GENDER STUDIES/PSYCHOLOGY/MEDICINE

"This is a brave book. Kessler says things that need to be said, and she says concisely, and with respect for the people whose lives are most affected by she confronts. A must read for anyone concerned with intersex issues." —
author of *Gender Blending: Confronting the Limits of Duality* and *FTM: Female-to-Male Transse*

"While the physician's response to an infant with ambiguous genitalia produce categories like the 'successful vagina' and the 'good enough p takes her cues from intersexuals themselves. This book is a brilliant and lon for the reevaluation of gender variability." —**JUDITH HALBERSTAM**, author of *Female Masculinity*

"Fascinating in what it tells us not only about situations in which sex assignment is uncertain but about the astonishingly weak empirical foundations on which the medical orthodoxies of binary sex and gender are built. A must for anyone interested in the ways widely accepted social beliefs and scientific explanations generate and reinforce each other." —**RUTH HUBBARD**, author of *The Politics of Women's Biology* and *Exploding the Gene Myth*

From the moment intersexuality—the condition of having physical gender markers (genitals, gonads, or chromosomes) that are neither clearly female nor male—is suspected and diagnosed, social institutions are mobilized in order to maintain the two seemingly objective sexual categories. Infants' bodies are altered, and the "ambiguous" is made "normal." As Kessler argues, the way the medical and psychological professions manage intersexuality is guided by our culture's beliefs about gender and genitals rather than by the needs of the child.

Interviews with pediatric surgeons and endocrinologists as well as parents of intersexed children and adults who were treated for this condition in childhood lead Kessler to propose several new approaches for physicians in dealing with parents and children. Beyond the medical sphere, the author also evaluates a political vanguard intent on gaining acceptance by physicians and society at large of an intersexed identity.

Lessons from the Intersexed explores the possibilities and implications of suspending a commitment to two "natural" genders. It addresses gender destabilization issues arising from intersexuality and compels a rethinking of the meaning of gender, genitals, and sexuality.

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SUZANNE J. KESSLER

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Introduction

Alex A. was born in 1971. He called me to talk about what he labeled his "sexual differentiation disorder" and related his story: Alex was given a female gender assignment at birth, despite having labial-scrotum fusion. By age one or two Alex's mother noticed that his phallus was enlarged, and by the time he could speak, he called it "my penis." At puberty his voice deepened, and he began to be called "he-man" by other kids. He did not develop breasts, but by age thirteen, was menstruating irregularly from his phallus. A rural doctor put him on estrogen, and he developed small breasts but considerable axillary body hair. In his late teens Alex was sent to an endocrinologist who asked whether he had ever taken hormones. At that point, Alex did not even know what hormones were. The endocrinologist said: "I think you should change to a male" and gave him a prescription for testosterone, but Alex never filled it. He recalls, "We were very religious people. We [mother and I] didn't know what was going on." Alex's mother was encouraging him to "try and grow breasts."

By age twenty-four his breasts started to enlarge. Recently, he saw another endocrinologist who said: "We can make you a girl" and bolstered this suggestion with the argument, "You know, women can even be managers now." Alex was told that his clitoris can be reduced and that an ultrasound revealed a uterus. In spite of the doctor's recommendation, Alex does not want to go this route. He is confused because he has always thought doctors were gods. He feels like a male and has no idea what his diagnosis is.

Alex B. was born in 1963. At birth Alex was diagnosed with the condition "mixed gonadal dysgenesis" and was given a male gender assignment. Although regarded as a boy, the child was never

really accepted as one. Everyone in the small town knew about Alex's genital abnormality.

Now an adult woman, Alex remembers that her mother regularly examined her genitals and told her that "something like this simply was not acceptable." Yet, she remembers being content with her body. She was hospitalized at age four for reasons she still does not know. Her parents said that it was a decision by some physician they had never consulted before. Her mother had her examined at a nearby hospital at age twelve because she was not experiencing puberty. Alex had hoped for breast development and sometimes tried to pass as a female, but her parents would correct other people's view. She was given testosterone shots for one and a half years. No one explained to her what the treatment was supposedly good for, and Alex was told she should not speak of it. Treatments were stopped because they did not achieve what was desired: growth of phallic tissue. But her voice did change, and she developed facial hair and involuntary clitoral erections, all of which enormously bothered her.

