
Hermaphrodites with Attitude

Mapping the Emergence of Intersex Political Activism

CHERYL CHASE

WITH THIS TOUR-DE-FORCE ARTICLE, CHERYL CHASE brought intersex issues into the purview of queer theory. She presents an overview of the medical management of intersex conditions that result in congenital ambiguous genitalia, recounts her own intersex autobiography, reviews the creation of the Intersex Society of North America, and analyzes Western feminist discourses on “genital mutilation.”

Chase argues that intersex, transgender, and sexual-orientation activism are closely linked through a shared liberal emphasis on protecting personal ethical choice and the right to control one’s own body. She effectively unmasks the cultural processes that have rendered intersexuality virtually invisible and largely unknown—in spite of the fact one in every two thousand individuals exhibits some degree of intersexuality at birth. Chase makes a forceful case for ending nonconsensual genital surgeries on intersex children too young to make decisions on their own behalf. She argues that these surgeries are almost always medically unnecessary, that they generally damage sexual functioning, and are done largely to comfort doctors and parents who feel unable to bond with or accept the humanity of an infant body that cannot be clearly labeled “boy” or “girl.” She argues as well that current medical practice effectively abolishes the natural diversity of sexed body types and uses the sharp end of a scalpel to impose a culturally constructed male/female dichotomy. She then offers a devastating critique of the deafening silence surrounding the medicalized genital cutting practiced on intersex individuals, exposing the racist and colonialist underpinnings of much feminist outrage over “African” genital cutting.

One question that remains unaddressed in Chase’s article is whether intersexuality, if allowed to exist without medical intervention, would lead to new minority forms of personal identity—or whether it might contribute to the overthrow of sexual identity categories for everybody.

The insistence on two clearly distinguished sexes has calamitous personal consequences for the many individuals who arrive in the world with sexual anatomy that fails to be easily distinguished as male or female. Such individuals are labeled “intersexuals” or “hermaphrodites” by modern medical discourse.¹ About one in a hundred births exhibits some anomaly in sex differentiation,² and about one in two thousand is different enough to render problematic the question “Is it a boy or a girl?”³ Since the early 1960s, nearly every major city in the United States has had a hospital with a standing team of medical experts who intervene in these cases to assign—through drastic surgical means—a male or female status to intersex infants. The fact that this system for preserving the boundaries of the categories male and female has existed for so long without drawing criticism or scrutiny from any quarter indicates the extreme discomfort that sexual ambiguity excites in our culture. Pediatric

genital surgeries literalize what might otherwise be considered a theoretical operation: the attempted production of normatively sexed bodies and gendered subjects through constitutive acts of violence. Over the last few years, however, intersex people have begun to politicize intersex identities, thus transforming intensely personal experiences of violation into collective opposition to the medical regulation of bodies that queer the foundations of heteronormative identifications and desires.

HERMAPHRODITES: MEDICAL AUTHORITY AND CULTURAL INVISIBILITY

Many people familiar with the ideas that gender is a phenomenon not adequately described by male/female dimorphism and that the interpretation of physical sex differences is culturally constructed remain surprised to learn just how variable sexual anatomy is.⁴ Though the male/female binary is constructed as natural and presumed to be immutable, the phenomenon of intersexuality offers clear evidence to the contrary and furnishes an opportunity to deploy “nature” strategically to disrupt heteronormative systems of sex, gender, and sexuality. The concept of bodily sex, in popular usage, refers to multiple components including karyotype (organization of sex chromosomes), gonadal differentiation (e.g., ovarian or testicular), genital morphology, configuration of internal reproductive organs, and pubertal sex characteristics such as breasts and facial hair. Because these characteristics are expected to be concordant in each individual—either all male or all female—an observer, once having attributed male or female sex to a particular individual, assumes the values of other unobserved characteristics.⁵

Because medicine intervenes quickly in intersex births to change the infant’s body, the phenomenon of intersexuality is today largely unknown outside specialized medical practices. General public awareness of intersex bodies slowly vanished in modern Western European societies as medicine gradually appropriated to itself the authority to interpret—and eventually manage—the category which had previously been widely known as “hermaphroditism.” Victorian medical taxonomy began to efface hermaphroditism as a legitimated status by establishing mixed gonadal histology as a necessary criterion for “true” hermaphroditism. By this criterion, both ovarian and testicular tissue types had to be present. Given the limitations of Victorian surgery and anesthesia, such confirmation was impossible in a living patient. All other anomalies were reclassified as “pseudohermaphroditisms” masking a “true sex” determined by the gonads.⁶

With advances in anesthesia, surgery, embryology, and endocrinology, however, twentieth-century medicine moved from merely labeling intersexed bodies to the far more invasive practice of “fixing” them to conform with a diagnosed true sex. The techniques and protocols for physically transforming intersexed bodies were developed primarily at Johns Hopkins University in Baltimore during the 1920s and 1930s under the guidance of urologist Hugh Hampton Young. “Only during the last few years,” Young enthused in the preface to his pioneering textbook, *Genital Abnormalities*, “have we begun to get somewhere near the explanation of the marvels of anatomic abnormality that may be portrayed by these amazing individuals. But the surgery of the hermaphrodite has remained a terra incognita.” The “sad state of these unfortunates” prompted Young to devise “a great variety of surgical procedures” by which he attempted to normalize their bodily appearances to the greatest extents possible.⁷

