

I N T E R S E X

SAM THOMPSON/EIKON



Is it a boy or a girl? This question – usually the first to be asked by and of new parents – tells us a great deal about the importance of sex as a social category. But although the primacy of the question is very significant, so too is its form. It is expressed as a dichotomy, and we expect the answer to be one or the other – after all, it usually is. However, as we shall see in this special issue, considerable effort has been made to maintain the dichotomy in the face of bodies that challenge it.

Although estimates vary, it has been suggested that around 1 in 4500 liveborn infants has genitals sufficiently ambiguous to make the immediate assignment to male or female difficult (Warne, 1998). The term 'intersex' is often used to refer to this developmental outcome, but also, more broadly, to the outcome of sexual differentiation processes resulting in the person's chromosomal, gonadal or genital characteristics not clearly corresponding to one of our categories of male and female. Some individuals to whom the term is applied have strong objections to it, partly because of their unambiguous identification as female or male. We use the term here with some reservations, to refer to the

LIH-MEI LIAO and MARY BOYLE introduce the special issue.

physical outcomes of certain developmental processes.

Conditions implicated in intersex are too numerous to mention and only two of the better-known conditions are briefly described here. Androgen insensitivity syndrome (AIS) affects only fetuses with XY (genetically male) karyotype. The fetus produces normal amounts of androgens but lacks receptors to respond to them. In its 'complete' form (CAIS) the infant typically has female external genitalia, so the condition may not be diagnosed until adolescence, usually prompted by absence of menstruation. The infant is without ovaries, womb and cervix and has abdominal testes and a vagina that is smaller than average. Where there is 'partial' androgen receptivity (PAIS) – the XY infant may present ambiguous (partially masculinised) external genitalia. In congenital adrenal hyperplasia (CAH), owing to diminished function of an enzyme, the fetus ends up with insufficient

cortisol and excess androgens requiring endocrine adjustment usually from birth and throughout the life span. In addition, the large amounts of fetal androgens often result in ambiguous genitalia for the XX infant, who typically also has a womb, ovaries, an upper vagina, and fertility potential.

The existence of such atypical bodies, which clearly challenges a male–female dichotomy, has always been acknowledged. In the late 19th and early 20th centuries, the management of what Michel Foucault has called the 'perverse bodies of the hermaphrodite and the homosexual' was part of a much larger social, medical and psychological project in the management of people and their bodies in general. The focus on these two 'perverse' bodies reflected their potential to disrupt a social order built on gender separation and hierarchy. The open acknowledgement (at that time) of intersex bodies as a threat to the social order provides an interesting



contrast to what was to happen later in the century. From about the mid-20th century, with the availability of surgical techniques for altering the genitals, management of intersex has consistently been presented as a medical response to the psychological threat it posed to the individual.

In most cases of ambiguous genitalia, surgery is carried out to 'feminise' the genitals, even for children who are known to be genetically male but whose penis is considered too small. The greater emphasis on female sex assignment has partly been influenced by the fact that it's easier to construct genitals that can be penetrated than genitals that can penetrate. Such surgery is usually carried out in the first two months of life and no later than two years (Creighton, 2001), with the intention of providing secure gender identity and psychological adjustment, and of relieving parents of what is assumed to be an intolerable burden of uncertainty. Following sex assignment and genital surgery, it has been traditional practice to recommend secrecy or at least not full disclosure to the child or siblings – again in the interest of psychological adjustment.

Recently, such practice has been the

subject of intense criticism, not least from people who have been non-consenting recipients of it in childhood. The debate raises profound issues about the social construction of sex and gender; about the psychological and social functions served by sex and gender dichotomies; about the ethics of cosmetic surgery on infants and children; about what genitals of certain sizes and structures are for; about medical and parental power; about informed consent and the right to medical information; and about how best to help people caught between rigidly imposed social norms and the exceptionally high costs of conforming to them. Inevitably, we are not able to cover all of these issues in depth. Perhaps equally inevitably, there is a strong focus on genital surgery, simply because it has been so central to the management of intersex.

The first article, by Iain Morland, adeptly switches our attention from the anxieties that professionals attribute to children and parents faced with ambiguous genitalia, to the far less acknowledged anxieties suffered by doctors themselves in the face of such ambiguity. Morland directly tackles the issue of the

psychologisation of modern intersex management but turns the issue on its head and critically considers some of the psychological processes that appear to inform medical decision making about sex assignment. Celia Kitzinger's article, with its central theme of the social construction of sex and gender, also focuses on surgery, through discussion of its traditional psychological rationale, and by placing surgery for intersex in the context of a range of (increasingly popular) surgical techniques used to 'enhance' femininity and masculinity. Melissa Hines discusses the implications of intersex conditions associated with masculinisation of XX fetuses, for our understanding of the role of androgens in masculine gender attributes. As her review shows, this area of research is complex and requires cautious interpretation, not least because the environments of children with intersex conditions may differ in important ways from those of other girls and boys. Finally, our own contribution to the special issue is concerned with clinical services. As we will see, changes in practice towards open discussion and informed consent to treatment bring with them another set of challenges.

Intersex starkly exposes the (literally) painful effects of particular constructions of sex and gender; the ways in which preoccupation with sex differences has influenced the lives of people deemed not differentiated enough and, above all, the inseparability of psychological experience and professional practice from the social and cultural context. We hope that this special issue will raise awareness and stimulate debate amongst all psychologists.

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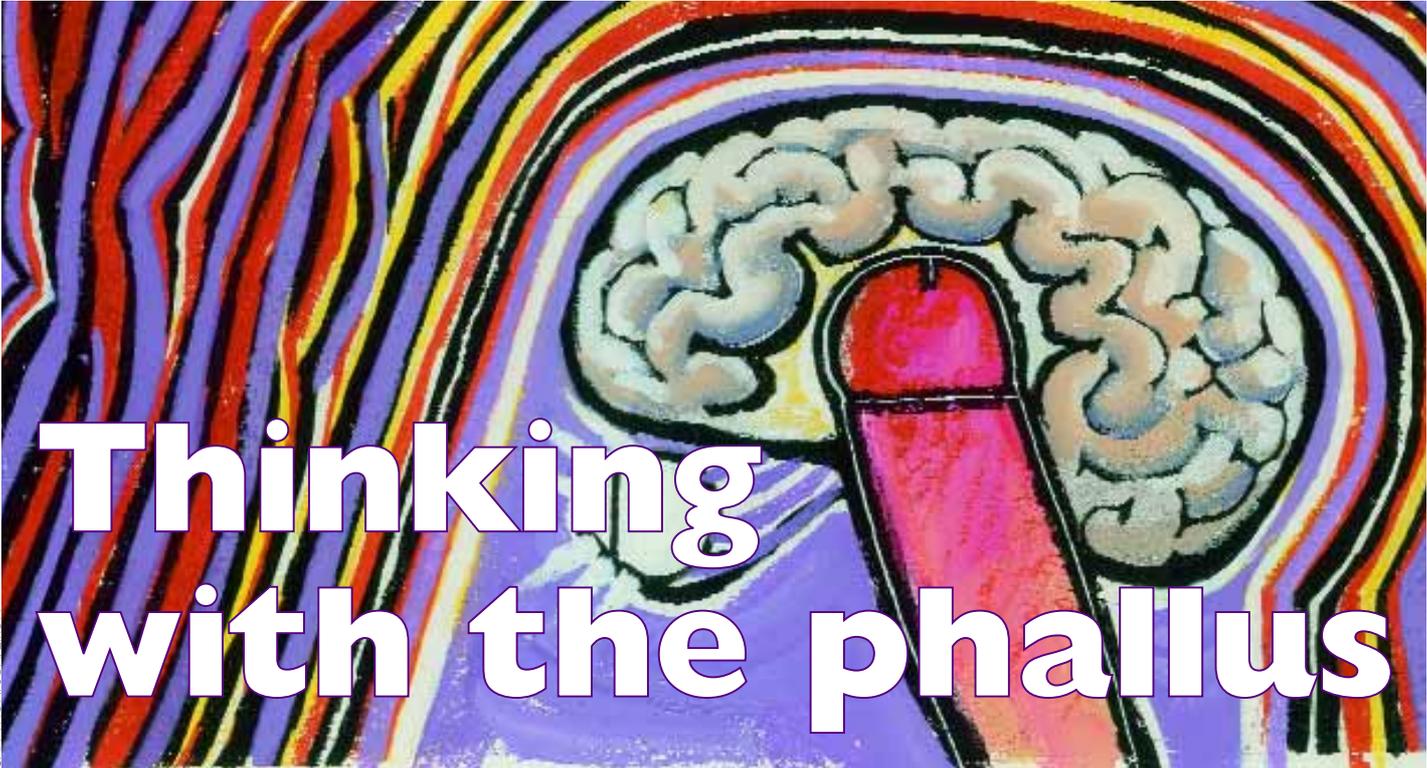
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Thinking with the phallus