At age twenty Alex left her hometown to get estrogen treatments and genital surgery. The first surgeon she went to said Alex did not have enough penile and scrotal skin to model a complete vagina and vulva. (Alex wanted to retain a functioning clitoris and put special emphasis on acceptable labia.) Her assessment is that he produced "at best a halfway aesthetically and functionally acceptable result." Although she considers the surgery as having been necessary, since she doubts whether she would have survived emotionally without it, she recognizes that she undertook it as an extreme reaction to previously extreme treatment that had been administered against her will.

One year later Alex had surgery again, urged by a physician who wanted to repair the scar tissue. Without consulting her, he tried to elongate what he felt was her too short vagina. The scar tissue rebuilt itself, and the few extra centimeters were lost again. Alex was offered a third surgery to correct these problems but turned down the offer, as well as an offer for breast augmentation. After a long period of viewing herself as "asexual," Alex began having sexual relationships with female partners. Although she had considered reestablishing a relationship with her parents, she has been unable to come to terms with their dishonesty and has completely broken off contact with them and others from her hometown.

Alex C. was born in 1960. Alex's mother went into labor too quickly to get to a hospital, so the baby was born at home in a large city. Relatives recall that her genitals were ambiguous. Her mother remembers that the doctor said she was "probably a girl." Her grandmother remembers that he said she was "probably a boy." Because of the bad weather that winter, Alex was home with her parents for a month before being seen by another physician. She was brought to the hospital due to her failing health and was diagnosed as having congenital adrenal hyperplasia (CAH). I asked her, "Were you raised as a boy that first month?" She says that no one will discuss that period with her. Alex and I agree that her current name would have been appropriate for either a male or a female.

Alex was treated by physicians continuously throughout her childhood. Blood was drawn repeatedly and her genitals were scrutinized. She claims that the endocrinologist and others at the hospital were conservative about surgery, possibly due to some bad experiences they had had. In addition, they were waiting for Alex's puberty to see whether her body would virilize further.

Alex recalls that, starting around age eight, she began getting pressured by her mother (who was being pressured by the physicians) to accept the idea of genital surgery. The argument was: Don't you want to be normal? Get married? Have babies? She remembers her answer as always being, "No." She held off until age fourteen, when both she and her mother capitulated. (By that time her father had left and her mother had remarried.) Alex was given no psychological preparation and remembers having temper tantrums in the hospital before surgery. She awoke from the surgery experiencing incredible pain.

The surgery was justified on the grounds that creating a vagina would eventually allow her to give birth. She remembers no mention of separating her scrotum to create labia or of reducing her clitoris. Her clitoris had been about three inches long and would have grown, according to her estimation, to be at the most five inches.

In spite of the surgery to create a vagina, Alex refused all physician recommendations to dilate her vagina and threw the dilators in the wastebasket. Consequently, although her vagina is of a normal length, the width has never been increased. She can barely accommodate a junior tampon. Interestingly, although her parents made her undergo the surgery, they in no way pressured her to

stretch her vagina. Her mother's attitude was that now that Alex had one, she could make the decision when and if to increase its size. After Alex's first painful intercourse, she asked a physician if that was normal. Although she was assured it was not, she was not motivated to do anything to increase her vaginal capacity. She has always found intercourse painful and unsatisfactory and identifies herself as a lesbian. During sex she suffers intermittent genital pain, probably due to scar tissue and adhesions, but she is orgasmic.

Alex says that her presurgical genitals were not a problem for her or her parents. Like most CAH girls, the family was more concerned about her state of health. Her situation differs from most other CAH girls (especially children today) in that she had no surgery until puberty. She developed strategies to avoid being seen in the locker room (such as changing before the others did), but she does not recall this as a particularly big deal. Although her urethra did not run through her clitoris, but rather underneath it (much like hypospadias), she used to stand to urinate.

Unlike many other intersexed adults, Alex feels some sympathy for her mother's predicament and believes that she was as much a victim of the medical profession as was Alex. She is sure that her mother has a great deal of anger toward the physicians who never told her that her daughter's clitoris was being removed and that she would be sexually dysfunctional. At present, mother and daughter do not discuss the surgery, and Alex believes that her mother has "blocked it out."

