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Gender Normalizing Surgery for Intersex Infants: A Patient's Need or Parent's Need?

Every year in the United States, approximately 1.7% of infants<sup>1</sup> are born with ambiguous genitalia that classify them as neither male nor female, but, rather, as *intersex*. An estimated 100 to 200 times a year,<sup>2</sup> these infants undergo surgery to shape their genitalia to become more traditionally “male” or “female”. The medical community is currently engaged in a hotly contested debate about the legality and ethicality of these surgeries, and parents are caught between the opposing sides.

There is often much confusion about what qualifies as person as “intersex”. There are various definitions of the term: some refer to chromosomal makeup, some count testes and ovaries; Anne Fausto-Sterling, professor of Biology and Gender Studies at Brown University, even goes so far as to create three sub-classifications of intersex persons, with terms such as “merms” and “ferms”.<sup>3</sup> I will default to a definition from a Purchase College psychology professor, Suzanne Kessler: intersex persons are simply persons with ambiguous genitals.<sup>4</sup> If a person is not intersex; that is, that ze<sup>5</sup> has genitalia and genes that fall into the sex binary, ze is referred to as cissexual.

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<sup>1</sup> Fausto-Sterling, A. (2000). The Five Sexes, Revisited. *The Sciences*, 40, 18-23.

<sup>2</sup> Ford, Kishka-Kamari. 2001. "First, Do No Harm" - The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants. *Yale Law and Policy Review*, 19 (469).

<sup>3</sup> Fausto-Sterling, A. (1993). The Five Sexes: Why Male and Female Are Not Enough. *The Sciences*, 20-24.

<sup>4</sup> Kessler, S. J. (1990). The Medical Construction of Gender: Case Management of Intersexed Infants. *Signs*, 16(1), 5.

<sup>5</sup> “Ze” is a commonly used gender-neutral pronoun that can replace “he” or “she”. It is used when a person’s gender identity is unknown, changing, or does not fall within the gender binary.

As stated, intersex infants are those born with ambiguous genitals; they may have a cliteropenis<sup>6</sup> too large to be considered female but too small to be considered male. They may have a urethra that is not at the tip of this cliteropenis; they may or may not have a vaginal opening. Because society is organized around a gender binary, many parents of intersex infants feel immediate pressure to “fix” the sex of their child so that the infant can be raised either male or female.

The most common “solution” to the “problem” of an intersex infant is sexual assignment surgery. Most of the science behind such a recommendation for this surgery comes from Dr. John Money, a psychologist and sexologist whose work with Johns Hopkins University was groundbreaking in the fields of gender and sex. According to John Calapinto, a journalist who researched Money’s practices in the 1990s,

Money’s protocols for the treatment of intersexual children hold to this day. Placing the greatest possible emphasis on the child’s projected ‘erotic functioning’ as an adult and taking into account that medical science had never perfected the reconstruction of injured, or tiny, penises, Money’s recommendations meant that the vast majority of intersexual children, regardless of their chromosome status, would be turned into girls.<sup>7</sup>

Money’s research dominates the field of gender assignment surgery, and his theories justify the procedures.

Anne Fausto-Sterling recounts from a physician’s standpoint what typically happens when doctors encounter an intersex infant.

When a treatment team is presented with an infant who has ambiguous genitalia,

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<sup>6</sup> A cliteropenis is an organ that serves the sexual function of a clitoris and a penis and cannot be distinguished as one or the other. All humans have a cliteropenis as fetuses until other sexual organs develop.

<sup>7</sup> Calapinto, J. (1997, December 11, 2007). John/Joan. *The Rolling Stone*, 54.

the team could make a gender assignment solely on the basis of what made the best surgical sense. The physicians could then simply encourage the parents to raise the child according to the surgically assigned gender. Following that course, most physicians maintained, would eliminate psychological distress for both the patient and the parents. Indeed, treatment teams were never to use such words as “intersex” or “hermaphrodite”; instead, they were to tell parents that nature intended the baby to be the boy or the girl that the physicians had determined it was. Through surgery, the physicians were merely completing nature’s intention.<sup>8</sup>

In the scientific field, it is generally considered bad practice to accept ideas from one researcher without an independent verification. Freud’s theories were criticized and even satirized, as many thought they were convenient explanations for a few cases rather than theories applicable to a wider populace.<sup>9</sup> Often, theories or practices that are researched by many individuals are considered more factual and less circumstantial. Thus, Money’s theories about gender identity and normalizing surgery should not be taken as fact. Though they initially were and gender normalizing surgery was commonly endorsed my generation, the practice is now more scrutinized, especially by the Intersex Society of North America.

