held so much pain that made me determined to find out the truth about my body. A few nights later I crossed the living room, my bare feet on the cool cork squares carrying me towards my parents, the two people who were my only safety. They sat at the dining room table. Big black and white photos of my sisters and me were laid out under the light. My mother picked mine up and I heard the word “boy” come out of her mouth. Fear heaved in me. I was a boy. I was supposed to be a boy. It was too late to stop myself. “What was that operation I had?” I blurted, as my gut tightened against the blow of the answer. My father, a surgeon, looked at me. The father I loved with abandon. The father who agreed to let this be done to me. The father who cherished me above all else, turned and, with no idea of what his words would do to the rest of my life, said, “Don’t be so self-examining.” The moment of silence that followed that brusque dismissal lasted for almost twenty-five years.

In warfare there is a technique called sapping. Saps are trenches that are dug underground, unseen, silently, beneath an enemy’s fortifications. Eventually the walls collapse under their own weight. To be lied to as a child about your own body, to have your life as a sexual being so ignored that you are not even given the decency of an answer to your questions, is to have your heart and soul relentlessly undermined. The thing that makes you wild and free is insidiously crippled. To reclaim that childhood state of wildness, you have to rescue your own life and learn to speak about who you are. The life you had no power to save when you were three weeks, or eighteen months, or six years old, or thirteen, you have to save at twenty-eight, or thirty-six or fifty-five. You have endless chances. And it is never too late.

So it was at thirty-five that I first started to ask questions, ever so carefully, gently, still protecting the little girl

terrified of her own reflection. I spoke with my father again, asked for my medical records, and heard my gynecologist read me the summary the hospital sent. Both men had the same sensible answer when I asked what sex I really was: I had children, wasn’t that proof enough? No, as a matter of fact, it wasn’t. During this time, I went to a resort in Arizona with my husband. I was fragile, with fear and love of myself battling in my head. For a banquet the first night, I wore a low-cut, elegant dress. My image in the mirror mocked me. My then short hair did not soften my throat, which seemed masculine and muscular. My arms stuck out hard, sinewy, and tan from my sleeves. I didn’t look or feel like a woman. I was in drag. I was a fraud. A mother with two young daughters at home, I spent the entire four days trying to find my

For a banquet the first night, I wore a low-cut, elegant dress. My image in the mirror mocked me. My then short hair did not soften my throat, which seemed masculine and muscular. My arms stuck out hard, sinewy, and tan from my sleeves. I didn’t look or feel like a woman. I was in drag. I was a fraud.

way out of believing I was a man. It was as close as I’d come to losing my identity completely and it frightened me back into total and terrified silence. No more questions, no more exploration. I slammed shut and bolted the door that had so briefly and tentatively opened.

Eight years later, I got another chance. Sex had been my obsession all my life. I started young, playing naked with a girl friend in a sleeping bag, talking another into licking my pussy, being peed on in the woods by a neighbor boy and liking how wrong it felt. My cunt was alive, my scar extra sensitive then to any touch. But wreaking havoc with my budding sexual self was the constant reminder that I was a freak. I was not

right in the place where everyone else was perfect. I wanted to be normal. I wanted to fuck. I wanted to be the hippie girl who smoked pot and got screwed everywhere and all the time. The first part came easily, the second part terrified me. The secret I carried about my body stopped every hand as it began its inevitable descent, and cut short every half-naked romp in narrow cabin beds. In high school, it was the sluts I envied, the girls I thought were so free with their bodies. Everything womanly and sexual, even yeast infections, had its allure.

I fell in love my freshman year in college with a kind and safe boy. One night, in bed, I told him about my operation — that I was different from other girls. He looked up from between my legs, said “Oh,” and went back to lapping happily away. Our first attempt at intercourse was right out of Sylvia Plath — it hurt, I hated it and it didn’t work. I married the boy and we spent hours together loving each other’s bodies, learning to come at the same time using our hands and our mouths. But in this society, and in my mind, it was the old in-and-out that counted. It was my measure of a woman and I was lousy at it. My vagina was shut tight and there was nothing that could be done about it. Not even my children could pass easily through that opening, and had to be birthed by Cesarean section. Years of fantasizing about sex ended with a new shame. A subtle and ever so devastating variation of the old shame.

When the inevitable end came to my marriage, I crashed. It was the response of a woman who was sick to death of being weird, of pretending, of feeling exhausted by a life of envy. Staring me in the face was the unavoidable fact that I was a sexual failure, had never satisfied the man who loved me, and had begun to hate the effort. I narrowly avoided the hospital because of sheer will, the constant attention of my father, my friends and my therapist, and the right prescription. When I surfaced, I found a raw and beautiful new life waiting for me. The Sufi poet Rumi said that the only way out of the pain is into the pain. I began to quit running from the fear and pain of my life.

Instead, I turned to embrace them. In the light of a growing affection for myself and my body, they started to lose their power to harm me. Alone much of the time, I would read poetry aloud and sing out in a new strong voice when I walked my dog at night. I started swimming in the nude more and more. I lay in the woods naked, on the earth, in the leaves. I began to crave the feel of my own flawed body, its smells, the taste of its juices. I found new ways of getting pleasure, new ways to come. Sex with myself got noisy and I loved crying out and hearing the sound explode out of me.

In the midst of this love affair with myself, my father died. He was my hero, always, and my most beloved companion. The profound devotion we had for each other is one of the great blessings of my life. To have me clitoridectomized in order to protect me from being mistaken for a hermaphrodite was not meant as a betrayal of me, but simply one of those most difficult decisions parents make that end up, tragically, to be wrong. Withholding the truth, when I asked him about myself, was a cruelty he could not understand at the time. Our life together was graced with too much love for bitterness to ever have a chance. In the end, his death did a surprising thing for me — it cut me loose to finally live my own life.

Lesbianism had always danced around me. Growing up, I thought that if I were attracted to girls, it would mean I was really a boy. When I read of women who loved women, like Gertrude Stein and Virginia Woolf, I ached at their bravery to claim who they really were. And although I felt an odd bond and natural connection with them, I didn't even dare to play with the possibility myself. I had no idea who I really was, and I was way too afraid to find out. Besides, even if their loving was strange, their bodies were normal. I put myself, again, outside the fold. When I was twenty-two, I went into a gay bar with a friend in Quebec City, where I was studying. I was entranced. For the first time, in that dark and smoky place, I saw women dancing pressed up against each other. I went back to my dorm room and cried for the next four months, filled with anguish at

my desire to return there and my fear at what it would prove about me. In the twenty years that followed, a sadness lived in me always that I would never know that kind of love. With the end of my marriage, the death of my father, and a growing determination to look squarely at my own life, I had no reasons to hold my desire at bay any longer. I was finally ready to let myself slowly fall into the patiently waiting arms of lesbianism. All the queerness I felt growing up finally had a home. Being a dyke fits my strangely hermaphroditic self so comfortably, so wonderfully. It feels totally and deeply right.

Embracing my love for women not only makes me happy, it is the thing that I had been waiting for to give me the courage to look at my body, and at who and what I truly was, without turning away. I could never have found my intersexual self until I had found and loved my sexual self. A friend introduced me to a new gynecologist — a wise, irreverent man — and he and I explored my body in detail. We prodded and spread, measured and probed with my complete medical records in hand, to understand what I might have looked like and exactly what the surgery had removed. I began to write vignettes of growing up, of sex, of gender struggles, of madness.

One of the things about being born with genitals that challenge what is considered normal, is that no one ever tells you that there is anyone like you. You feel completely and utterly alone. Even today, young children are never put in touch with others who are going through the same thing. You are purposely isolated, your difference covered up — and it is horrible. One day, I met with my writing teacher at her house. Next to my place at the table was a newsletter. *Hermaphrodites with Attitude* was written across the top. Upon seeing that word, which still had the power to terrify me, written so bold, so proud, I became suddenly unable to speak, even to breathe. Reading the text, I found my story in other people's words. People I did not even know existed. It was as if my whole life had been lived to reach just this one moment. I took the newsletter home, and for days and days would pick it up

in disbelief and hold it to my chest like a talisman.

And so it started, the strength that comes from finding those like you. The words that used to frighten me, make my skin crawl, like *gender* and *hermaphrodite*, roll off my tongue easier now. They are beginning to belong to me. I will never find the words of my six-year old self, and that is fitting. Today I have the reasoned and educated voice of a grown woman who knows harm when she sees it and is increasingly growing strong enough to name it and try to stop it. Saying this does not mean I am always brave, because I'm not. Speaking out as an intersexual, as a hermaphrodite, I go forward, but I also still retreat to protect myself. At one moment I may tell a friend my story, talk knowledgeably about it on the phone with a stranger. But then the subject comes up in a room full of people, and I speak in generalities, as if it were something that happens to other people. And I feel that silence between my legs, the place that sets me and my past apart from most other women. But I'm kind to myself when I can't quite tell the whole truth, as all intersexuals should be. We have lifetimes of shame to overcome and, for most of us, this has been a secret that we have guarded with our lives and at great expense. Coming out as a hermaphrodite has its own precious timing. You can't peel the chrysalis off a butterfly and expect it to survive any more than we can speak out, or even face our own truth, before we are ready.

If you are intersexed, listen to your heart — slowly you will emerge. It takes commitment and courage, it is frightening, but not nearly as frightening as that monster you created all those years out of your own sweet body. As you tell your story, and tell it again and again, a sort of transformation takes place. You start to speak for all intersex people who have ever lived and are yet to be born. Your intensely personal story drops into the background, and what comes forward is your story as myth, as a kind of transcendent truth. Try to love yourself enough to free your hermaphroditic voice, so we can all claim our lives, and the bodies we deserve to celebrate. CQ

Cont. From p. 10

stenosis: Narrowness. A condition of meatuses and minds.

surgical sex reassignment (infant): Making a sow's ear out of a silk purse. Known to cause deafness.

testosterone: An *androgen* taking its

name from the test in which it is applied to a micropenis. Micropenises that do not grow must be cut off; if they do grow then no further treatment is needed. Compare the water ordeal, beloved of witch-hunters, in which witches that float must be drowned, while those that

sink may remain as they are. We Americans may be justly proud at the advances in our enlightened Society.

urologists: Those benefactors of humanity who, with considerable difficulty, distinguish intersexed infant boys from intersexed infant girls. These infants, when grown, may with

I pray that some day I will have the means to repay, in some measure, the American Urological Association for all they have done for my benefit. I am having some trouble, though, in connecting the timing mechanism to the fuse.

(From a letter to ISNA, reprinted in Hermaphrodites with Attitude)

The drawing below is by Charles Rodrigues. Mr. Rodrigues is a prolific artist whose cartoons have appeared many times in Playboy, Stereo Review, and the late National Lampoon. Although we made queries to Playboy and Stereo Review and looked in vain to find contact information in his book *Total Harmonic Distortion*, and even searched the World Wide Web, we were unable to locate Mr. Rodrigues to ask permission to reprint his work. We beg his forgiveness.



This short story was previously published in the Winter 1994 issue of Libido Magazine.

(Not) Another Clit Story

by Cheryl Chase

Karen sat on the edge of Zara's bed and her body began to shake. It was late, and the two women were tired. Karen had flown into town to speak on a panel organized by Zara. In the course of the evening, Zara's film had been screened several times, perhaps one time too many for Karen.

The images came back to her now. Zara speaking, recalling her own initiation ceremony in Mogadishu. "The worst was the sound of the scissors, cutting, snipping, taking away part of my body." There was fire, but no tears, in her eyes. She had the dark olive skin, beautiful features, and thick black hair of a Somali. Karen was strongly attracted to her. With each screening the video Zara recounted the story, and Karen's imagination filled in the image of 13-year-old Zara struggling, struggling and losing.

