Intersexions

Seeking the Right to be Ourselves

Paper presented at the "After Homosexual" conference in Melbourne on 4th February 2012, by Morgan, O.I.I. Australia
Article appeared in Polare magazine: April 2012 Last Update: October 2013 Last Reviewed: September 2015

It is almost impossible for us to engage with the medical profession directly.

Introduction

> ***We've been here all along, and we need to be included - especially in campaigns around health and social services practices and policies, employment protection ...***

I'm speaking today as a member of O.I.I. Australia, a local intersex activist organisation that's aligned with the L.G.B.T.I. movement because of our common experience of homophobia, and misogyny. There is no settled view on the inclusion of the 'I.' in L.G.B.T.I.

Firstly, though, what is intersex?

Intersex is where a person's biological sex is not clearly male or female; a person might have characteristics of both or neither. It's always congenital. Someone can find out or be discovered to be intersex at birth, puberty, when trying to conceive a child, or serendipitously.

It's not an identity: it's not in our heads, although some of us will opt out of the gender binary. It's typically carved into our bodies.

Medicalisation

Medicalisation goes back centuries, and for much of that time there was no clear differentiation between L.G.B., T. and I..

Mogul, Ritchie and Whitlock state:

> **Siobhan Somerville in *Queering the Colour Line* reports "as late as 1921, medical journals contained articles declaring that a physical examination of [female homosexuals] will in practically every instance disclose an abnormally prominent clitoris" and that this is "particularly so in coloured women".**

A key change happened in the 1950s when New Zealand doctor John Money declared that sex equals nurture, not nature, and that the "brain is an object for behavioural engineering". His (now discredited) work led to standard medical protocols that still result in cosmetic genital surgery on infants and children with intersex variations.

Even now in Australia, these are performed to prevent social and familial discomfort, despite medical research that shows poor satisfaction with surgery.

The trauma associated with these surgeries led to the establishment of an intersex movement, initially through a magazine advert and later online. The immediate priority of the movement, led by the Intersex Society of North America, was to engage with the medical profession, and this led in 2006 to a "consensus statement" that changed the terminology associated with intersex. It introduced the term "Disorders of Sex Development" or D.S.D.

The aim was to create a non-pejorative, value-neutral term to replace "intersex" and "hermaphrodite". In a very literal sense it was homophobic: it aimed to eliminate a parental and social fear of homosexuality and queerness in an attempt to improve patient outcomes.

It failed.

Current rationales for infant genital surgery

Dr. Dix Poppas, working at Cornell University, describes his current "rationale for early reconstruction" on infant genitals as including:

> **... minimizing family concern and distress, and mitigating the risks of stigmatization and gender identity**

> **confusion ..."**

Prenatal treatment to prevent homosexuality and masculinisation in C.A.H. women

Congenital Adrenal Hyperplasia (C.A.H.), is a manageable salt-wasting condition that requires lifelong treatment. In women, it's also associated with higher levels of pre-natal testosterone, and a degree of physical and mental "masculinisation".

In 1999, Columbia University psychologist Heino Meyer-Bahlburg published a paper entitled What Causes Low Rates of Child Bearing in C.A.H.?:

> **C.A.H. women as a group have a lower interest than controls in getting married and performing the traditional childcare/housewife role. As children, they show an unusually low interest in engaging in ... maternal play, motherhood ...**

Meyer-Bahlburg proposes that "treatment with prenatal dexamethasone might cause these girls' behaviour to be closer to heterosexual norms.

In an analysis that clearly shows the homophobic nature of these concerns, Alice Dreger tells how Meyer-Bahlburg and Dr. Maria New of Mount Sinai School of Medicine in New York published research in 2008 stating:

> **Most women were heterosexual, but the rates of bisexual and homosexual orientation were increased above controls ... and correlated with the degree of pre-natal androgenisation.**

Dreger describes, in 2010, Maria New and fellow paediatric endocrinologist Saroj Nimkarn (Weill Cornell Medical College) to be defining "low interest in babies and men - and even interest in what they consider to be men's occupations and games - as "abnormal," and potentially preventable with pre-natal dexamethasone.

Dexamethasone is a class C steroid that, in tests on sheep, has been shown to result in reduced mental capacity. It's also linked to low birth weight, a greater incidence of cleft palate and other issues.

Dr. Maria New began clinical trials on pregnant human mothers in 2010 to reduce masculinisation effects on C.A.H. girls.

Dexamethasone has no impact on the salt-wasting associated with C.A.H..

Terminations

Genetic screening is now available for C.A.H. and XXY, via amniocentesis. O.I.I. Australia is currently examining the effects of this in Australia, and preliminary research shows a drop in number of live births with these intersex variations.

Conclusions

The shift to D.S.D. failed to change the system. It's failed to change medical protocols.

It has also come close to destroying the intersex movement. We've had to start again almost from scratch.

It is almost impossible for us to engage with the medical profession directly.

In many ways, the experience of intersex people shows what happens when a group of "disordered" people are found to be "born this way".

Being trans* remains a disorder, although no treatable biological cause has been established.

Being gay or lesbian is no longer a disorder to doctors in most countries, even though this remains contentious in some major political and religious institutions.

The big weakness in the early intersex movement was a failure to organise around the causes of this medical treatment - homophobia, misogyny. We have to focus on the human rights and ethical cases for liberation.

Intersex people are aligned with the "L.G.B.T.I. movement because of the nature of our oppression.

We seek the right to be ourselves as we are, in the context of infant and adolescent surgery, adult relationship and medical issues.

Even "straight" intersex people and their partners have to question and address issues with their sexual orientation and gender identity. We've been here all along, and we need to be included - especially in campaigns around health and social services practices and policies, employment protection, and other frameworks for our L.G.B.T.I. communities.

Notes

1. O.I.I. Australia does not support the establishment of a third gender category, but does seek the ability for all adults to opt out of the gender binary and use neutral sex or gender markers on legal documents.
2. Intersex is about an experience of the body, not identity. Nor is intersex synonymous with androgyny. Any person, intersex or otherwise, may feel more comfortable with a non-binary identity such as intergender, or gender-queer.
3. There are many more intersex variations than those mentioned in this presentation.
4. We reject pathologising language, such as "disorders". Intersex variations are a natural part of the human condition.
5. With thanks to Gina Wilson, chairperson of O.I.I. Australia, Hida Viloria, chair of O.I.I., and Gavriel Ansara for help during the researching of this paper. This article includes some minor changes post-delivery at the conference.

Polare Magazine is published quarterly in Australia by The Gender Centre Inc. which is funded by the Department of Family & Community Services under the S.A.A.P. program and supported by the N.S.W. Health Department through the AIDS and Infectious Diseases Branch. Polare provides a forum for discussion and debate on gender issues. Unsolicited contributions are welcome, the editor reserves the right to edit such contributions without notification. Any submission which appears in Polare may be published on our internet site. Opinions expressed in this publication do not necessarily reflect those of the Editor, The Gender Centre Inc., the Department of Family & Community Services or the N.S.W. Department of Health.
