Intersex and Identity

The Contested Self

SHARON E. PREVES

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Chapter 1 Beyond Pink and Blue

If doctors really want to do something for their intersexed patients, I would say the first thing is [to] put the intersex person in touch with other people who are intersexed. Number two is see number one. And number three is see number one. That's it. Doctors think that you're going to kill yourself if you find out the truth. People kill themselves because they feel alone and isolated and helpless; that's why they kill themselves. When doctors don't tell their patients the truth, they're cutting them off from the opportunity of incredible support.

—Excerpt from interview with Sherri

RECENTLY I PARTICIPATED in a cultural diversity fieldtrip with twenty-two second graders in St. Paul, Minnesota. When I arrived at their school, the kids were squirrelly with anticipation. They were a colorful and varied bunch—some were tall and thin, others short and stout. Moreover, they were from a variety of racial and ethnic backgrounds and spoke nearly a half dozen native languages. When it was time to begin our community walking tour, the teachers attempted to bring the busy group to order quickly. How did they go about doing so? They told the children to form two lines: one for girls and the other for boys. The children did so seamlessly because they had been asked to line up in this manner countless number of times before. Within moments, the children were quiet and attentive. I was struck then, as I had been many times before, by how often and in the most basic ways societies are organized by a distinction between sexes. Even with children of every shape and color, the gender divide worked as a sure way to bring order to chaos. "Girls in one line, boys in the other." But sometimes the choice between the lines—and sexes—isn't so easy.

Which line would you join? Think about it seriously for a minute. How do you know whether to line up with the girls or the boys? For that matter, what sex or gender *are* you and how did you *become* the gender you are? Moreover, how do you *know* what sex and gender you are? Who decides? These questions may seem ridiculous. You may be saying to yourself, "Of course I know what gender I am; forget this book." But really stop to think about how you know what sex you are and how you acquired your gender. Most of us have been taught that sex is anatomical and gender is social. What's more, many of us have never had the occasion to explore our gender or sexual identities, because neither has given us cause for reflection. Much like Caucasians who say they "have none" when asked to explore their racial identity, many women and men find it difficult to be reflective about how they know and "do" gender.[1]

This book explores what happens to people who, from the time of their birth or early adolescence, inhabit bodies whose very anatomy does not afford them an easy choice between the gender lines.[2] Every day babies are born with bodies that are deemed sexually ambiguous, and with regularity they are surgically altered to reflect the sexual anatomy associated with "standard" female or male sex assignment. There are numerous ways to respond to this plurality of physical type, including no response at all. Because sex and gender operate as inflexible and central organizing principles of daily existence in this culture, such indifference is rare if not nonexistent. Instead, interference with sex and gender norms are cast as a major disturbance to social order, and people go to remarkable lengths to eradicate threats to the norm, even though they occur with great regularity.

Recent estimates indicate that approximately one or two in every two thousand infants are born with anatomy that some people regard as sexually ambiguous. These frequency estimates vary widely and are, at best, inconclusive. Those I provide here are based on an exhaustive review of recent medical literature.[3] This review suggests that approximately one or two per two thousand children are born with bodies considered appropriate for genital reconstruction surgery because they do not conform to socially accepted norms of sexual anatomy. Moreover, nearly 2 percent are born with chromosome, gonad, genital, or hormone features that could be considered "intersexed"; that is, children born with ambiguous genitalia, sexual organs, or sex chromosomes. Additional estimates report the frequency of this sexual variance as comprising approximately 1 to 4 percent of all births.[4]

These estimates differ so much because definitions of sexual ambiguity vary tremendously.[5] This is largely because distinctions between female and male bodies are actually on more of a continuum rather than a dichotomy. The criteria for what counts as female or male, or sexually ambiguous for that

matter, are human standards. That is, bodies that are considered normal or abnormal are not inherently that way. They are, rather, classified as aberrant or customary by social agreement.[6] We have, as humans, created categories for bodies that fit the norm and those that don't, as well as a systematic method of surgically attempting to correct or erase sexual variation. That we have done so is evidence of the regularity with which sexual variation occurs.

Melanie Blackless and colleagues suggest that the total frequency of nongenital sexual variation (cases of intersexed chromosomes or internal sexual organs) is much higher than one in two thousand.[7] They conclude that using a more inclusive definition of sexual ambiguity would yield frequency estimates closer to one or two per one hundred births, bringing us back to the 1 to 2 percent range.

To put these numbers in perspective, although its occurrence has only recently begun to be openly discussed, physical sexual ambiguity occurs about as often as the well-known conditions of cystic fibrosis and Down syndrome.[8] Since there are approximately four million babies born annually in the United States, a conservative estimate is that about two to four thousand babies are born per year in this country with features of their anatomy that vary from the physical characteristics typically associated with females and males.[9] Some are born with genitalia that are difficult to characterize as clearly female or male. Others have sex chromosomes that are neither XX nor XY, but some other combination, such as X, XXY, or chromosomes that vary throughout the cells of their bodies, changing from XX to XY from cell to cell. Still others experience unexpected physical changes at puberty, when their bodies exhibit secondary sex characteristics that are surprisingly "opposite" their sex of assignment. Some forms of sexual ambiguity are inherited genetically, while others are brought on by hormonal activity during gestation, or by prescription medication women take during pregnancy. Regardless of its particular manifestation or cause, most forms of physical sexual anatomy that vary from the norm are medically classified and treated as forms of intersexuality, or hermaphroditism.