The images came back and she was overwhelmed with grief. So much destruction, so much unnecessary pain. She wept for Zara and for herself, for African girls and for American infants. "Why are you crying now? Was someone cruel to you there today?" Karen recalled the reactions as she spoke about how surgeons had removed parts of her genitals while still an infant, how it had been kept secret from her. A strange resistance seemed to come over her listeners, some of them physically drew back from her. They had come to learn about *African* clitorrectomy. But cruelty? No, no one had been cruel to her.

Zara put her arms around Karen, looked close into her face. Karen shook her head, tried to speak, but her voice failed her. She couldn't understand how Zara could remain so calm, controlled. "It's ok, baby. Go ahead, cry all you want to. I still cry, God knows I do."

Author's Note

I wrote this story in 1993, before ISNA was founded. I had not yet met another woman who had been clitorrectomized because she was intersexual, but I had met some African women who were working to eliminate clitorrectomy in their countries. In this piece of fiction, I projected my own experience of sexuality onto an African woman. Please read it with that understanding; it is not my place to say what another's experience is.

"I've never seen you cry."

"I cry, but I can't cry in front of anyone. Maybe I'm gonna be able to do it with you, sometime."

They wrapped their arms around each other and rocked, Zara speaking, stroking her friend's hair. Gradually Karen's tears subsided, she pushed her grief back down to its usual hiding place, and another feeling rose up in its place. She rubbed her cheek against Zara's, pressed her lips, moist and swollen from crying, against Zara's. She drew her head back slightly, searched delicately with her tongue in the corner of Zara's lips. She opened her eyes briefly, the better to appreciate the effect of this delicate touch on Zara's countenance.

Zara let her head roll backward, moved her hands up into Karen's hair and gripped. She released the two fistfuls of hair and slid the fingertips of one hand down Karen's neck and across her shoulder, producing a shudder. Karen cupped one of Zara's breasts in her hand, feeling the soft flesh through the thin silk. Zara's pelvis began to roll, just perceptibly. Karen wrapped both arms about her, enjoyed the feeling of breast against breast, and of both their breasts against the inside of her own arms. She drew breath, slid her right arm up Zara's back, tunneled the fingers into the mass of black hair. A little purr of pleasure escaped the Somali woman's lips. Karen's hands moved down now, and Zara put her arms up as her blouse was slipped off over her head.

Karen looked, appreciated the full round feminine figure, laid Zara back

across the bed, and slipped out of her own dress. She stroked her face, running fingertips over forehead, cheeks, chin, sliding across to the earlobe. She lay her body down onto Zara's, took earlobe between her teeth, tongued it as the two women pressed bellies, thighs together. She rolled onto her side, Zara's face followed and their mouths came together. As tongues explored lips, teeth and tongue, Karen's hand stroked Zara's breast and belly, her fingers sliding into her pants. She removed her hand and slid it between Zara's thighs, pressed upward, and felt the growing warmth and dampness there, the more insistent motion now of Zara's hips.

Zara unfastened her belt buckle, and three hands cooperated to slide pants over hips, past thighs, knees and ankles. Returning her attention to Zara's ear, Karen took the outer circle of cartilage between her teeth, applied gentle pressure. She traced out its inside diameter with her tongue, directed a measured volume of hot moist breath into the deeper recesses as her hand stroked buttock and lower back. Zara squirmed, goose flesh rose on her arm and thigh. Karen's tongue slipped around now, pressed behind the ear, tickled the hairline, then worked down Zara's neck. She took a large area of flesh into her mouth, compressed it with her teeth, and a spasm passed through Zara's back, her body bucked. Adjusting her position, Karen reached further around and lower, bit into another mouthful of neck and shoulder muscle as she raked nails up Zara's back, and was rewarded this time with a delighted squeal.

Karen found herself pushed over onto her back, and she stroked Zara's hair and back as tongue and teeth traced out her own nipples, skimmed across to her underarm. As this reversal was repeated several times, heat rose and swelled in the two women.

Now Karen ran her tongue down the crease between belly and thigh, used one hand to urge Zara's thighs apart wider. Avoiding the broad pad of scar in the center, she lapped along the sensitive flesh outside what remained of Zara's lips. A moan escaped from deep inside of Zara, and Karen pressed on, down and back, tonguing the intact flesh behind her vaginal entrance as she brought both hands under buttocks and around hips, stroked the other woman's belly.

Zara rolled onto her side and raised one knee. She stroked her own side as Karen's tongue slid further back, circled the opening which was now revealed to her. She slid a finger at the same time gently into Zara's vagina, pressed and swirled it, careful to avoid too much pressure against the scarred entrance. Her other hand searched out a foot, she slid fingers between toes. Zara's energy grew and grew, was expressed in her voice, her breathing, the rocking motion of her hips.

Their bodies intertwined, Karen pressed and Zara strove, hips thrusting. They continued so until Zara, finally tiring, brought her hands down and took hold of Karen's face, directed it up until the women were face to face again. Karen held Zara tightly, stroked her gently and whispered to her while her energy subsided, her tension slowly eased, the rocking motion of her pelvis gradually receded. CQ

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Adult Psychotherapy • Sex and Relationship Therapy

"I am happily working with several transgendered people now and would appreciate any future referrals."

Paper presented as part of a plenary symposium titled "Genitals, Identity, and Gender," at the Society for the Scientific Study of Sexuality, November, 1995, San Francisco.

Meanings of Gender Variability

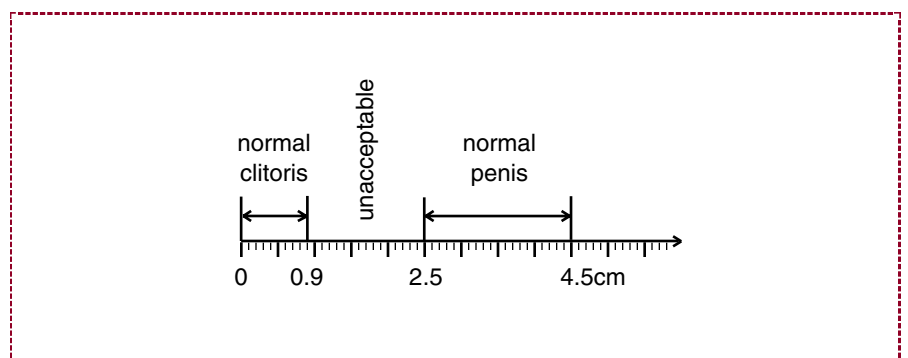
Constructs of Sex and Gender

by Suzanne J. Kessler

Purchase College, State University of New York

In our world there are two different kinds of genitals to mark the two genders. In spite of this apparently obvious fact, there is a natural range of genital formations within the two genders. There is variation in penile and clitoral sizes, labial lengths, vaginal depths, degree of scrotal fusion, and amount of testicle mass.

Figure 1. Clitoral & Penile Non-Erect Lengths at Birth (cm)



Medical standards permit infant penises as small as 2.5 centimeters to mark maleness and infant clitorises as large as 0.9 centimeters to mark femaleness. Infant genital appendages between 0.9 cm. and 2.5 cm. are unacceptable (Fig. 1).

Table 1. A Comparison of Terminology

	Pre-Surgical Genitals	Intervention	Post-Surgical Genitals
Medical	“deformed”	“create”	“corrected”
Alternative	“intact”	“destroyed”	“damaged”

Table 2. Possible Meanings of Variable Genitals

1. Your genitals signify neither of the two gender categories. We need to know what gender you are, therefore we must do further testing. (This meaning implies medical diagnosis, but not necessarily surgical intervention.)
2. We know your gender. Your genitals signify the wrong gender. We must operate to make them conform to the right gender. (The “must” implies that surgery is a medical advancement.)
3. We know your gender. Your genitals, although not within the normal range for your gender **now**, will be in the future. We expect they will clarify on their own. (For example, children with 5-alpha-reductase deficiency raised as males).
4. Your genitals are providing a clue that there is an underlying medical problem that needs to be addressed. We prescribe a non-surgical treatment. (For example, medication for children with the salt-losing form of CAH.)

Meanings 1, 2, and 3 assume a link between genitals and gender and reflect the viewpoints of the medical establishment, which has strict criteria for genitals and technical solutions for variations. Meaning 4, although medical in its outlook, doesn't link the meaning to gender. This *could* be the primary medical attitude, in a different world.

Table 3. More Possible Meanings of Variable Genitals

5. Your genitals are inferior (less functional, ugly). We pity you and suggest you have corrective/cosmetic surgery.
6. Your genitals are superior (more versatile, attractive). We envy yours and want ones like them.
7. Your genitals are just another body-part that varies from person to person, like noses and ears, and it doesn't matter what they look like as long as they function well. We don't think that much about your genitals or our own.
8. Your genitals signify something about your parents. They have misbehaved or are genetically unsuitable. They are embarrassed by you and your genitals.

Meanings 5, 6, and 7 reflect a conceptualization of the genitals as either aesthetic objects or as just another body part. Meaning 5 is promoted by some plastic surgeons, while meaning 6 is promoted by some members of the transgender community. Meaning 7 might be something worth working toward. Meaning 8 is, I believe, is at least part of the significance given by some parents to their childrens' genitals.

Genitals that don't meet size and shape standards are typically referred to by physicians as "ambiguous." Some are ambiguous in the sense that they don't clearly match either the male or female gender. Others are "ambiguous" because, even though they match one of the genders, they don't do it very well. They aren't good representatives of the genital category. For example, the penis is a micropenis or the clitoris is enlarged. The scrotum is not fused enough or the labia are too fused. Pediatric surgeons "fix" these genitals, so that we end up with diminished genital variability within the genders, and exaggerated differences between the genders. It's not just infants and children who are subject to efforts to "correct" genitals that aren't "good enough." In a world where fashioning the perfect body is more and more of an obsession and technical solutions are more and more available, it's not surprising that there are adults deciding to exercise their right to reshape or ornament their genitals. Men and women are piercing their genitals; some women are getting their labia trimmed; some men are getting their foreskins restored or their penises thickened.

At the heart of this issue are assumptions about how seriously to take genitals and what genitals are essentially for. Are they essentially for signaling gender — in that sense a guide for physicians and parents? Are they essentially for ornamentation and pleasure — in that sense for oneself and one's sex partners?

Let's look at some of the terminology (see Table 1): On the first line is the conventional terminology of medical professionals. On the second line is an alternative terminology used by critics of the "status quo," including members of the intersex advocacy movement and members of the anti-circumcision movement. For example, the latter describe circumcision as "amputation." Instead of referring to foreskin removal as a "snipping" of the foreskin as physicians would, anti-circumcision activists write about "*stripping* of the glans" and even "*skinning* the infant penis alive." They accuse the medical profession of being inconsistent by treating circumcision as natural since, when on rare occa-

sion a male is born without a foreskin, it is noted in his records as a birth defect, suggesting that the foreskin should have been there all along. Intersexuals, who are politicking to change the way the medical profession thinks about intersexuality, argue that the term genital "ambiguity" is predicated on assumptions about the naturalness of two genders, and actually creates the intersex category. The term "variability" that I've used in the title of my talk is deliberately neutral.

Who has the power to name? Those who are happy with their own surgically altered genitals, or their children's, or their patients', never refer to circumcision or intersex surgery, or other genital surgeries as "genital mutilation." In contrast, some of those who are subjected to such surgeries never refer to them as "medical advancement."

I would like to explore some possible meanings of genital variability (Table 2). Meanings 1, 2, and 3 assume a link between genitals and gender and reflect the viewpoints of the medical establishment, which has strict criteria for genitals and technical solutions for variations. Meaning 4, although medical in its outlook, doesn't link the meaning to gender. This *could* be the primary medical attitude, in a different world.

In addition to these four meanings, there are four others (Table 3). Meanings 5, 6, and 7 reflect a conceptualization of the genitals as either aesthetic objects or as just another body part. Meaning 5 is promoted by some plastic surgeons, while meaning 6 is promoted by some members of the transgender community. Meaning 7 might be something worth working toward. Meaning 8 is, I believe, at least part of the significance given by some parents to their children's genitals. I won't talk about that today.

