

Research note: intersexuality, feminism and the case for gender binaries

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Introduction

I am currently undertaking a PhD on the topic of *Gender and medicine: identities and bodies beyond the male/female binary code*. My research involves studying the clinical management of intersexuality and analysing current clinical practice from ethical and human rights perspectives, one issue being trauma. I will briefly analyse some publications by community/support and medical organisations about intersex issues, and show what feminist themes emerge from them. Finally, I will discuss what these publications tell us about gender binaries: that while the male/female binary code can be discriminatory in terms of ‘normalisation’, it can also be an effective tool in analysing gender injustices – particularly in relation to trauma.

Transgender Inquiry – Human Rights Commission

The Transgender Inquiry by the Human Rights Commission (which included submissions from intersex people) noted that intersex people held wide-ranging views about gender identity and sex physiology (HRC, 2007, pp 80-81). The Inquiry also noted that while some intersex people had gender identities that were neither male nor female (such as intersex and genderqueer), others firmly identified as male or female and found such terms offensive:

My gender identity is unequivocally female... While it seems to fascinate some non-intersex folk that there could be a state of engenderment outside a male-female binary, I find that labelling to be demeaning when applied to me. Although some intersex people might want to avoid rigid gender labelling, I would not like to see a situation where a history of intersexuality was always equated with gender fluidity: I am hurt when my gender is not affirmed in the same way as the general population. (Woman born with an intersex condition; cited in HRC, 2007, p 81).

A feminist theme that emerges from the woman’s comments is the issue of marginalisation and silencing – that women’s voices and experiences have been excluded and ignored, and a feminist concern that also emerges is about women (hence female identity) becoming invisible. Similarly, Imelda Whelehan comments that politically feminists have a strong case to retain the male/female binary code in their analysis of power structures (Whelehan, 1995, p 199), and argues that a postmodern feminist stance against gender binaries takes away the chance for feminist academics “to analyse the impact of their own female identity” in a social setting (Whelehan, 1995, pp 201-202).

Other emerging feminist themes from the woman’s comments are of essentialism – the view that “there are properties essential to women, in that any women must necessarily have those properties to be a woman at all”, and of the sex/gender distinction – that biological sex is different from gender (Stone, 2007, p 18). So despite the woman being born with a variation of sexual anatomy – possibly without some properties “essential to women” (such as a uterus), her gender is very much female.

Intersex Society of North America (ISNA)

The internationally-recognised Intersex Society of North America (ISNA) (which closed in March 2008 to become the Accord Alliance¹) also dispels a myth that they advocate bringing up intersex children in a “third gender”. While the ISNA would like society to become less gender-phobic, they do not believe that “dumping intersexed kids into a gender-phobic world with no gender or a ‘third gender’ is the way to go”. They state that one problem is trying to determine who would classify as third gender; that is, trying to decide where to begin the “intersex category” in the male-female spectrum. Another problem, states ISNA, is that they are trying to create a safe environment for intersex children, thus “we don’t think labelling them with a gender category that in essence doesn’t exist would help them” (ISNA, 2008, online).

Feminist poststructuralist theoretical themes emerge from the ISNA’s comments. While the ISNA raises a concern about bringing children up outside the male and female boxes, feminist poststructuralist theory aims to “trouble the very categories of male and female” by examining the male/female binary code and how power relations are constructed and maintained in them. By questioning the construction of individuals, poststructuralist theory shows how power works “not just to force us into particular ways of being but to make those ways of being desirable”, so that individuals adopt them as their own (Davies & Gannon, 2005, p 318). The ISNA’s statement of trying to create a “safe environment” thus echoes deep fears of gender power structures so entrenched in society: that those who dare step outside the male and female boxes risk their safety – and face serious consequences such as harassment and discrimination.

CAH booklet – Royal Children’s Hospital, Melbourne

Your Child with Congenital Adrenal Hyperplasia is a booklet written by Professor Garry Warne, a paediatric endocrinologist and surgeon at the Royal Children’s Hospital in Melbourne. It contains extensive information about health concerns of congenital adrenal hyperplasia (CAH) (such as the salt-losing and non-salt losing types) with “user friendly” illustrations, and information about appropriate medication doses. Information about “treatment” states: “Girls with CAH usually require surgery to restore the genital appearance to normal. Boys do not.” Warne later advises: “Girls with CAH usually need surgery to reduce the size of the clitoris to normal, separate the fused labia, and to enlarge the vaginal entrance.” And that: “Some stretching of the vagina may be necessary later to allow menstruation and comfortable sexual intercourse” (Warne, 2010, online). First published in 1980, the booklet can now be accessed online via the websites of the Royal Children’s Hospital and the CAHNZ Trust², a support organisation for New Zealanders with CAH.

Like the woman’s comments in the Transgender Inquiry, contemporary feminist themes about essentialism also emerge from Warne’s advice. Essentialism closely relates to universalism, the view “that there are some properties shared by, or common to, all women – since without those properties they could not be women”. Essential properties are thus universal, in which general feminist debates hold the view “that there are properties essential to women and which all women (therefore) share” (Stone, 2007, pp 18-19). So Warne’s booklet appears to be raising essentialist views that, in order to become “normal” women, all girls should have vaginas and “normal”-sized clitorises.