Much of Money’s proof relied on a single case: the John/Joan case. The patient, “John”, a cissexual male, lost his male genitalia in a botched circumcision. Money believed that since the child was still in the gender formative stage (less than 24 months old), he could live life happily as a girl. At twenty-two months, John underwent surgery to make his genitalia resemble those of a girl and the study began to refer to him as “Joan”. For years, Money reported that the surgery and subsequent therapy were successful and that John was living happily as Joan, thereby proving that intersex infants

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<sup>8</sup> Fausto-Sterling, A. (1993). *The Five Sexes: Why Male and Female Are Not Enough*.

<sup>9</sup> Sulloway, 64

could find a static gender through sexual assignment surgery and that gender was flexible and fluid. However, further follow-ups with Joan found that she rejected his female gender and later underwent surgery to have male genitalia. The patient, who took the adult name of David Reimer, asserted that Money's tactics were psychologically harmful and did nothing to improve his childhood<sup>10</sup>. Reimer eventually committed suicide in 2004. Thus, it is reasonable to understand why Money's practices are not as popular as they once were.

Money's research relied heavily on an understanding between sex and gender. The definition of sex refers solely to a person's anatomy; it does not consider the way that ze dresses, how ze present zirself in society, or how ze feel that ze fit into society. These attitudes form gender. A person's gender is independent of zir sex; it is a personal and social identity<sup>11</sup>.

Though preconceived societal notions are that sex and gender fall into a binary (male or female, man or woman), this assumption is false. Furthermore, it cannot be assumed that gender and sex are complementary and always match. As Judith Butler, a philosopher and professor at University of California, Berkeley, states, "gender is a

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<sup>10</sup> Colapinto, J. (1997, December 11, 2007). John/Joan. *The Rolling Stone*, , 54.

<sup>11</sup> Male and female gender identities are simply customary markers invented by society to describe male and female sexes. In reality, gender markers are fluid, and sex can be too. In past times, other societies have acknowledged third or alternate genders and have not adhered to such a strict gender binary as modern society does. The ancient Greek philosopher Plato sought to define three sexes: male, female, and an intermediary, stating "the original human nature was not like the present, but different. The sexes were not two, as they are now, but originally three in number; there was man, woman, and a union of the two, having a name corresponding to this double nature." (Plato 190) Anne Fausto-Sterling attempts to divide sex into five categories, though she concedes, "sex is a vast, infinitely malleable continuum that defies the constraints of even five categories." (Fausto-Sterling, 1993) Some Native American tribes traditionally embrace a duality of gender as well. Males who reject traditional gender roles are called "two-spirited": they are encouraged to dress as they please and work as they please. (Calimach) Their personal preferences are embraced and supported by other members of their community. It is clear that it is possible for societies to rise above a gender binary. Until then, however, intersex persons are left in limbo and feel pressure to conform to a binary.

different sort of identity, and its relation to anatomy is complex.”<sup>12</sup> Gender is commonly seen as a spectrum, with male on one side and female on the other. Gender presentation can fall anywhere on this spectrum, with androgynous presentations falling in the center, equally male and female. Sex can also be seen as a spectrum, with intersex persons falling somewhere between male and female. Money noted that sex was a fixed and stable marker through which gender identity could be found, leading to his advocacy of gender assignment surgery.

Despite the lack of evidence that sexual assignment surgery leads to a better life, and the presence of intersex adults speaking against sexual assignment surgery, the practice is still common. Though “the aims of the policy are genuinely humanitarian, reflecting the wish that people be able to ‘fit in’ both physically and psychologically,”<sup>13</sup> the practice of sexual-assignment surgery is met largely with disdain and is viewed very differently in the intersex and medical communities.

Most parents undoubtedly want what is best for their children. Though parents can raise their intersex children in loving, supportive, and gender-free environments at home, parents cannot control the influences of peers and the media on their children. It is understandable why parents may want to define a gender for their child: they would rather do so than risk their child having to face bullying and discrimination. “It’s kind of a bombshell,” says Kim Surkan, Women’s and Gender Studies at The Massachusetts Institute of Technology, regarding parents’ reactions to their child’s condition. In 2011, a Toronto family was thrown into the limelight by their decision to raise their third child,

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<sup>12</sup> Butler, J. (2004). *Doing Justice To Someone: Sex Reassignment and Allegories of Transsexuality. Undoing Gender.* (63) Routledge.

<sup>13</sup> Fausto-Sterling, A. (1993). *The Five Sexes: Why Male and Female Are Not Enough.*

Storm, gender-free. Storm's sex is kept a close family secret and Storm is free to choose their gender identity. However, the family's decision was met with harsh criticism; experts expressed concern for Storm's identity and self-confidence.<sup>14</sup> Says Surkan, "I'm not necessarily saying that every parent of an intersex child should attempt to raise them as a gender-neutral person... that is probably far-fetched." In light of these parental challenges, it is understandable why parents agree to the surgeries.