It is obvious which meanings have more authority now — the ones that reify gender. We need to think more about the advantages and disadvantages of acknowledging or promoting genital variability. I don't have much time to talk about this today, but it is something I am working on.

I'm proposing here, at least as a working hypothesis, that it would be good to broaden the criteria for what

constitutes normal looking genitals. Larger-than-typical clitorises and absent vaginas should be acceptable for girls and smaller-than typical penises and misshapen scrotum should be acceptable for boys. In other words, what we mean by a female or a male must be given more latitude in the body, just as people have been arguing for more latitude in behavior. How would such a genital re-conceptualization start, and how would it impact on ideas about gender?

It's striking that in the medical literature, although ambiguous genitals in and of themselves rarely pose a threat to the child's life, the post-delivery situation is treated as life-threatening and the genital surgery is described as necessary. Yet I've delineated three categories of distinguishable genital surgery:

- 1) saves life
- 2) improves quality of life
- 3) satisfies social needs

1) Some genital surgery is *life saving*, e.g. a urethra needs to be re-routed so that the infant can pass urine out of the body; 2) Some surgery *improves the quality of life* — e.g. the urethral opening needs to be redesigned so that the child can eventually urinate without spraying urine on the toilet seat; and 3) Some surgery is *social* [e.g. the penis needs to be refashioned or enlarged so that the (eventual) man will feel more manly and be better able to satisfy his sexual partner].

The focus of my work is on the third category and how it is too often merged with the other two. Medical professionals discuss how important it is that genitals look "right" as a potential life or death issue, with the assumption that "wrong" or "bad" looking genitals can have serious, perhaps fatal psychological consequences. This is a largely untested hypothesis.

Despite this rhetoric, though, there is very little research on what people think about how their genitals look. I've collected some preliminary data on what college students think about their genitals and will be reporting today only on answers to one set of questions. The women were asked: "Suppose you had been born with a larger than nor-

mal clitoris and it would remain larger than normal as you grew to adulthood. Assuming that the physicians recommended surgically reducing your clitoris, under what circumstances would you have wanted your parents to give them permission to do it?" The men were asked to imagine being born with a smaller than normal penis and told that physicians recommended phallic reduction and a female gender assignment. All the subjects were shown a scale with the normal ranges for clitorises and penises demonstrated in actual size, and labeled in centimeters. It's reasonable to question exactly what we can infer from these subjects' answers, but I'll first report the findings.

About a fourth of the women indicated they would not have wanted a clitoral reduction under *any* circumstance. About half would have wanted their clitoris reduced *only* if the larger than normal clitoris caused health problems. Size, for them, was not a factor. The remaining fourth of the sample *could* imagine wanting their clitoris reduced if it were larger than normal, but *only* if having the surgery would *not* have resulted in a reduction in pleasurable sensitivity. Only one woman mentioned that other people's comments about the size of her clitoris *might* be a factor in her decision to have surgery. My analysis of medical follow-up studies suggests that clitoroplasty and vaginoplasty results are far from perfect. For example, scarring, insensitivity and discomfort are not uncommon. These results are confirmed by an independent meta-analysis by biologist Anne Fausto-Sterling and sexologist Bo Laurent. Given these findings, my sample's hesitancy about genital surgery under most circumstances ought to make physicians think more about whose needs they are serving when they recommend genital surgery for infants and young children.

What about the men? All but one man indicated they would not have wanted surgery under any circumstance. The remaining man indicated that if his penis were 1 cm. or less *and he were going to be sterile*, he would have wanted his parents to give the doctors permission to operate and make him a female. Granted the males were given a

different and more difficult choice to imagine than the females — either living as a male with a small penis or not being themselves at all, being a female. You could argue that because of this impossible choice, their wish to live with a small penis is uninformative. And yet, these men know what is required to be a male in our culture, and they seem to be saying that it is possible to be a male, regardless of the size of their organ.

There's no reason to expect that college students' suppositions about what they would have wanted as infants matches what prospective parents would want for their infants. I'm guessing that parents would be more conservative in their choice of genitals for their children. (And I should have data available soon on that point.) What would a difference in perspective between the hypothetical grown up infant and the hypothetical parent mean? I don't believe that parents' predictions about what's in store for their children without surgery are any more likely to be accurate than college students' predictions about what it would have been like to grow up with genitals that varied from the norm.

Given this inability to predict, should physicians continue to satisfy the parents' need to have a presentable child? Or should physicians be more attuned to the potential needs of their patients? One argument physicians make to justify doing immediate surgery on intersex infants is that this will maximize the child's social adjustment and acceptance by the families. Implicit in this defense is that the genitals themselves carry the burden of evoking acceptance. There's no sense that the burden is (or ought to be) on the parents to learn to accept the genitals. One endocrinologist who specializes in treating intersexed infants said in an interview with a reporter that not doing the surgery would be unacceptable to parents because "some of the prejudices run very deep." This assertion ignores the fact that many prejudices that physicians collaborate in maintaining have changed over the last few decades. For example, in the 1990s psychiatrists are at least somewhat less likely to accede to a parent's wish to

"transform" a homosexual adolescent into a heterosexual one than they were in the 1950s.

Because physician-researchers (and not parents) publish articles, the parents' perspective is missing from most discussions of intersex management. One mother who was dissatisfied with the level of support provided by the medical profession wrote a letter to a woman's magazine asking to hear from other parents who had a child with Congenital Adrenal Hyperplasia (CAH), a condition that sometimes involves non-typical genitals. Over the next year she received letters and phone calls from more than a hundred different people, mostly parents who had never talked to anyone outside their family about their child's condition and who had never personally known of another family with a CAH child. She generously allowed me to read these letters, and they provide a glimpse of what the parents of intersex infants think about their "education" from the physicians and what they think about their intersexed children. I don't have time here today to discuss all of what I learned from these letters, but instead will confine myself to a few issues related to the meaning of genital variability. It seems to me that some parents are taught by the doctors that what looks like a perfectly normal child to them, is not. They are taught to ignore their sense that the genitals are unremarkable and just another feature in the context of a beautiful baby. The physicians, as authorities, define the genitals as outside the normal range, and are often granted the authority to undertake any kind of alteration.

One parent wrote, "He was a perfect male, but his testes never dropped into the scrotum." Another said, "She was born perfectly healthy and looking like a girl — but she had skin fusion, and no opening to her vagina, which her urologist wants to correct soon. Another mother wrote, "We thought we had two perfectly healthy children. The bomb fell when I took [my daughter] to her two week check up. Her pediatrician discovered that she had no vaginal opening. He very gently told me that she had what was called

“ambiguous genitalia.” Although the parents needed to be educated about their child’s *medical* abnormality, from a “looks” point of view, what they saw looked normal to them. Each example suggests that some parents do not have as strict criteria for what constitutes normal genitals as the physicians who have diagnosed an underlying disorder. In another family the presumably normal baby girl was taken home after the birth only to be returned to the hospital six weeks later with breathing difficulties. The mother wrote, “They told us she may possibly be a boy. Her clitoris was enlarged but her vagina had only closed partially. However the lips that overlap the vagina had not formed. Tests proved she was definitely a girl and a very slight operation around one year old opened her vagina to the proper length. That was all the surgery she needed. The large clitoris now seems smaller as her new body has grown around it.” There are two important points about this last example. First, this girl with an enlarged clitoris and unusual labia was unremarkable to these parents, and presumably to the physicians who delivered her, until it was discovered a month and half later that she had CAH. Second, clitoral surgery was averted by just waiting long enough for the body to grow, a management strategy that is not followed often enough. How many surgeries might be avoided if physicians would just wait and let nature take its course — “nature” being either the body changing on its own and/or the parents coming to accept the genitals as a reasonable marker of the child’s gender?

The physicians, and subsequently the parents, place disproportionate emphasis on how the post-surgical genitals look, as opposed to how well they function. A number of the letters contained general assertions about the “success” of the surgeries in terms of how the genitals look. For example, after a second clitoroplasty a six-year-old girl’s mother wrote, “It looks better than it did, but my husband thought maybe another operation, but I think it’s fine like it looks now! Her vagina looked good so they left it alone and they said she might not have to have the third operation if her vagina stays good...

Lately she’s been saying it hurts down there.... It looks fine on the outside.... I’d say all in all she did very well with the surgery.”

Based on other data, I believe this mother, who takes comfort in thinking that the physicians won’t require further surgery, may be overly optimistic. Because parents are not equal partners in the *diagnosis* (which, of course, they shouldn’t be because they have no medical expertise), they aren’t equal partners in the surgical decision. They take the surgeon’s recommendations as to what kind of surgery to give their child and when to have it as more than just recommendations. I’m not saying that parents are dissatisfied with this arrangement. Given the medical worries some of them have, they are probably relieved to have this aspect of the condition handled by someone else and solved for good. If there is anxiety about whether their child is really a male or a female, that too has been managed and erased by expeditious surgery. Not all parents are successfully socialized to see it the physicians’ way. One mother I’ve been in contact with has a son with the supposedly embarrassing problem of a micropenis. With the support of one physician she opted *not* to change the child’s gender. His micropenis seems not to be a problem for her. She has no difficulty thinking of her son as male. Intersex surgeries can be traced, in part, to the taking of both gender and genitals too seriously.

Although it’s unlikely mainstream America will embrace a third or fourth category in the near future, I believe people *can* learn to accept more genital variation. Although doing so will (at least temporarily) maintain the two gender system, it might help unlock gender and genitals. This could ultimately subvert gender by subverting genital primacy. Gender will be shifted from the biological body onto the social interactional one. So even if there are still two genders, male and female, how you do “male” or “female,” including how you do “genitals,” will be expanded. I’d like you to imagine the following communication from an obstetrician to the new parents: “Congratulations, you have a beautiful

baby girl. The size of her clitoris is providing a clue to what might be an underlying medical problem that we’ll need to treat. I’ll consult an endocrinologist about any possible medical treatment. Although her clitoris is on the large side, it’s definitely a clitoris. Who knows what it’ll look like as she grows? Some parents don’t have a realistic sense of what a baby’s genitals look like. You probably haven’t seen that many, but I have. No, we won’t need a surgeon, since there’s nothing we need to do about the clitoris. The important thing about the clitoris is how it functions, not how it looks. She doesn’t have a vagina now and she can decide whether she wants one constructed when she is older. Surgical techniques will be more advanced then and her grown body will tolerate the surgery better if she chooses to have it.”

I mentioned earlier that some adults are deliberately altering their genitals, treating their genitals as innate but malleable, much like hair in our culture. Will this lead to greater acceptance of natural genital variability in infants and fewer infant surgeries? I’ll admit that I’m concerned that promoting elective genital surgery could lead to *less* tolerance of variability, rather than more. The analogy to noses is obvious. People choose the small upturned one, characteristic of the privileged class, rather than a variety of wonderfully ethnic ones. Given that pattern, what will happen if it becomes fashionable to alter one’s genitals? Will this mean that everyone — female and male — will elect to have large phalluses like the privileged gender, or will it mean that males, evoking their privilege, will restrict large phalluses to males and demand that *more* females have their clitorises reduced? This is a risk we need to consider as we express tolerance for adult genital experimentation. Everything hinges on our understanding that there is no one best way to be a male or a female or any other gender possibility — not even in terms of what’s between your legs. Accepting *genital* variability will need to occur in the social context of accepting *gender* variability. And in that acceptance lies the subversion of both genitals and gender. CQ

Date _____

Operations Exploratory laparotomy, biopsy of gonads, clitorectomy

Pre-operative Diagnosis:	Female pseudohermaphrodite.
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enlarged clitoris, with a fairly normal separate vaginal and urethral orifice. It was demonstrated that the child was born, and did not have a hernia. The abdomen, the pelvis and the genitalia were found to be normal.