CLEAR plastic rulers fell from the fretful hands of men everywhere when the *British Medical Journal* announced in 2002 that patient anxiety about penis size is not a disease (Smith, 2002). But what about doctor anxiety? For the last 50 years, the size of a child's penis has been the principal criterion of sex assignment by clinicians responsible for intersexed infants.

Harvard professor of surgery Patricia Donahoe recommended in 1991 that the decision to raise a child with testes and male genes as a boy should be 'dictated entirely by the size of the phallus' (1991, p.537). As recently as 2000 the American Academy of Pediatrics stated that phallus size is 'of paramount importance' in sex assignment (2000, p.141). It might appear that 'phallus' in these influential accounts can be translated plainly as 'clitoris for girls' and 'penis for boys'. Yet as we shall see, phallus is a cipher for the persistence of psychoanalysis in contemporary medical practice.

Phallic potency was emphasised again during a 2002 conference on intersex (Creighton *et al.*, in press). Philip Ransley, urological surgeon at Great Ormond Street Hospital, gravely disclosed that 'however much we pretend it to be otherwise, the size, [and] functionality of the phallus – of the penis – is regarded by many as the index of successful maleness'. He may well be right. But this move from phallus to penis, which suggests that the phallus was perhaps the penis all along, is a Freudian slip *par excellence*.



IAIN MORLAND *exposes the psychoanalytic roots of modern surgical management of intersexuality.*

In Freud's account, the phallic stage of psychosexual development is propelled by the little girl seeing the penis. She notices the pendulous genital of a male contemporary, and is impressed by, and envious of, its size. This organ, Freud enthuses, is 'strikingly visible and of large proportions' (1925/1991a, p.335). The girl notices the penis because it is visible, and its visibility is the *only* thing she notices. She infers that she has no genitals of her own, concluding (like boys) that '*maleness* exists, but not femaleness' (Freud, 1923/1991b, p.312). Freud continues: 'the antithesis here is between having a *male genital* and being *castrated*'.

Of course, no one has been castrated here. As adults we know that female genitalia are not lacking anything, and we chuckle at the childish error – as we may also chuckle at the suppositions of psychoanalysis. It's clear that children, if they do make a mistake, err in ascribing primacy not to the actual genitals but rather to the visibility – from a particular angle – of the singular male organ. In turn, Freud's famous blunder was to treat female castration as if it were a fact that needed to be accepted both for individual

psychosexual maturity, and for the development of psychoanalysis itself. On the acknowledgement of the 'fact' of castration hinges the psychoanalytic account of men's normal attitudes towards women, as well their occasional fetishism (Bernheimer, 1991). So, when Freud explains that for children 'what is present...is not a primacy of the genitals, but a primacy of the *phallus*' (1923/1991b, p.308), he could arguably be describing psychoanalysis itself. The penis, elevated to this role as the mismeasure of all genitalia, becomes the phallus.

Does size matter?

If phallic thinking categorises genitalia by their amount of phallic tissue, this is not just psychoanalytic theory; it is modern medical practice. When physicians deal with intersex, they employ the reductive standards of the phallic stage. Paediatricians at Cambridge University currently evaluate (one could say *organise*) all intersex infants according to a scale of genital masculinisation (Ahmed *et al.*, 2000). As Freud noted of the phallic stage, 'only one genital, namely the male one, comes into account' (1923/1991b, p.308).

Although doctors know that some healthy females are born with large clitorises, they emphasise that such clitorises must be cut down because they are 'disfiguring', 'embarrassing', and 'offensive' anatomical 'derangements' which are 'ungainly' and 'challenging to a feminine cosmetic result' (Kessler, 1998). These prickly descriptions are not the work of one maverick paediatrician; they are cropped from papers published over 26 years in key surgical and urological journals. They represent the views of 10 authors in all.

A large penis is never perceived by clinicians as a disfiguring embarrassment. Its size – strikingly visible and of large proportions, as Freud said – is what *makes* it a penis. Feminine adjustment, in accordance with psychoanalytic theory, is held to be contingent upon the visual absence of a phallus, because a visible phallus is a penis, and a penis makes a person masculine (Freud, 1924/1991c). A large genital is challenging only to a *feminine* cosmetic result. For males it is a small genital that causes offence. John Gearhart, a surgeon at Johns Hopkins University, speculates that men with atypically diminutive members 'sometimes try to kill themselves' (cited in Hendricks, 1993).

In fact, one team of writers on intersex surgery stress the 'inadequacy' of genetic males with cute little penises no less than six times in a nine-page article (Coran & Polley, 1991). Such inadequate phalluses are typically renamed clitorises and accordingly reduced (Donahoe, 1991; Kessler, 1998). As in psychoanalysis, genital inadequacy is incompatible with masculinity, but is the defining characteristic of femininity. The first such operation was done in 1934 (Papageorgiou *et al.*, 2000), and became established as a protocol in the 1950s (Diamond, 1999).

Correspondingly, those physicians who described a large clitoris as offensive have written that a boy raised with a small penis is 'doomed to life without a penis' (Newman *et al.*, 1992). They unscientifically equate a small penis with the absence of a penis. Freud (1918/1991d) records an identical error in the psychic life of girls who perceive themselves to 'lack' a phallus altogether. They have misrecognised the 'diminished size' of their clitoris. This melodramatic mistake is the basis of penis envy – another 'non-disease'

according to the *British Medical Journal* (Smith, 2002).

To think with the phallus is not merely reductive. It's childlike. In Freud's words, 'the main characteristic of this "infantile genital organization" is its *difference* from the final genital organization of the adult' (1923/1991b, p.308). Psychoanalysis has too often failed to think beyond this juvenile level, because it insists upon the psychic obduracy of childhood experiences. The salient quality of medicine's approach to intersexuality for the past 50 years has likewise been its distance from an adult understanding.

The truth about sex

Intersexual genitals tell a different story. Their existence shows that the developmental border between clitoris and penis is indeterminate and that a penis does not always entail testes, masculinisation, or maleness. They reveal that sexual differentiation is *not* synonymous with phallic length, but rather that it is a mosaic – an intricate patchwork of somatic possibilities (Morland, 2001). Conversely, in clinical practice, the clitoris and penis

'sexual differentiation is not synonymous with phallic length'

are considered so discrete that an organ of ambivalent length, between 0.9–2.4cm on a newborn, must be eradicated (Kessler, 1998). Outside this ambivalent range it is regarded as a normal clitoris or a normal penis.