Intrigued with Intersexuality

Who is each Alex "really"? Female or male? We tend to think that genitals, gonads, and secondary gender characteristics have some objective status and ought to be describable and describably female or male. Psychologists treat gender identity as objective. But how people categorized each Alex, as well as how the Alex's categorize themselves, seems rather elusive. Gender, that supposedly objective thing, is highly complex.

Twenty years ago, Wendy McKenna and I analyzed (among other things) the exceptional case of transsexualism in order to demonstrate how gender is socially constructed in all cases.[1] At that time, transsexualism was discussed only by transsexuals, and social constructionism was an "alternative" viewpoint. Today,

transsexualism is the subject of many fine analyses,[2] and social constructionism is a mainstream theoretical perspective, grounding much of the work in Gender Studies and Queer Studies within which there is a particular interest in people who violate categories. Transsexualism, as pointed out maintains a dichotomous gender system. Other "transgressions," though, especially intersexuality and especially now, call the whole system into question.

Gender theorists are intrigued by intersexuality (often referred to as "hermaphroditism"), an idea symbolizing complexity and fluidity.[3] Television talk shows parade the real people who are living in intersexed bodies for the entertainment of an audience that is motivated like any old-fashioned side show crowd to gawk at the bizarre. Unlike a real sideshow, though, the remarkable genitals are not on view, and the audience is titillated only by the idea of intersex. Producers and consumers of pornography are intrigued by intersex genitals, it being almost incidental that they are connected to people and are usually the result of good special effects and not of actual body parts. The viewer can think: Look at how many different sexual acts can take place at the same time! I can watch "homosexual acts" without my heterosexuality being called into question (or vice versa) because the gender of those people on the screen is (in some sense) both or neither.

The theory and practice of gender reflects a completely different set of concerns for some adult intersexuals. Because they resent the shame they experienced due to the secrecy surrounding their condition and the surgeries that were performed on them as infants, they started a political movement to change medical management and to halt infant surgeries. Intersex, for them, is an identity, even if the original mark has been surgically eliminated.

All of these interests contrast with how the medical profession conceptualizes intersexuality—as a correctable birth defect. The meaning of the genital ambiguity for endocrinologists is limited to its marking of a more serious underlying medical disorder, much like a fever indicates infection. For the surgeon, the ambiguity signals an opportunity to fashion the inappropriate into the appropriate. Once the intersex marker has been corrected, the intersexed person (as intersexed) fades into the culture. The meaning of the genital variation is deflected. Physicians claim this is what the parents want. Parents are almost never heard from, but when they are, theirs is yet another perspective on this issue.

What can be learned from examining all these perspectives?

That, in essence, is the subject of this book, but before I describe its content in more detail, I will discuss yet another "case."

Virtually all academic writing on sex and gender refers to a case first described by sexologist John Money in 1972. An infant boy's penis was ablated during routine surgery to free up his constricted foreskin. The physicians, believing that he could not develop a normal male gender identity without a penis, reassigned the boy to the female gender and performed surgery to create female genitals.

The case was particularly interesting because the infant was an identical twin. This "experiment in nature" was used to test the gender socialization hypothesis. Would identical twins, one raised male and the other raised female, develop different gender identities and gender roles? Would biology (specifically prenatal hormones) be overridden by socialization?

Money's initial report was very clear.[4] Socialization ruled. The child was described as a typical little girl who could not be more different from her twin brother. The case was cited as proof of the plasticity of gender and appeared to have struck a mighty blow to biological determinism.

When Money's theory was first introduced, it impressed people in the field of psychology as very radical. Gender was not only a social construction in theory, it could literally be constructed through human intervention. The surgeons would do their part in creating the necessary genitals, and the parents would do their part by creating the appropriate social environment, one in which the child was referred to with the relevant pronoun. Gender identity and gender role would then fall into place.

Subsequent data about the twin forces us to reconsider Money's assertion. Sex researcher Milton Diamond located this twin, who Money claimed had been lost to follow-up, and reported that the child never accepted the female gender label, never acted like a "normal" girl, and at the age of fourteen requested hormones and surgery to convert him back to the male gender.[5] Surgery and hormone treatment were provided, and Joan became John. Diamond and his colleague Sigmundson concluded that the prenatal androgen that the twin had been exposed to "overrode" the socialization, proving that you cannot make a girl out of a boy or vice versa.[6]

inconsistent gender messages from the parents), the failure of reassignment in this particular case is not in question.[7]

Unlike the media, my interest in this case is not whether it supports a biological or social theory of gender development but why gender theorists (including McKenna and myself) were so eager to embrace Money's theory of gender plasticity.[8] Why, also, did it become the only theory taught to parents of intersexed infants—those born with neither clearly female nor clearly male genitals, gonads, or chromosomes?