Take Claire's experience as an example.[10] Claire is a middle-class white woman and mother of two teenage daughters who works as a writer and editor. She was forty-four years old when she conveyed the following story to me during a four-hour interview that took place in her home. Claire underwent a clitorectomy when she was six years old at her parents' insistence, after clinicians agreed that her clitoris was just "too large" and they had to intervene. The size of her clitoris seemed to cause problems not for young Claire, but for the adults around her. Indeed, there was nothing ambiguous about Claire's sex before the surgery. She has XX chromosomes, has functioning

female reproductive organs, and later in life went through a physically uneventful female puberty. Claire's experience illustrates that having a large clitoris is perceived as a physical trait dangerous to existing notions of gender and sexuality, despite the sexual pleasure it could have given Claire and her future sexual partners. In fact, doctors classify a large clitoris as a medical condition referred to as "clitoral megaly" or "clitoral hypertrophy." Conversely, small penises for anatomical boys, are classified as a medical problem called "micropenis." These are topics that I will discuss further in chapter 2.

Reflecting on the reasons for the clitorectomy she underwent at the age of six, Claire said, "I don't feel that my sex was ambiguous at all. There was never that question. But I'm sure that [clitorectomies] have been done forever because parents just [don't] like big clitorises because they look too much like a penis." Even more alarming are the physical and emotional outcomes of genital surgery that might be experienced by the patient. About the after effects of her surgery, Claire said,

> They just took the clitoris out and then whip stitched the hood together, so it's sort of an odd-looking thing. I don't know what they were hoping to preserve, although I remember my father thinking that if someone saw me, it would look normal because there's just a little skin poking out between my lips so it wouldn't look strange. I remember I was in the hospital for five days. And then it just got better and everything was forgotten, until I finally asked about it when I was twelve. [There was] total and complete silence. You know, it was never, never mentioned. I know you know what that does. I was just in agony trying to figure out who I was. And, you know, why . . . what sex I was. And feeling like a freak, which is a very common story. And then when I was twelve, I asked my father what had been done to me. And his answer was, "Don't be so self-examining." And that was it. I never asked again [until I was thirty-five].

During the course of my research I spoke with many other adults across North America who had childhood experiences remarkably similar to Claire's. Their stories are laden with family and medical secrecy, shame, and social isolation, as well as perseverance and strength of spirit, and eventual pride in their unique bodies and perspectives.

Personal Narratives

Being labeled as a misfit, by peers, by family members, or by medical diagnosis and treatment, is no doubt a challenge to one's identity development and stability. This is especially true for children whose bodies render traditional

gender classification ineffective, for there is seemingly no place to belong without being gendered, especially during childhood. Negotiating identity, one's basic sense of place and self, is a challenge for many of us, and is potentially far more challenging for people whose sex is called into question. The social expectation for gender stability and conformity is prevalent across social spheres. Nearly every aspect of social life is organized by one's sex assignment — from schooling and relationships, to employment and religion, sports and entertainment, medicine and law. Because North American cultures are structured by gender, successful participation in society's organizations and personal relationships requires gender categorization. Many of us negotiate questions of sex and gender with little effort. Others, however, do not have the luxury or ease of fitting neatly into a dual-gendered culture.

In an attempt to understand how intersexuals experience and cope with their marginality in a society that demands sexual conformity, I turned to them directly for answers. In the end, I interviewed thirty-seven individuals throughout North America whose bodies have been characterized by others as intersexed.

Previous research on this topic has explored the history, procedures, and clinical success of medical sex assignment, but has rarely focused on questions addressing quality of life for patients who undergo medical intervention. In addition, most research in this area has been either case study research or quantitative in nature. These studies are valuable and have contributed significantly to the fields of gender identity research and medical sex assignment. Despite these notable contributions, the scope of this research has been limited. Moreover, it is difficult to gain a deep and broad understanding of people's experiences using either quantitative or case study research because quantitative measures typically limit answers to closed-ended responses and case studies often focus on only one or two people's experiences.

In turning directly to people characterized as intersexed for answers, I attempted to bridge this gap when I conducted in-depth life history interviews with more than three dozen people who were born sexually ambiguous. My research methods were geared toward gleaning a deep understanding of these individuals' experiences and lives. Such depth of understanding is commonly achieved through qualitative life history research. Given that there has been very little follow-up research with adults born intersexed, and the success and value of medical sex assignment has recently been called into question, such in-depth exploration of their experiences and perspectives is crucial to a more nuanced understanding of the implications of living with bodies characterized as sexually ambiguous and the long-term impact of medical sex assignment procedures.

The heart of this book is built upon the personal narratives intersex activists and support group members relayed to me during these in-depth face-to-face interviews. Focusing on the stories told to me during these life history interviews is particularly important in the study of intersexuality because most research in this area has centered upon physiological and biomedical concerns related to intersexuality, rather than on the experiences of intersexuals themselves.

HOW I BECAME INTERESTED IN THE PROJECT

I began this research in 1993, when I was a first-year doctoral student in medical sociology at the University of California, San Francisco.[11] I was enrolled in a class on medicine and the family and was given an assignment to conduct research on some aspect of medicine as it relates to families. My interest in intersexuality was sparked earlier that spring when I read Anne Fausto-Sterling's article "The Five Sexes: Why Male and Female Are Not Enough."[12] After reading this article, I was compelled to address several questions that remained unanswered, the foremost of which was, "What is the experience for individuals who were born sexually ambiguous and medically assigned to a category of female or male?"[13] As I began to formulate a topic for my class research assignment, I focused first on families' involvement with sex assignment decisions. For this task I looked for research on parents' experiences with sexually ambiguous children, and found nothing. I examined research literature in social work, psychology, and sociology and found neither information about families and intersex, nor information about intersex as a social category. Then I went in search of former patient narratives and came up dry. When I finally turned to the medical literature, I hit the proverbial jackpot. What I found was a plethora of clinical articles detailing the diagnosis and treatment of sexual ambiguity.