Parents agree to these surgeries for another reason: they tend to trust their doctors. However, Kessler's research indicates that even the doctors are not sure about the surgeries; they only feign confidence in order to keep patients and parents assured of their expertise.<sup>15</sup> Even if doctors are unsure as to whether the infant qualifies as male or female under Money's guidelines, they often arbitrarily advocate for a gender to the child's parents. The hope is that the confidence in gender will help parents raise their child in an unambiguous manner.

However, the physicians' expertise leaves little room for parents to question what is happening. Kessler describes the stress of the situation well: "The time-consuming nature of intersex diagnosis and the assumption, based on gender theory, that gender should be assigned as soon as possible thus present physicians with difficult dilemmas... There's pressure on parents [for a decision] and the parents transmit that pressure onto physicians."<sup>16</sup> Ford mirrors this urgency and further asserts "it is the parents and doctors

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<sup>14</sup> Donaldson James, S. (2011, 26 May 2011). Baby Storm Raised Genderless Is Bad Experiment, Say Experts. *ABC News*.

<sup>15</sup> Kessler, S. J.

<sup>16</sup> Kessler, S. J. 13

of intersex infants who are experiencing a medical emergency, not the intersex infant.”<sup>17</sup>

Parents often cannot handle having a genderless child, so they are eager to pursue surgery and raise a “normal” child.

Since Money’s evidence has turned against his theories, the surgeries have been scrutinized much more than they were in the 1960s and 1970s. John Colapinto’s book *As Nature Made Him: The Boy Who Was Raised A Girl* was published in 2000, public awareness of the issue has also increased, meaning parents of intersex children may have some background information before they learn of their child’s condition.

David Reimer of the John/Joan case is only one of many adults who have come forward against infant sexual assignment surgery. Most are intersex persons who underwent sexual assignment surgery, rejected their assigned gender and sex, and now embrace their intersex identity. Organizations such as the Intersex Society of North America hope to show that it is possible to live in modern society without having a clear gender or sex identity. Until society lets go of a binary, however, intersex persons must find others ways to fight gender normalizing surgery for infants.

First, there is the legal issue of parental consent for infant gender normalizing surgery, presented by law students such as Kishka-Kamari Ford of Yale University and Alyssa Connell Lareau of Georgetown University. Ford states that the surgeries are unnecessary because, medically, they are not immediately required and are unreasonably harmful; she further claims that the surgeries serve more purpose to the parents and their comfort level with their child than they do for the children themselves.

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<sup>17</sup> Ford, Kishka-Kamari. 2001. "First, Do No Harm" - The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants. *Yale Law and Policy Review*, 19 (469). 477.

Drawing on the principle of “first do no harm”, Ford asserts that parents cannot legally consent for their children to undergo these surgeries because the benefits to the parents are tied into decisions about the child.<sup>18</sup> Lareau proposes informed consent as an intermediate step towards total elimination of gender normalizing surgery for infants, reinforcing that parents are often ill-informed of the full range of consequences of the surgery. Lareau also states the questionable necessity of the surgery, citing “the... question that legal advocates should be asking: whether parents have the legal right to consent to surgery on their infants that is irreversible, essentially cosmetic, and most often medically unnecessary.”<sup>19</sup>

The negative effects of gender normalizing surgery continue throughout life. If a person undergoes gender normalizing surgery and subsequently rejects the assigned gender, they may also feel *dysphoria*, an overwhelming feeling that their bodies do not match their mindsets, which can also lead to overwhelming stress and depression as a result of this feeling. Quite simply, they feel that their body is wrong. Furthermore, because surgery often eliminates the ability to experience sexual pleasure and some reproductive organs, intersexed adults find that they cannot maintain healthy relationships in a way that cisgendered adults can. Often, initial surgery is not the only step needed for a “normal” lifestyle: hormone treatments are needed throughout puberty, and post-puberty surgeries, as well as maintenance surgeries, may also be necessary.

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<sup>18</sup> Ford, Kishka-Kamari. 2001. "First, Do No Harm" - The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants. *Yale Law and Policy Review*, 19 (469).

<sup>19</sup> Lareau, A. C. (2003-2004). Who Decides? Genital-Normalizing Surgery on Intersexed Infants. *Georgetown Law Journal*, 92(1), 129.



Furthermore, psychological health is a major concern for surgery patients and they often need to undergo costly and time-consuming therapy in order to feel comfortable as a normal, inconspicuous member of society.