For whatever reason, gender researchers were blinded to a number of unexamined and deeply conservative assumptions embedded in Money's argument:

1. Genitals are naturally dimorphic; there is nothing socially constructed about the two categories.
2. Those genitals that blur the dimorphism belonging to the occasional intersexed person can be and should be successfully altered by surgery.
3. Gender is necessarily dichotomous (even if socially constructed) because genitals are naturally dimorphic.
4. Dimorphic genitals are the essential markers of dichotomous gender.
5. Physicians and psychologists have legitimate authority to define the relationship between gender and genitals.

Those of us who are social constructionists and have postulated the primacy of gender attribution or gender performance should have been more critical of Money's theory for putting so much emphasis on the genitals as evidence of gender.[9] We should have asked a number of questions, among them, Why did the twin boy have to be a girl if he did not have a penis?

In this book I will examine the five assumptions above and try to answer the following questions:

1. How dimorphic are genitals?
2. How successful are genital surgeries?
3. Is gender necessarily dichotomous; could it be socially constructed to be trichotomous—at least?
4. Must genitals be the essential marker of gender?
5. How does the medical profession use its authority to manage a particular version of gender?

Meanings of Variability

We can think about variations in two very different ways. The first way is to note that most measurements of a feature cluster around the mean, thus creating a norm. The conventional medical view of intersexuality is that knowing the norms of a feature like phallic size, and knowing that most measurements cluster around the mean, validates the existence of underlying pathology when norms are not met. According to this view, genitals that vary from the norm mark a disorder (for example, an enzyme deficiency), and treatment involves correcting both the deficiency and the marker.

A second way to think about variation is to see it as validating the continuum of the feature, thus providing proof that there are arbitrary categories and subjective markers of acceptability. This is the view of gender theorists like Morgan Holmes, an intersexed woman who writes about the social construction of intersexuality. She objects to the typical medical phrase "enlarged clitoris" because it assumes that all "normal" clitorises are virtually identical in size.[10]

I have been deliberately using the term "variability" rather than the medical referent "ambiguity." As we will see in the next chapter, something needs to be done about "ambiguity," but it is less obvious what (if anything) needs to be done about "variability." Genital variability has a number of possible meanings. I will review these meanings here and consider throughout the remaining chapters which constituencies advance which meanings and how meanings gain authority.

Genitals that vary from a narrowly defined standard could have any number of different meanings:[11]

1. Your genitals signify neither of the two traditional 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, but your genitals signify the wrong gender category. 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 th[illegible]

that needs to be addressed. We prescribe (nonsurgical) treatment (for example, medication for children with the salt-losing form of congenital adrenal hyperplasia).
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 does not matter much what they look like as long as they function well. We do not think very much about yours or ours.
8. Your genitals signify something about your parents. They must have misbehaved or be genetically unsuitable. They are embarrassed by you and your genitals.

Obviously, these meanings emanate from the particular communities I mentioned earlier in the chapter. 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. These meanings have authority, at least partly because they concretize gender. Meaning 4, although medical in its outlook, does not link the meaning to gender. This could be the primary medical attitude in a different world. 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 at least part of the significance given to genital variability by some parents of intersexed infants.

One argument for reducing the number of intersex surgeries hinges on changing the meaning of variant genitals, such that a large clitoris does not necessarily mean "offense," a small penis does not necessarily mean "not a real man," and an absent vagina does not necessarily mean "not a real woman." I will discuss this further in the last chapter.

Most writings on intersexuality are either explicitly meant for medical professionals (and consequently highly technical and not analytic) or popular promotions of the status quo.[12] This book

and providing a scholarly context for understanding the contemporary intersexual movement whose goals are to halt genital surgeries on intersexed infants and bring intersexuality "out of the closet" in families confronted with a "gender crisis."

Chapter 2 describes the events following the birth of an intersexed infant. I delineate the cultural factors that influence physicians' decisions and the way physicians normalize intersexuality for parents and discuss the consequence of this management approach for the intersexed individual's family and for the two-gender classification system.