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Father's full name D. Arthur J. Sullivan
Husband's or wife's name L
Mother's full maiden name D

Name changed
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Name changed from Arthur J. Sullivan

1-26-58

Husband's or wife's name L
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a separate vaginal and urethral demonstrated that the child born, and did not have the abdomen, the found to be

11

identical rounded soft pale yellow, and a elongated, and of firmer side the biopsy was taken from and on the right from the lateral of any vestigial structures. The labial empty.

Procedure:

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Service of
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Anesthetist

CLITOROMEGALY

PRE-OPERATIVE DIAGNOSIS
POST-OPERATIVE DIAGNOSIS
OPERATION (Standard Nomenclature) PARTIAL CLITORECTOMY

..... girl presented with an enlarged clitoris secondary to intrauterine
..... progesterone.
..... draped in the usual manner. With pen and ink
..... marked out on the clitoris with the apex
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This little girl presented with an enlarged clitoris secondary stimulation by progesterone.

The patient was prepped and draped in the usual manner. With pen and ink a U-shaped dorsal incision was marked out on the clitoris with the apex at the base of the pubis. With the glans and clitoris under tension, the U-shaped incision was carried out around the dorsal aspect of the clitoris to the glans. The dorsal hood of skin was then removed and heavy dexton sutures were placed through the base of the crura of the enlarged clitoris. The redundant corpora was then excised dorsally. Hemostasis was obtained by coagulation. The glans was then recessed into the infrapubic area with several fine dexton sutures and then the skin approximated as a new clitoral hood with interrupted fine dexton sutures. The patient tolerated the procedure well and returned to the R.R. in satisfactory condition.

Specimen: Gonad biopsy and cl

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 None
 Gonad biopsy and clitoris

Hypospadias, in which the pee-hole exits the penis not at the tip, but somewhere along its underside, is quite common, occurring in nearly one percent of all males. Some men who have had hypospadias surgery are left with strictures — scarring in the urethra which can tighten up and prevent the passage of urine. Inability to urinate is very painful and can become a life-threatening medical emergency. In this article, Sven Nicholson provides a step-by-step guide to using graded catheters at home to open up your own urethra, eliminating regular visits to a urologist — Ed.

Take Charge!

A Guide to Home Catheterization

by Sven Nicholson

I am now forty-four years old. When I was eleven, I had three operations to repair hypospadias. These operations were performed by a competent physician who considered my family a charity case and never sent us a bill. The artistry of his work has been commented on by most urologists who have subsequently examined me. He sincerely believed this was the best treatment for me, and did the best job he could. However, a stricture developed within two months of the final operation, and ever since my life has been drastically altered.

After these operations, my family moved. The next physician used a dilating procedure where a thin catheter was inserted, curling up inside the bladder, followed by a thicker catheter. Each increase in thickness required the lead catheter to curl up inside the bladder. It drove me crazy, but then we moved again, and the procedure used by the physician in the new neighborhood was worse.

He used steel probes to force the stricture open. The gruesome procedure had the same outcome every week: urine passed freely but painfully immediately after the procedure; then the stricture clammed up again a few hours later. Again and again my father had to drive me to the physician's home in the evening in order to open me up again. Though this physician was a professor at a research hospital, he never varied his technique or tried to solve the post-procedural problem.

Finally, I began to commute to a physician in another city who used a different set of catheters, made of rubber. Including the commute, the visits took about ten hours, but the problem of “clamming up” did not recur, to my great relief.

Throughout my teenage years, physicians seemed to take the attitude that my condition could be somehow healed through a catheterization regime. In my early twenties, the physicians dropped this pretense. When I finished college, I became a lay missionary for my church. The mission board physician asked my urologist for a letter stating that my condition would not cause problems overseas. The physician gave me a set of silicon-coated catheters and instructed me in their use. His casual attitude reassured me, “You can live anywhere in the world, as long as there’s soap and warm water.” However, he was extremely reluctant to commit this to writing; in retrospect, I think that he did not want to create any written statement that a medical condition such as mine can be casually and easily treated by the patient himself. In any case, he wrote the letter (which I never saw) at the last minute and gave me a generous supply of anti-bacterial sulfa drugs and anesthetic lubricant, and I was on my way.

For several years I continued to visit physicians in order to receive prescriptions for anesthetic jelly and anti-bacterial sulfa drugs (gantrisin or gantanol) to protect against bladder infection while catheterizing myself. In my mid-thirties, I visited a urologist who refused to prescribe these drugs unless he first performed another surgery on me, to the tune of several thousand dollars. I determined to learn how to open my urethra without any prescription drugs.

I consider self-catheterization a vast improvement over visits to the urologist’s office. The physician who gave me the catheters did so reluctantly, only because I was traveling overseas, and resisted making any kind of statement in writing about the ease with which this procedure could be performed by the patient himself. This reluctance probably has two sources; the first and obvious motivation is financial gain. The second is that any profession-

al has seen amateurs botch things up, and naturally feels that s/he can do a better job. Regardless of the physician’s attitude, I believe the patient is best served by obtaining his own set of catheters and treating himself.

I still use the set of silicon-coated catheters (sizes 14 to 24) I received before going overseas; they remain in perfectly good condition. The following paragraphs describe my “theory” and “method” of self-treatment, using this set of catheters.

Long-term Problems

I catheterize myself about once a week. The urinary tract is normally sterile; though it involves no cutting, this is a surgical procedure performed at home, and I take it seriously. The problems encountered in treating urethral stricture by catheterization are: bladder infection; physical pain; various involuntary rejection reactions, including desire to urinate; and unnecessary stimulation of the prostate gland.

Bladder infection

The key is not drugs but simply to force fluids. On the day of catheterization I drink a lot of water and acidic fruit juices. On some occasions when I have been careless, I have developed infection serious enough to cause fever, but cleared it out simply by forcing fluids.

A frequent desire to urinate may be a sign of bladder infection.

Another reason for forcing fluids is the soothing effect of passing a large amount of water soon after catheterization. This always makes me feel better. Diuretic teas, available in health food stores, help the body to expel liquid by irritating the bladder. If you do develop a bladder infection, you may want to use these teas, but I think the irritation is a negative factor (this is true of caffeine, too).

To better understand the principle of forcing fluids to avoid bladder infection, envision bacteria: they like to live in colonies. A single bacterium by itself cannot produce enough chemicals to destroy the mucosal lining of the bladder, but a colony can do this. By constantly diluting the colony and the

chemicals they produce, you make it impossible for them to live and reproduce.

Water is really the best, being free of nutrients for the bacteria. Pure cranberry juice (almost undrinkably sour) is next, but it’s difficult to obtain. Sweetened cranberry juice is useful, but contains lots of energy for the colonies you wish to destroy.

It is not advisable to insert the catheter all the way into the bladder. This is what causes bladder infections. As long as the widest part of the catheter is acting against the stricture, that’s the main thing.

Physical pain

Involuntary rejection reactions

Unnecessary stimulation of prostate

I don’t understand these completely, but they are all factors that I consider in living my life and developing my procedure. There are psychological links between physical pain and stimulation of the prostate, but I don’t think in “psychosomatic” terms. Rather, I have noticed that my urethra has a mind of its own, and I need to pay attention. Sometimes it wants to clam up, to prevent the introduction of any catheter. At other times it’s yielding. Sometimes it gets inflamed, even angry. I don’t think of it as a “voice” that I must “listen” to, but over the years I’ve developed some ideas about what it wants and what makes it happy. Similarly, my bladder and my prostate also have their own ideas about the things that get done to them.

Basically my approach is to reduce stress and make the experience as pleasant as possible for everybody.

My Procedure

If I have gone, say, two or three weeks without catheterization and I know my urethra is getting tight, I will be especially careful to use over-the-counter analgesics such as aspirin, Tylenol, and Ibuprofen twenty minutes before catheterization (sometimes I use all three; I’ve never checked if this actually increases effectiveness or not). I do not use wine or marijuana because these drugs throw the judgment off.

Alcoholic beverages deaden the sense of touch. Under the influence of alcohol, I might force the catheter in roughly, only to feel the effects later on. Caffeine enhances the effect of aspirin, but it also makes the hands jumpy and irritates the bladder. This might cause a “spastic” desire to urinate later on. (The effect is slight; I usually have coffee every day whether I plan on therapy or not.)

Relaxing atmosphere

At first I simply sat on the commode and treated myself, but this is an extremely uncomfortable position for catheterization and psychologically reinforces the inherent ugliness of the act.

It's far better to think of catheterization as one type of personal grooming. I like to shave when I'm taking a bath or shower. My skin is more relaxed and cooperative, and I seem to be able to shave an extra millimeter or two off each whisker. I recommend that catheterization be integrated into the bathing routine. In detective novels, one sometimes reads about someone who slashed their wrists in the bathtub. The reason? The hot water deadens the pain.

I rate locations as follows: (1) hot bath; (2) hot shower; (3) in bed while e.g. reading an absorbing book. Warmth during and after the operation are essential. During the winter, plan on staying indoors afterwards.

I have noticed that if a “spastic” desire to urinate occurs, it usually happens during cold or chilly weather.

Choice of salve

After forsaking prescription drugs, I first used KY jelly. Then medicated jellies began to appear in the drug stores for males who had difficulty maintaining an erection during coitus. The jelly works by deadening the penis. This is an inexpensive way to treat the immediate pain. Medicated jellies might not be available over-the-counter in foreign countries, so bring extra tubes when you travel. In an emergency, you might use almost any household oil to lubricate the catheter, even butter or olive oil. However, the oil will heat up due to

friction when the catheter is introduced, so in this case, you must be extra slow.

Some commercial brands of medicated jellies are *Detain* and *Maintain*. The *Maintain* label says: “desensitizing lubricant for men. Active Ingredient: Benzocaine 7.5% in a water washable base. Also contains Carbomer, Polyethylene Glycol.” The carrier jelly itself is water soluble, but one of the other ingredients seems to be insoluble in water and soap. I find this ingredient slightly irritating and I hope I never develop an allergy to it, because it would be hard to live without it.

The insoluble ingredient seems to cling to the skin, and the urethra produces a mucous to wash it out; this process takes a little over 24 hours, during which time mucous will likely come in contact with the scrotum and adjacent areas. For this reason, plan to change underwear after the operation (say, 4-6 hours later), and take a shower before you go to bed. Although the ingredient doesn't seem to be water- or soap-soluble, it does respond to washing; perhaps it is the mechanics of sluicing water.

Catheterization

When I was visiting physicians during my teenage years, a major emphasis was placed on dilation up to 24 Foley. I'm not sure that my masculinity depends on the internal diameter of my urethra; in terms of plumbing, anything about 14 is fine.

I prefer to perform the operation in the bathtub. Immediately prior to inserting a catheter, I wash it with warm water and mild soap (e.g. “Dove”; I'm allergic to stronger soaps). I also wash the area around the genitals more than once. Sometimes I hold the catheter in my teeth while I wash my genitals (so it doesn't have to touch anything); in this case, I hold the “distal” end (not the end to be inserted).

I usually begin catheterization by applying the medicated jelly to a 14 catheter and introducing this to deaden the tissue in the urethra. At the same time, I apply it to the outside of the penis; the chemical seems to penetrate through the tissue. The purpose is to make the tissue numb, not to widen the stricture.

Then I wash my hair. Then rinse. Now the urethra is numb. Then I wash the 16 catheter and coat it with jelly. While that's inside, I might shave or use a pumice stone to remove dead skin from my feet.

You get the idea. Because I'm scrubbing my back, stimulating my scalp, and tending my toes, my mind is not focused on the area of the operation, except at those moments when I'm actually inserting a catheter. I don't go beyond 18. Catheterization is a type of personal grooming. I expect as much pain and pleasure from it as I do from shaving or brushing my teeth.

I keep the water as hot as the water heater will let me. When I'm done, I run the shower for a bit to sluice off the irritating “active ingredient.”