Whereas medical professionals evoke and reiterate a sharp dichotomy between penis and clitoris, developmentally the two are analogous. They are *both* known in embryology as the phallus. This proto-genital usually differentiates into either a clitoris or a penis. Yet even regular sexual differentiation entails more than a change in external size. When the phallus becomes a penis, it acquires a urethra and a particular shape of glans. The internal clitoral structures, of which only the tip is visible, are 30 times larger than the external clitoris (McLean, 1980).

Hence in medicine's own terms the prehistories of female and male genitalia are decidedly intersexual. Genital surgery guided by phallic principles does not uncover the truth of sex; it falsifies it.

Copulation or conjunction?

I stumbled on an informative account of intersex in a free magazine for drinkers of Carling lager:

A woman gives birth and is approached by her doctor. 'I have to talk to you about your baby,' he says. 'What's wrong?' she asks, concerned. 'Well, your baby's what's known as a hermaphrodite – that means your baby has... er... the features of a male and a female.' The woman turns pale. 'Oh my God! You mean it has a penis AND a brain?'

Club Carling magazine's editors would be surprised to hear that the joke can be used to illuminate how the traditional surgical management of intersexuality relies on what psychoanalyst Jacques Lacan (1958/1977) termed 'the signification of the phallus'. Signification here means not one specific meaning, but rather, as we shall see, the possibility of genitals being meaningful at all.

Correspondingly, the eradication of meaningless genitalia is a key aim of surgery for intersex. 'Ambiguous genitalia' doesn't refer to genitals that flicker in and out of existence, or shapeshift into miniature wings and tails: it refers to a crisis of meaning, of sexual congruity. Notice that the joke's humour works by *incongruity*: we are surprised by the clash of two body parts whose conjunction appears unusual, even though their combination is actually commonplace. Of course many babies have penises and brains. But still we laugh.

We laugh because the doctor's description of hermaphroditism as the possession of 'the features of a male and a female' provides a template for the formulation of an incongruity: *having x and y*. 'A penis AND a brain' is absurd only because 'the features of a male and a female' is incongruous. It is the conjunctive template, rather than the penis, the brain, or their combination *per se*, which is made funny. Hence 'AND' is larger, both on the page and on the ear, than any other word in the joke.

Conjunction or copulation?

Now, for a moment let us fantasise about a future in which intersexuality is tolerated by medicine and culture. How would intersex characteristics be described? There would be infants who *had* a penis *and* labia

and a testicle and an ovary, for instance. But such characteristics would not denote maleness, femaleness, or even intersexuality as we think of it today. They would be simply a series of conjoined features in the same way that I have a larynx and a tongue and teeth and gums. These body parts do not mean I am anything in particular. They imply only that I have, precisely, a larynx, tongue, and so forth.

However, returning to the contemporary management of intersex, we find that sexual features are described not in terms of the possession of a series of body parts, but in terms of meaning and being: a penis means maleness and therefore its owner is a man. This is the crucial point. According to Lacan the phallus is this copulation of meaning and being (1958/1977, p.287). Lacan sought to fuse psychoanalysis's sexualised account of our identities with post-structuralism's emphasis on the linguistic construction of selfhood, so the phallus was the lynchpin of his theory.

It's also the key to John Gearhart's comment that men with small penises 'sometimes try to kill themselves'. Gearhart is suggesting that without

a meaningful penis, one's very being is at risk. Remember that in the phallic stage, it's not the penis *in toto* that acquires importance, but only its attribute of size. This isn't a question of having a penis; it's a question of having a genital that means 'penis', and so *is* a penis, when judged by the phallic standard of size.

Likewise, only through phallic reasoning could a clitoris ever be perceived as ill-sized: because it is too small *to be* male, too large *to be* female. My tongue couldn't be too big to be a tongue. But the destructive cutting of a clitoris is paradoxically claimed to make it more of a clitoris, more feminine.

Here lies the secret of the *Club Carling* joke. Lacan punningly describes the phallus as a copula, which in logic and grammar is indeed the verb 'to be'. The joke's copular logic – nothing less than the relation between meaning and being itself – invites us to laugh at the conjunctive template, *having x and y*.

The phallic conflation of meaning and being – or, as I put it earlier, the very Freudian idea of genitals *being meaningful* – should be replaced by the conjunction as a way of talking about, and living with, our

sexual features. Biologist Anne Fausto-Sterling and psychologist Suzanne Kessler have made similar calls in two important recent books on intersex (Fausto-Sterling, 2000; Kessler, 1998).

Sexual differences, then, cannot be reduced to variations in genital visibility. Psychoanalysis, although routinely derided by health professionals – including many psychologists – for its overdetermined emphasis on the psychic consequences of phallic appearance (Pilgrim, 1998), persists in the conventional surgical management of intersex. Because the organ's apprehension is erroneously considered the crux of sexual differentiation, it follows that atypically differentiated genitalia are apprehended by the diagnosis 'intersex' and disciplined through surgery. I'm proposing that if we disagree with Freud, we *must* disagree with the established protocol of surgery for intersex.

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KATE GREY

The myth of the two biological sexes

INTERSEXUALITY – as biological reality, as lived experience and as a political movement – is an important issue in its own right and, as such, merits the serious and committed attention of psychologists, healthcare professionals, educators and human rights activists. It also has profound implications for those of us working within the psychology of women, and poses fundamental challenges for our field.

Ever since the pioneering work of psychologist John Money (Money *et al.*, 1955a, 1955b) the study of intersexuality has been of interest to psychologists, in part for what it teaches us about gender identity more broadly. For Money and his collaborators, and for the many psychologists who drew on his work, its key contribution was to provide compelling evidence for the important contribution of ‘nurture’ or ‘socialisation’ in the development of gender. Drawing on his own empirical findings in which matched pairs of intersexed children were (apparently successfully) assigned and reared as different sexes, Money developed his theory of ‘sexual neutrality at birth’:

In place of a theory of instinctive masculinity or femininity which is innate, the evidence of hermaphroditism lends support to a conception that psychologically, sexuality is undifferentiated at birth and that it becomes differentiated as masculine or feminine in the course of the



CELIA KITZINGER *on the implications of intersexuality for the psychology of women.*

various experiences of growing up.
(Money *et al.*, 1955b)

Money’s work was welcomed and celebrated within the psychology of women as offering important (and scientifically credible) evidence for the possibility of changing oppressive gender roles. Being born with XY chromosomes did not, it seemed, necessitate aggression; possession of a uterus did not automatically destine its owner to passivity. Feminist psychologists relied on Money’s discussion of the distinction between ‘sex’ (as biological) and ‘gender’ (as social) and rapidly incorporated that distinction into their own work. One of Money’s case studies in particular has been, for the last 25 years, the centrepiece of psychologists’ textbook presentations on behalf of ‘nurture’ (e.g. Archer, 1976; Lips, 1997; Nicholson, 1984).

Generally referred to as ‘the John/Joan case’, this is the story of a seven-month-old boy (not born intersex) whose penis was destroyed in a circumcision accident, and who was successfully reared as a girl. Psychologists routinely cited Money’s

follow-up studies purporting to show that (despite her XY chromosomes) she preferred dresses to slacks, took pride in her long hair, liked to help in the kitchen (Money & Ehrhardt, 1972), was ‘neat’, ‘dainty’ and ‘loved being her daddy’s little sweetheart’ (Money & Tucker, 1975). For Money, as for many psychologists who drew on his work, the John/Joan case supported the findings of his research on intersex, and provided incontrovertible evidence for the relative importance of ‘nurture’ over ‘nature’. Feminists, in particular, used Money’s findings (both with John/Joan, and with intersex people) as a lynchpin in challenging the biological determinism used to justify women’s subordination.

