Disciplining Sex: Economies Etched in Intersexed Flesh

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for

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To begin, I want to tell you a story of a medical emergency.

> Zippora, a 41-year-old Israeli, has given birth to an intersexed child. Sociologist Meira Weiss happens to be in the delivery room; she is researching parental reactions to diseased and deformed babies. When the nurse shows Zippora her baby, Weiss reports that the new mother turns pale, trembles, and bursts into tears: "What will I do? What will I tell people on the street when they ask me what I had, a girl or a boy? What will I tell them? [crying]... Can you operate? Maybe you can do an operation or ... several operations, and then everything will be O.K. ... and then people will know whether it is a boy or a girl... Oh, how disgusting" (Morland 2001, 527).

I've told this story several times to open a discussion of intersex, and the reactions are always quite diverse. Some people 'tsk' audibly during conference presentations. Some people's eyes widen, whether because they have never imagined this scene occurring, or because they are astonished at the vehemence of Zippora's reaction, I'm not sure. But most people look vaguely uncomfortable, caught imagining themselves in Zippora's situation, perhaps, feeling that even as the words she uttered at a moment of great distress sound harsh, unfair, too stark and cruel, that they could not guarantee that they themselves would not react in the same way, confronted with the body of a longed-for child, which has abruptly become something other than they had imagined. There is, perhaps, a kind of comfort in

knowing that medicine will not downplay the distress and anxiety expressed at such a moment. Such a situation is treated as a medical emergency. Most NICUs (Neonatal Intensive Care Unit) at most hospitals have a team ready to jump into action, to offer, supposedly, answers and solutions to the medical emergency of an infant with genitalia which doesn't meet expectations.

Before I go on, I want to offer just a brief rundown of what intersex is, for those who have not encountered this phenomenon before. Intersex is the term that replaced 'hermaphrodism' in designating those bodies which did not fall neatly within those categories of 'male' bodies and 'female' bodies. The occurrence of intersex has been variously reported, but about 1.7 % of all live births seems to be the most accurate number so far. There are so many forms of intersex that sometimes talking about them collectively can be a bit misleading. There are some forms of genetic or chromosomal anomalies that will never manifest in variant genitalia or hormones at all, so that such people may never know that they are intersex in some sense. There are some which are the result of an insensitivity to a particular hormone, which can result in bodies which have testes and a vagina, because the 'virilizing' effect of that hormone never alters the body as it does in 'males'. Or there can be micropenis, where the penis winds up shorter than expected in men. Or hypospadias, in which final part of the development of a 'male' feotus, the movement of the peehole from the base of the penis to the tip never quite completes. These are just a few examples of intersex, not an exhaustive list, but the majority result in what intersex advocates call 'variant' genitalia. As you can hear, every description I offer can only be fully understood in relation to those bodies taken as the measure of normalcy: male and female bodies. This is the standard from which intersex bodies are thought to vary. I'll come back to this point. Some intersex advocates have recently adopted the term 'DSD' or 'Disorders of Sexual Development' as a better term than intersex (see www.isna.org). I resist this for a number of reasons, which I hope will become clear as the discussion progresses; but briefly: the adoption of medical language in this case works to reinforce that there is a proper *order* of sexual development, an order which intersex bodies fail to follow properly. This minimises the challenge that intersex poses to our assumptions about sexual dimorphism, as we shall see.