Kishka-Kamari Ford asserts that gender normalizing surgery is analogous to female genital mutilation<sup>20</sup>, a practice common in Africa and parts of Asia and the Middle East. This practice, culturally accepted by some and fought by others, helps ensure that women will not have premarital or extramarital sex. Both female genital mutilation and infant sexual assignment surgery typically involve the cutting of a woman's clitoris, which can reduce libido and sexual pleasure. However, in the case of intersex infants, the surgery is used to "normalize" the infant, while female genital mutilation is used to "control" women.

There are several solutions to the problem of the questionable ethicality and legality of gender normalizing surgery for intersex infants. The first, proposed by Alyssa Connell Lareau, is to completely ban gender normalizing surgery for infants on the basis that it is unnecessary, that its implications and risks outweigh its immediate benefits, and that parents do not have the legal right to consent for surgery.

Anne Fausto-Sterling asserts in her book *Sexing the Body: Gender Politics and the Construction of Sexuality* further asserts that refraining from surgery does not mean an intersex person cannot live a happy, normal life: "Intersexual children who grow up with genitalia that seem to contradict their assigned gender identities are not doomed to lives of misery... children adjust to the presence of anomalous genitalia and manage to develop into functioning adults, many of whom marry and have active and apparently

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<sup>20</sup> Ford, Kishka-Kamari.

satisfying sex lives.” Fausto-Sterling asserts extensively that intersex individuals have not only the right to choose for themselves if they will undergo any surgeries, but also the right to refuse surgeries. Says Surkan, “I don’t think anyone should be imposing surgical solutions on other people.”

Arlene Istar Lev, a psychologist and therapist for those affected by LGBT issues, summarizes many arguments to three concise terms for boundaries on gender normalizing surgery for intersex infants, noting that surgery is not advisable if it will in any way be detrimental to the sexual abilities of the patient; if it is simply because the child’s appearance is deemed “unacceptable”; or if there is a chance the child could be assigned incorrectly.<sup>21</sup> Under Lev’s third assertion, nearly all gender-normalizing surgeries are not advisable, since often deciding a gender is a gamble and it is not uncommon for those who have undergone gender assignment surgery to reject their assigned genders.

Others feel that rather than eliminating the surgery, it is best to eliminate the need for surgery. If society were to adopt a third gender or a gender continuum (as opposed to the currently accepted gender binary), intersexed persons would not need to “find” or “declare” a gender or sex; they would be free to express themselves in a way that makes them feel comfortable with themselves and comfortable around others.

Historically, this idea is not totally unfounded. Plato asserted a duality of gender in some and acknowledged a third gender, as did many Native American tribes. Perhaps modern society could see historic examples and begin to reconsider a strict adherence to a

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<sup>21</sup> Lev, A. I. (2006). Intersexuality and the Family: An Unacknowledged Trauma. *Journal of Gay and Lesbian Psychotherapy*, 10(2), 27.

gender binary. In fact, some part of society are drifting from a gender binary. Grinnell College in Iowa, United States, has pioneered a movement towards gender-neutral spaces by offering its students dorms, bathrooms and locker rooms that anyone can use, whether they are cisgendered, transgendered, or do not identify with the gender binary.<sup>22</sup> By embracing alternate mindsets, Grinnell not only offers its students a safe place to explore their identities but also sets an example for an idealized society in which one's anatomy does not have to define them in any way. Since 2010, male supermodel Andrej Pejic has shattered expectations and erased gender lines in the fashion industry, modelling for designers in both male and female attire. The fashion community has embraced, rather than exploited, his androgynous appearance. Pejic sets an example, showing that appearance does not need to be gendered, and that one person can take on appearances of both genders if they so please. Though society has yet to completely reject a gender binary, small communities have chosen to push boundaries and ignore definitions; perhaps soon, their viewpoint will be more widespread.

Though many people take their sex and gender for granted, some, including intersex persons, find that they cannot rely on their bodies to find their identities. Intersex persons have ambiguous genitalia at birth and often have chromosomes that are neither a male or female pair. Often, these intersex children undergo surgeries as infants or young children to create male or female genitalia so that, according to John Money's research, they can find a gender identity through their clear and defined sex. Now, critics of the surgery are raising their voices for the rights of intersex infants. They cite that the surgery can be painful and the loss can be traumatizing. Some fight for the rights of intersex

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<sup>22</sup> Kilen, Mike(2011)Grinnell College Dorms: Where Gender Doesn't Matter.

persons to decide their own fate and strive to take the right to consent away from parents; others fight the gender binary in an attempt to mold a society where clear gender or sex are not necessary markers for identity. In the coming years, gender normalizing surgery for intersex infants may no longer be performed unnecessarily as alternatives take hold and parents become more informed.

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