While completing this early project, I was astonished to find that so little research had been conducted with former patients or families about the social experiences and outcomes of these medical procedures. However, around that same time, the publication of Fausto-Sterling's "Five Sexes" article acted as a catalyst for some adult intersexuals to come forward and tell their stories. From this point, they began to form intersex support and advocacy groups, spurring the beginnings of a burgeoning intersex social movement. Due to the fact that these events coincided with my own research on intersex, I became aware of the important opportunity to speak with intersexuals about their experiences and perspectives firsthand.

INTERVIEWING MEMBERS OF AN INVISIBLE POPULATION

Initially, recruiting willing interviewees for my study was a challenge because sexual ambiguity is generally not visible, and members of this population typically don't self-identify as intersexed and therefore are generally not mobilized. During the course of my research, however, several intersex support and advocacy groups either emerged or came to my attention. Because they are a self-selected group, members of these organizations cannot be expected to represent the diversity of experience within the intersex population. In fact, given the difficulty of identifying members of this population, it is not possible to get a truly representative sample. Rather, these organizations served as a strategic and theoretically promising sampling base, given the social context of an emerging intersex social movement and my interest in the experience and process of social marginalization.

I began to recruit subjects for my study by mailing information packets to the sixteen currently established intersex support organizations in the United States and Canada. I was amazed at how quickly people responded to my initial study announcement when I heard back from four different support group leaders within two weeks. I felt the need for this study was validated when the first person responded by calling within three days of my initial mailing. I assume she called the day she received my packet, as she lived several states away.

In contrast with prior research in this area, which is primarily medical and quantitative in nature, my approach is sociological and qualitative, with in-depth interviews with adult intersexuals serving as the primary data source. I conducted intensive interviews with adult intersexuals to address their subjective experiences with intersexuality. The interviews concentrated on participants' life histories with specific attention to how they learned of their intersexuality, their experiences with medical intervention, as well as how they dealt with issues of identity development, and what significance they placed on social support. In addition, the interviews explored participants' sexual identities, their experience of gender and sexual identity development, challenges associated with being intersexed, and how they respond to those challenges. (See chapter 7: Methodological Appendix for further information on how I conducted the research.)

In conducting this research I attempt to inform and reshape existing theory on intersex clinical management, using the technique of the extended case method suggested by Michael Burawoy.[14] In the traditional use of this method, I reevaluate an existing theory via the analysis of an anomalous case. I use Erving Goffman's theory of stigmatized identity, which articulates how people who are socially outcast internalize feelings of self-despair. In particular,

I focus on Goffman's expectation that deviant individuals will attempt to conform or pass as normal. I evaluate Goffman's work on identity management as it relates to the negotiation of the self, with special regard for potentially stigmatized individuals.[15] In the interview guide, I also incorporate the theories outlined by Candace West and Don Zimmerman, and later by Judith Butler, to explore these individuals' responses to anatomical disruptions of gender binarism.[16]

Allowing individual voices to be heard through the use of life history interviews is particularly important in the study of intersexuality because most research in this area has been centered only on physiological and biomedical concerns related to intersexuality. I employed the method of phenomenological interviewing, which is "an interviewee-guided investigation of a lived experience."[17] In using this technique, I asked intersexuals to relay the most central elements of their life histories related to intersex, within a thematic framework I created through extensive literature review.

While my primary method of data collection was in-depth interviewing, I employed additional methods, as is common in fieldwork. In this regard, I supplemented intersexuals' narratives with my own field notes on the process of conducting the research, detailing my interactions with participants, my own feelings throughout the project, and key themes as they emerged during analysis. In addition, I used two self-administered instruments that I created for this project: a life course gender identity time line and a sexual identity questionnaire (see chapter 7: Methodological Appendix).

In the end, I interviewed thirty-seven intersexed adults from March of 1997 to September of 1998. Research participants ranged in age from twenty to sixty-five with a mean age of forty, and lived in nineteen different states and Canadian provinces. At the time of interview, 24 percent of interviewees were living as a gender different from their sex of assignment and rearing; six were transitioning or had transitioned from male to female, and three from female to male. In 51 percent of the sample, intersexuality was apparent at birth or in infancy due to genital ambiguity; for 49 percent intersexuality was not apparent until puberty.

The sample was exceedingly well educated, in that all are high school graduates and 96 percent have at least some college education. Seventy-eight percent are college graduates, 43 percent have at least some graduate education, and 27 percent have graduate degrees. Thirty-eight percent were living with a spouse or domestic partner, and 27 percent were single and not dating. The other 35 percent were engaged in some form of dating or monogamous relationship. Sixteen percent reported that they were not sexually active. Of

those who were, 46 percent engaged in sexual activity with partners living in the same gender role. That is, 46 percent engaged in sexual relations that are "homosexual" in outward appearance. Twenty-seven percent of the sample elected to use their real first names in the study instead of a pseudonym. Interestingly, 24 percent had also changed their legal names, taking on and using new names in their daily lives rather than the ones they were given at birth. Despite my attempts to talk with a diversity of people, 89 percent of the sample is Caucasian, and 11 percent is Latino/a, Asian/Pacific Islander, Native American, or biracial. Forty percent were employed in medical fields or in social services, 14 percent as teachers and writers, and 14 percent were unemployed.