Usually, I don't actively remove the catheters. The urethra seems to expel them naturally while I'm washing other parts of my body. (Or, the effect of gentle washing movements is to cause the catheter to be expelled). I often leave the bathtub without removing the final catheter.

Post-op

After the operation, I always plan on doing something sedentary: respond to e-mail, read, have a meal with a friend. I can circumspectly leave the catheter in for these activities. I think leaving the catheter in for a longer period of time increases the effectiveness of the operation. The urethra seems to have a mind of its own, sometimes tightening around the catheter, sometimes relaxing and allowing it to drop out. Promote relaxation. Usually, the catheter will be expelled within thirty minutes, depending on my level of activity.

I usually have something hot to drink right away, preferably an herbal tea (but not diuretic). The main thing is the fluid, and secondarily the relaxation. Some teas, such as echinacea, stimulate the immune system and thus have a positive effect in preventing bladder infection. Obviously, there is no reason why you can't have alcoholic beverages at this time, if you so choose. The major consideration is not the type of beverage, but the amount. A large Evian Spring Water

bottle contains 1.5 liters of water. Try to drink two. Passing large quantities of water has a soothing effect, both psychologically, physically, and chemically (it helps to expel the irritant in the salve).

Your physician has probably already given you a list of activities which should be avoided: riding bicycles, equestrian sports, sliding down banisters, etc.

Reflections

As I mentioned earlier, the surgeon who treated me did not charge for his services. I'm sure he sincerely felt that this was the best course of action for me. In retrospect, I wish that the operations had never happened, that I had simply been allowed to live out my life with the plumbing system originally given to me by my Creator.

The operation was explained briefly to me at the outset, but alternatives were never discussed, no scenario other than the desired outcome was ever presented. I had never heard of "informed consent," and it would not have applied to my situation.

The hypospadias repair was performed in three stages, when I was eleven years old. Between the ages of twelve and sixteen, I lived a life of denial alternating with acute crises. Under the care of one physician, a urology professor at a medical university, my urethra would actually become completely occluded after dilation, rather than become more open. Yet he never varied his procedure in the slightest way, which suggests that he also continued teaching his students the same counter-productive methods. So much for research hospitals.

During my high school years, while all this was happening, popular culture was full of references to Freud, to counselors and therapists and psychoanalysts and pastors who had a counseling ministry, etc., etc., etc. Yet none of this affected my life. Not once did I discuss my problem with a trained counselor. Nor did my parents. And probably my doctors never looked at the problem in psychological terms.

No literature existed. I was encouraged to deny reality, to think that

the cure lay in just a few more visits to the doctor.

I've never heard of a contest where men parade the internal diameters of their urethras, and I'm not sure how it would be done. However awkward the concept might be, much of the therapy I received for the first ten years seems to have been designed with the intention to prepare me to become a world champion.

When I started treating myself, my first act was to abandon this concept. Which is not to say that I stopped denying reality. But my weird world is more comfortable to live in now. I open my urethra just as far as necessary to allow me to pass urine.

I'm sure I'll have more problems as I grow older, but I don't know what they are, and I suspect that doctors don't understand them either. In any case, I have no desire to become a world champion in a masculine beauty contest, a ticker tape parade down Fifth Avenue as the challengers for widest urethra in the welterweight division for sixty-five years old and older head towards Madison Square Garden. CQ

Letter to My Physicians

The following is a letter which ISNA member Angela Moreno recently sent to two pediatric endocrinologists, women who presided over her treatment for intersexuality in 1985 (See "In Amerika They Call us Hermaphrodites," page 11). We have not used the names of the women, because our aim is to open a dialog, not to publicly embarrass individual physicians – Ed.

August 10, 1996

Doctors W and S,

I wonder how many of your intersex patients ever contact you again in adulthood. I imagine — given the enormous distrust of the medical profession which many of us develop — that most are "lost to follow-up." You (and your profession's misguided treatment protocol) can never hope to return to me what you have taken, but you *can* listen to me. As you admitted to me, Dr. W, adult intersexual voices are very rare. My willingness to speak is

relatively unique; I urge you to listen. In fact, I am writing with the hope of initiating a dialogue with clinicians like yourselves.

If I had not persisted in obtaining my medical records, I might never have known the specifics of my intersex status. I've only managed to get fifteen pages of my records from Children's Memorial Hospital, but I have managed to glean my karyotype and other diagnosing information. I am shocked and angered to realize that you have lied to me, convinced my parents to lie to me, and that you never intended to disclose my diagnosis to me — the patient. I wonder how you thought that deceiving me might have been therapeutic or even ethical. I wonder if you thought so little of me as to believe that I would never discover the truth on my own.

I am enclosing some literature from the Intersex Society of North America, a peer support and advocacy group. I hope you will thoughtfully consider these materials. Let me empha-

size that my intention in writing is to open a dialogue. I hope, someday, to sit face to face with both of you and discuss the particulars of my case and treatment of intersex conditions more generally. This is very important to me, but I also believe this is an opportunity which you must not dismiss. Your willingness to listen can only increase your understanding of intersexuality from the patient's perspective. I encourage you to contact me by phone, e-mail, or post. I make occasional weekend trips to your city and am usually able to arrive on Friday or stay through Monday. I hope that we can arrange to meet soon. If I don't receive a response to this letter within the month, I will contact both of you to pursue the possibility of our meeting, but I sincerely hope that you will feel strongly enough to contact me on your own. I look forward to hearing from you soon.

Sincerely,

Angela Moreno

Caught Between

An Essay on Intersexuality

by D. Cameron

I t is only recently that I have discovered the term “intersexed” and how it relates to my body. I like the term because I prefer more choices than male or female. I think there is a continuum of Male to Female; like shades of gray from black to white. It wasn’t until I was twenty-nine years old that a label was put on my physical differences, differences that I never quite understood. I had large nipples on smallish breasts, peanut-size testicles and cellulite-type hairless fatty tissue over most of my body. I was told at an infertility clinic that I had an extra “X” chromosome and a karyotype of XXY-47. This is commonly known as Klinefelter’s syndrome. I was informed that I was genetically sterile and that my “sex glands” produced only 10% of what was considered normal testosterone levels for a male. I was advised to immediately start testosterone replacement therapy. I was told that my “sex drive would increase,” I would “gain weight and my shoulders would broaden,” and that I would have to do this every two weeks for the rest of my life. The medical journals called my condition “feminized male.” I had always felt caught between the sexes without knowing why.

This reality was not evident at my birth in 1947. When puberty came, I knew I was different from other boys. I was often teased for having small testicles, and I had gynecomastia (breast growth in a male). It was an awkward time for me, as I was very tall (6' 9" at 15 years old). As I now have learned, testosterone is needed to stop the growth of the long bones, in arms and legs. I was a self-conscious, sensitive and emotional kid. My mother was concerned about the lack of development and after several visits the doctor — incorrectly — assured her that I would grow up “normal” and that I could produce children.

Not having any other information or knowledge about my situation, I faithfully got my 300 mg injections of testosterone every two weeks. I soon found myself going through puberty all over again — in my early 30s. I was a first tenor turning into a baritone. I began shaving, and eventually grew a beard. Hair sprouted everywhere on my once smooth body. There were phenomenal changes for me both physically and psychologically. The greatest change was having so much sexual energy. For the first time I appreciated what the word “horny” meant.

During this period (1976-1981), I did not have any counseling for emotional issues. My main support came from my life-partner, Peter, whom I met in 1978. I dealt with most of my “transformation” alone.

The first few years of testosterone replacement therapy, I had the sensation of “reverse menopause” combined with the feeling that my female persona was dying. It was an overwhelming time of confusion, yet mixed with discovery. I didn’t understand why I had been chosen to have this experience in my life, and wondered whether I should instead have stayed who I was. In the end, because I was so tall, I decided to proceed, in order to find out what being “male” was like. I often regret that decision. When I first moved to San Francisco in 1979, I got my injections at Kaiser Hospital, but by 1983 I had learned how to inject myself. I would have to get into a semi-yoga position to push the large needle intra-muscularly into my buttocks.

For the next ten years I became quite strong and trim. I exchanged sedentary employment for more physically challenging work, and started my own home and garden renovation business. By now my once hairless body was covered — much to my dismay — with hair, and my hair was beginning to bald. I did not realize that these were side-effects of testosterone replacement therapy. Now my body appeared very masculine and I was told that, to further “improve the effect,” I could have testicular implants and have my breast tissue removed. I chose not to have surgery.

In 1991, my sex drive began to diminish significantly. I feared that my testosterone replacement therapy had failed. I started to think of the testosterone as a poison in my system. I started to get back in touch with my female side — and realized that I had never completely lost her.

Emotionally and spiritually, I have always felt more feminine, and I began to doubt the correctness of the decision I had taken, in 1976, to find out what being male was like. My sexual orientation had not changed — I was attracted to men. I considered lowering my hormone dosage, but doctors advised against it. There would be serious side-effects, they told me. But could the side-effects be any more painful than the fear of prostate, breast or testicular cancer by continuing the injections, I wondered? Why wasn’t I told any of this when I started hormone therapy? Have I become a “virilized female?” (Not unlike a female-to-male transsexual with a penis?) I felt caught between again.

For two or three years, my doctor raised my testosterone dosage to 350 – 400 mg every two weeks to see if that would improve my sex drive. My sex drive was unchanged, but I started having more prostate and urinary problems. I was put on another drug to try to compensate for the side-effects of the first drug.

In October 1995, I attended the first national conference of K.S. & Associates (a Klinefelter’s Syndrome support group) in Washington DC. The Conference was a disappointment to me, in that intersex and gender issues were never discussed. I assumed this was probably due to homophobia on the part of the group’s founders (who are parents of children with Klinefelter’s Syndrome) and of the supporting staff of Johns Hopkins Hospital. There was a small group panel which was to discuss gender, but instead they discussed sexual orientation. The panel immediately became polarized and did not move forward. There were about eighty people with Klinefelter’s attending, including quite a few children. Some twenty of us adults spotted each other as queer, and got together spontaneously to discuss our sexuality and our disappointment

over the lack of support by K.S. & Associates for gender issues.

At that conference, I learned the FDA had just approved the Androderm patch, a method of delivering testosterone without injection. I was unable to wear the Testoderm patch because my scrotum is so small that it does not provide enough area for the patch to work on. In December 1995, I decided to stop my injections as they had become painful and I needed a rest after nineteen years. Some side-effects occurred within five weeks: fatigue, mood swings, depression, more difficulty urinating. I had my testosterone level checked. It was 12 (normal male levels are 400 to 1100). I realized that I could not return to where I was in 1976, before the testosterone injections, and decided that it was best to stay on the journey I had started. Somehow I would cope. I knew that being “caught between” would be my life challenge and that would be OK since I felt whole with all my unique parts. I needed to treasure my “X”ception.

In January I returned to testosterone therapy, with one Androderm patch a day. My energy improved, but flattened out in two weeks. Three weeks later I began wearing the recommended two patches to see if my moods and depression would improve. They have. My sex drive, however, is still nonexistent, and I’m not sure why. It has been strange adjusting to wearing patches. They must be changed once a day and cannot be worn on the same site again for seven days. You rotate the placement, with preferred sites being upper arm, back, thigh or abdomen. They are about three inches in diameter and have white rings around the circumference of the adhering portion. I feel self-conscious at the gym and in the shower. The last thing I wanted to do was draw more attention to myself.

Having done this, I realize that this is an important educational opportunity. There are many courageous intersexed people on our planet, not just males and females. Our sex hormones define us or set us free from categories. When others look at me they probably see a big hairy bearded man. But I know the *truth*. I will strive to continue to redefine myself. CQ

Hermaphrodites with Attitude Take to the Streets

by Max Beck

I n late October of 1996, Hermaphrodites with Attitude took to the streets, in the first public demonstration by intersexuals in modern history. On a glorious fall day, the like of which you can only find in New England, under a crackling, cloudless sky, twenty-odd protesters joined forces to picket the Annual Meeting of the American Academy of Pediatricians in Boston (*see cover photo – Ed.*).