But this argument has backfired. In the early 1990s, the adult John/Joan was tracked down by Milton Diamond, a biologist who, for the past two decades, had opposed Money’s theories on the grounds that ‘biology calls the tune’. His prediction that John/Joan ‘has a good likelihood of rebelling at the assignment of rearing which is in conflict with biological heritage’ (Diamond, 1979, p.51) turned out

to be accurate. Despite the pink dresses and dolls, John/Joan (real name David Reimer; see Colapinto, 1998) reports that he never accepted a female identity. After a troubled childhood and difficult puberty (during which he had to be compelled to take the oestrogen necessary for breast development), he began – from the age of 14 – to live as a boy, and subsequently had a double mastectomy and a surgically constructed penis and scrotum. He is married to a woman and is an adoptive father to three children.

Despite the fact that parallel cases of male children reared as girls – including another survivor of a circumcision accident also treated by Money – deny any uncertainty about their femaleness (Bradley *et al.*, 1998), and despite the fact that the overwhelming majority of people born with XY chromosomes but without testes and penile development – complete androgen insensitivity syndrome (CAIS) – report commitment to a female gender identity (Warne, 1997), the John/Joan case is now widely used to support ‘a biological substrate’ for gender (Diamond & Sigmundson, 1997, p.303). Contradicting Money’s claims of infant gender plasticity, biologist Diamond (1996, p.145) asserts that ‘nature must be given its due, or it will exact it’. His arguments support those of the Intersex Society of North America (ISNA) and other intersex groups internationally that have highlighted the widespread anger of some intersex people at having been assigned, socialised and surgically altered to fit a sex which, like David Reimer, they later rejected, or of which they feel inauthentic members (e.g. Dreger, 1999; Kessler, 2000).

Gender as a social construction

Until very recently, most people working within the psychology of women have accepted as given the ‘natural’ or ‘biological’ separation of human beings into two (and only two) sexes; basing their work on Money’s, they separated ‘sex’ from ‘gender’ and treated ‘gender’ as the socialised overlay of culturally specific behaviours on to already existing sexed bodies. The widespread use, within the psychology of women, of Money’s research to support ‘socialisation’ theories of gender identity is part of this more general (essentialist) approach. This approach posits ‘sex’ (maleness and femaleness) as a biological category that is somehow ‘natural’ and not constructed by

SUE CUNNINGHAM/SCP

Not all cultures organise their social world through a perception of human bodies as male or female

human systems of sense-making. By contrast, social constructionist approaches (though widely misunderstood as nothing more than the ‘nurture’ end of the ‘nature/nurture’ debate), attempt to deconstruct the very notion of dichotomous biological sex – and this is an approach which some feminist psychologists (notably Suzanne Kessler) have been developing for some time:

To take the sexes for granted, to treat the existence of two sexes as an irreducible fact, obscures each individual’s responsibility for creating the world in which she/he lives... Our theoretical position is that gender is a social construction, that a world of two ‘sexes’ is a result of the socially shared, taken-for-granted methods which members use to construct reality. (Kessler & McKenna, 1978, vii)

The existence of intersexed bodies shows that our Western dichotomous sex categories are not mandated by biology. Anthropologists have described ‘third sex’ categories in other cultures (e.g. Herdt, 1994), thereby relativising our Western

concept. The Nigerian anthropologist Oyeronke Oyewumi has taken European and North American feminists to task for the assumption that all cultures organise their social world through a perception of human bodies as male or female (cited in Fausto-Sterling, 2000).

The naturalisation of the dichotomous categories ‘male’ and ‘female’ is a fundamental and compelling narrative of contemporary Anglo-American culture. Intersex offers a radical disruption of conventional (Western) categories of biological sex. The intersexed ‘embody viscerally the truth of Judith Butler’s dictum that sex, the concept that accomplishes the materialisation and naturalisation of power-laden, culturally constructed differences, has really been ‘gender all along’ (Chase, 1998). Instead of asking how successfully people who are neither one sex nor the other can be surgically and socially modified to fit a dichotomous sex system, psychologists could be exploring how, in the face of incontrovertible evidence to the contrary (i.e. the birth of intersex infants who are biologically neither of the two sexes society recognises), the myth of two

(a procedure in which the midsection is removed and the glans reattached to the base) to be 'a serious amputation in which a perfectly functioning body part is stolen'. Angela Moreno, now in her late twenties, describes how her intersex condition (partial androgen insensitivity) went undetected until puberty, when the increased androgen production from her testes caused her to 'masculinise' – resulting in a clitoridectomy without her informed consent in a Chicago hospital in the 1980s:

I'd been aware for a few months that my clitoris was growing longer, but I'd thought that it was normal – just puberty. From Mum's alarmed reaction, though, it wasn't. She called the doctor, who told her to bring me in the next day... I was now told I had ovarian cancer and needed a hysterectomy... After my 'secret' operation, I woke up screaming with pain... I felt a crusty blanket of dried blood in my genital region – what had they done to me? I didn't know that I'd actually just undergone a clitoridectomy – female genital mutilation. (Moreno, 1998)

biological sexes is reproduced, regulated – and sometimes resisted. Feminist psychologists might consider how we, too, are implicated in the reproduction of these conventional notions of 'sex' and how we might begin critically to interrogate and challenge them.

Surgery or mutilation?

In 1996, in the first public demonstration by intersexuals in modern history, 26 activists gathered outside the annual meeting of the American Academy of Pediatricians to protest against its continued support of 'intersex genital mutilation' (Wilchins, 1997). They argued that cosmetic genital surgery on intersex infants whose genitals do not conform with the culture's dichotomous sex system violates the human rights of the child and subordinates the value of sexual pleasure to notions of heterosexual normality (Chase, 1993). Adult intersex people have spoken movingly of the consequences of this type of surgery, performed without their consent and often without their being offered any information either about their diagnosis or about their surgery. Morgan Holmes (1994) considers her 'clitoral recession'

Genital mutilation (clitoridectomy and infibulation) affects over 100 million girls and women worldwide (Ortiz, 1998), the majority of whom live in Africa. Intersex genital mutilation has been described as 'the homegrown version of female genital mutilation' (Wilchins, 1997) – although clitoridectomies were also recommended by several well-known British and North American gynaecologists in the mid-19th century as a cure for neuroticism or nymphomania (Sheehan, 1997).

A common uncertainty

Clinicians treating intersex via concealment and surgery see their job as providing 'compassionate certainty' to their patients: 'yet it is painfully obvious, from talking with many intersex parents and clinicians, that acknowledging the uncertainties that come with intersex could be a huge relief to all concerned' (Dreger, 2002). Uncertainty about one's gender – the sense of not being adequately 'male' or 'female' – is part of the human condition for most of us under current gender arrangements. People who are not heterosexual, for example, often feel disqualified from authentic 'maleness' or 'femaleness'. Historically, non-heterosexuals have been

labelled 'third sex', 'intermediate sex', or 'intersex', and for more than a century there has been a concerted effort to uncover the biological underpinnings of homosexuality (phallic size, hip measurement, hormone levels, finger length, features of the brain, etc.) based on the assumption of intersex biology: that gay men will have physical characteristics more like those of (heterosexual) women, and that lesbians will have biological similarities to (heterosexual) men.