In chapter 3, I discuss the language that physicians use when they write about ambiguous genitals, and I analyze their beliefs that deviant-looking genitals require surgery. In order to understand how physicians recognize ambiguous genitals, it is necessary to consider what normal genitals are supposed to look like and how they are supposed to function. I conclude the chapter by reviewing the various surgical interventions for intersexuality, especially clitoral reduction and vaginoplasty techniques.

Chapter 4 begins with an analysis of the criteria that physicians use for determining success in cases of genital surgeries. I review the follow-up studies in medical literature and draw conclusions about the costs and benefits of doing genital surgery on infants and children. Some comparisons are made with vulvar and vaginal construction for transsexuals and for women who are recovering from gynecological cancers and have had reconstructive surgery.

The management philosophy discussed in chapter 2, because it is from the physicians' point of view, effectively ignores adult intersexuals. In chapter 5, I describe their assessment of surgical treatment, discuss the goals of the intersexual movement, and evaluate the movement's potential to alter the way physicians and parents respond to the intersexuality of children. I also characterize the parents' experience with medical professionals and with their intersexed children. In addition to analyzing medical assumptions, I draw upon data I have collected from samples of college women and men asked to reflect on genitals. What would it mean if the average person permits more genital variability than the average physician? Findings from all these sources are used to develop a thesis of how cultural understandings about gender are constructed in particular circumstances and how those understandings might be different.

In chapter 6, I connect analyses of cosmetic surgery with an analysis of intersex management, considering the consequences of either refusing surgery or demanding it without justification. I explore the meaning of genital variability and conclude with the argument that there are both practical and theoretical implications of managing intersexuality differently, were we to take genitals less seriously and to think differently about gender.

addressed by practitioners, the very practical suggestions I have made for handling intersexuality will seem preposterous.

Treating genital formations as innate but malleable, much like hair, would be to take them and gender less seriously. In the acceptance of genital variability and gender variability lies the subversion of both genitals and gender. Dichotomized, idealized, and created by surgeons, *genitals mean gender*. A belief in two genders encourages talk about "female genitals" and "male genitals" as homogenous types, regardless of how much variability there is within a category.[105] Similarly, the idea of "intersexed" masks the fact that "intersexed genitals" vary from each other as much as they vary from the more idealized forms.

Although it is unlikely that the nontransgender public will embrace an intersexed gender in the near future, as I have shown, people are capable of accepting more genital variation. Accepting more genital variation will maintain, at least temporarily, the two-gender system, but it will begin to unlock gender and genitals. Ultimately, the power of genitals to mark gender will be weakened, and the power of gender to define lives will be blunted.

By subverting genital primacy, gender will be removed from the biological body and placed in the social-interactional one. Even if there are still two genders, male and female, how you "do" male or female, including how you "do" genitals, would be open to interpretation.[106] Physicians teach parents of intersexed infants that the fetus is bipotential, but they talk about gender as being "finished" at sixteen or twenty weeks, just because the genitals are. Gender need not be thought of as finished, not for people who identify as intersexed, nor for any of us. Once we dispense with "sex" and acknowledge gender as located in the social-interactional body, it will be easier to treat it as a work-in-progress.

This is assuming, though, that gender is something worth working on. It may not be. If intersexuality imparts any lesson, it is that gender is a responsibility and a burden—for those being categorized and those doing the categorizing. We rightfully complain about gender oppression in all its social and political manifestations, but we have not seriously grappled with the fact that we afflict ourselves with a need to locate a bodily basis for assertions about gender. We must use whatever means we have to give up on gender. The problems of intersexuality will vanish and we will, in this way, compensate intersexuals for all the lessons they have provided.