Quite a few of Young’s patients resisted his efforts. One, a “snappy” young negro woman with a good figure” and a large clitoris, had married a man but found her passion only with women. She refused “to be made into a man” because removal of her vagina would mean the loss of her ‘meal ticket,’ namely, her husband.⁸ By the 1950s, the principle of rapid postnatal detection and intervention for intersex infants had been developed at John Hopkins with the stated goal of completing surgery early enough so that the child would have no memory of it.⁹ One wonders whether the insistence on

early intervention was not at least partly motivated by the resistance offered by adult intersexuals to normalization through surgery. Frightened parents of ambiguously sexed infants were much more open to suggestions of normalizing surgery, while the infants themselves could of course offer no resistance whatever. Most of the theoretical foundations justifying these interventions are attributable to psychologist John Money, a sex researcher invited to Johns Hopkins by Lawson Wilkins, the founder of pediatric endocrinology.¹⁰ Wilkins's numerous students subsequently carried these protocols to hospitals throughout the United States and abroad.¹¹ Suzanne Kessler notes that today Wilkins and Money's protocols enjoy a "consensus of approval rarely encountered in science."¹²

In keeping with the Johns Hopkins model, the birth of an intersex infant today is deemed a "psycho-social emergency" that propels a multidisciplinary team of intersex specialists into action. Significantly, they are surgeons and endocrinologists rather than psychologists, bioethicists, representatives from intersex peer support organizations, or parents of intersex children. The team examines the infant and chooses either male or female as a "sex of assignment," then informs the parents that this is the child's "true sex." Medical technology, including surgery and hormones, is then used to make the child's body conform as closely as possible to that sex.

The sort of deviation from sex norms exhibited by intersexuals is so highly stigmatized that the likely prospect of emotional harm due to social rejection of the intersexual provides physicians with their most compelling argument to justify medically unnecessary surgical interventions. Intersex status is considered to be so incompatible with emotional health that misrepresentation, concealment of facts, and outright lying (both to parents and later to the intersex person) are unabashedly advocated in professional medical literature.¹³ Rather, the systematic hushing up of the fact of intersex births and the use of violent techniques to normalize intersex bodies have caused profound emotional and physical harm to intersexuals and their families. The harm begins when the birth is treated as a medical crisis, and the consequences of that initial treatment ripple out ever afterward. The impact of this treatment is so devastating that until just a few years ago, people whose lives have been touched by intersexuality maintained silence about their ordeal. As recently as 1993, no one publicly disputed surgeon Milton Edgerton when he wrote that in forty years of clitoral surgery on intersexuals, "not one has complained of loss of sensation, *even when the entire clitoris was removed*."¹⁴

The tragic irony is that, while intersexual anatomy occasionally indicates an underlying medical problem such as adrenal malfunction, ambiguous genitals are in and of themselves neither painful nor harmful to health. Surgery is essentially a destructive process. It can remove and to a limited extent relocate tissue, but it cannot create new structures. This technical limitation, taken together with the framing of the feminine as a condition of lack, leads physicians to assign 90 percent of anatomically ambiguous infants as female by excising genital tissue. Members of the Johns Hopkins intersex team have justified female assignment by saying, "You can make a hole, but you can't build a pole."¹⁵ Positively heroic efforts shore up a tenuous masculine status for the remaining 10 percent assigned male, who are subjected to multiple operations—twenty-two in one case¹⁶—with the goal of straightening the penis and constructing a urethra to enable standing urinary posture. For some, the surgeries end only when the child grows old enough to resist.¹⁷

Children assigned to the female sex are subjected to surgery that removes the troubling hypertrophic clitoris (the same tissue that would have been a troubling micropenis if the child had been assigned male). Through the 1960s, feminizing pediatric genital surgery was openly labeled "clitorectomy" and was compared favorably to the African practices that have been the recent focus of such intense scrutiny. As three Harvard surgeons noted, "Evidence that the clitoris is not essential for normal coitus may be gained from certain sociological data. For instance, it is the custom of a number of African tribes to excise the clitoris and other parts of the external genitals. Yet normal sexual function is observed

in these females.”¹⁸ A modified operation that removes most of the clitoris and relocates a bit of the tip is variously (and euphemistically) called clitoroplasty, clitoral reduction, or clitoral recession and is described as a “simple cosmetic procedure” to differentiate it from the now infamous clitorectomy. However, the operation is far from benign. Here is a slightly simplified summary (in my own words) of the surgical technique—recommended by Johns Hopkins Surgeons Oesterling, Gearhart, and Jeffs—that is representative of the operation:

They make an incision around the phallus, at the corona, then dissect the skin away from its underside. Next they dissect the skin away from the dorsal side and remove as much of the corpora, or erectile bodies, as necessary to create an “appropriate size clitoris.” Next, stitches are placed from the pubic area along both sides of the entire length of what remains of the phallus; when these stitches are tightened, it folds up like pleats in a skirt, and recesses into a concealed position behind the mons pubis. If the result is still “too large,” the glans is further reduced by cutting away a pie-shaped wedge.¹⁹

For most intersexuals, this sort of arcane, dehumanized medical description, illustrated with close-ups of genital surgery and naked children with blacked-out eyes, is the only available version of *Our Bodies, Ourselves*. We as a culture have relinquished to medicine the authority to police the boundaries of male and female, leaving intersexuals to recover as best they can, alone and silent, from violent normalization.