So, having discussed one form of authority over intersex bodies—that of medicine—I want to briefly mention another: the law. In NSW, there are criminal laws (Section 45 of the Crimes Act) which are designed to prevent "female genital mutilation". They set down that any person who "excises, infibulates or otherwise mutilates the whole or any part of the labia majora or labia minora or clitoris of another person" should be imprisoned for 7 years. There are numerous recountings from intersexed people which use terms such as "excision" and "mutilation" to refer to the procedures performed upon their genitalia, and indeed, it is hard to see how the shortening of the clitoris, a fairly regular 'treatment' for intersexed infants, falls outside this part of the section. And indeed, some have suggested that cases should be brought against those who have performed 'intersex corrective surgery' under these laws. But the Act also contains an exception for those modifications deemed "necessary for the health of the person on whom it is performed." And health is neatly described: "In determining whether an operation is necessary for the health of a person only matters relevant to the medical welfare of the person are to be taken into account." It's pretty clear what's at stake here: the Act is trying to outlaw one form of genital modification--that form known in the West as 'female genital mutilation', whilst ensuring that there are ways to argue in favour of others—and not only intersex, but 'cosmetic' genital procedures, which do not always differ significantly from those which are deemed 'mutilation'. In order to ensure that this distinction is made and maintained, the law relies upon medical expertise as to what "medical welfare" actually means. A side note here is that this assumes that a special form of objectivity adheres to Western medical science's understanding of healthy, normal genitalia, and so law relies upon Western medicine's supposedly self-evident legitimacy to specifically preclude any non-Western ideas about what 'normal' genitalia look like. In other words, legitimising Western medical authority in this way ensures that genitalia which might be 'normal' in Kenya or Sudan can never be considered 'healthy'.

So what *does* constitute "medical welfare" in the context of intersex? Well, clearly the medical community agrees that there is something of a medical problem with intersexed bodies, or it would not have developed so many techniques for dealing

with them. But while some of these techniques are designed to avoid serious medical problems, such as genital formations which divert urine back into the uterus, the majority of surgeries performed on infants with variant genitalia are designed to alter the *appearance* of that genitalia. Indeed, it has been argued that such surgeries aren't for the health or medical welfare of the individual child, but is designed primarily to treat parental distress, as we saw in the case of Zippora. She cries out for someone to normalise her child's genitalia, and in most if not all cases, this cry is answered, the suffering resolved. Through the surgical 'normalisation' of the child's genitalia.

The 'normalisation' of the child's genitalia is, in contemporary times, taken to be a resolution of the child's 'sex'. I want to draw attention now to the specificities of the assumption that genitalia which adheres to some sense of normal 'male' or 'female' genitalia is 'healthy' genitalia. We think we know what sex is—know it so well and easily that it doesn't need specific description, or discussion is superfluous. But people have always felt this way, even in the eighteenth century, and our contemporary understanding of what constitutes a healthy sexed body is quite different from historical knowledges. Intersex advocate Alice Dreger draws attention to the specificity of our own take on sex by examining eighteenth century understandings, in which sex was considered to be given by the gonads. There's a case of a woman who is having difficulty having sex due to a short vagina. She goes to the doctor who examines her, and upon discovery of an undescended testicle, exclaims "But, my good woman! You are a man!" This woman was then expected to dissolve her marriage and begin living and working as a man. The economy of sex at this time was entirely given by the gonadal tissue they found: if you had testes, you were a man; if you had ovaries, you were a woman. Nothing else decided your sex (Dreger 2003, esp. the prologue).

Obviously, we have accounts of sex which, by comparison, are very sophisticated. If the eighteenth century was the Age of the Gonads, the twentieth and twenty-first might be considered the Age of the Genes, Chromosomes, Hormones, Gonadal Tissues, Primary and Secondary sex characteristics. Amongst other things. It might be tempting to say that we simply know more about what makes sex sex, now. But

it's not quite that simple. Knowing 'more' about what makes sex sex has *changed* what sex is: it has changed what counts as deeming someone of a particular sex. Sex was once defined by the presence of testicular tissue. No longer is this the case. Sex is now defined by an array of different aspects, any one of which could diverge from 'normal' sex. In other words, our knowledge of sex has changed, and as a result *disciplines* sex differently. A different economy of sexual difference—one premised on more than just testicular tissue—is now at work.

Yet for all that contemporary understandings of sex, even in popular discourse, are more complex than they once were, there's another shift that has occurred in our economies of sex. What produces Zippora's anxiety, her pallor, her trembling is, as Iain Morland observes, the visible unknowability of her child's sex:

> What kind of disgust does Zippora feel? She articulates an anxiety about language and knowledge: what will she tell people? How will they know her child's sex? For Zippora, the relationship between telling and knowing has been fractured because she knows something about her child that she cannot tell: her new baby is intersexed. Its genitals are a mixture of male and female characteristics. The baby's body has not differentiated as clearly male or female—for instance, it may appear to have both a clitoris and testes (Morland 2001, 527).