I conducted the interviews in a private, face-to-face format, primarily in participants' homes.[18] Privacy was essential for these meetings because the interview guide covered many sensitive topics. Face-to-face encounters were important for this reason as well. Building a feeling of rapport with interviewees was particularly significant given the sensitivity of the subject matter. Face-to-face meetings also provided ample contextual data and opportunities to glean more from people's lives than their spoken words provided. Finally, based on recurrent feedback I received from participants, meeting face to face allowed for a valuable interview experience.

Organization of the Book

Throughout my research, I have heard stories of powerlessness, violation, reclamation, and personal empowerment. Interview after interview, participants shared stories of feeling scrutinized and sexualized by medical professionals, of being treated as oddities and freaks, of lacking control over their own bodies, and of the resulting shame and secrecy of such experiences. They also spoke of arduous battles to gain accurate information about their bodies and attempts to find other intersexuals—aiming to piece together a puzzle whose solution was sure to hold the key to identity. In spite of these difficulties, participants were largely capable of overcoming this sense of despair and were able to claim the power of their difference.

In order to make sense of medical sex assignment and the stories and activism of intersexed adults, I weave several bodies of literature and theoretical perspectives into the pages of this book. I begin by exploring the importance of gender to social structure and social order. This context is vital to understanding the experiences of those who are labeled as sexually ambiguous, as well as the objectives of medical sex assignment. In doing so, I

draw on the work of several symbolic interactionists and gender theorists to explore gender as a social process and social structure that is central to identity formation, social relations, and the ability to function in society.

In chapter 2, I examine the social context within which the current medical paradigm originally took hold and the tenets of medical sex assignment, with special attention to the historical development of medicine as an institutional authority on gender and sexuality. I provide this history to illustrate that there have been institutional shifts in responding not only to intersexual "deviance," but to other types of nonconformity as well. In this chapter, I incorporate the work of several medical sociologists, as well as the work of historians of medicine and sexuality.

In chapter 3, I explore how interviewees experienced medical sex "normalizing" procedures. I turn to participants' narratives and experiences to explore the impact of medical sex assignment on the formation of identity. Participants spoke repeatedly of sex assignment procedures as compounding feelings of alienation and shame, rather than alleviating the feelings of social isolation and exclusion as they were intended to do. Here I again incorporate the work of several symbolic interactionists and social psychologists to explore the impact of stigmatization on identity formation and social interaction.

I explore in chapter 4 the major social changes, such as the gay pride movement, that set the groundwork for the current mobilization and activism of intersexuals who are critical of surgical sex assignment of sexually ambiguous children. I provide this context as a backdrop to participants' stories of coming to terms with their intersexuality and their stories of seeking others like them who have been similarly outcast. This chapter is the foundation for understanding the intersex social movement and a reworking of intersexed identity from one of stigma and shame, to that of pride and potential activism.

In chapter 5, I once again turn to the narratives of former patients for further insight into intersex mobilization, empowerment, and pride. As in the previous two chapters, I apply models of coming out and community empowerment and note a similar process of coming to terms with difference that has been identified in other marginal groups, such as people with disabilities or those who identify as gay, lesbian, bisexual, or transgender (GLBT).

Identity-based social movements are powerful to behold. They teach volumes about the power and efficacy of individual or small group action on making social change. In the case of redefining sexual ambiguity in a more positive and empowering light, individual and collective action has had a tremendous impact in a very short period of time. I conclude the book, in chapter 6, with a discussion of the impact of such change, and suggest direction for future action and research with parents and doctors of intersex children. Chapter 7 is a methodological appendix, where I provide more detail about the research I conducted that serves as the backbone of this book.

Before discussing interviewees' personal narratives in more depth, I will first set the context for their experiences by exploring the predominant cultural agreements and understandings about gender and medicine that shape all of our lives so profoundly.

Intersex is a Social, Not Medical, Problem

The occurrence of physical sexual variation is a given. How to respond to that variation is not. In fact, there is tremendous disagreement about what that response ought to be. This book went to press during a long and heated debate between intersex activists, scholars, and clinicians all seemingly dedicated to a similar goal: destigmatizing people who are born with sexual ambiguity. Primary points of contention between these groups are whether or not most medical intervention on intersex children is necessary for their physiological or mental health, or whether these procedures are primarily cosmetic or potentially physiologically and psychologically harmful and alienating.

The jury is still out on this issue, and has been for a long time. Many people say there isn't valid evidence to support continued medical attempts to efface sexual variation. Others dismiss the critiques of intersex activists as representative of only an unhappy minority. What is clear is that a considerable number of former patients have recently come forward to speak out against procedures they consider harmful not only to their lives, but also to the lives of their families and culture at large. I explore their stories and what they teach us at length in the pages of this book. Furthermore, I frame their stories with a sociological discussion of gender, the history of intersex medicalization, recent mobilization of intersexed adults, and the implications of their activism on identity negotiation, medical practice, academe, and cultural norms.

While being born with indeterminate sexual organs indeed problematizes a binary understanding of sex and gender, several studies show—and there seems to be general consensus (even among the doctors performing the "normalizing" operations)—that most children with ambiguous sexual anatomy do not require medical intervention for their physiological health.[19] Nevertheless, the majority of sexually ambiguous infants are medically assigned a definitive sex, often undergoing repeated genital surgeries and ongoing hormone treatments, to "correct" their variation from the norm.