A queer theoretical theme that emerges from Warne’s booklet is about the normalisation of bodies – that of socially acceptable and non-acceptable anatomy in the “girl” category. Feminist political themes about power structures within the male/female binary also emerge from Warne’s advice that “boys do not” usually require surgery. Thus *non-male* children have little

chance of escaping the power wielded by this institution – a *trusted* institution (being a hospital), on what defines socially-acceptable physiology. Another queer theoretical theme of compulsory heterosexuality also emerges from Warne’s advice. When a baby with CAH is found to have a uterus, ovaries and an XX karyotype (chromosome type), how do we know the later-young adult will want a vagina for heterosexual intercourse – let alone want to have periods or become pregnant? Also, the young adult may be perfectly happy about having a large clitoris which s/he may wish to use for penetration during intercourse.

The power wielded by language

Postmodern feminist theory argues that “sex” is something constructed by *language* instead of biology. French feminist Monique Wittig argues that “sex” is a category that regulates “the social configuration of bodies” via a “coerced contract”, and that the voices of non-male, non-heterosexual people have no position “within the linguistic position of compulsory heterosexuality”. The power wielded by this “system of language” is enormous, Wittig continues, and that “concepts, categories and abstractions” can create “physical and material violence” towards bodies. The power of language is thus “the cause of sexual oppression” but also “the way beyond that oppression” and that, when repeated, language has the ability to “become entrenched practices and, ultimately, institutions” (cited in Butler, 1990, pp 147-148).

Indeed, language when repeated has the ability to “become entrenched practices”, as what happened with the work of former Victoria University student John Money, who became an internationally-recognised “gender identity expert” with intersex cases. Postmodern feminist theoretical themes about sex emerge from Money’s and Patricia Tucker’s book *Sexual Signatures* (1975), in which they advise a “female” assignment and surgery to reduce the size of the “clitorine penis” for children with the partial form of androgen insensitivity syndrome (PAIS)³. Money and Tucker’s rationale is similar to Warne’s advice about “girls requiring surgery” in that, though the child’s penis “may be capable of erection and orgasm”, it will “not be adequate for the male role in sexual intercourse” (Money & Tucker, 1975, pp 55-57). Postmodern feminist theoretical themes about language’s power and ability also emerge from paediatric endocrinologist Melvin Grumbach, who remembers when Money spoke at a conference about the well-known “twins case”⁴ – that “one of them is now a girl, and the other is a boy”. Grumbach remarks how “really powerful” Money’s words were, that doctors “can really do anything” such as changing a “normal XY male” neonate into a female. “John Money is a major figure, and what he says gets handed down and accepted as gospel by some” (Colapinto, 2000, pp 70 & 75-76).

Queer theoretical themes about forced “normalisation” of bodies and sexuality also emerge from Money and Tucker’s book. With regard to queer theoretical arguments, intersex activist and ISNA founder Cheryl Chase comments how, according to clinicians, “male genitals are for active penetration and pleasure, while female genitals are for passive penetration and reproduction: men have sex; women have babies” (Chase, 1998, p 210). She also argues that the terms “homosexual”, “lesbian” and “intersex” were invented by the medical institution to classify “disapproved sexualities” as diseases. Chase later states, “I must proudly assert my identity and insist that the medical construction of intersexuality as disease is oppression, not science” (Chase, 1998, p 212).

Queer theoretical themes again emerge when Warne comments about surgery to *normalise* the size of the clitoris and genital appearance, and when Money and Tucker warn about “clitorine penises” being incapable of the “male role” in intercourse. Hence anatomy outside the “male role” is “deviant” and “abnormal” because, as Chase points out, female genitals are for

“passive penetration and reproduction”. And what’s so bad about a young adult with an XX karyotype, ovaries and a uterus wishing to play the “male role” during intercourse with an enlarged clitoris? That because this young adult has these *essential* and *universal* properties of “recommended gender assignment” as a girl then, according to what’s acceptable by society, she is meant to play the *female* role of being penetrated during intercourse (by a “proper man” with a penis of course!). As Wittig points out, the power wielded by language (“*clitorine penises*”, “*normal size*”, “*not be adequate*”...) is enormous.

Trauma

Arising from my research findings is another major issue that constantly confronts me – trauma. I have read many accounts and seen documentary films by intersex people talking about traumatic experiences in hospitals as children, such as being “shown” to groups of medical students as if they were research objects, and being denied full and truthful explanations of why they were in hospital as they were “under the age of consent”. Another contributing factor to trauma is, of course, loss of tissue (particularly genital tissue from clitoral reduction surgeries) and organs such as removal of testes from “female assigned” children. Many intersex people have talked about the shock and devastation of finding out about this, when they finally – often after a long battle with hospital bureaucracies – obtained their medical records on reaching adulthood. Another intersex person who submitted to the Transgender Inquiry sums up these findings about trauma so well: “We need to be allowed the option of being ourselves, without surgery” (HRC, 2007, p 81).