Deeply aware of the historical and personal significance of the action, and — correctly — surmising that a notebook diary would not be practical on such a whirlwind, windy week-end, I took a small hand-held tape recorder with me. What follows are excerpts from the resulting transcript.

October 24, 1996

2:45 PM, Atlanta's Hartsfield International Airport

The trip has only just begun and I am already exhausted. Hot. Starving. Fifteen minutes until take-off. Every businessman boarding the plane looks like a pediatric endocrinologist, Boston-bound. Silly thought, testimony to what? My anxiety? My fear? My giddy anticipation? If these bespectacled, suit-and-tie sporting men were pediatricians, would they be flying coach on Continental, with a layover in Newark?

I'm headed for Boston, for the Annual Meeting of the American Academy of Pediatricians (AAP). Tens of thousands of pediatricians. I'm not a pediatrician, though, nor am I a nurse; in fact, I barely managed to complete my B.A. I'm a manager of a technical laboratory. We don't work with children, and the AAP certainly didn't invite

me, so why am I going? With the plane taxiing toward take-off, this is a lousy time to reassess. I'm going.

I'm going because I am intersexed. I'm going because the doctors and nurses who treated me as an infant and a child and an adolescent, and those who continue to treat intersexed infants and children today, consider me "lost to follow-up." I was lost — that's part of the problem. Now, I'm back.

9:02 PM: Boston's North End

I'm comfortably ensconced in Alice's warehouse condo in Boston's North End, a renovated warehouse with a view of the city skyline, ceilings easily twenty feet high, exposed beams and brick, gorgeous tile floor. As I speak, my hostess is preparing an absolutely phenomenal meal. The aroma of roasted peppers permeates the entire space.

Tomorrow, the work begins; my project this evening is to unwind and enjoy this wonderful meal. Easier said than done. I'm feeling excited, enervated, I feel very alive, something I don't feel very often, I feel very present and aware. It could be my exhaustion, it could be the Chardonnay. But I think, rather, that the excitement is anticipation about what we are about to do. Being here, finally being prepared to raise a voice, to be heard, to be seen, a vocal, out, proud *hermaphrodite* who is standing up to say, "Let's rethink this, this isn't working, we've been hurt, stop what you're doing, listen to us!"

I'm really looking forward to meeting Morgan at the airport in the morning; it's always amazing to make eye contact with someone else who has been there.

October 25, 7:38 AM Boston Commons

En route to my encounter with the AAP, walking the approximately two miles from my hostess' domicile to the Marriott Hotel at Copley Square, I pause in the Boston Commons to enjoy a park bench, to sip my Starbucks decaf, and to watch a group of senior citizens performing Japanese swordsmanship on top of the hill beneath a monument to some forgotten general.

The city is cool this morning, but clear, and it promises to be a beautiful weekend. That's good: we won't be rained out.

I've got a stack of about ninety ISNA brochures in the bag at my side, crammed in the inside pocket of my leather jacket. If I want these pamphlets to get inside, I've got to get to the site of the Nurses' Panel at the Marriott before they close the doors. Then it's back out to the airport, to pick up Morgan.

My feet are already killing me.

October 26, 9:15 AM: North End

Morgan and I are sitting at our hostess' breakfast table, pulling our thoughts together. In a few minutes, we'll have to leave to pick up Riki at the airport.

The logistics of pulling together an action are mind-boggling. There's no describing the thrill, though, of all that work, all those phone calls, all those miles. Riding a clattering subway on a Saturday morning, seated beside another living, breathing, laughing, swearing intersexual, hugging near-strangers at unfamiliar airports, then riding back, together, defiant, determined, organized, to the heart of so much of our pain, so much of our anger, so much of our need.

We gathered in front of the huge Hynes Auditorium, pamphlets and leaflets in hand, and met the AAP attendees as they left the convention center for lunch. The next hour-and-a-half was a blur, as we positioned ourselves in strategic locations before the Hynes, held signs and "Hermaphrodites with Attitude" banner aloft, distributed our literature, engaged AAP members and passers-by in conversation and debate, spoke to microphones, to cameras. In all that time, I recorded only one fragment of a breathless sentence:

Saturday, 12:20 PM Outside the Hynes

We've got all the exits covered, and it's an incredible, incredibly empowering experience.

I remember the words I spoke to the TV camera, if only because I had scribbled a rough outline on the airplane, pirating mightily from Cheryl's

press release. And because the moment was so salient, so real. Me, Max, bespectacled, with blisters on my feet and chapped lips, speaking out to untold numbers of invisible viewers (and a few bewildered pediatricians behind me.)

When an intersex child is born, parents and caregivers are faced with what seems to be a terrible dilemma: here is an infant who does not fit what our society deems normal. Immediate medical intervention seems indicated, in order to spare the parents and the child the inevitable stigmatization associated with being different. Yet the infant is not facing a medical emergency; intersexuality is rarely if ever life-threatening. Rather, the psychosocial crisis of the parents and caregivers is medicalized.

Intersexuality is assumed to be a birth defect which can be corrected, outgrown and forgotten. The experiences of members of the intersex support groups indicate that intersexuality cannot be fixed; an intersex infant grows up to be an intersex adult. This hasn't been explored, because intersex patients are almost invariably "lost to follow-up." The abstract of a talk that will be given at this very conference by a doctor who treats intersex infants concedes that "the psychological issues surrounding genital reconstruction are inadequately understood."

Part of the problem is that we were lost to follow-up, and there were reasons for that. But we're here today to say we're back, we're no longer lost, and we'd like to offer some feedback.

We're here to say that the treatment paradigm for "managing" intersexuals is in desperate, urgent need of re-examination.

We're back to say that early surgical intervention leads to more than "just" physical scars and sexual dysfunction.

We're back to say that the lack of education and counseling for intersexuals, our families and the community at large does not lead to a blissful, healthy, well-adjusted ignorance. Rather, it too often leads to a life-threatening shroud of silence, secrecy, and self-hatred.

I'm here representing over one hundred fifty intersexuals throughout North America. One hundred fifty intersexuals

Concluded on P. 50

Silence = Death

by Tamara Alexander

I have been typing and writing the introductory paragraph of this story for several days now, and I keep arriving in the same place. It is hard to get the pieces in place because creating this picture has been like trying to assemble a 1,000 piece jigsaw puzzle in the dark: leave out or misplace one fragment and the picture no longer makes sense. Then there is the difficulty of where to begin.

We met in college, the first day of the spring semester, junior year. Having had an earlier class in that room, I stayed on. She was the first to arrive. Our eyes met across an empty classroom... The neon sign-board in my head lit up: something was forever changed. I would spend the next two years chasing down the mystery behind that moment. Love at first sight? Nonsense. Soul mates? Ridiculous. But...

We became friends. Dinners at each other's houses. Study groups. Movie marathons. We even had a date — candlelight and wine, out alone, glowing at each other across the table. And I told myself that I had been wrong, that she was straight. Hell, she even got married. I resolved to live with that. It wasn't until April of the following year that I finally told her about the one and only love affair I'd ever had with a woman, and she responded in kind. I thought that this bit of history must have been what I'd been reading when we first met: not that she didn't have feelings for women, just that they had not been about me. How could I have known how wrong I would be?

I returned home to Georgia after graduation. I held her hand in the procession and reminded myself that this was where it ended. She was happily married, and I was... adrift. We started a correspondence, ostensibly because she had missed out on having someone to talk to when she was figuring out her sexual orientation and wanted to be that person for me. She was finally talking to me, after two years, about being a lesbian. Need I say that this correspondence took some dangerous turns?

I was mad about her and always had been, and she was telling me her life story. About how she ran away to California in her senior year of college and got embroiled in a lesbian love triangle. About why she married Harold. Oh, and by the way — she thought I was beautiful. I wrote back that when I had first met her, I'd been equally enamored. Letters flew on a one-day turnaround. I was sleeping with her letters under my pillow without really understanding why.

We were peeling the onion, one layer at a time.

In my confusion, I reunited with my ex. It was only then that she wrote to tell me how involved she really had been, how deeply it hurt her to have missed our chance, how badly she really had wanted to be with me. I wrote back that I loved her. That I expected to live with the ache of that regret for the rest of my life. I was with Jenny and intended to be, but I could not help but hope our paths would cross again. I sent her Robert Frost's "The Road Not Taken," copying it out by hand on the back of the envelope sitting on the floor of a bookstore. She left Harold.

We fell out of touch. Three months later, I spent an entire day thinking of her, and came home to find a book of poetry she had sent. "You can control it," she quoted one of Margaret Atwood's characters, "You can make yourself stop loving someone." The other responded: "That is such horse-shit!" The jig was up.

We spoke at all hours of the day over the next two weeks. I called her at work. "I need to come see you." I had expected her excitement, joy, anticipation. She sighed. Her tone was ominous. "Okay," she said. "Come. We'll talk. There are some things you should know about me." "That sounds serious," I said. She agreed: "It is." My first thought was that she had cancer. My next thought....

The visit was to be two weeks later. The topic kept coming back up: things that I should know about her. She didn't want to talk about it over the phone. Panic would break into her voice at the subject. "Why are you so afraid to tell me?" I asked. "Nothing could change the way I feel about you." "This could," she said. "It's horrid." Eventually the strain of not talking about it won out, and she told me. By

this time, I was already fairly certain what she was going to say.

"When I was born, the doctors couldn't tell whether I was a boy or a girl." She dictated the speech as if she'd told it many times before and all of the emotion had fallen right out of it. I finally heard the complete story of her college affair with a woman and five words she said in bed that altered the entire course of Max's life: "Boy, Jude, you sure are weird." Max told me she knew then that she was a lesbian, but she could not be with women because they would know how her body was different. She married Harold because men were just less sensitive to the subtleties of women's anatomy.

My response was tears: "I can't believe you've been carrying this around by yourself your whole life." I hadn't been surprised; growing up in a house full of medical texts had acquainted me with intersexuality. I was not, as she had feared, horrified, repulsed, or anxious.

"What did you think," she asked me in the car as I was preparing to write this essay about loving her, "what did you expect my body to be like?" "I thought it would be mysterious and wonderful," I told her. "And it was."

I went up to Philadelphia for four short days over her birthday in February. We attempted to cook, burned the butter, and collapsed in each others' arms on the floor. We left the house only to pick up take-out and Ben & Jerry's Wavy Gravy ice cream. Nonetheless, for the first two nights, she would not take off her boxer shorts. I could feel the wonder of her hardened clit pressing up between my legs through the flannel, but I was not allowed to touch. Although the rest of her body lay out before me to be charted, her cunt was a zealously guarded region. She told me she couldn't lubricate because of the scar tissue, and because the surgeons had taken her labia to make a vaginal opening when she was fifteen. "Lots of women can't lubricate," I told her. "That's why they make feminine lubricants. There's at least three on the market."

We decided to go shopping. In the feminine hygiene aisle, we compared the relative merits of Gyne-Moistrin and its competitors. I was carefully examining the quality, price, and recommendations of each when I looked up at Max. Her eyes were wide and

glazed. She was shaking. Her breath was irregular. I picked up the nearest product, sent her outside to wait, and paid at the register. We went home.

That night we slept downstairs in front of the fire. It was February 5, her 29th birthday. There was easily a foot of snow on the ground and it had all frozen over. Only her boxers still remained between us. Later that night she went upstairs to the bathroom, and when she slipped back under the covers, my hands slid from one end of her body to another. The boxers were gone. I will never be able to recapture the magic of that moment. "Ohhh..." She was terrified, and I was aware of her fear and the cost of offering herself up to me in that moment. I have never wanted to pleasure someone, never wanted to offer my hands and my fingers to heal and to love and to delight... I have never been so awed by the feeling of touching as I was that night. I wanted to stroke and explore and learn and know every inch of her, her large and proud clit, the lines and crevasses from scars and healings, the tight cavern of her cunt which held my fingers so tightly. She pulled me down on top of her and wrapped her arms around me and came, calling my name, sobbing against my shoulder. And I wept with her.