It is my argument that medical treatments to create genitally *unambiguous* children are not performed entirely or even predominantly for the sake of preventing stigmatization and trauma to the child. Rather, these elaborate,

expensive, and risky procedures are performed to maintain social order for the institutions and adults that surround that child. Newborns are completely oblivious to the rigid social conventions to which their families and caregivers adhere. Threats to the duality of sex and gender undermine inflexibly gendered occupational, education, and family structures, as well as heterosexuality itself. After all, if one's sex is in doubt, how would they identify their sexual orientation, given that heterosexuality, homosexuality, and even bisexuality are all based on a sexual binary? So, when adults encounter a healthy baby with a body that is not easily "sexed," they may understandably experience an inability to imagine a happy and successful future for that child. They may wonder how the child will fit in at school and with its peers, and how the child will negotiate dating and sexuality, as well as family and a career. But most parents don't find a real need to address these questions until years after a child's birth. Furthermore, it is my contention that parents and caregivers of intersexed children don't need to be so concerned about addressing the "personal troubles" of their children either. Rather, we should all turn our attention to the "public issues" and problems wrought by unwavering, merciless adherence to sex and gender binarism.[20]

That medical sex assignment procedures could be considered cosmetic raises several important questions, including the human influences in constructing definitions of health and pathology. Bodies are classified as healthy or pathological (or as normal and abnormal) through social expectations, human discourse, and human interaction. As a result, what is seen as normal or standard in one culture and time is seen as aberrant and strange in another. Indeed, deviance itself is created socially through human actions, beliefs, and judgments.[21] Consider Gilbert Herdt's anthropological research in Papua New Guinea. The Sambia males of Papua New Guinea believe that they become masculine by ingesting the semen of adult men. In order to become virile, therefore, Sambian boys perform oral sex on and ingest the semen of adult men.[22] According to Herdt, such activity is considered a standard rite of passage to manhood among the Sambia in Papua New Guinea, much like a bar or bat mitzvah is seen as a customary ritual of young adulthood among Jews.

I offer the above example to illustrate that definitions of normal and abnormal vary tremendously by culture. That said, there is no reason to consider intersex as necessarily problematic in itself. In fact, since physical sexual ambiguity has been shown to be a cause of health problems in only very rare cases, sexual ambiguity could be considered a *social* problem, rather than a physical problem. Rare physical problems do occur in cases where eliminating bodily waste, such as urine and feces, is difficult because of internal physiological complications or infrequent cases of salt-wasting congenital adrenal

hyperplasia, which is a condition where children have hyperactive adrenal glands and hormone therapy is required to regulate the endocrine system.[23] Because Western cultures place such strong emphasis on sexual (and other forms of) categorization, intersex ambiguity causes major social disruption and discomfort. If there were less concern about gender, there would be less concern about gender variation. Because intersex is often identified in a medical setting by physicians during childbirth or during a pediatric appointment in later childhood, the social response to intersex "deviance" is largely medical.

The Salience of Gender

There is tremendous emphasis on sexual categorization in this culture and in many others. As a matter of illustration, try—for just one hour—to stop yourself from classifying others' gender as you encounter them. Doing so is nearly impossible and will most likely heighten your awareness of the gender attribution process we go through every day to sort people into one category or another.[24] Of course we go through this classification process with other visible characteristics as well, such as race, ethnicity, body type, age, and attractiveness, but the importance of gender attribution to basic social interaction may outweigh the others. For example, we may be familiar (and therefore more comfortable) with people who are of mixed race, in contrast with people who are intersexed. While there is still a tendency to simplify the complexities of racial heritage by classifying people into one category or another, racial ambiguity does not cause the level of discomfort that sexual ambiguity does—in large part because of our familiarity with persons of mixed race.

Gender or sexual ambiguity is less integrated into the cultural mainstream and is therefore experienced as more disruptive. Consider the popularity of the "It's Pat" skit from the *Saturday Night Live* television program. The subject of this long-lived skit, and subsequent movie, was the troubling ambiguity of Pat's sex. Pat's androgyny caused such a stir, and was such a familiar quandary for TV and studio audiences, that the popularity of this skit endured endless attempts by its characters to unravel the mystery of Pat's sex. If gender attribution were less important to social interaction and belonging, the skit would have been a flop because audiences wouldn't have found it meaningful or interesting.

Why is gender attribution so meaningful to social order and why does the inability to classify someone's sex cause such a major disruption? In an effort to answer this question, I turn to the symbolic interactionist tradition of sociology. Symbolic interactionists study how people present and perceive themselves and one another in social interaction. More specifically,

interactionist sociologists explore the tools or props people use, such as costumes and official titles, to designate their status, power, and role in relation to one another for the sake of making social interaction more coherent and predictable. An interesting aspect of this framework is its contribution to understanding how people create meaning, agreement, categorization, and stratification through human interaction. Working from this interactionist tradition, sociologists such as Erving Goffman and Eviatar Zerubavel claim that being able to classify ourselves and others into distinct categories is essential to smooth and meaningful social interaction.[25]

In his study of interaction rituals, Goffman concluded that we seek information about others, such as their gender or racial identification, in an attempt to define the rules and parameters for a given social exchange.[26] According to Goffman, people engage in this process of classifying others in order to make sense of the world around them so that they know what to expect from social encounters and how to act appropriately. Those not familiar with Goffman's theory might be saying, "I don't need to categorize someone in order to know how to act with them. I'm just myself, no matter the situation." Such confidence is important, but most likely exists alongside an unconscious process of sorting people into familiar categories to make interaction go more smoothly. Take e-mail or Internet chat rooms as an example. Unless you actually know the person beyond the electronic medium, you have no way to verify people's claims to identity online. Have you ever thought you were e-mailing a woman or man, and discovered your "gender sensor" was off? I recently had an experience like this of my own. A journal editor whom I knew only by name e-mailed to ask if I was willing to write a book review for a journal. I was delighted to be invited to do so, and e-mailed this person several times during the process of writing the piece, all the while thinking I was interacting with a man. Months later I discovered my mistake, and wondered if I would have presented myself differently or interacted in a different manner had I known the editor was female. Why on earth would I have considered altering my behavior based on someone else's gender?