Similarly, in a review of *Hermaphrodites Speak!* (1997), a documentary film produced by the ISNA, Angela comments how “painful” it is to consider that “a very specific eroticism, a hermaphroditic eroticism” was taken from her, and that such an eroticism is “a really special part” of intersex culture: “our sexuality, that sacred sexuality [which] has been ripped from us” (Rye, 2000, online). Angela’s comments raise an ethical and human rights issue: why should young adults with variations of sexual anatomy be denied the right to a “very special eroticism” – their *own* sexuality?

Second wave feminist themes about power relations and dominations emerge from these findings about trauma, particularly power relations between clinicians and patients as outlined in Sandra Coney’s book *The Unfortunate Experiment* (1988), an account of the 1988 Cervical Cancer Inquiry at National Women’s Hospital, Auckland – and the subsequent trauma experienced by the women involved. Coney vividly illustrates this power relationship from a feminist perspective, between men in positions of power (clinicians – “world traveller, resplendent in his professorial title...”) and women (patients – “working women, mothers, ordinary folk, without degrees, gender status, titles...”) (Coney, 1988, p 246).

On reading Coney’s book, one feels that the medical institution – National Women’s Hospital – was maintaining oppressive power structures towards gender. Other themes that emerge are those of feminist poststructuralist theory, which examines power relations within binaries – the “dominant half” and the “subordinate half” (Davies & Gannon, 2005, p 318). These accounts by Coney and intersex people show how power relations work between the “dominant half” (clinicians in positions of power and privilege – higher income and status in the community) and “subordinate half” (intersex children – under the age of consent and taught to respect adults).

The case for gender binaries

The woman's comments in the Transgender Inquiry tell us that male and female identity – *separate* from the male/female binary code – can and do exist, irrespective of physiology. So as well as amongst people in the community born “normal male” or “normal female”, male and female identity also exists amongst people with variations of sexual anatomy. This then raises a point in relation to essentialism: society nor clinicians cannot assume or decide an individual's gender identity based on visible physical traits – it is only the individual who can. I would also like to point out that, while I support gender diversity and fluidity, I also support male and female gender identities.

Thus the woman submitter has every right to be female – just as female voices and experiences should not be excluded or ignored. Similarly, Imelda Whelehan has valid concerns about the postmodern feminist stance against gender binaries; that in cases such as the Cervical Cancer Inquiry feminists indeed have a strong case to retain the male/female binary code in order to analyse power structures between “dominant” (male clinicians) and “subordinate” (women) halves. And just because women have experienced discrimination throughout history does not mean that female gender identity is “bad” and should be discouraged.

On the other hand, the ISNA's case to retain the male/female binary code is to ensure that children feel safe; that being beyond male or female can be unsafe and dangerous in terms of harassment and discrimination. And in order to eliminate harassment and discrimination clinicians perform surgery – “*normalising*” surgery, in order for intersex children to be “safe” in society. It is also interesting to note that boys are regarded as facing less danger than girls. So clinicians will spare boys the scalpel because, in accordance with society, boys are meant to have phallic-like genitals, boys do not have vaginas, boys get older and penetrate during intercourse... whereas girls do not (*must* not). Whelehan's concerns about retaining gender binaries – hence feminist theoretical themes about power structures – again emerge, in that the gender binary is a useful tool in analysing *differences* in clinical management between boys and girls.

However, moving beyond the male/female binary code, while organisations such as the ISNA have a valid concern about wanting to make children feel safe, others such as Angela and the other intersex person (who submitted to the Transgender Inquiry) have every right to be themselves – to have their own gender identity and sexuality. So clinicians who are trying to “keep them safe” from teasing and harassment may be creating more harm – hence the issue of trauma emerges, because they may be permanently removing something (something *unique*) that the child may want later. Therefore, while the male/female binary code is a useful tool for my research to analyse power structures and injustices, people should never be pressured to conform to gender binaries.

Notes

- 1 Despite being closed, the ISNA's website (www.isna.org) is still running as an “historical artefact” and provides extensive information. The website of the Accord Alliance is www.accordalliance.org.
- 2 The CAHNZ Trust's website can be visited at www.cah.org.nz.
- 3 Individuals with the *incomplete* (partial) form of AIS (PAIS) have a 46,XY (male) karyotype, and present during the first month of life as a “phenotypical [physically] male” with a penile-like structure, a small vaginal pouch and small testes. However, at puberty PAIS individuals “show some, but not complete” masculinisation and breast development. Individuals with the *complete* form of *androgen insensitivity syndrome* (CAIS) also have a 46,XY karyotype and testes, but at puberty characteristics of CAIS individuals include a “normal female” phenotype, developed breasts, small clitoris and a short and blind-ending vagina. Because of their physical appearance CAIS individuals have commonly been assigned “female” (Forest, 2001, pp 1993-1995).

- 4 The “John/Joan” case (as it is also known) involved David Reimer, one of a set of “normal male” twins born in Canada in 1965, who at seven months lost his penis in a circumcision accident. John Colapinto gives an excellent and extensive account of the case in his book *As Nature Made Him: The Boy Who Was Raised as a Girl* (HarperCollins, 2000). Sadly, Reimer committed suicide in 2004.

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