Notes

1 *Introduction*

1. By "social construction," we mean that beliefs about the world create the reality of that world, as opposed to the position that the world reveals what is really there. Suzanne Kessler and Wendy McKenna, *Gender: An Ethnomethodological Approach* (New York: Wiley-Interscience, 1978; Chicago: University of Chicago Press, 1985).
2. See, for example: Holly Devor, *FTM: Female-to-Male Transsexuals in Society* (Bloomington: Indiana University Press, 1997).
3. See, for example: Morris Kaplan's chapter, "Psychoanalyzing the 'Third Sex,'" in his book *Sexual Justice* (New York: Routledge, 1997).
4. John Money and Anke A. Ehrhardt, *Man & Woman, Boy & Girl* (Baltimore: The Johns Hopkins University Press, 1972).
5. Milton Diamond, "Sexual Identity, Monozygotic Twins Reared in Discordant Sex Roles and a BBC Follow-Up," *Archives of Sexual Behavior* 11, no. 2 (1982):181–1987.
6. Milton Diamond and Keith Sigmundson, "Sex Reassignment at Birth: Long-term Review and Clinical Applications," *Archives of Pediatric and Adolescent Medicine* 151 (May 1997):298–304.
7. Kenneth J. Zucker, "Commentary On Diamond's Prenatal Predisposition and the Clinical Management of Some Pediatric Conditions," *Sex and Marital Treatment* 22, no. 3 (1996):148–160.
8. In a 1973 collection of readings, the editor (who coauthored a paper with Money) introduces Money's chapter on femininity and masculinity with, "John Money should receive the acclaim in the study of sexism that Kinsey or Masters and Johnson have received in the study of sexuality." (Clarice Stasz Stoll, ed., *Sexism: Scientific Debates* [Reading, Mass.: Addison-Wesley Publishing Company, 1973], 13). For the media's recent reinterpretation, see: Natalie Angier, "Sexual Identity Not Pliable After All, Report Says," *New York Times*, 14 March 1997, pp. A1 and A18.
9. In addition to Kessler and McKenna, see Holly Devor, *Gender Blending: Confronting the Limits of Duality* (Bloomington: Indiana University Press, 1989), and Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990).
10. Morgan Holmes, "Re-membering a Queer Body," *Undercurrents* (May 1994):11–14.
11. This discussion of genital meanings was originally presented at a plenary symposium titled "Genitals, Identity, and Gender" at The Society for the Scientific Study of Sexuality, San Francisco, November 1995, and later published in Suzanne J. Kessler, "Meanings of Genital Variability," *Chrysalis: The Journal of Transgressive Gender Identities* 2, no. 4 (fall/winter 1998):33–38.

12. A popularized version of Money and Ehrhardt's *Man & Woman, Boy & Girl* is John Money and Patricia Tucker's *Sexual Signatures: On Being a Man or a Woman* (Boston: Little Brown and Co., 1975). With few exceptions (see Julia Epstein, "Either/Or—Neither/Both: Sexual Ambiguity and the Ideology of Gender," *Genders* 7 [spring 1990]: 99–142; Deborah Findlay, "Discovering Sex: Medical Science, Feminism, and Intersexuality," *The Canadian Review of Sociology and Anthropology* 32 [February 1995]: 25–52; and material written by self-identified intersexuals), the intersex literature is not analytic.

2 *The Medical Construction of Gender*

1. For historical reviews of the intersexed person in ancient Greece and Rome, see Leslie Fiedler, *Freaks: Myths and Images of the Second Self* (New York: Simon and Schuster, 1978); and Vern Bullough, *Sexual Variance in Society and History* (New York: John Wiley and Sons, 1976). For the Middle Ages and Renaissance, see Michel Foucault, *History of Sexuality* (New York: Pantheon Books, 1980). For the eighteenth and nineteenth centuries, see Michel Foucault, *Herculine Barbin* (New York: Pantheon Books, 1978); and Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex* (Cambridge: Harvard University Press, 1998). For the early twentieth century, see Havelock Ellis, *Studies in the Psychology of Sex* (New York: Random House, 1942).
2. Traditionally, the term "gender" has designated psychological, social, and cultural aspects of maleness and femaleness, and the term "sex" has specified the biological and presumably more objective components. Twenty years ago, Wendy McKenna and I introduced the argument that "gender" should be used exclusively to refer to anything related to the categories "female" and "male," replacing the term "sex," which would be restricted to reproductive and "lovemaking" activities (Kessler and McKenna). Our reasoning was (and still is) that this would emphasize the socially constructed, overlapping nature of all category distinctions, even the biological ones. We wrote about gender chromosomes and gender hormones even though, at the time, doing so seemed awkward. I continue this practice here, but I follow the convention of referring to people with mixed biological gender cues as "intersexed" or "intersexuals" rather than as "intergendered" or "intergenderals." The latter is more consistent with my position, but I want to reflect both medical and vernacular usage without using quotation marks each time.
3. See, for example: M. Bolkenius, R. Daum, and E. Heinrich, "Paediatric Surgical Principles in the Management of Children with Intersex," *Progress in Pediatric Surgery* 17 (1984):33–38; Kenneth I. Glassberg, "Gender Assignment in Newborn Male Pseudohermaphrodites," *Urologic Clinics of North America* 7 (June 1980):409–421; and Peter A. Lee et al., "Micropenis. I. Criteria, Etiologies and Classification," *The Johns Hopkins Medical Journal* 146 (1980):156–163.