The 'anatomical referents' at work here, then, are more complicated than they were in the eighteenth century, and more clearly about *appearance.* In contemporary understandings of sex, there tends to be some familiarity with the complex scientific knowledge of sex, but the really defining part of sex is genitalia: a penis and testes makes a man, whilst a vagina and clitoris (the ovaries not being visible) make a woman. And this is evident in some of the ways that people articulate anxieties about variant genitalia: one of the most familiar is a fear of teasing or even bullying at school based on the appearance of a child's genitals. The 'locker room' is regularly raised as a site in which visibility might produce problems, especially in American high schools (where cultures of nakedness would seem to differ substantially from my own experience in Australian schools). Yet as Alice Dreger points out, "Yes, what about the locker room? If so many people feel trepidation around it, why don't we fix the locker room? There are ways to signal to children that they are not the problem, and normalization technologies are not the way" (Preeves 2003, 44).

And it is in reaction to these strict requirements of appearance that surgical intervention is made into the bodies of those who are intersexed. Lest we think that the insistence on a clear visual distinction between masculine and feminine genitalia is not properly legitimated, not properly 'scientific,' I want to read a few different ways that doctors frame the decision to intervene in intersexed bodies, as collected by Susan Kessler:

> Feelings about larger-than-typical clitorises are illustrated by these representative quotations:
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> The excision of a hypertrophied clitoris is to be preferred over allowing a disfiguring and embarrassing phallic structure to remain.
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> The anatomic derangements [were] surgically corrected... Surgical techniques... remedy the deformed external genitals... [E]ven patients who suffered from major clitoral overgrowth have responded well... [P]atients born with obtrusive clitoromegaly have been encountered. [N]ine females had persistent phallic enlargement that was embarrassing or offensive and incompatible with satisfactory presentation or adjustment. [After] surgery no prepubertal girl... described troublesome or painful erections.
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> Female babies born with an ungainly masculine enlargement of the clitoris evoke grave concern in the parents... [The new clitoroplasty technique] allow[s] erection without cosmetic offense.
>
> Failure to [reduce the glans and shaft] will leave a button of unsightly tissue
>
> [Another surgeon] has suggested... total elimination of the offending shaft of the clitoris.
>
> [A particular surgical technique] can be included as part of the procedure when the size of the glans is challenging to a feminine cosmetic result. (Kessler 1998, 36)

Susan Kessler's research demonstrates that most clitorises longer than .9 centimetres are considered 'offensive' in this way, and prompt surgical intervention of some kind, disciplining the body that might challenge the easy visual distinction between male and female bodies. And on the other side of the coin, infants whose 'phallus' contains a urethral opening (the urethral opening within the penis being apparently the defining difference between a penis and a clitoris) but which fall below about 2.5 centimetres are thought to have penises which are 'too small'. Such children have often been 'reassigned' to being female, and given surgery to reflect this decision.

The economies of visual difference between men and women, then, are quite specific, and the bodies of those who are intersexed are altered to adhere to such these economies. I'll return to this point shortly.

But there's a little more to the question of the economies of sexual difference in contemporary culture. We've seen already that they require the visual distinctiveness of male and female bodies to be maintained, even when that involves the reduction, excision and sometimes irreparable damage done to the bodies concerned. But this leads into another aspect of the requirements of sexual dimorphism: all bodies, it would seem, need to be made as capable as possible of heterosexual reproduction. Thus, fertility is often a consideration in whether to deem a body male or female, and the form of surgery performed. Further, hypospadic penises, that is, those penises in which the urethral opening occurs somewhere on the underside of the penis, and is sometimes not simply a 'hole', must be remedied, in order not only that boys be able to compete in pissing contests (yes, according to some doctors, this rite of passage is key to male identity development), but also to ensure that heterosexual reproductive sex is perfectly facilitated. In some cases, 'repairing' a hypospadic penis can take multiple surgeries, requiring long hospital visits throughout childhood. According to Robert Crouch, surgeries are shaped by the requirement that one have "a sufficiently large penis so that one can look like and 'perform' as a male in childhood, and so that one can satisfy one's partner later on even if that means having a scarred and desensitised penis" (Crouch 1999, 34). The heterosexual functionality of the penis—its capacity to get hard and ejaculate 'properly'—is more important, it would seem, than pleasure or any other considerations. Similarly, short vaginas are lengthened to ensure that the vagina offers a proper 'sheath' to the penis during heterosexual intercourse. In fact, according to some surgeons,