The production of gendered bodies is not limited to intersex: body-altering techniques (from cosmetic surgeries to depilation) are widely employed to 'improve' bodies insufficiently dichotomised by nature. Cosmetic surgeries to 'feminise' (or to 'masculinise') the body are commonplace in contemporary Anglo-America. Many women today express high levels of anxiety about the 'unfeminine' shape, size or proportions of their 'natural' vulva, such that elective female genital surgery (designer vaginoplasty) is booming business (Braun & Kitzinger, 2001). Likewise breast augmentation (and reconstruction post-mastectomy) is designed to enhance the femininity of women, and breast reduction to enhance the masculinity of men (with 'gynecomastia' or breast development consequential upon bodybuilding). Many other body regulation regimes are used (by both 'men' and 'women') to produce culturally appropriate gendered bodies – diet, exercise and gendered patterns of depilation (Kitzinger & Willmot, 2002; Toerien & Wilkinson, 2003). People's distressing sense that their ageing, sick or disabled bodies are insufficiently male or female is part of the anxiety that attends loss of erectile capacity for many men, infertility for women, and physical disability for both sexes.

In sum, the 'natural' body is rarely experienced as adequately gendered. Nor is it even clear that intersex people are at one end of some continuum of body dysphoria: there are intersex people (especially those who have not been surgically altered) who express contentment with their bodies (see the video *Hermaphrodites Speak!* available from the ISNA) and apparently biologically 'normal' men and women who are deeply unhappy with the maleness or femaleness of their bodies. Without diminishing the specificities of intersex experience, we need, as feminists, to make connections between intersex and gendered

embodiment more widely. Far from being simply an anomalous biological condition, peripheral to our main concerns, the definition, management and oppression of intersex people is inextricably connected with many long-standing feminist issues.

A way forward

Dichotomous sex categories mask the diversity of actual human bodies and identities – and yet such categories are routinely built into the research used within psychology of women. It has been argued for some time (see Kitzinger, 1994) that psychology of women needs to move beyond sex-differences research – that we should take a critical stance towards the

commonly used categories of dichotomous sex rather than simply reinscribe them in our theoretical assumptions and research designs. As Lorber (1996) argues, in place of the common practice of comparing males and females (women and men, heterosexuals and homosexuals, etc.) we could use existing social science methodologies that do not rely on comparing polarised categories: social network analysis (Knocke & Kuklinski, 1982), Q sorts (Kitzinger, 1999), grounded theory (Glaser, 1992), ethnomethodology (Fenstermaker & West, 2002), or conversation analysis (Kitzinger, 2000).

At present, the psychology of women as a field routinely assumes the ‘natural’

(biological) existence of two sexes as a pre-social fact and treats only ‘gender’ as falling within the domain of the sociocultural; research on intersex, by contrast, points to the social construction of sex itself. Intersex – along with ‘race’/ethnicity, class, sexual identity and other ‘differences’ among women – interrogates the concept of ‘woman’ as a unitary category, most fundamentally, at the level of biology itself. Feminist theories of oppression can be enriched by incorporating an understanding of, and challenge to, the oppression of intersex people, which – like the oppression of women – is a direct consequence (and manifestation) of the enforcement of a dichotomous (and heteronormative) sex system, and as such is inextricably enmeshed with gender oppression more generally.

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Neuroscience and intersex

SAM THOMPSON/EIKON

IMPORTANT as extrinsic factors are, individual sexuality has a physical substrate. Researchers interested in the physical basis of sexuality have focused on the role of the sex hormones (androgens). Intersex conditions can further clarify the importance of androgens because in most cases, intersex genitalia are a result of prenatal abnormalities involving androgen. The question is, could these same hormonal abnormalities also lead to intersex brains or intersex behaviour? In non-human mammals, androgens direct sex-linked brain development during early life and exert permanent influences on sex-typed behaviours. So can research tell us whether similar hormonal effects occur in people?

Sexual differentiation in mammals

Sexual differentiation (or the process of becoming male or female) is initiated by the sex chromosomes, with XX producing a female and XY producing a male. However, the main role of these chromosomes is to determine whether the primitive gonads develop into testes or ovaries. From then on, hormonal products of the gonads, particularly the androgen testosterone, determine whether the external genitalia develop along male or female lines.



MELISSA HINES on the role of hormones in brain development and behaviour.

In humans, at about week 6 of gestation, information on the Y chromosome directs the gonads to become testes, and by week 8 of gestation, they are producing androgens, including testosterone. In the absence of the Y chromosome (e.g. in an XX individual), the gonads become ovaries, which produce little or no hormone prenatally. Therefore, testosterone is several times higher in XY (male) fetuses than in XX (female) fetuses, particularly between weeks 8 and 24 of gestation. During this period, androgens promote penile and scrotal development. In the absence of androgens, the same tissues develop in the female direction, as clitoris and labia.

In most mammals, androgens not only determine development of the external genitalia, but also shape the development of certain brain regions. As a consequence, they produce permanent behavioural changes. Indeed, hormone administration

during early development (but not later in life) can sex-reverse the subsequent behaviour of animals, making females behave like males and males behave like females (for reviews, see Goy & McEwen, 1980; Hines, 2004). For example, female rats given a single injection of testosterone on the day of birth will show increased levels of male-typical, rough-and-tumble play as juveniles. As adults, these same testosterone-treated females will attempt to copulate with other females and will show little or no interest in the sexual approaches of males. Similarly, if testicular hormones are removed from a developing male rat, he will subsequently show more female-typical behaviour, and less male-typical behaviour.

These permanent behavioural changes are thought to occur because gonadal hormones influence the basic organisation of the brain during critical periods of development. Consistent with this, brain

structures that show sex differences, like behaviours that show sex differences, can be sex-reversed by manipulating androgens during early life. Hormones cause these changes in brain structure and behaviour by influencing whether brain cells live or die, by regulating the growth of axons and dendrites, and by determining which neurotransmitters are used for cell-to-cell communication (De Vries & Simerly, 2002).

Although most studies of hormonal influences on sexual differentiation have focused on rodents, similar influences have been seen in all mammals studied to date, including rhesus monkeys and other non-human primates. In addition, although these hormonal influences were first demonstrated for reproductive behaviours, hormones also influence many other behaviours that show sex differences (i.e. differ on the average for males and females of the species), including activity levels, aggression, strategies for learning spatial mazes, feeding and body-weight regulation, lateral (e.g. paw) preferences, and juvenile play, particularly

rough-and-tumble play. Some of these behaviours, such as rough-and-tumble play, appear similar (at least superficially) to human behaviours that show sex differences.

Hormones and human sexual differentiation

Hormones clearly influence the development of the external genitalia in humans in the same way as they do in other mammals. Congenital adrenal hyperplasia (CAH), which causes higher than normal levels of androgens prenatally in genetic females, is the most common and most studied intersex condition.

Girls with CAH are born with masculinised or ambiguous genitalia. Daughters of women who were prescribed androgenic hormones during pregnancy also can be born with ambiguous genitalia. In both situations the high levels of androgen have had a similar effect to the androgens produced by the male fetus; they have caused phallic enlargement and some degree of labial fusion. Similarly, XY individuals whose cells are unable to respond to androgen, because they have complete androgen insensitivity syndrome (CAIS), are born with female-appearing external genitalia.

Hormones and sex-typical human behaviour

Do the hormonal abnormalities that cause genital ambiguity at birth in people with physical intersex conditions also influence brain development and behavioural predispositions? The answer appears to be yes. For example, girls exposed to high levels of androgens prenatally (because of CAH or for other reasons), show increased male-typical play behaviour, including enhanced preferences for toys usually chosen by boys (e.g. cars, trucks, guns), and reduced preferences for toys usually chosen by girls (e.g. dolls, cosmetics, kitchen equipment), as well as increased preferences for boys as playmates and for male-typical playstyles, such as rough, active play (for a review, see Hines, 2004). These outcomes have been observed in studies carried out in the United States, Canada, the Netherlands, Germany, Sweden, and the UK, and the same outcomes are seen whether androgen-exposed girls are compared with their unaffected female relatives (e.g. sisters and first cousins) or with controls matched for demographic background. The male-typical

behaviour occurs even though the girls are surgically feminised in infancy and reared as girls.