According to Michael Schwalbe and Douglas Mason-Schrock doing so would be not only sensible, but also predictable. They argue that by attaining information about others, we begin to formulate social expectations, allowing us to prepare for and predict the tone or projected outcome of subsequent social encounters.[27] This ability to classify allows for some comfort in being able to predict, certainly with some inaccuracy, what to expect from people with whom we interact in daily social life. Given this line of thinking, when one is unable, for whatever reason, to assess a person's gender, the rules for social negotiation with that person are suddenly made unclear simply because

the attempts to classify her/his gender fail. Relating this failure directly to the development of self, John Hewitt says that when an ascribed characteristic, such as sex, receives a negative evaluation from others, low self-esteem may result, for we base our own self-concept, in part, on others' evaluations. In fact, Hewitt argues that individuals' claims about identity are meaningful only when validated by others.[28] In this sense, one's gender identity or presentation of gender (or any other type of identity) requires reinforcement and acceptance from others in order for the identity claim to be successfully maintained.

Gender Socialization, Norms, and Attribution throughout the Life Course

Whether we are conscious of it or not, gender structures our most basic sense of self as well as our primary social institutions. From issues of identity development and everyday social interaction, to the structure of family, economic, political, religious, and educational relations, gender is one of the primary organizing principles of society and daily living.[29] Indeed, it is difficult to conceive of a world where distinctions based on gender do not exist because our experiences are so rooted in a society structured by gender.

At a very young age, children learn that gender is a central principle by which their lives are shaped. They also learn to expect clear distinctions between genders because, from the very moment of birth, girls and boys are socialized to inhabit and experience very different social worlds.[30] How and why do we teach our children that gender is so important?

Gender classification begins at birth (and sometimes well before via neonatal technology, such as ultrasound). Attaching a sex label (female or male) to newborns is one of the most basic elements of early socialization. Once a child's sex is assigned, typically based on its genital appearance at birth, gender-specific socialization may begin. Immediately thereafter parents often give their children gender-specific names, swaddle them in pink or blue blankets and clothing, and send out "It's a Girl!" or "It's a Boy!" birth announcement cards to family and friends in celebration. In fact, with ultrasound technology, many expectant parents are choosing to identify their child's sex even before it is born. One of the primary reasons they do so, no doubt, is the reality that social life is organized by gender. Many parents find it difficult to prepare for or even imagine a child's life without first knowing its sex.

Adults often interact with children in ways that reinforce the importance of gender and the expected distinction between gender roles. This includes family members surrounding children with "girl" and "boy" toys and teachers

using gender as a way to separate children into competitive teams or lunchroom lines. Some parents are so concerned that people might mistake their baby for the wrong sex, that they tape pink bows to their bald heads, have their ears pierced in infancy, or dress them in gender-specific primary- or pastel-colored clothing.

Most children first learn about such cultural norms from their parents and other family members. Other important agents of (gender) socialization are teachers, literature, peers, media, religion, and even toys. Lawrence Kohlberg demonstrated in his research forty years ago that children are able to identify themselves as female or male by the age of three. By the age of five, Kohlberg argues, children adhere closely to traditional gender-typed behavior that is taught and reinforced by the society in which they live.[31] Likewise, children learn at an early age to interact with one another in ways that reinforce the importance of gender by playing gender-segregated games on the playground, such as jump rope for girls and baseball for boys. Children strengthen the supposed gender divide by playing games that create and reinforce gender boundaries, such as pretending to pollute one another with the germs or "cooties" that are imagined to be associated with one gender or the other.[32] Toys such as Easy Bake Ovens and G.I. Joe prepare children to inhabit vastly different worlds in child- and adulthood, replete with emotions, occupations, economic standing, personal tastes, and even physical stature that all become laden with gendered meaning. Certainly gender roles are more flexible now than they were even twenty years ago, and there is significantly more crossover between genders. Even so, toys that are deemed "gender neutral," such as Big Wheels, boast gendered accessories, such as pastel or primary color schemes and frilly or angular edging, so that a distinction between genders is reinforced.

After early childhood, the significance of gender increases substantially when young adults consider and seek out dating and romantic endeavors. In fact, the very ability to identify one's sexual orientation as lesbian or gay, bisexual, or straight is dependent on one's identity as female or male and the social distinctions between those categories. From early high school romances to lifelong partnerships and parenting relationships, gender plays a central role. Gender continues to shape social life in education and career choices and in the division of parenting and housekeeping duties at home.

GENDER BINARISM AND THE HETEROSEXUAL MATRIX

It nearly goes without saying that a predominant expectation about gender is that there are only two "flavors," female or male, and that initial sex assignment is based on genital appearance at birth.[33] Social expectations about gender, however, do not stop there. In fact, they are much more complex. In their

study of gender expectations and nonconformity based on the work of Harold Garfinkel, Suzanne Kessler and Wendy McKenna make several of these nuances clear. They summarize these expectations as follows:

1. There are two, and only two, genders.
2. One's gender is invariant.
3. Genitals are the essential sign of gender.
4. Any exceptions to the two genders are not to be taken seriously.
5. There are no transfers from one gender to another except ceremonial ones.
6. Everyone must be classified as a member of one gender or the other.
7. The female/male dichotomy is a natural one.
8. Membership in one gender or the other is natural.[34]

So, not only are the options for gender limited to two categories, membership in a gender category is also seen as natural and permanent.