MY CAREER AS A HERMAPHRODITE: RENEGOTIATING CULTURAL MEANINGS

I was born with ambiguous genitals. A doctor specializing in intersexuality deliberated for three days—sedating my mother each time she asked what was wrong with her baby—before concluding that I was male, with a micropenis, complete hypospadias, undescended testes, and a strange extra opening behind the urethra. A male birth certificate was completed for me, and my parents began raising me as a boy. When I was a year and a half old my parents consulted a different set of experts, who admitted me to a hospital for “sex determination.” “Determine” is a remarkably apt word in this context, meaning both “to ascertain by investigation” and “to cause to come to a resolution.” It perfectly describes the two-stage process whereby science produces through a series of masked operations what it claims merely to observe. Doctors told my parents that a thorough medical investigation would be necessary to determine (in the first sense of that word) what my “true sex” was. They judged my genital appendage to be inadequate as a penis, too short to mark masculine status effectively or to penetrate females. As a female, however, I would be penetrable and potentially fertile. My anatomy having been relabeled as vagina, urethra, labia, and outsized clitoris, my sex was determined (in the second sense) by amputating my genital appendage. Following doctors’ orders, my parents then changed my name, combed their house to eliminate all traces of my existence as a boy (photographs, birthday cards, etc.), changed my birth certificate, moved to a different town, instructed extended family members no longer to refer to me as a boy, and never told anyone else—including me—just what had happened. My intersexuality and change of sex were the family’s dirty little secrets.

At age eight, I was returned to the hospital for abdominal surgery that trimmed away the testicular portion of my gonads, each of which was partly ovarian and partly testicular in character. No explanation was given to me then for the long hospital stay or the abdominal surgery, nor for the regular hospital visits afterward, in which doctors photographed my genitals and inserted fingers and instruments into my vagina and anus. These visits ceased as soon as I began to menstruate. At the time of the sex change, doctors had assured my parents that their once son/now daughter would grow into a woman who could have a normal sex life and babies. With the confirmation of menstruation, my

parents apparently concluded that that prediction had been borne out and their ordeal was behind them. For me, the worst part of the nightmare was just beginning.

As an adolescent, I became aware that I had no clitoris or inner labia and was unable to orgasm. By the end of my teens, I began to do research in medical libraries, trying to discover what might have happened to me. When I finally determined to obtain my medical records, it took me three years to overcome the obstruction of the doctors whom I asked for help. When I did obtain them, a scant three pages, I first learned that I was a “true hermaphrodite” who had been my parents’ son for a year and a half and who bore a name unfamiliar to me. The records also documented my clitorectomy. This was the middle 1970s, when I was in my early twenties. I had come to identify myself as lesbian, at a time when lesbianism and a biologically based gender essentialism were virtually synonymous: men were rapists who caused war and environmental destruction; women were good and would heal the earth; lesbians were a superior form of being uncontaminated by “men’s energy.” In such a world, how could I tell anyone that I had actually possessed the dreaded “phallus”? I was no longer a woman in my own eyes but rather a monstrous and mythical creature. Because my hermaphroditism and long-buried boyhood were the history behind the clitorectomy, I could never speak openly about that or my consequent inability to orgasm. I was so traumatized by discovering the circumstances that produced my embodiment that I could not speak of these matters with anyone.

Nearly fifteen years later, I suffered an emotional meltdown. In the eyes of the world, I was a highly successful businesswoman, a principal in an international high tech company. To myself, I was a freak, incapable of loving or being loved, filled with shame about my status as a hermaphrodite and about my sexual dysfunction. Unable to make peace with myself, I finally sought help from a psychotherapist, who reacted to each revelation about my history and predicament with some version of “no, it’s not” or “so what?” I would say, “I’m not really a woman,” and she would say, “Of course you are. You look female.” I would say, “My complete withdrawal from sexuality has destroyed every relationship I’ve ever entered.” She would say “Everybody has their ups and downs.” I tried another therapist and met with a similar response. Increasingly desperate, I confided my story to several friends, who shrank away in embarrassed silence. I was in emotional agony, feeling utterly alone, seeing no possible way out. I decided to kill myself.

Confronting suicide as a real possibility proved to be my personal epiphany. I fantasized killing myself quite messily and dramatically in the office of the surgeon who had cut off my clitoris, forcibly confronting him with the horror he had imposed on my life. But in acknowledging the desire to put my pain to some use, not to utterly waste my life, I turned a crucial corner, finding a way to direct my rage productively out into the world rather than destructively at myself. I had no conceptual framework for developing a more positive self-consciousness. I knew only that I felt mutilated, not fully human, but that I was determined to heal. I struggled for weeks in emotional chaos, unable to eat or sleep or work. I could not accept my image of a hermaphroditic body any more than I could accept the butchered one the surgeons left me with. Thoughts of myself as a Frankenstein’s monster patchwork alternated with longings for escape by death, only to be followed by outrage, anger, and a determination to survive. I could not accept that it was just or right or good to treat any person as I had been treated—my sex changed, my genitals cut up, my experience silenced and rendered invisible. I bore a private hell within me, wretchedly alone in my condition without even my tormentors for company. Finally, I began to envision myself standing in a driving storm but with clear skies and a rainbow visible in the distance. I was still in agony, but I was beginning to see the painful process in which I was caught up in terms of revitalization and rebirth, a means of investing my life with a new sense of authenticity that possessed vast potentials for further transformation. Since then, I have seen this experience of movement through pain to personal empowerment described by other intersex and transsexual activists.²⁰

I slowly developed a newly politicized and critically aware form of self-understanding. I had been the kind of lesbian who at times had a girlfriend but who had never really participated in the life of a lesbian community. I felt almost completely isolated from gay politics, feminism, and queer and gender theory. I did possess the rudimentary knowledge that the gay rights movement had gathered momentum only when it could effectively deny that homosexuality was sick or inferior and assert to the contrary that “gay is good.” As impossible as it then seemed, I pledged similarly to affirm that “intersex is good,” that the body I was born with was not diseased, only different. I vowed to embrace the sense of being “not a woman” that I initially had been so terrified to discover.