> The clitoris is not essential for adequate sexual function and sexual gratification... but its preservation would seem to be desirable if achieved while maintaining satisfactory appearance and function... [So long as clitoral] presence does not interfere with cosmetic, psychological, social and sexual adjustment (Kessler 1998, 37).

Yet what, precisely, is adequate sexual function? Intersex advocate Cheryl Chase (also known as Bo Laurent) describes a telling experience: when a doctor found that clitoral tissue had withered as a result of invasive surgeries, he said "you'll find someone to hold you nice and you'll be okay" (Kessler 1998, 57). As Crouch observes, "looming in the background of all of this is a moralistic and gendered cultural script that views women as passive recipients during sex, simply there to please their partners, and not themselves agents of sexual desire or feeling" (Crouch 1999, 33). Both these cases demonstrate how key heteronormativity—the presumed normalcy and naturalness of a particular kind of reproductive heterosexuality—is to contemporary economies of sex.

So now we have begun to unpick what, precisely, it is that constitutes the "medical welfare" of the intersexed infant. Medicine participates in deeming particular kinds of bodies good and healthy, and others as problematic and unhealthy. It would be easy to say, and medical professionals sometimes offer this as a defence, that altering the body of an intersexed infant offers that child the chance to 'grow up normal'. On the one hand, yes, maybe they do; but why do we fear raising 'different' children? Yet on the other, it cannot be denied that the stories of intersexed people are shaped by shame, stigma, the secrecy and the mysterious sense of something being wrong. Max Beck, once Judy before transitioning, describes having been told she was an "unfinished girl", yet feeling like a "sexual Frankenstein's monster," a sense that led her to have to deny her desire for other women and marry a man who was "non-plussed about [her] man-made parts" ("My Life as an Intersexual"). But as well as the often devastating effects of surgery on intersexed infants, the normalisation of these bodies has another, significant effect on our economies of sex. Intersexed bodies are covered over, the challenge that they pose to traditional economies of sex are forcibly effaced. In disciplining these unruly bodies, we replicate and reiterate a narrow normative understanding of what sex can be. As Canguilhem observes, "[t]he normal is then at once the extension and the exhibition of the norm. It increases the rule at the same time that it points it out" (Canguilhem 1991, 239). When our heteronormative visual economies of sex are such that bodies which *challenge* the limitations of those economies are altered to reiterate those limited

economies, we effectively silence the corporeal challenge to our contemporary economies of sex, refusing to hear or negotiate with bodies, people and experiences which are different, unexpected, and which challenge our assumptions about the world.

In this respect, I want to suggest that it is not simply the lives of intersex people which are at stake, although it is certainly at the expense of intersex people's happiness that these sexual economies are maintained. I mentioned, briefly, earlier, Max Beck. Max was raised as Judy, and his current partner, Tamara Alexander wrote about Max/Jude's experiences in a piece called "Silence = Death". Alexander recollects Max's story of her college affair with a woman and the six words she said in bed that altered the entire course of Max's life:

> 'Boy, Jude, you sure are weird.' Max told me she knew then that she was a lesbian but she could not be with women because they would know how her body was different. She married Harold because men were just less sensitive to the subtleties of women's anatomy (Alexander 1999, 105).