I wept for the loss of what she hadn't had and the lovers who hadn't reveled in the wonder of her body, wept for what I hadn't had before I held her in love, and I am weeping as I write this now.

It was a full year before she let me touch her that way again. January 17. Our one year anniversary. The boxer shorts had been long gone, but most of our lovemaking was by full body contact, tribadism, pressured touch. We made love that anniversary night, and I asked: please. Please let me touch you. Please don't shut me out. Please just lie back and let me love you, the way I want to, the way you deserve to be loved. Let me know you. Let me look. Let me run my tongue into the places you haven't let me before. Let me celebrate you, because I love this, and this, and this. I don't love you despite your differences, I love you because of them. I want you to be this way. I want to enjoy your being this way, because it is good, lovely, delicious. Let me.

And she let me feel her, let me bury my face in her cunt and smell the

rich scent of her. Let me slide my tongue over her aching clit and along the entry to her vagina, let me stroke and tease and caress with my fingers. She came in a gush, spilling out over me and the bed. And there were more tears for this ritual, more love, and more letting go. A full year. We were still taking baby steps toward completely open lovemaking. Still peeling onions.

We moved to Atlanta in the summer of 1995. Broken by the stresses of new jobs, financial worries, lack of friends and supports and a 1912 bungalow which we loved but could barely afford renovating — Max lapsed into a depression. She began to tell me that she was a monster and she just shouldn't be here. The day she did not go to work because she was planning to hang herself, I took her to the hospital. It was the hardest thing I have ever done in my life.

I had the unenviable task of surrendering the illusion that my unconditional love and acceptance were going to save her. No matter how much I loved her, no matter what I would give to heal her, I was not enough. I could not keep her safe. I could not erase thirty years of grief and doubt about her worth and her place in this world.

I was isolated from other people in ways I hadn't been before; no one knew her past medical history, and she was not ready for me to talk to anyone else about it. My friends from Philly called to check on me; they loved me and understood only that I was in agony because Max was depressed. They assured me that she would get better, that she would come home to me and the beautiful life we had created together. I was not certain she could ever recover from the damage that had been done.

I read her medical records over and over. Sorted through John Money's articles left from college psych classes. Read her journal, trying to understand. At night, I screamed my lungs out at the sheer futility of trying to help her. I had nightmares of surgeons wielding shiny scalpels tying her down and rearranging her body. I wept at work. I wept at home. I did endless battle with our mounting financial doom: the mortgage was late, the car unpaid, utilities coming due — all without her income. How would I ever keep things intact so that she had a life to return to when — *if* — she recovered?

Why was there no one to talk to? Why was she sleeping in a tiny bed in a hospital corridor with hourly safety checks instead of at home with me? What had I done to merit losing her this way? How could she think she was bad when I loved her so much? How could she not know how amazing and special she was?

Life became a parade of visiting hours, drive-thru hamburgers at Wendy's on the way home, buying her books, taking her Joshua Bear, keeping her family at bay so that she could rest. I was spending all of my time being busy, painting the room that had been the final stressor, borrowing cash, calling on all of her breaks to check in. For the first weeks, I only cried. I railed at my therapist about the injustice of life. I mourned that I couldn't be the one to save her. I could only hold her hand, tell her to hold on, and pray.

I read her records, and I wondered, if this had happened to me, if my body had been desecrated and abused and held up in public for the amusement of interns, would I have survived it even half as well as she had? Would I have had the courage to go on for thirty years with the memory of those rapes, my mother's shame and my own, and the lies of doctors? A lesser person would not still be in the world. I do not think I would have survived this. No, I know I would not have.

I made promises to keep myself sane. I swore that I would not lose her. I swore that I would not allow this to happen to anyone else. I promised myself that if she slid off the face of this earth out of the exhaustion of fighting for her right to exist, I would not allow this to happen to any child like her. I would find out how and by whom this awful process was being perpetuated, and I would make it stop. I would become louder and louder until I could not be ignored. I have never doubted that I could be a force to be reckoned with, and I was finding out by juggling my whole life those months that I was indeed, incredibly strong and capable, and that I could accomplish miracles out of my love for her.

It took four months. Three hospitalizations. Persistent suicidal ideation and unwavering depression. She lost her job because she couldn't stop crying. I dragged her to monthly support group meetings in the gender

community. I made her return calls to Cheryl Chase at ISNA. I pushed her to call the people Cheryl sent out to make contact with her. Each time, she would feel a little less alone, and a little more hopeful. And then the depression would creep back, telling her to give up. Telling her she would never be whole, would never be accepted, would never be anything but a shameful secret. As many times as I had learned in that first precious year together that love is an amazing healer, I had still to learn that sometimes shame and blatant evil can be stronger. I might love her with all my heart, but that was one small glow against the bitterness and dark of the rest of her experiences. Would it be enough?

It is now almost a year since that last depression. It still creeps up on us from time to time. When she doesn't come home on time, I have to pace myself not to panic. I have to remind myself that not being home does not mean she has killed herself. But the danger is always there. It's only in the last few weeks that it feels less close, less powerful than me. Less powerful than the sense of self I'm amazed and awed to watch her discover.

She has cut her hair, embraced butch, and found a good endocrinologist. We marched together in the parade at gay pride. I have come to believe myself a part of this community. I may not be transgendered, transsexual, or intersexed. I may have been fortunate enough to be born into a body that matches my sense of self and is accepted by society in its original form. But this is still my fight.

There is a popular slogan in the gay community that proclaims "Silence = Death." Her silence, and mine, almost meant her death. I am reminded of the words of the Catholic priest who recalled that during the holocaust he did not speak because he was not a member of any of the groups they were rounding up for execution. When they came for him, there was no one left to speak for him.

She is my partner, my lover, the greatest gift life ever gave me. I choose to honor her decision to stay alive. I choose to speak on a daily basis. I honor her courage and her complexity. If she walks between the worlds set up by a gender-dichotomous society, then that is where my path leads as well. CQ

Continued from P. 46

are saying: Please! Listen! You doctors, you pediatric endocrinologists and urologists treating intersexuals, you nurses interacting with intersexuals and their families, listen to us! We understand intersexuality, not because we have studied the medical literature — although many of us have — not because we have performed surgeries, but because we have been grappling with intersexuality every day of our lives.

We're here to say that those who would have us believe that intersexuality is rare, cloud the issue by breaking us and separating us into narrow etiological categories which have little meaning in terms of our actual, lived experience.

We're here so that other intersexuals can find us — for many of us, finding others like ourselves has been a life-altering, even life-saving, experience.

We're here to reach parents before their intersex child is born.

We're here to elicit the help of other sympathetic professionals.

We *can* take a stand as openly intersex adults without being crushed by shame!

And we did!

7:20 PM: Boston's North End

Goddess, this is so sweet, so liberating! I was so reluctant a week ago, having my Jesus-in-Gethsemane experience, reluctant to accept — not an onus or responsibility but — to accept who I am. And here's where the hard work really begins. I'm exhausted when I think of the road before us. But then, it's nothing like the road behind us.

[AAP officials did not reply to a letter from ISNA, delivered several days before the convention, inviting them to talk with ISNA members before, during or after the convention. During the demonstration, an AAP PR man came out to distribute a press release (reproduced at right) asserting that "from the viewpoint of emotional development" the age six weeks to fifteen months is the optimal time for genital surgery, and announced that while AAP officials would be happy to meet with members of the press privately, inside, they had no interest in meeting any Hermaphrodites with Attitude — Ed.] CQ



The Author (left) at AAP Demo, Boston, 26 October, 1996

American Academy of Pediatrics • 141 Northwest Point Blvd. • Elk Grove Village, IL 60009-0927

News Release: American Academy of Pediatrics Position on Intersexuality

The American Academy of Pediatrics, a voice for children for over 60 years, is aware of the concerns and sensitive to the needs of intersexuals.

- Intersexuals are individuals who are born with anatomical characteristics of both males and females.
- The Academy is deeply concerned about the emotional, cognitive, and body image development of intersexuals, and believes that successful early genital surgery minimizes these issues.
- Research on children with ambiguous genitalia has shown that a person's sexual body image is largely a function of socialization, and children whose genetic sexes are not clearly reflected in external genitalia can be raised successfully as members of either sexes if the process begins before 2 1/2 years.
- Management and understanding of intersex conditions has significantly improved, particularly over the last several decades.
- From the viewpoint of emotional development, 6 weeks to 15 months seems the optimal period for genital surgery.

The American Academy of Pediatrics is an organization of 51,000 pediatricians dedicated to the health, safety and well-being of infants, children and young adults.

In Process

by Derick

I don't quite remember when I became aware that I was not quite like other boys. My father never discussed it, never mentioned it, and never asked me how I felt. My mother broke the news to me when I was about eight, but even then I didn't know that I wasn't "right," though I had nothing to compare to. I remember being hauled off to a doctor's office, where a steel probe was inserted into my meatus (*the pee-hole in his penis — Ed.*) And I remember the doctor saying something would have to be done. I, of course, had no idea what he meant — but I was soon to find out. My mother explained that I had something called *hypospadias* and that I would be going into the hospital for an operation that would make me like other boys. At the time, I couldn't understand the need for this. After all, I could urinate with no problem.

This was in the late forties. Endocrinology wasn't yet well established as a medical specialty, chromosomes were just around the corner, and the surgery for hypospadias was, at best, experimental. I awoke from the anesthetic in intense pain that I still remember vividly. An oversized catheter had been inserted to stretch the meatus. For the next two weeks, I fought back the urge to cry — because big boys don't cry. Then another operation. I awoke; the catheter was gone. After a couple of days, I went home. I thought that it was all over — but it had only just begun. My mother explained that the surgeon didn't do a good job and now I had to see a specialist, something about a plastic surgeon. My penis by now had a lot of scar tissue (it didn't used to). I had also missed the start of the school year. When I eventually went to school, I was asked why I was in hospital. I couldn't, wouldn't answer. It became my secret.

Over the next three years, I spent about 50% of the time in hospital, many stays. I had a total of sixteen operations, performed by the plastic surgeon. I remember waking up from those procedures, the inevitable catheter — followed by the inevitable bladder infection. I missed a lot of school and had to repeat a year. That usually only

happens to academic failures. I didn't like it, my friends were now in the next grade. Even worse, I was thirteen — the age when boys focus on sex, and like to display their enlarged genitals: locker room stuff. For the first time, I became very aware that my penis was not like theirs. Mine had a gash on the underside, and their penises were obviously larger than mine. Embarrassed, I withdrew from the locker room scene.

But it gets worse. The other kids were now obsessed with masturbation. To my horror, although I could get an erection, I couldn't masturbate. The surgery had so desensitized the glans that most of the feeling had gone. My artificially constructed urethra now began to develop a stricture (*a narrowing — Ed.*), necessitating an outpatient visit every three months to have it stretched, causing more pain. This continued until I went to college, at eighteen. My main concern was how to lose my virginity, something that everyone else seemed to have already done. I was very concerned that some female would look at my penis and say, "Oh my God! what happened?" or "I'm out of here." I did eventually lose my virginity — under conditions of total darkness. I also became aware that my sex drive didn't seem to be as strong as the other guys. That was probably due to some chromosomal combination that wasn't right either, but what the hell. I was not even going to investigate that one.