I began searching for community and consequently moved to San Francisco in the fall of 1992, based entirely on my vague notion that people living in the “queer mecca” would have the most conceptually sophisticated, socially tolerant, and politically astute analysis of sexed and gendered embodiment. I found what I was looking for in part because my arrival in the Bay Area corresponded with the rather sudden emergence of an energetic transgender political movement. Transgender Nation (TN) had developed out of Queer Nation, a post-gay/lesbian group that sought to transcend identity politics. TN’s actions garnered media attention—especially when members were arrested during a “zap” of the American Psychiatric Association’s annual convention when they protested the psychiatric labeling of transsexuality as mental illness. Transsexual performance artist Kate Bornstein was introducing transgender issues in an entertaining way to the San Francisco gay/lesbian community and beyond. Female-to-male issues had achieved a new level of visibility due in large part to efforts made by Lou Sullivan, a gay FTM activist who had died an untimely death from HIV-related illnesses in 1991. And in the wake of her underground best-selling novel, *Stone Butch Blues*, Leslie Feinberg’s manifesto *Transgender Liberation: A Movement Whose Time Has Come* was finding a substantial audience, linking transgender social justice to a broader progressive political agenda for the first time.²¹ At the same time, a vigorous new wave of gender scholarship had emerged in the academy.²² In this context, intersex activist and theoretician Morgan Holmes could analyze her own clitorrectomy for her master’s thesis and have it taken seriously as academic work.²³ Openly transsexual scholars, including Susan Stryker and Sandy Stone, were visible in responsible academic positions at major universities. Stone’s “*Empire Strikes Back: A Posttranssexual Manifesto*” refigured open, visible transsexuals not as gender conformists propping up a system of rigid, binary sex but as “a set of embodied texts whose potential for productive disruption of structured sexualities and spectra of desire has yet to be explored.”²⁴

Into this heady atmosphere, I brought my own experience. Introduced by Bornstein to other gender activists, I explored with them the cultural politics of intersexuality, which to me represented yet another new configuration of bodies, identities, desires, and sexualities from which to confront the violently normativizing aspects of the dominant sex/gender system. In the fall of 1993, TN pioneer Anne Ogborn invited me to participate in a weekend retreat called the New Woman Conference, where postoperative transsexual women shared their stories, their griefs and joys, and enjoyed the freedom to swim or sunbathe in the nude with others who had surgically changed genitals. I saw that participants returned home in a state of euphoria, and I determined to bring that same sort of healing experience to intersex people.

BIRTH OF AN INTERSEX MOVEMENT: OPPOSITION AND ALLIES

Upon moving to San Francisco, I started telling my story indiscriminately to everyone I met. Over the course of a year, simply by speaking openly within my own social circles, I learned of six other intersexuals—including two who had been fortunate enough to escape medical attention. I realized that intersexuality, rather than being extremely rare, must be relatively common. I decided to create a support network. In the summer of 1993, I produced some pamphlets, obtained a post office box,

and began to publicize the Intersex Society of North America (ISNA) through small notices in the media. Before long, I was receiving several letters per week from intersexuals throughout the United States and Canada and occasionally some from Europe. While the details varied, the letters gave a remarkably coherent picture of the emotional consequences of medical intervention. Morgan Holmes: "All the things my body might have grown to do, all the possibilities, went down the hall with my amputated clitoris to the pathology department. The rest of me went to the recovery room—I'm still recovering." Angela Moreno: "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." Thomas: "I pray that I will have the means to repay, in some measure, the American Urological Association for all that it has done for my benefit. I am having some trouble, though, in connecting the timing mechanism to the fuse."

ISNA's most immediate goal has been to create a community of intersex people who could provide peer support to deal with shame, stigma, grief, and rage as well as with practical issues such as how to obtain old medical records or locate a sympathetic psychotherapist or endocrinologist. To that end, I cooperated with journalists whom I judged capable of reporting widely and responsibly on our efforts, listed ISNA with self-help and referral clearinghouses, and established a presence on the Internet (<http://www.isna.org>). ISNA now connects hundreds of intersexuals across North America, Europe, Australia, and New Zealand. It has also begun sponsoring an annual intersex retreat, the first of which took place in 1996 and which moved participants every bit as profoundly as the New Woman Conference had moved me in 1993.

ISNA's longer-term and more fundamental goal, however, is to change the way intersex infants are treated. We advocate that surgery not be performed on ambiguous genitals unless there is a medical reason (such as blocked or painful urination), and that parents be given the conceptual tools and emotional support to accept their children's physical differences. While it is fascinating to think about the potential development of new genders or subject positions grounded in forms of embodiment that fall outside the familiar male/female dichotomy, we recognize that the two-sex/gender model is currently hegemonic and therefore advocate that children be raised either as boys or girls, according to which designation seems most likely to offer the child the greatest future sense of comfort. Advocating gender assignment without resorting to normalizing surgery is a radical position given that it requires the willful disruption of the assumed concordance between body shape and gender category. However, this is the only position that prevents irreversible physical damage to the intersex person's body, that respects the intersex person's agency regarding his/her own flesh, and that recognizes genital sensation and erotic functioning to be at least as important as reproductive capacity. If an intersex child or adult decides to change gender or to undergo surgical or hormonal alteration of his/her body, that decision should also be fully respected and facilitated. The key point is that intersex subjects should not be violated for the comfort and convenience of others.