4. It is difficult to get accurate statistics on the frequency of intersexuality. Chromosomal abnormalities (like XOXX or XXXY) are registered, but those conditions do not always imply ambiguous genitals, and most cases of ambiguous genitals do not involve chromosomal abnormalities. None of the physicians interviewed would venture a guess on frequency rates, but all claimed that intersexuality is rare. One physician suggested that the average obstetrician may see only two cases in twenty years. Another estimated that a specialist may see only one a year or possibly as many as five a year. A reporter who interviewed physicians at Johns Hopkins Medical Center wrote that they treat, at most, ten new patients a year (Melissa Hendricks, "Is It a Boy or a Girl?" *Johns Hopkins Magazine* 45, no. 5 [November 1993]: 10–16). The numbers are considerably greater if one adopts a broader definition of intersexuality to include all "sex chromosome" deviations and any genitals that do not look, according to the culturally informed view of the moment, "normal" enough. A urologist at a Mt. Sinai School of Medicine symposium on Pediatric Plastic and Reconstructive Surgery (New York City, 16 May 1996) claimed that one of every three hundred male births involves some kind of genital abnormality. A meticulous analysis of the medical literature from 1955 to 1997 led Anne Fausto-Sterling and her students to conclude that the frequency of intersexuality may be as high as 2 percent of live births, and that between .1 and .2 percent of newborns undergo some sort of genital surgery (Melanie Blackless et al., "How Sexually Dimorphic Are We?" unpublished manuscript, 1997). The Intersex Society of North America (ISNA) estimates that about five intersex surgeries are performed in the United States each day.
5. Although the interviews in this chapter were conducted more than ten years ago, interviews with physicians conducted in the mid- to late-1990s and interviews conducted with parents of intersexed children during that same time period (both reported on in later chapters) indicate that little has changed in the medical management of intersexuality. This lack of change is also evident in current medical management literature. See, for example, F.M.E. Slijper et al., "Neonates with Abnormal Genital Development Assigned the Female Sex: Parent Counseling," *Journal of Sex Education and Therapy* 20, no. 1 (1994):9–17; and M. Rohatgi, "Intersex Disorders: An Approach to Surgical Management," *Indian Journal of Pediatrics* 59 (1992):523–530.
6. Mariano Castro-Magana, Moris Angulo, and Platon J. Collipp, "Management of the Child with Ambiguous Genitalia," *Medical Aspects of Human Sexuality* 18, no. 4 (April 1984):172–188.
7. For example, infants whose intersexuality is caused by congenital adrenal hyperplasia can develop severe electrolyte disturbances unless the condition is controlled by cortisone treatments. Intersexed infants whose condition is caused by androgen insensitivity are in danger of eventual malignant degeneration of the testes unless these are removed. For a complete catalogue of clinical syndromes related to the intersexed condition, see Arye Lev-Ran, "Sex Reversal as Re-

phalloplasty: Any surgery on the penis.

progestin virilization: A form of intersexuality caused by the mother's ingestion of synthetic androgens during pregnancy. The genitals of the XX fetus become "masculinized."

stenosis: The narrowing of a canal or cavity (e.g., the vagina).

true hermaphroditism: A form of intersexuality in which both ovarian and testicular tissue are present in either the same gonad or in opposite gonads. It is extremely rare.

urinary meatus: The external opening of the urethra through which urine passes out of the body.

vaginoplasty: Any plastic surgery on the vagina, especially to build, lengthen, or widen it.

5-alpha-reductase deficiency: A form of androgen-insensitivity caused by a genetic enzyme disorder that prevents testosterone from "masculinizing" the XY fetus's genitals before birth. The genitals "masculinize" at puberty.

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