In summary, I wouldn't wish the "corrective" surgery on anyone. I endured much pain, had my childhood partially destroyed, was deprived of crucial friendships, suffered endless self-doubts concerning my "manhood," and for what? CQ

To: Derick@domain.net
From: cchase@isna.org (Cheryl Chase)
Subject: Re: Write for Chrysalis?
Cc:
Bcc:
X-Attachments:

Hi Derick,

What I would like you to write about is not just about the surgery, but about what it has been like to be intersexed, how you were treated and what it felt like (emotionally, physically), and how you wish you had been treated.

best,

cheryl

From: Derick@domain.net
Date: Sat, 3 Aug 1996 14:37:35 -0400
To: cchase@isna.org
Subject: My Story

Cheryl..... is this what you are looking for?.... if you want it changed, expanded, etc... please let me know.....
Regards

Derick

To: Derick@domain.net
Date: 6 Aug 1996
From: cchase@isna.org (Cheryl Chase)
Subject: Re: My Story

>Cheryl..... is this what you are looking for?.... if you want it
>changed, expanded, etc... please let me know.....

Thank you!

If you could expand somewhat on what your life has been like since then... what you wrote seems to end at about 18. But it is now many years later; how did you fare, how did you connect with your current partner, how has sex been for you, and has your adult life been affected by your sexual difference?

Did you ever learn to masturbate? Are you orgasmic? Do you find pleasure in sex?

One of the goals of hypospadias surgery is to make you able to pee standing up. How did you pee before the surgery? After the surgery?

love,

cheryl

From: Derick@domain.net
Date: Tue, 13 Aug 1996 11:47:41 -0400
To: cchase@isna.org
Subject: Re: Article

Cheryl,

I am having a struggle trying to put into words my inner feelings, emotions, etc. that you asked for as an addition to the stuff I sent you. I think it's because it's something I've never consciously tried to do.. it's been repressed for a long time. I've only known about ISNA for about a month now... and I guess you could say that I am still in the process of coming out.....

Derick

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Some portions of this material were drawn from an interview conducted by independent radio producer Robin White for a radio story on intersex for National Public Radio.

Growing up in the Surgical Maelstrom

by Jeff McClintock

I'm now forty, and I've done a lot of healing. I am a licensed therapist, and I've used my experience — of being made to suffer unnecessarily by treatment for being intersexual — to make patient advocacy an important aspect of my work. I've healed a great deal through my involvement with the cancer community, where I was able to help people avoid unnecessary medical interventions. And I have studied sex and sexuality, which has been an important element in coming to a place where I can help others, rather than feeling like I was the only one in the world. It also helped me to realize that I could have successful relationships, including sexual relations. A lot of the defeat and depression that I felt growing up left me when I realized that doctors and parents were wrong. They believed I could not be happy without normal genitals. When I understood that wasn't true, my life completely changed.

It was my mother's job to shuttle me back and forth to the hospital. I've had sixteen surgeries on my genitals, and they performed ten operations by age ten, pretty regularly once a year. It's pretty hard on a father if his son is sexually different, and it's still not easy for my father to discuss.

It was hard on my mother, a typical fifties mom who didn't work. She was the one who had to deal with these teams of high-powered doctors all the time. She's told me what it was like when I was born — the doctor didn't say anything, she looked around and saw the two

nurses look down, avoiding eye contact with her. My parents weren't

allowed to see me until the doctors had performed lots of tests, and had made up their minds to assign me as male.

My childhood was filled with pain, surgery, skin grafts, and isolation. I remember when school vacation came, the other kids went somewhere fun. I went to the hospital during vacation, so I wouldn't miss too much school. When vacation was over, I would return to school, often not yet healed from the latest surgery. Sometimes I went back to school with tubes coming out of me, and stitches and scars, and I couldn't walk well. They made arrangements for me to use the teacher's rest room. I have no idea what they told the teachers.

I didn't know any other children who were like me. I asked doctors questions all the time, but they would never tell me anything except to be careful and don't complain. They never told me there were any other children like me. Other children went on vacation; I went to the hospital. Children, of course, are quick to pick up on difference, and they were very cruel to me. I felt like a freak, an embarrassment and a burden to my family. But I got the message that I had to pretend everything was OK. The privacy of my hell was something that I had to deal with on my own, and I was very withdrawn and

depressed. By the time I was a teenager, I was just hopeless, suicidal. I thought that was a good way out. I let out a little bit of what was going on with me to a friend's mother who was a psychotherapist. She got me in to see someone who evaluated me and saw that I was seriously suicidal.

Early on I had gotten very, very strong warnings not to let other children see me with my clothes off, and particularly not to let them see my genitals. Of course, it was pretty easy for the other kids to pick up on the fact that for years I didn't use the kids' bathroom, or that I couldn't walk well when we came back from vacations. I was lucky I didn't have to expose my genitals to the other children in elementary school. By junior high, the psychiatrist helped make it possible for me to participate in mandatory gym classes, but not have to shower with other boys. They would have had a great deal of trouble making sense of or understanding what they would have seen. The doctors insist that you can't let a child go to school with ambiguous genitals, but the genitals they created were certainly strange-looking.

Each year they performed surgery on me, and I watched and felt how rapidly the surgery would break down each time. They couldn't have missed it, either — there's no reason for some of the work that they did on me outside of arrogance or incompetence. I spent many years in surgery whose purpose was to make me pee at the end of my penis. If they had

just left my urinary meatus [pee-hole] where it was, at the base of my penis right by the scrotum, I could have avoided at least twelve of those surgeries. And it's not just my genitals. They would take large pieces of tissue from other parts of my body to try to create a tube of skin for me to pee through, and those areas are scarred as well.

The tube that most men pee through is not made of skin, it's made of a special kind of tissue that can handle contact with urine, and be continuously moist and warm without breaking down or becoming infected. The tubes that they made for me out of skin from other parts of my body broke down over and over, and I regularly get bladder infections. And I still have to sit to pee. I have never been without fistulae [holes in the penis where the surgery has broken down], and I've had the entire tube replaced twice, with large skin grafts. If they had just let me pee sitting down, neither I nor my family would have had to suffer all of that — the expense, the pain, the repeated surgeries, the drugs, the repeated tissue breakdowns and urine leaks. It would have been just fine to have a penis that peed out of the bottom instead of the top, and didn't have the feeling damaged.

The promise that you will be able to pee standing up is just plain false, especially when the urinary meatus is at the bottom of the penis. Such a large skin graft can't heal with the blood supply that is available in the genitals. I believe they know that, but it seems



Showering “Sans Penis”

by Brynn Craffey

Showering “sans penis” in the YMCA men’s locker-room presents a few logistical challenges. Every time I pull it off, though, I feel such a thrill and sense of accomplishment.

It’s surprisingly easy. Attitude is everything. When I pad, barefoot and dripping in swim trunks into the crowded shower-room, first thing I do is check in with myself. Am I feeling utterly self-confident? Am I totally convinced of my right to be there, even without a large, dangling member between my legs?

In other words, do I feel legitimate penetrating this traditional male sanctum without first paying homage to our culture’s binary notion of gender by spreading my thighs to the surgeon’s scalpel?

Most of the time, the answer is a resounding yes! I thread my way down the center aisle, a lone “post top-surgical” female-to-male transsexual who eschews bottom surgery, surrounded by naked, penis-equipped men. On my way to a nozzle in a far corner, my feelings run the gamut. Curiosity: Penises fascinate me no end (pun intended). Entitlement: This is where I’ve belonged my whole life, dammit! And caution: Don’t let my transgression be discovered.

I glance right and left out of the corners of my eyes. Is anyone paying me undue attention? I maintain a blank facial expression and avoid gazing long on any individual. In two years’ transition from living as a woman to living as a man, I’ve mastered the fundamentals of heterosexual male locker room etiquette.

I give myself permission to bail at any point. If I’m uneasy, even if I don’t know why. If someone’s crowding me. If I can’t claim a corner nozzle. Or if I simply lack the nerve. I’ll not drop my trunks that day. I can always shower with them on — a lot of guys do.

For me, the decision to shower or not rests on being true to myself in that it depends on listening to my inner voice. It’s a minor variation on the theme of my coming out as FTM only to discover

At an ISNA presentation in San Francisco, Brynn Craffey wondered how intersexual children, if assigned male in spite of having a diminutive penis, would deal with “the locker room problem.” It happens that Brynn was an acquaintance, and I knew that he was an FTM transsexual, and had decided against genital surgery. “How do you deal with the locker room, Brynn?” I asked him. You could almost see the light bulb go off over his head as it dawned on him that he himself deals successfully with “the locker room problem” on a regular basis. While there are important differences between an adult like Brynn — who can choose to brave the locker room or not — and a child, I found Brynn’s story fascinating, and asked him to write it up for Chrysalis readers — Ed.

that “hermaphrodite” more closely approximates my gender identity.

My physical form, like my life, is far too diverse to be neatly categorized as either female or male. I love my testosterone-induced “in between” genitalia and am uninterested in lower surgery. Top surgery, however, was life-saving. As was starting testosterone injections, developing secondary male sex characteristics and living publicly as a man.

There’s more than just my male side, though. The peak experience of my life to date has been bearing, birthing and raising my daughter. In short, mothering. I’ve no desire to disavow that traditionally “female” experience, even as I say that to live the second half of my life as a woman would have rendered me suicidal.

For me, encompassing these seemingly contradictory gender characteristics is both easy and natural. Hence, my comfort with the label hermaphrodite. Granted, I’ve come to this identity as an adult and thereby avoided the distress of growing up physically different in a culture that demands conformity. And, unlike most intersexed people, I chose the terms under which I submitted to the surgeon’s scalpel.

These distinctions are huge. On the other hand, I wrestle with similar identity questions and logistical issues as those who were born physically intersexed. Some struggles, such as those involving my self-esteem, are private. Others, like showering at the Y or coming out to potential lovers, operate in a

more public realm. In every case, I strive to remain faithful to my truth by listening closely to my heart.

Thus, if for any reason I don’t want to shower naked, I don’t. But most of the time, after checking in with myself, I want to. Which brings me back to showering strategy.

Second to attitude, positioning is critical. The YMCA shower is laid out on a rectangular plan, with nozzles spaced roughly every half-meter the entire length of the room. Only two corners afford privacy — the other two are compromised by proximity to an exit. If the two safe corners are occupied, I’ll position myself at a nearby nozzle, start my shower with trunks on and move over when a corner becomes free.

If done casually, this maneuver goes unnoticed. Remember, gang, showers inspire modesty. If anybody notices that I always choose a corner, I imagine they chalk it up to shyness or assume my dick is smaller than theirs. Which it most likely is. No problemo, as long as no one sees how different my genitals are and tries to bar my entry into male space.

Once I claim my corner, I drop my trunks, keeping my back to the room at all times. Even if a guy is showering inches away at an adjoining nozzle, he can’t see my crotch as long as I face the corner. If I need to turn, to rinse off soap for example, I cup my hand over my genitals as if cradling them — a common enough gesture in the showers.

When I’m done, I securely wrap my towel around my waist — don’t want it accidentally slipping — and walk to my locker. I’ve dressed at my locker with as many as four guys inches away, all of us putting on or taking off clothes. Again, the key to success is to choose a corner and keep your back turned or towel on. Pull up underwear under the towel.

Locker room etiquette dictates that straight men not check each other out. While we all know they do, when crowded elbow-to-elbow the big concern is to avoid being checked out or — worse — get caught looking. Everyone’s too preoccupied about themselves to pay much attention to anyone else. This may be the single way that the perversity of homophobia works in favor of FTMs and others with non-conventional genitalia.

I believe in challenging homophobia — and I do in other venues. Likewise, I want to overturn our culture’s dominant male/female gender paradigm. However, I prefer to choose my battleground and the YMCA locker room is a place I’d rather just slip in and out unnoticed. Showering there serves as subversively inspirational for myself and my friends — a way to circumvent the gender police rather than confront them head-on.

And it’s fun. Dare I say, “good clean fun”? As I stated in the beginning, I get a thrill every time I pull it off, both from a subversive place and for the simple reason that I’m in the men’s locker room. CQ