One part of reaching ISNA's long-term goal has been to document the emotional and physical carnage resulting from medical interventions. As a rapidly growing literature makes abundantly clear (see the bibliography on our website, <http://www.isna.org/bigbib.html>), the medical management of intersexuality has changed little in the forty years since my first surgery. Kessler expresses surprise that "in spite of the thousands of genital operations performed every year, there are no meta-analyses from within the medical community on levels of success."²⁵ They do not know whether postsurgical intersexuals are "silent and happy or silent and unhappy."²⁶ There is no research effort to improve erotic functioning for adult intersexuals whose genitals have been altered, nor are there psychotherapists specializing in working with adult intersex clients trying to heal from the trauma of medical intervention. To provide a counterpoint to the mountains of medical literature that neglect intersex experience

and to begin compiling an ethnographic account of that experience, ISNA's *Hermaphrodites with Attitude* newsletter has developed into a forum for intersexuals to tell their own stories. We have sent complimentary copies of the newsletter filled with searing personal narratives to academics, writers, journalists, minority rights organizations, and medical practitioners—to anybody we thought might make a difference in our campaign to change the way intersex bodies are managed.

ISNA's presence has begun to generate effects. It has helped politicize the growing number of intersex organizations, as well as intersex identities themselves. When I first began organizing ISNA, I met leaders of the Turner's Syndrome Society, the oldest known support group focusing on atypical sexual differentiation, founded in 1987. Turner's Syndrome is defined by an XO genetic karyotype that results in a female body morphology with nonfunctioning ovaries, extremely short stature, and a variety of other physical differences described in the medical literature with such stigmatizing labels as "web-necked" and "fish-mouthed." Each of these women told me what a profound, life-changing experience it had been simply to meet another person like herself. I was inspired by their accomplishments (they are a national organization serving thousands of members), but I wanted ISNA to have a different focus. I was less willing to think of intersexuality as a pathology or disability, more interested in challenging its medicalization entirely, and more interested still in politicizing a pan-intersexual identity across the divisions of particular etiologies in order to destabilize more effectively the heteronormative assumptions underlying the violence directed at our bodies.

When I established ISNA in 1993, no such politicized groups existed. In the United Kingdom in 1988, the mother of a girl with androgen-insensitivity syndrome (AIS, which produces genetic males with female genital morphologies) formed the AIS Support Group. The group, which initially lobbied for increased medical attention (better surgical techniques for producing greater vaginal depth, more research into the osteoporosis that often attends AIS), now has chapters in five countries. Another group, K. S. and Associates, was formed in 1989 by the mother of a boy with Klinefelter's Syndrome and today serves over one thousand families. Klinefelter's is characterized by the presence of one or more additional X chromosomes, which produce bodies with fairly masculine external genitals, above-average height, and somewhat gangly limbs. At puberty, people with K. S. often experience pelvic broadening and the development of breasts. K. S. and Associates continues to be dominated by parents, is highly medical in orientation, and has resisted attempts by adult Klinefelter's Syndrome men to discuss gender identity or sexual orientation issues related to their intersex condition.

Since ISNA has been on the scene, other groups with a more resistant stance vis-à-vis the medical establishment have begun to appear. In 1995, a mother who refused medical pressure for female assignment for her intersex child formed the Ambiguous Genitalia Support Network, which introduces parents of intersexuals to each other and encourages the development of pen-pal support relationships. In 1996, another mother who had rejected medical pressure to assign her intersex infant as a female by removing his penis formed the Hermaphrodite Education and Listening Post (HELP) to provide peer support and medical information. Neither of these parent-oriented groups, however, frames its work in overtly political terms. Still, political analysis and action of the sort advocated by ISNA has not been without effect on the more narrowly defined service-oriented or parent-dominated groups. The AIS Support Group, now more representative of both adults and parents, noted in a recent newsletter,

Our first impression of ISNA was that they were perhaps a bit too angry and militant to gain the support of the medical profession. However, we have to say that, having read [political analyses of intersexuality by ISNA, Kessler, Fausto-Sterling, and Holmes], we feel that the feminist concepts relating to the patriarchal treatment of intersexuality are extremely interesting and do make a lot of sense. After all, the lives of intersexed people are stigmatized by the cultural disapproval of their genital appearance, [which need not] affect their experience as sexual human beings.²⁷

Other more militant groups have now begun to pop up. In 1994, German intersexuals formed both the Workgroup on Violence in Pediatrics and Gynecology and the Genital Mutilation Survivors' Support Network, and Hijra Nippon now represents activist intersexuals in Japan.

Outside the rather small community of intersex organizations, ISNA's work has generated a complex patchwork of alliances and oppositions. Queer activists, especially transgender activists, have provided encouragement, advice, and logistical support to the intersex movement. The direct action group Transsexual Menace helped an ad hoc group of militant intersexuals calling themselves Hermaphrodites with Attitude plan and carry out a picket of the 1996 annual meeting of the American Academy of Pediatrics in Boston—the first recorded instance of intersex public protest in modern history.²⁸ ISNA was also invited to join GenderPAC, a recently formed national consortium of transgender organizations that lobbies against discrimination based on atypical expressions of gender or embodiment. More mainstream gay and lesbian political organizations such as the National Gay and Lesbian Task Force have also been willing to include intersex concerns as part of their political agendas. Transgender and lesbian/gay groups have been supportive of intersex political activism largely because they see similarities in the medicalization of these various identities as a form of social control and (especially for transsexuals) empathize with our struggle to assert agency within a medical discourse that works to efface the ability to exercise informed consent about what happens to one's own body.

Gay/lesbian caucuses and special interest groups within professional medical associations have been especially receptive to ISNA's agenda. One physician on the Internet discussion group glb-medical wrote:

The effect of Cheryl Chase's postings—admittedly, after the shock wore off—was to make me realize that THOSE WHO HAVE BEEN TREATED might very well think [they had not been well served by medical intervention]. This matters a lot. As a gay man, and simply as a person, I have struggled for much of my adult life to find my own natural self, to disentangle the confusions caused by others' presumptions about how I am/should be. But, thankfully, their decisions were not surgically imposed on me!