The concept of gender becomes even more complicated when we consider the commonplace distinction between one's anatomy and one's identity, in that *sex* is considered by many to be anatomical and gender is considered a social category. That is, there is a tendency to differentiate sex from gender by defining sex as physiological (that is, genitals, gonads, chromosomes, and hormones) and gender as social (that is, the subsequently developing sense and presentation of self as a sexed individual).[35] More explicitly, we tend to infer children's gender from their genital sex in infancy and subsequently interpret their behaviors as "feminine" or "masculine." As children age, the reverse process occurs. Because we are typically unfamiliar with a child's genital makeup, we infer a child's sex from its behavior and other outward cues, such as clothing, name, and body type. In a culture that is heteronormative, there is often the presumption that girls and boys will grow up to desire each other.

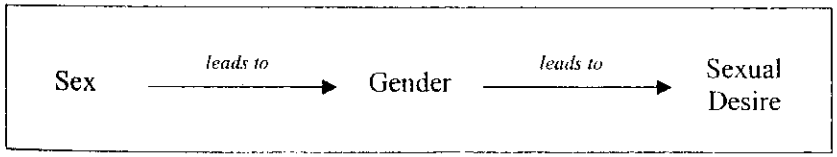

Figure 1. Butler's Heterosexual Matrix. Butler put her finger on the causal and linear assumptions most Westerners believe exist between the three components of sexual identity: anatomical sex, gender identity and presentation, and sexual desire. Here I provide a diagram of Butler's theory to visually characterize the widely presumed connections between these concepts. To my knowledge, Butler has no graphic depiction of the heterosexual matrix.

It is this complex set of linear and causal assumptions of sexual identity development which Judith Butler calls the heterosexual matrix.[36]

In her discussion of the heterosexual matrix, Butler demonstrates that normative Western assumptions about sexual identity are based on a belief that anatomical sex causes gender development which, in turn, causes sexual desire. In this sense, one is assumed to be anatomically "hard wired" to develop a gender identity (one's gendered sense of self) and gender role (one's gendered presentation of self) that correlate with one's birth genitalia. In addition, this model assumes heterosexuality, that is, that one will naturally be attracted to individuals whose genitals are different from their own. However, as Butler and others note, this model has many limitations, because gender identity and gender role do not always coincide with genitalia or result in heterosexual attraction.[37]

Given the tendency to conflate the categories of sex and gender, Kessler and McKenna, Butler, and others see no meaningful distinction between the two terms and, therefore, primarily use the term *gender* to refer to either anatomy *or* identity throughout their work. In the same fashion, I use the terms sex and gender interchangeably throughout this book, except in rare cases when distinction between the two terms is useful for clarity. The conflation of the terms sex and gender is particularly evident and apt when considering intersexuality, because physicians typically weigh quite heavily the success of a child's imagined future gender identity and presentation when making sex assignment decisions about newborns.[38]

Gender Nonconformity

Even though gender roles are far more flexible than they once were in our culture's recent history, gender continues to structure and shape all of our lives day in and day out from birth until death, and perhaps even before birth and after death as well; for example, when decorating an unborn child's nursery or planning a deceased love one's memorial service. Sexual ambiguity is disruptive precisely *because* of the emphasis we place on gender. If gender classification were socially less important, or if criteria for membership in one gender category or another were more flexible, variation in sexual anatomy would be of much less concern.

Despite their significance, our expectations for sex and gender categorization most often go unnoticed, until we are presented with a deviation from the norm.[39] Babies born with bodies that vary from traditional appearance, or children who undergo pubescent changes later in life that vary from the norm, challenge the most basic of social expectations. The belief that there

are only two sexes, and that sex is defined by a specific genital appearance, creates a significant problem in that some people, with considerable frequency and regularity, have bodies that don't fit the norm. In a world where only two sexes are thought to exist, a person must be, or must present oneself as, one sex or the other in order to gain valid membership and recognition in that society's predominant culture. In this rigid belief system—if someone's identity or anatomy is not consistent with dualistic expectations—some people may take drastic measures to make others (or themselves) comply with the norm because it is considerably problematic to (involuntarily) challenge the norm when dealing with something as central to social identity and belonging as gender categorization.

The case of an intersex birth, a birth where one's sex cannot readily be ascertained, announced, and counted upon, provides a poignant example of normative expectations remaining unfulfilled. According to sociologist Harold Garfinkel, one is most able to ascertain the strength and specific nature of social norms by deviating from them and then closely gauging the response.[40] Garfinkel's theory, known as ethnomethodology, stems from an understanding of the three basic elements of social deviance. These elements are (1) the existence of a shared social expectation, or social norm; (2) a marked violation or deviation from the norm; and (3) the social response to such a deviation. Gauging the social response to normative violations is key to understanding the salience of the initial social expectation. That is, when there is very little response to a norm violation (say, for example, jaywalking), the indifferent response itself indicates that the expectation isn't all that important to maintaining social order. To further illustrate what may be learned about social expectations by breaching the norm, I'll provide a personal example. When I was eleven years old, I went to horse camp in rural northern Minnesota with my twelve-year-old girlfriend Gaelle, who was from Paris and was visiting the United States for the very first time. Gaelle and I decided to go swimming at the camp's beach. When we arrived at the beach, we both proceeded to take off our shorts and T-shirts in the same manner, with one major exception. I was wearing my swimsuit underneath my shorts and T-shirt; Gaelle was wearing nothing. Despite the stares, she proceeded to undress, take her bathing suit out of her beach bag, and change into her suit in broad daylight. Based on Gaelle's French upbringing, doing so was within the realm of beach etiquette. The gawks and stares she received from fellow campers and counselors at Little Elk Ranch quickly informed her that Americans aren't so free with public nudity, and served to reinforce the norm of public decorum.