It has been suggested that the male-typical behaviour of girls born with ambiguous genitalia could result from the surgical process, rather than from androgenic influences on the developing brain. For instance, parents of girls with CAH could treat them in a way that produces masculine behaviour. However, parents are encouraged to promote feminine behaviour in their daughters with CAH, and questionnaire and interview data suggest that they do so (Berenbaum & Hines, 1992; Ehrhardt & Baker, 1974). In addition, preferences for male-typical play styles have been found to relate to prenatal testosterone levels in a population sample of healthy girls with no genital abnormalities (Hines *et al.*, 2002). In this study, testosterone in the maternal circulation during pregnancy predicted sex-typed play behaviour and interests in daughters at the age of three and a half years. The relationship between testosterone and behaviour remained when other factors related to gender development (e.g. how traditionally sex-typed the parents were) were controlled.

Similarly, levels of available testosterone in the maternal circulation during pregnancy, along with the daughters' own testosterone levels in adulthood, have been found to predict

Zucker *et al.*, 1996). However, outcomes for adult sexuality could be influenced by problems related to ambiguous genitalia and surgery. Feminising surgery does not usually produce genitalia that are identical to those of other females, and surgery can have consequences that would make intercourse problematic. XY females with CAIS almost always report a heterosexual orientation (i.e. towards men) (Hines *et al.*, 2003; Wisniewski *et al.*, 2000). This suggests that their inability to respond to androgens, or their feminine appearance and socialisation, is more important than the Y chromosome in determining sexual orientation.

Hormones and core gender identity

Perhaps the most important domain of psychosexual development in individuals with intersex conditions is core gender identity, or the sense of self as male or female. Although some cultures or societies have a separate niche for intersex individuals, most do not. For the great majority of individuals with CAH, or other causes of intersex conditions, core gender identity is consistent with the chosen sex of rearing, regardless of what sex that is (see Hines, 2004). For example, one study followed up on a group of XX infants with CAH who were severely masculinised at birth and found that those assigned and reared as boys developed a male gender identity, whereas similarly masculinised girls who were surgically feminised and reared as girls evolved a female gender identity (Money & Daléry, 1976). Outcomes for other intersex conditions are generally similar (Wisniewski *et al.*, 2001).

Nevertheless, some individuals with intersex conditions experience gender dysphoria relative to their assigned sex, and some express a desire to change sex. Although gender dysphoria is rare in intersex individuals, it is more frequent than in the general population (Meyer-Bahlburg *et al.*, 1996; Migeon *et al.*, 2002; Zucker *et al.*, 1996). One interpretation is that the prenatal hormone environment, perhaps in combination with certain genetic predispositions or social experiences (as yet to be identified), can limit an individual's flexibility in regard to gender identity.

In addition to intersex conditions, there are some instances where infants who have XY chromosomes and normally functioning testes have been assigned and

reared as girls, again with surgical feminisation. This can occur, for example, when an XY infant is born with a severely underdeveloped penis or no penis at all. In addition, there are a few cases where male infants have suffered accidental penile destruction (e.g. during surgery), and have been reassigned as females. Currently, there is controversy regarding outcomes in these cases. There are two well-documented reports on boys reassigned as girls following penile destruction. As we saw in the previous article, in one individual the damage occurred at about seven months of age, and, although psychosexual development appeared to be feminine in childhood, the reassigned child is now living as a heterosexual man. In the other individual, the damage occurred at about two months of age, and the boy who was reassigned as a girl now identifies as a bisexual woman, with no evidence of gender dysphoria (Bradley *et al.*, 1998). It is not known whether the different outcomes relate to the time when the reassignment occurred or to other factors. Outcomes in cases where XY infants with underdeveloped or absent penises have been assigned and reared as girls also are varied. One group reports that these individuals experience problems developing a female identity (Reiner & Gearhart, 2004; Reiner *et al.*, 1999), whereas others find outcomes similar to those for girls with CAH – increased male-typical play, but a feminine core gender identity (Schober *et al.*, 2002; Wisniewski *et al.*, 2001).

Apparent differences in outcomes for core gender identity from one report to another may relate in part to insufficient attention to methodological issues, such as selection biases or experimenter expectancies. For instance, one report recruited 10 participants from among the membership of the Intersex Society of North America, and found that eight of them preferred to be identified as intersex individuals, rather than as females or males, although all had been assigned as either female or male in infancy (Schober, 2001). This highly unusual finding probably reflects a bias caused by the recruitment source, rather than the typical situation for individuals born with ambiguous genitalia. Other issues that could influence outcomes are experimenter expectations, differences in clinical management, including the availability of psychological support services, or

male-typical gender-role behaviour in daughters at the age of 27–30 years (Udry *et al.*, 1995). Thus, prenatal androgen appears to relate to sex-typed behaviour in the absence of genital ambiguity and of potential changes in socialisation that could result from genital ambiguity. A report that non-human primates show sex-typed toy preferences (e.g. for dolls vs. cars) similar to those seen in children, despite no prior familiarity with the toys, provides additional evidence that sex differences in toy choices do not result solely from social or cultural influences (Alexander & Hines, 2002).

Other behavioural differences have also been observed in individuals born with ambiguous genitalia, although the evidence is less extensive and striking than that for juvenile play. For instance, females with CAH are more likely than their sisters, or than demographically matched controls, to report bisexual or homosexual erotic interests. These findings have been reported in research in the United States, the UK, Germany and Canada (reviewed in Hines, 2004). Nevertheless, the majority of women with CAH identify themselves as heterosexual. This suggests that although in some women prenatal exposure to high levels of androgens may enhance erotic interest in other females, this is not universally the case. Women with CAH also report reduced erotic interest in general (i.e. in either males or females:

differences in the social, cultural or family environment of individual patients. Finally, in some cases, cross-gendered childhood interests and behaviour may be misinterpreted as evidence of gender-identity problems. As noted above, most girls with CAH show cross-gendered behaviour and interests, but have a feminine core gender identity.

How do psychologists contribute

The early hormone environment clearly influences development of the human genitalia, and probably influences some aspects of human neural and behavioural development as well. However, psychosexual differentiation is a complex process. Psychological outcomes in one area (e.g. childhood play interests or adult sexual interests) do not necessarily predict outcomes in another (e.g. core gender identity). In particular, human beings appear to be remarkably flexible in regard to core gender identity, the aspect of

psychosexual development that historically has been the most important consideration related to gender assignment in intersex conditions. Nevertheless, although many individuals with intersex conditions identify with the gender to which they have been assigned, some do not. Further research is needed to explain the different outcomes. Another important research question involves the influence of surgical feminisation (or in rarer instances, surgical masculinisation) on sexual pleasure and the ability to develop satisfying sexual relationships.

Psychologists typically have extensive training in research methodology, and attention to methodological issues, such as

selection biases, could help resolve some of the varied research findings in this area. Other potentially important methodological considerations include awareness of the possible influences of experimenter expectancies on results, the need for valid and reliable measures of psychosexual outcomes, and the potential value of animal models in guiding clinical research. Psychologists, with their broad training, should be well placed to contribute to both social/cultural and biological/hormonal understanding of intersex.

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Surgical feminising

The right approach?