Queer psychiatrists, starting with Bill Byne at New York's Mount Sinai Hospital, have been quick to support ISNA, in part because the psychological principles underlying the current intersex treatment protocols are manifestly unsound. They seem almost willfully designed to exacerbate rather than ameliorate already difficult emotional issues arising from sexual difference. Some of these psychiatrists see the surgical and endocrinological domination of a problem that even surgeons and endocrinologists acknowledge to be psychosocial rather than biomedical as an unjustified invasion of their area of professional competence.

ISNA has deliberately cultivated a network of nonintersexed advocates who command a measure of social legitimacy and can speak in contexts where uninterpreted intersex voices will not be heard. Because there is a strong impulse to discount what intersexuals have to say about intersexuality, sympathetic representation has been welcome—especially in helping intersexuals reframe intersexuality in nonmedical terms. Some gender theory scholars, feminist critics of science, medical historians, and anthropologists have been quick to understand and support intersex activism. Years before ISNA came into existence, feminist biologist and science studies scholar Anne Fausto-Sterling had written about intersexuality in relation to intellectually suspect scientific practices that perpetuate masculinist constructs of gender, and she became an early ISNA ally.²⁹ Likewise, social psychologist Suzanne Kessler had written a brilliant ethnography of surgeons who specialize in treating intersexuals. After speaking with several "products" of their practice, she, too, became a strong supporter of intersex activism.³⁰ Historian of science Alice Dreger, whose work focuses not only on hermaphroditism but on other forms of potentially benign atypical embodiment that become subject to destructively normalizing

medical interventions (conjoined twins, for example), has been especially supportive. Fausto-Sterling, Kessler, and Dreger will each shortly publish works that analyze the medical treatment of intersexuality as being culturally motivated and criticize it as harmful to its ostensible patients.³¹

Allies who help contest the medicalization of intersexuality are especially important because ISNA has found it almost entirely fruitless to attempt direct, nonconfrontational interactions with the medical specialists who themselves determine policy on the treatment of intersex infants and who actually carry out the surgeries. Joycelyn Elders, the Clinton administration's first surgeon general, is a pediatric endocrinologist with many years of experience managing intersex infants but, in spite of a generally feminist approach to health care and frequent overtures from ISNA, she has been dismissive of the concerns of intersexuals themselves.³² Another pediatrician remarked in an Internet discussion on intersexuality: "I think this whole issue is preposterous. . . . To suggest that [medical decisions about the treatment of intersex conditions] are somehow cruel or arbitrary is insulting, ignorant and misguided. . . . To spread the claims that [ISNA] is making is just plain wrong, and I hope that this [on-line group of doctors and scientists] will not blindly accept them." Yet another participant in that same chat asked what was for him obviously a rhetorical question: "Who is the enemy? I really don't think it's the medical establishment. Since when did we establish the male/female hegemony?" While a surgeon quoted in a *New York Times* article on ISNA summarily dismissed us as "zealots,"³³ there is considerable anecdotal information supplied by ISNA sympathizers that professional meetings in the fields of pediatrics, urology, genital plastic surgery, and endocrinology are buzzing with anxious and defensive discussions of intersex activism. In response to the Hermaphrodites with Attitude protests at the American Academy of Pediatrics meeting, that organization felt compelled to issue the following statement to the press: "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." Further protests were planned for 1997.

The roots of resistance to the truth claims of intersexuals run deep in the medical establishment. Not only does ISNA critique the normativist biases couched within most scientific practice, it advocates a treatment protocol for intersex infants that disrupts conventional understandings of the relationship between bodies and genders. But on a level more personally threatening to medical practitioners, ISNA's position implies that they have—unwittingly at best, through willful denial at worst—spent their careers inflicting a profound harm from which their patients will never fully recover. ISNA's position threatens to destroy the assumptions motivating an entire medical subspecialty, thus jeopardizing the ability to perform what many surgeons find to be technically difficult and fascinating work. Melissa Hendricks notes that Dr. Gearhart is known to colleagues as a surgical "artist" who can "carve a large phallus down into a clitoris" with consummate skill.³⁴ More than one ISNA member has discovered that surgeons actually operated on their genitals at no charge. The medical establishment's fascination with its own power to change sex and its drive to rescue parents from their intersex children are so strong that heroic interventions are delivered without regard to the capitalist model that ordinarily governs medical services.

Given such deep and mutually reinforcing reasons for opposing ISNA's position, it is hardly surprising that medical intersex specialists have, for the most part, turned a deaf ear toward us. The lone exception as of April 1997 is urologist Justine Schober. After watching a videotape of the 1996 ISNA retreat and receiving other input from HELP and the AIS Support Group, she suggests in a new textbook on pediatric surgery that while technology has advanced to the point that "our needs [as surgeons] and the needs of parents to have a presentable child can be satisfied," it is time to acknowledge that problems exist that "we as surgeons . . . cannot address. Success in psychosocial adjustment is the true goal of sexual assignment and genitoplasty. . . . Surgery makes parents and doctors comfortable, but counseling makes people comfortable too, and is not irreversible."³⁵

While ISNA will continue to approach the medical establishment for dialogue (and continue supporting protests outside the closed doors when doctors refuse to talk), perhaps the most important aspect of our current activities is the struggle to change public perceptions. By using the mass media, the Internet, and our growing network of allies and sympathizers to make the general public aware of the frequency of intersexuality and of the intense suffering that medical treatment has caused, we seek to create an environment in which many parents of intersex children will have already heard about the intersex movement when their child is born. Such informed parents we hope will be better able to resist medical pressure for unnecessary genital surgery and secrecy and to find their way to a peer-support group and counseling rather than to a surgical theater.