In applying this model of social deviance to intersex, the shared social expectation is that babies are born in one of two clearly delineated anatomical

types—female or male—as ascertained by genital presentation at birth. In the case of intersexuality, normative violation occurs when genitalia and/or later pubescent development are not congruent with this two-sex model. The social reaction to this form of deviance is primarily medical, due to the medicalization of childbirth and the medicalization of normality in this culture—a point I develop further in chapter 2. The social response to intersexual "deviance" is so strong that we have developed institutional means of covering up or erasing the violation, so that the initial social expectation of sex binarism may be upheld. More specifically, we have developed medical means of surgically and hormonally engineering bodies that adhere to a two-sex social system, thereby reinforcing and maintaining sex binarism and genital signification of sex as necessary and natural.

Recall that the process of being labeled as deviant is a social one. Being characterized as deviant is the result of people perceiving, naming, and treating one as an outsider. Therefore, qualities that are considered deviant, such as atypical genitalia, aren't fundamentally distinct from those that are considered normal. The difference lies in the act of successfully labeling and treating one physical type as deviant and the other as customary.[41]

LABELING, STIGMA, AND THE SELF

Why would a culture go to such great lengths to uphold a two-sex system when there are clearly consistent exceptions to this norm? One reason is because intersex is incongruent with the predominant, binary understanding of sex and gender, and this gender system provides the foundation for even the most basic social interaction and organization. Thus, any exception to gender norms generates the potential for social stigma and alienation. According to Goffman, such difference is often perceived as "Other," immoral, and odd. Being labeled as different often prevents a person or group from achieving total social acceptance, and that alienation may in turn cause a person to have difficulty accepting her- or himself.[42] Prevailing medical and psychological theories suggest the psychological necessity of surgically altering intersexed bodies to preclude such social stigma.[43] These theories are based on a fundamental assumption that without medical "clarification" of their sexual anatomy, intersexuals will lead a life of isolation and despair. The underlying thought here is that if intersexuals' bodies are altered so that they don't appear unusual, people who are intersexed won't come to see themselves or be seen by others as abnormal. This theory illustrates the centrality of sex binarism to Western cultural belief systems. It also highlights both the importance of self-evaluation and the impact that others' perceptions may have on the development of identity.

DEVELOPMENT OF THE SELF

In their brilliant contributions to the field of social psychology, Charles Horton Cooley and George Herbert Mead theorized the interplay between self-assessment and reflected appraisal in the development of the self.[44] Their theories are pertinent to the discussion of stigma, labeling, and identity, in that they discuss the development of the self in relation to the impact of others' perceptions of one's identity. Cooley uses the clever metaphor of the "looking-glass" to discuss his concept of the self.[45] According to the theory of the looking-glass, the self operates in the imagination and is based on what we think others think of us, whether their judgment is real or not. In Cooley's words,

> A self-idea of this sort seems to have three principle elements: the imagination of our appearance to the other person, the imagination of his [*sic*] judgement of that appearance, and some sort of self-feeling, such as pride or mortification.[46]

In short, Cooley's looking-glass self can be summarized by the saying, "I am not what I think I am. I am not what you think I am. I am what I think you think I am." The concept of the looking-glass self is especially pertinent to the discussion of social stigma and development of psychosocial identity because one's self-concept is thought to develop in line with others' reflected appraisals.

Like Cooley, Mead saw the self as a social object. In his own words,

> The individual experiences himself [*sic*] . . . indirectly, from the particular standpoints of other individual members of the same social group, or from the generalized standpoint of the social group as a whole to which he belongs. For he enters his own experience as a self or individual, not directly or immediately, not by becoming a subject to himself, but only in so far as he first becomes an *object* to himself . . . and he becomes an object to himself only by taking the attitudes of other individuals toward himself within a social environment or context of experience and behavior in which both he and they are involved [emphasis added].[47]

Mead's theory, like Cooley's, is relevant to understanding the impact of social stigma on the development of identity.[48] If others identify and react to us as aberrant and strange, we may in turn come to see ourselves in a similar fashion.

MEDICAL RESPONSE

Given that gender is so important to social organization and interaction, and that genitals are regarded as an essential sign of gender, the attempt to conform

"deviant" genitalia to the norm makes some sense and may even be a relief to some. Indeed, some adults surrounding an intersexed child are likely to have great difficulty interacting with the child socially until its sex is somehow normalized or made to appear clear. In a culture where so much emphasis is placed on the appearance of genitalia in initial sex categorization, clarity of genitalia literally grants an individual "personhood"; that is, being clearly sexed gives a person the capacity to be socially understood and accepted.[49]

Because of an inflexible social expectation for anatomical and sexual conformity, variations from the norm are covered up, erased, and hidden away in the hopes of precluding intense social stigma that may await a child who is identified and labeled as sexually deviant from the start.[50] Not surprisingly, in a culture where childbirth, sexuality, and normalcy are within medical purview, the social response to sexual ambiguity is primarily medical. Despite the typically medically benign occurrence of intersexuality, the social problem of physical sexual variation and the medicalization of childbirth lead to the social definition of intersexed bodies as diseased, unruly, and in need of medical attention or cures.

Surgery is just one of many possible responses to sexual variation and medical sex assignment is a product of specific cultural and historical factors. In setting the context for intersexuals' experiences, I turn next to an exploration of the conditions within which medical sex assignment became a viable response to sexual variation.