SAM THOMPSON/EIKON

PSYCHOLOGISTS are interested in intersex for many reasons, but do intersex people share our preoccupations? What do they tell psychologists about their concerns, and how should we respond? What contradictions and paradoxes have to be negotiated in this highly politicised area of professional practice? In this article we put forward our interpretation of client concerns and the challenges faced by clinical services in the context of theoretical and clinical debates.

Professional disagreement

How and when intersex is presented and diagnosed is variable depending on the condition (Hughes, 2002). Where the external genitalia look ambiguous, diagnosis is often made at birth. Diagnosis is sometimes reached after investigations into pubertal development during childhood, or atypical physical sexual development in adolescence.

Currently, the most prominent debate that frames intersex services relates to the lack of professional consensus on surgical 'feminising' of ambiguous genitalia in



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ask what we can learn from intersex people themselves.

infancy and childhood. At one end of this debate, opinion favours business as usual (e.g. American Academy of Pediatrics Committee on Genetics, 2000; Lawson Wilkins Pediatric Endocrine Society & the European Society for Pediatric Endocrinology, 2002). At the other end, a complete moratorium on medically non-essential infant surgery is called for (e.g. Kipnis & Diamond, 1998), and clinicians are urged to consider assigning sex while deferring surgery until consent can be given (e.g. Schober, 1998).

Recent research with adults paints a negative picture of the standard approach, of female sex assignment with surgical alignment of the genitals. But recent research can be criticised for recruiting participants who attended clinics or peer support groups such as the Androgen

Insensitivity Syndrome Support Group (www.medhelp.org/www/ais) and Adrenal Hyperplasia Network (www.ahn.org). Clinical and lay forums may be well represented by people for whom experiences or outcomes have been negative, although research that recruited participants from childhood medical records suggests that negative outcomes are not uncommon (e.g. May *et al.*, 1996). The heterogeneity and rarity of intersex conditions means that people who do not present themselves to an organised forum cannot easily be recruited. So the debate could remain in stalemate indefinitely, whilst experts continue with their own favoured regime (Wilson & Reiner, 1998).

Patient disappointment

Feminising of genitalia may comprise one

or more of the following: removal of the gonads, reduction of the size of the clitoris/penis, opening the vaginal introitus, construction of a vagina from skin or gut, and cosmetic alterations to the labia/scrotum. There are limitations, of course. It has become clear that genital surgery carried out in infancy and childhood needs to be repeated in adolescence or adulthood if vaginal intercourse is to take place or, sometimes, just to permit menstrual flow or tampon use (Creighton, 2001). For adults and adolescents, a dilation regime, which may be distasteful or painful, is often required to maintain the constructed vagina in readiness for intercourse. Where there is dissatisfaction with the cosmetic or functional effects – often brought on by anticipatory or experienced sexual difficulty – yet more surgery may be carried out. Repeat procedures can lead to, amongst other problems, scarring and sensation loss (Creighton, 2001; Crouch *et al.*, 2004).

Several recent studies suggest that sexual difficulties are commonly reported by intersex women (e.g. May *et al.*, 1996; Minto, Liao, Conway *et al.*, 2003; Minto, Liao, Woodhouse *et al.*, 2003). There may be many possible reasons for the difficulties aside from physical factors, but it is worth mentioning that in a study comparing intersex women who have had clitoral surgery and those who have not, failure to achieve orgasm is more commonly reported in the former group (Minto, Liao, Woodhouse *et al.*, 2003). Even so-called ‘nerve sparing’ surgery to the clitoris, an organ whose only known function is erotic pleasure, could compromise sexual sensitivity and capacity for orgasm (Crouch *et al.*, 2004; Minto, Liao, Woodhouse *et al.*, 2003). Recent research in the neuroanatomy of the human clitoris (Baskin *et al.*, 1999) has helped to clarify why any incision at all could damage the diffuse nerve supply.

One would think that, given the nature of the investigations and treatments, continued dialogue between doctor, patient and family would be unavoidable. Yet secrecy has been central to the traditional management of intersex. A recurrent theme in our conversations with clients is past difficulty in getting full diagnostic and treatment information. This is corroborated by personal (e.g. Anonymous, 1994; Simmonds, 2004) and professional accounts (Alderson *et al.*, 2004; Boyle *et*

al., 2004; Liao, 2003; May *et al.*, 1996). Complaints range from inadequate information and non-discussion to outright deception (e.g. being told that the procedure was a hysterectomy when testes were being removed). Some of our clients and research participants have taken decades to piece together their medical history; catalysts in the process might be a television programme or magazine article on intersex, a smear test that could not take place, or fertility investigations that did not identify a womb.

It remains a mystery how some practitioners have managed to reconcile their repeated gaze at their patients’ genitals – sometimes involving them in humiliating demonstrations or photography – with simultaneous non-explanation for their actions. Evasive answers appear to have failed to ‘protect’ people from knowing their difference, rather delivering a message of unspeakable shame. Such practices have also hindered the development of peer support and psychological input. Medical secrecy also means non-consensual treatment, and consequently an absence of thorough evaluation of cosmetic, psychological, social and sexual outcomes from both clinician and patient perspectives. This, in turn, is contributing to the current lack of consensus.

A changing paradigm and its new dilemmas

Criticism from intersex forums (e.g. the Intersex Society of North America) has led to changes in clinical management in select quarters. Within the emerging paradigm, collaboration between experts, patients and families is envisaged, and with psychological input as an integral part of clinical management (e.g. Howe, 1998; Kipnis & Diamond, 1998; Warne, 1998; Wilson & Reiner, 1998). These changes, however, raise new issues and pose further challenges to parents, patients and professionals.

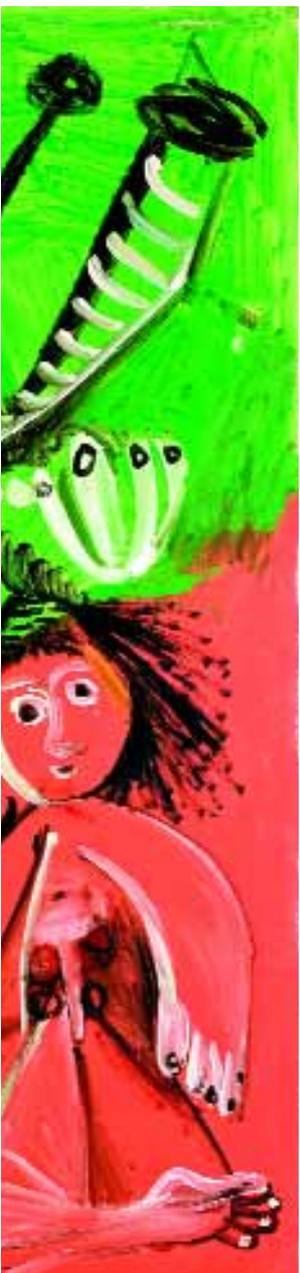
Parents Although the alleviation of parental distress is often cited as a major reason for childhood feminising genitoplasty, we are not sure to what extent such surgery mitigates distress or doubt over the sex of the child (Wilson & Reiner, 1998). Since genital feminising typically involves either incision to the clitoris/penis or creation of a vagina that has no purpose for the child, or both, how can parents and



MAN AND CHILD (1969) – © SUCCESSION PICASSO/DACS 2004 – PRIVATE COLLECTION / BRIDGEMAN ART

surgeons be sure that these procedures are less traumatising for the child than the presumed catastrophe of non-intervention?

The negative publicity about high-profile cases of sex reassignment later in life (see for example the articles in this special issue by Hines and Kitzinger), coupled with testimonies of negative experiences and outcome, could undermine parents whose children have already received genital surgeries. Notions of guilt or blame could further isolate them. In the light of recent debates, a mother expressed her sadness in having been ‘duped’ – in agreeing to her daughter’s first surgery, she had not realised that more procedures



would ensue. It is surely the responsibility of health professionals to communicate all the uncertainties and controversies relating to intersex surgery, especially the improbability of a one-off fix.