FIRST-WORLD FEMINISM, AFRICAN CLITORECTOMY, AND INTERSEX GENITAL MUTILATION

We must first locate and challenge our own position as rigorously as we challenge that of others.

—Salem Mekuria, “Female Genital Mutilation in Africa”

Traditional African practices that remove the clitoris and other parts of female genitals have lately been a target of intense media coverage and feminist activism in the United States and other industrialized Western societies. The euphemism *female circumcision* largely has been supplanted by the politicized term *female genital mutilation* (FGM). Analogous operations performed on intersexuals in the United States have not been the focus of similar attention—indeed, attempts to link the two forms of genital cutting have met with multiform resistance. Examining how first-world feminists and mainstream media treat traditional African practices and comparing that treatment with their responses to intersex genital mutilation (IGM) in North America exposes some of the complex interactions between ideologies of race, gender, colonialism, and science that effectively silence and render invisible intersex experience in first-world contexts. Cutting intersex genitals becomes yet another hidden mechanism for imposing normalcy upon unruly flesh, a means of containing the potential anarchy of desires and identifications within oppressive heteronormative structures.

In 1994, the *New England Journal of Medicine* paired an article on the physical harm resulting from African genital surgery with an editorial denouncing clitorrectomy as a violation of human rights but declined to run a reply drafted by University of California at Berkeley medical anthropologist Lawrence Cohen and two ISNA members detailing the harm caused by medicalized American clitorrectomies.³⁶ In response to growing media attention, Congress passed the Federal Prohibition of Female Genital Mutilation Act in October 1996, but the act specifically exempted from prohibition medicalized clitorrectomies of the sort performed to “correct” intersex bodies. The bill’s principal author, former Congresswoman Patricia Schroeder, received and ignored many letters from ISNA members and Brown University professor of medical science Anne Fausto-Sterling asking her to recast the bill’s language. The *Boston Globe*’s syndicated columnist Ellen Goodman is one of the few journalists covering African FGM to respond to ISNA. “I must admit I was not aware of this situation,” she wrote to me in 1994. “I admire your courage.” She continued, however, regularly to discuss African FGM in her column without mentioning similar American practices. One of her October 1995 columns on FGM was promisingly titled, “We Don’t Want to Believe It Happens Here,” but it discussed only immigrants to the United States from third-world countries who performed clitorrectomies on their daughters in keeping with the practices of their native cultures.

While clitorrectomized African immigrant women doing anti-FGM activism in the United States have been receptive to the claims made by intersex opponents to medicalized clitorrectomies and are in dialogue with us, first-world feminists and organizations working on African FGM have totally

ignored us. To my knowledge, only two of the many anti-FGM groups contacted have responded to repeated overtures from intersex activists. Fran Hosken, who since 1982 has regularly published a catalogue of statistics on female genital mutilation worldwide, wrote me a terse note saying that “we are not concerned with biological exceptions.”³⁷ Forward International, another anti-FGM organization, replied to an inquiry from German intersexual Heike Spreitzer that her letter was “most interesting” but that they could not help because their work focuses only on “female genital mutilation that is performed as a harmful cultural or traditional practice on young girls.” As Forward International’s reply to Spreitzer demonstrates, many first-world anti-FGM activists seemingly consider Africans to have “harmful cultural or traditional practices,” while we in the modern industrialized West presumably have something better. We have science, which is linked to the metanarratives of enlightenment, progress, and truth. Genital cutting is condoned to the extent that it supports these cultural self-conceptions.

Robin Morgan and Gloria Steinem set the tone for subsequent first-world feminist analyses of FGM with their pathbreaking article in the March 1980 issue of *Ms.* magazine, “The International Crime of Genital Mutilation.”³⁸ A disclaimer warns, “These words are painful to read. They describe facts of life as far away as our most fearful imagination—and as close as any denial of women’s sexual freedom.” For *Ms.* readers, whom the editors imagine are more likely to experience the pain of genital mutilation between the covers of their magazine than between their thighs, clitorectomy is presented as a fact of foreign life whose principal relevance to their readership is that it exemplifies a loss of “freedom,” that most cherished possession of the liberal Western subject. The article features a photograph of an African girl with her legs held open by the arm of an unseen woman to her right. To her left is the disembodied hand of the midwife, holding the razor blade with which she has just performed a ritual clitorectomy. The girl’s face—mouth open, eyes bulging—is a mask of pain. In more than fifteen years of coverage, Western images of African practices have changed little. “Americans made a horrifying discovery this year,” *Life* soberly informed its readers in January 1997 while showing a two-page photo spread of a Kenyan girl held from behind as unseen hands cut her genitals.³⁹ The 1996 Pulitzer Prize for feature photography went to yet another portrayal of a Kenyan clitorectomy.⁴⁰ And in the wake of Fauziya Kassindja’s successful bid for asylum in the United States after fleeing clitorectomy in Togo, the number of FGM images available from her country has skyrocketed.⁴¹

These representations all manifest a profound othering of African clitorectomy that contributes to the silence surrounding similar medicalized practices in the industrialized West. “Their” genital cutting is barbaric ritual; “ours” is scientific. Theirs disfigures; ours normalizes the deviant. The colonialist implications of these representations of genital cutting are even more glaringly obvious when images of intersex surgeries are juxtaposed with images of African FGM. Medical books describing how to perform clitoral surgery on white North American intersex children are almost always illustrated with extreme genital close-ups, disconnecting the genitals not only from the individual intersexed person but from the body itself. Full-body shots always have the eyes blacked out. Why is it considered necessary to black out the eyes of clitorectomized American girls—thus preserving a shred of their privacy and helping ward off the viewer’s identification with the abject image—but not the eyes of the clitorectomized African girls in the pages of American magazines?⁴²