This might seem insignificant, such a comment, but as surely as Zippora's pallor, trembling and her tumble of distressed words and pleas, what is articulated is an inability to see beyond extremely limited economies of sex, an inability to perceive an intersexed person as anything other than weird or lacking, an inability to see anything but the failure to achieve the unambiguous genitalia of 'normalcy'. There is little doubt that intersexed people are made to pay the majority of the cost for this need to discipline sex, in shame and secrecy and self-hatred and self-doubt, in bodies which they may never feel at home in; but it also shapes the limitations of experiences for non-intersexed people. Zippora misses the opportunity to welcome her child into the world with joy. Jude's sexual partner misses the opportunity to experience Jude as Jude. But this is not an inevitability: Tamara Alexander gives us another way of encountering the intersexed other, describing their first sexual encounter:

> She [Judy, as Max was then] was terrified, and I was aware of her fear and the cost of offering herself up to me in that moment… I have never wanted to pleasure someone, never wanted to offer my hands and fingers to heal and to love and to delight… I have never been so awed by the feeling of

> touching as I was that night. I wanted to stroke and explore and learn and know every inch of her, her large and proud clit, the lines and crevasses from scars and healing, the tight cavern of her cunt that held my fingers so tightly. She pulled me down on top of her and wrapped her arms around me and came, calling my name, sobbing against my shoulder. And I wept with her. I wept for the loss of what she hadn't had and the lovers who hadn't revelled in the wonder of her body, wept for what I hadn't had before I held her in love, and I am weeping as I write this now (Alexander 1999, 106).

The response of Alexander to Jude is to Jude, not to Jude as she is described by categories, or her position in relation to normalcy ('her' "weird"ness). Alexander's sense of wonder and delight in Jude's body is not dependent upon the achievement or non-achievement of proper, unambiguous sex. Rather, she demonstrates that the imagination and openness that doctors and parents fear is too much to ask of the world is in fact possible; she opens up the possibility that what constitutes "medical welfare" or 'health' might be better thought of as that which allows and encourages this kind of openness to those born intersexed, rather than deeming their bodies, from the very beginning, to be "emergencies" of "anatomic derangements" in need of discipline.

What we can see here is that legal, medical and social regulation are bound up with each other, reinforcing not only authority, but also ensuring the reiteration of a singular economy of sex. This economy requires the disciplining of those bodies which fall outside its circumscription of legitimate categories: male and female. It deems worthless, or worse, threatening, those bodies which cannot be recognised as valuable according to its requirements. This economy not only disadvantages those who are different and thus cannot be recognised as valuable, but disadvantages all of us in ways that many of us have the privilege to not even be aware of. We forget—we have to forget—the gifts offered by those not recognized by existing economies of sex. Indeed, our forgetting occurs at their expense: in the disciplining wielding of the scalpel, in the requirement that traditional dichotomies of sex be maintained, in the supposed necessity that they understand themselves as disordered. And this is my response to those medical professionals who say that their techniques are 'improving' - what you mean by this is that your techniques are approximating heteronormative imaginaries better and better, replicating the very

dichotomy that these bodies demonstrate the falsity and restrictiveness of. This is not to say that there are easy solutions, for there are not. And when those, like Zippora, are distressed, the impulse to help is important and ethical. But the response needs to take account of and negotiate *with* the diversity of bodies, rather than concealing the challenges that these various variant bodies pose to knowledge, to regulation, to discipline, and perhaps most intimately, most tellingly, to our very everyday lived experiences of sex.

References

Alexander, Tamara (1999) "Silence=Death" in Alice Dorumat Dreger (ed) *Intersex in the Age of Ethics* University Publishing Group

Beck, Max "My Life as an Intersexual" accessed 2/5/09 http://www.pbs.org/wgbh/nova/gender/beck.html

Canguilhem, Georges (1991) *The normal and the pathological*. C. Fawcett & R. Cohen (Trans.) Zone Books

Crouch, Robert (1999) "Betwixst and Between: The Past and Future of Intersexuality" in Alice Dorumat Dreger (ed) *Intersex in the Age of Ethics* University Publishing Group

Dreger, Alice Dorumat (2003) *Hermaphrodites and the Medical Invention of Sex* Harvard University Press

Kessler, Suzanne (1998) *Lessons From the Intersexed* Rutgers University Press

Morland, Iain (2001) "Is Intersexuality Real?" *Textual Practice* 15(3) 527-547

Preeves, Sharon (2003) *Intersex and Identity: The Contested Self* Rutgers University Press