Some clinicians expect that technical advances could make parental decision making and ethical considerations more complex still (Creighton & Liao, 2004). For example, recent advances in tissue engineering suggest that it may become possible to grow penile tissue (Kwon *et al.*, 2003). This information could put some parents at odds with the professional leaning towards female sex assignment of genetically male infants deemed under-masculinised. Furthermore, the advent of intracytoplasmic sperm injection (Katz *et al.*, 1997) could mean that sperm could be

aspirated from the testes of some XY women and used to fertilise an ovum which could then be carried by a surrogate mother. Such advances are likely to raise ethical issues for childhood gonadectomy.

In the absence of information on living with genital ambiguity – an absence due precisely to the lack of attempts to formulate alternatives to infant and childhood surgery – it is understandable that parents would want to line up the genitals with the assigned sex. For parents to consider deferring surgery until their child can give consent, intensive professional and community support may be needed. Not choosing genital surgery,

though rare, will eventually contribute to a future context in which it is possible to talk and think openly about intersex and its management, with richer vocabularies and conceptual frameworks than are available at the moment.

Whatever the decision about interventions, information management is now the responsibility of parents, though translating this new openness into practice is easier said than done (Carmichael & Ransley, 2002). Intersex adults who have suffered the consequences of lack of openness have told us that parents need to come to terms with intersex themselves first. Coming to terms may require sustained support, for coping with losses and fears, for examining our taken-for-granted beliefs about ‘normal sexuality’ and ‘normal life’.

Adults For adults, finding out that they have an intersex condition and that experts cannot eradicate all the physical signs can mean facing very complex decisions. The most popular discussion in psychological consultation is what, when, who and how to tell (Liao, 2003). Information relating to infertility (for women unable to conceive) is often thought of as less risky to disclose, while information relating to XY karyotype is often anticipated as the most damaging. Whereas the women can choose not to disclose in many situations, given the physical signs, which may include those left behind by surgery, choosing not to disclose to sexual partners can be difficult. In our clinical context, this represents by far the greatest challenge for heterosexual women not in relationships – whether or not they have had genital surgery and regardless of outcome. For some, surgical fixing has been an exercise in swapping one set of problems for another.

Discussion about the condition is often avoided even when there is an overwhelming desire to be open. At a recent consultation, a young woman who had previously disclosed her condition to a male partner described the attendant feelings of relief as ‘really, really great’. And yet, despite ‘total acceptance’ by the ex-partner, disclosure to potential future partners was expected to be a major hurdle. Fearful of both disclosing and not disclosing, some women report terminating social interaction well before it is likely to become sexual. Indeed the lack of discursive resources for thinking and communicating about intersex creates such

dilemmas that some women have not felt able to fully disclose to spouses.

Health professionals are under a great deal of pressure to ensure that information simultaneously comes with offers of some form of corrective solution. But, whilst this may help to contain doctor and patient anxiety (see the article by Morland), such action inadvertently comes with the subtext that genital difference is unacceptable, indeed inconceivable.

Problematising and privileging treatment ‘choice’

Dominant ways of conceptualising ‘normal’ sexuality have informed both the provision of and desire for surgical sexing of intersex genitals. Intersex activists, interested scholars and sympathetic clinicians have, quite reasonably, focused their ethical, theoretical and scientific critique on infant and childhood surgery. But surgical sexing at any age similarly panders to delimiting sexual imperatives. The idea that having dainty genitals that can contain and pleasure a penis is a prerequisite of womanhood not only dictates action by clinicians, intersex people and their families, it raises profound questions for society. The alteration of genital ambiguity in adults may appear to remove the issue of consent but, conceptually and politically, such interventions remain problematic and deserve discussion.

It is significant that pleasure is seldom cited by the women we see as an important reason for engaging in sex; nor is enhancing pleasure ever cited as a reason for genital alteration, even when its sole purpose is to allow the woman ‘to have sex’ (Boyle *et al.*, 2004; Liao, 2003). Despite physical suffering or anxious anticipation about intercourse, few of the women have considered non-penetrative sexual activities as valid alternatives, even if such activities lead to sexual pleasure and orgasm. The reasons given almost always reflect a fear that ‘men’ would not accept anything ‘less’ than intercourse. Even if a male partner were to claim otherwise, the relationship is still deemed unable to survive the burden of non-intercourse in the long run. Such notions are, of course, not unique to intersex women.

Vaginal intercourse, far from being one of many possible sexual activities, is singled out as the only activity that can properly and unambiguously be referred to as ‘sex’. The unquestioned privileging of

vaginal sex (see Boyle, 1993; Kessler, 1998) cuts across the question of treatment 'choice' for intersex women. Perhaps this is why even recent challenges to traditional intersex management are dominated by rhetoric of 'consent' and not 'choice'.

Surgery may for some time remain the main response to genital difference. Given the limitations and implications, however, in counselling patients, experts should avoid perpetuating the usual conflation of 'sex' with intercourse and the presupposition that genitals of certain dimensions are preconditions for sexual intimacy. Experts also have a duty to advise patients about the likelihood of further procedures, and to discuss how surgery may make little difference to dilemmas surrounding disclosure. A sensitive exploration is also needed to consider the possibility that the desired

genital appearance and function, even if technically feasible and even if patients or guardians willingly risk damage that could go beyond sensual loss, may not realise the gendered aspirations.

But there are limits to what can be achieved simply by changing clinicians' behaviour. Discursive theorists may de-emphasise the personal context of individuals, but it is often the intersecting of troubled personal circumstances and cultural discourses that shapes action. At a recent clinic, a woman with CAH presented yet again with clitoral regrowth as a result of non-adherence to anti-androgen medication. She declined psychological input and was clear that more feminising surgery would help her achieve greater personal control and confidence. What unproblematic response is available to her surgeon?

Questions like this highlight the fact that clinical services operate a project of problem solving for the individual in the here and now. But clinical services must also be accompanied by a parallel project in which all (including psychology as a discipline) can participate – a project that seeks to change the social construction of sex and sexuality. Without this, clinicians, patients and families will continue to struggle in their attempt to enact disempowering sexual mandates.

Conclusions

Intersex signifies continuity between maleness and femaleness, but surgical techniques to mask this have helped to preserve the dichotomy. The belief that all genitals look discretely male or female, that they are not only capable of but are naturally inclined towards blissful union with each other, seldom comes into question. Against this cultural backdrop, where surgery fails, a serious problem ensues, whose solution appears to be more of the same. This overreliance on medical solutions, together with the secrecy and taboo, has resulted in an impoverished linguistic framework with which to address genital difference. That 'corrective' procedures are so readily offered and accepted should come as no surprise.

Are these techniques a solution to social intolerance, or collusion with a false sexual dichotomy that will continue to trap intersex in shame and secrecy? A new clinical paradigm may in itself not remove the 'need' for secrecy, if responsibility for it changes hands from doctor to patient.

It will be through imaginative social and psychological processes, not 'better treatment', that more positive narratives of intersex will emerge. Our ability to make a significant contribution to the lives of intersex people will depend on our capacity to join with and assist clients and colleagues in shaping alternative frameworks with which to tell a different kind of story. In a recent newsletter of the Androgen Insensitivity Syndrome Support Group for example, a member tells us that she now sees life as being 'much more than vagina and penis, ovaries and testes'. She writes: 'We – all of society – expend far too much energy attempting to be and act "normal"'. A pertinent question for clinicians and researchers may be: In what way will our work ultimately facilitate or subvert more enabling constructions of intersex?

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