First-world feminist discourse locates clitorectomy not only “elsewhere,” in Africa, but also “elsewhen” in time. A recent *Atlantic Monthly* article on African clitorectomy asserted that the “American medical profession stopped performing clitoridectomies decades ago,” and the magazine has since declined to publish a contradictory letter to the editor from ISNA.⁴³ Academic publications are as prone to this attitude as the popular press. In the recent *Deviant Bodies* anthology, visual artist Susan Jahoda’s “Theatres of Madness” juxtaposes nineteenth- and twentieth-century material depicting “the conceptual interdependence of sexuality, reproduction, family life, and ‘female disorders.’”⁴⁴ To

represent twentieth-century medical clitorrectomy practices, Jahoda quotes a July 1980 letter written to *Ms.* magazine in response to Morgan and Steinem. The letter writer, a nurse's aide in a geriatric home, said she had been puzzled by the strange scars she saw on the genitals of five of the forty women in her care: "Then I read your article. . . . My God! Why? Who decided to deny them orgasm? Who made them go through such a procedure? I want to know. Was it fashionable? Or was it to correct 'a condition'? I'd like to know what this so-called civilized country used as its criteria for such a procedure. And how widespread is it here in the United States?"⁴⁵ While Jahoda's selection of this letter does raise the issue of medicalized American clitorrectomies, it safely locates the genital cutting in the past, as something experienced a long time ago by women now in their later stages of life.

Significantly, Jahoda literally passed over an excellent opportunity to comment on the continuing practice of clitorrectomy in the contemporary United States. Two months earlier, in the April 1980 issue of *Ms.*, feminist biologists Ruth Hubbard and Patricia Farnes also replied to Morgan and Steinem:

We want to draw the attention of your readers to the practice of clitoridectomy not only in the Third World. . . . but right here in the United States, where it is used as part of a procedure to "repair" by "plastic surgery" so-called genital ambiguities. Few people realize that this procedure has routinely involved removal of the entire clitoris and its nerve supply—in other words, total clitoridectomy. . . . In a lengthy article, [Johns Hopkins intersex expert John] Money and two colleagues write. . . . that "a three-year old girl about to be clitoridectomized. . . . should be well informed that *the doctors will make her look like all other girls and women*" (our emphasis), which is not unlike what North African girls are often told about their clitoridectomies. . . . But to date, neither Money nor his critics have investigated the effect of clitoridectomies on the girls' development. Yet one would surely expect this to affect their psychosexual development and their feelings of identity as young women.⁴⁶

While Farnes and Hubbard's prescient feminist exposé of medicalized clitorrectomies in the contemporary United States sank without a trace, there has been an explosion of work that keeps "domestic" clitorrectomy at a safe distance. Such conceptualizations of clitorrectomy's geographical and temporal cultural remoteness allow first-world feminist outrage to be diverted into potentially colonialist meddling in the social affairs of others while hampering work for social justice at home.⁴⁷

Feminism represents itself as being interested in unmasking the silence that surrounds violence against women. Most medical intersex management is another form of violence based on a sexist devaluing of female pain and female sexuality. Doctors consider the prospect of growing up as a boy with a small penis to be a worse alternative than growing up as a girl *sans* clitoris and ovaries; they gender intersex bodies accordingly and cut them up to make the assigned genders support cultural norms of embodiment. These medical interventions transform many transgressive bodies into ones that can be labeled safely as women and subjected to the many forms of social control with which women must contend. Why then have most first-world feminists met intersexuals with a blank stare?

Intersexuals have had such difficulty generating mainstream feminist support not only because of the racist and colonialist frameworks that situate clitorrectomy as a practice foreign to proper subjects within the first world but also because intersexuality undermines the stability of the category "woman" that undergirds much of first-world feminist discourse. We call into question the assumed relation between genders and bodies and demonstrate how some bodies do not fit easily into male/female dichotomies. We embody viscerally the truth of Judith Butler's dictum that "sex," the concept that accomplishes the materialization and naturalization of power-laden, culturally constructed differences, has really been "gender all along."⁴⁸ By refusing to remain silenced, we queer the foundations upon which depend not only the medical management of bodies but also widely shared feminist assumptions of properly embodied feminine subjectivity. To the extent that we are not normatively female or normatively women, we are not considered the proper subjects of feminist concern.

As unwilling subjects of science and improper subjects of feminism, politicized intersex activists have deep stakes in allying with and participating in the sorts of poststructuralist cultural work that exposes the foundational assumptions about personhood shared by the dominant society, conventional feminism, and many other identity-based oppositional social movements. We have a stake, too, in the efforts of gender queers to carve out livable social spaces for reconfigured forms of embodiment, identity, and desire. In 1990, Suzanne Kessler noted that “the possibilities for real societal transformations would be unlimited” if physicians and scientists specializing in the management of gender could recognize that “finally, and always, people construct gender as well as the social systems that are grounded in gender-based concepts. . . . Accepting genital ambiguity as a natural option would require that physicians also acknowledge that genital ambiguity is ‘corrected’ not because it is threatening to the infant’s life but because it is threatening to the infant’s culture.”⁴⁹ At that time, intersexuals had not yet been heard from, and there was little reason to think that physicians or other members of their culture would ever reflect on the meaning or effect of what they were doing. The advent of an activist intersex opposition changes everything.

NOTES

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