

Violent Care: An Analysis of Intersexuality and Medical Treatment

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Intersex is an umbrella term used to describe a wide range of natural bodily variations, and to refer to people born with sex characteristics that do not fit typical binary notions of male or female bodies (Pagonis 2017). Similarly, Georgiann Davis's *Contesting Intersex*, describes intersex as "used to describe the state of being born with a combination of characteristics (e.g., genital, gonadal, and/or chromosomal) that are typically presumed to be exclusively male or female" (2015, 2). For most medical professionals, intersex bodies are meant to be treated or corrected, and this treatment manifests into sexual assignment as male or female. Children born with an intersex condition face medical intervention, such as genital 'corrective' surgery, authorized and encouraged by their parents and medical professionals. This medical intervention often comes to be seen as non-consensual by the patient despite their parent's consent at the time. Despite numerous psychological and physical complications, medical professionals perform genital corrective surgery on intersex infants and children. Using Foucault's *biopolitics*, which is defined as "a set of regulatory mechanisms that establish an equilibrium, maintain an average, establish a sort of homeostasis, and compensate for variations within this general population and its field" (Foucault 2003:246), I will analyze medical intervention, Western understandings of sex and gender, intersex conditions, and the intersex liberation movement, as they relate to Stevenson's conception of *care*: the way someone comes to matter (2014). Specifically, since intersex bodies do not fit binaristic sex categories, medical professionals impose non-life-saving medical treatment to regulate intersex bodies through a violent form of biopolitical care.

I situate my analysis of the body's materiality using Kleinman and Butler. For Kleinman, medicine is a vehicle for the expression and recreation of cultural and social pluralities made evident by biomedicine's focus on materialism and binaries. This focus on materialism is evident within Judith Butler's *Bodies that Matter*, throughout which she analyzes the materiality of the body and its relationship to gender performativity. For Butler, "...sexual difference is often invoked as an issue of material differences" (1993, 1). These material differences occur as a strict dichotomy wherein an individual's sex is either categorized as male or female based on the physical appearance of their genitalia. Sex is not something inherent to an individual, but a standard used to regulate and gender bodies. Biomedicine expresses strict dualisms between male and female, mind and body, by taking materialism as its intellectual foundation (1995, 29-30). This regulatory force is evident in the societal need to ascribe 'one true sex' to an individual with any intersex characteristics. Foucault further asks, "Do we really need a true sex? With a persistence that borders on stubbornness, modern Western societies have answered in the affirmative. They have ultimately brought into play this question of a 'true sex' in an order of things where one might have imagined that all that counted was the reality of the body and the intensity of its pleasures" (Foucault 1980, vii). Cartesian dualism has permeated western society with binaristic modes of thought, made especially evident in Western biomedicine's obsession with two genders, two sexes, to explain the spectrum of human experience and existence. Foucault emphasizes the biomedical need to regulate the body. He further claims, "...when confronted with a hermaphrodite, the doctor was no longer concerned with recognizing the presence of the two sexes, juxtaposed or intermingled, or with knowing which of the two prevailed over the other, but rather with deciphering the true sex that was hidden beneath ambiguous appearances" (1980, viii).

Furthermore, we contextualize biomedicine using Lisa Stevenson's understanding of 'care' as an ethnographic object. Throughout her monograph, *Life Beside Itself*, she takes *care* as her object of analysis and situates it within Foucault's logic of *biopolitics*. Stevenson conceives of care as "the way someone comes to matter, and the corresponding ethics of attending to the other who matters", and continues to discuss how bureaucratic and biopolitical forms of care are perceived by the targeted population, which in Stevenson's work are Inuit peoples (2014, 17). Similarly, I wish to analyze the way in which people come to matter to biomedical institutions and how bureaucratic and biopolitical forms of care are perceived by intersex people. The emergence of *biopower* and *biopolitics* is first discussed in Foucault's *Lecture 11*. Here Foucault states,

So after a first seizure of power over the body in an individualizing mode, we have a second seizure of power that is not individualizing but, if you like, massifying, that is directed not at man-as-body but at man-as-species. After the anatomo-politics of the human body established in the course of the eighteenth century, we have, at the end of that century, the emergence of something that is no longer an anatomo-politics of the human body but what I would call a "biopolitics" of the human race (Foucault 2003, 243).

For Foucault, sexuality was not a universally distinguishable identity or social construction, but an apparatus of biopower that sought to penetrate the body and its faculties in order to consolidate power over life. 'Sex', he wrote, 'was a means of access both to the life of the body and the life of the species' (1981, 146). For him, sex served as the fundamental connection between body and population through which life could be managed. Following this Foucauldian understanding of sex, sexual assignment allows for biomedicine to inscribe the body with societal expectations, reinforcing cultural norms regarding sexual activity, sexual orientation, and gender expression. The regulation and categorization of an individual based on the material differences that occur throughout the body emphasize the regulatory power that is present throughout biomedicine as medical professionals attempt to 'fix' and treat the reality of the intersex body. Biopolitical modes of care concern themselves with management of lives of the

individual, regulating biological processes that are necessary for the control of the population.

Within the context of intersexuality, biopolitical forms of care often manifest themselves as corrective genital surgery and forced sex assignment or reassignment.

Sexual assignment is a process that determines an individual's future, since their sex designations have important legal and social ramifications. By attempting to decipher a body's 'true sex', medical professionals who impose corrective surgeries or lifestyle changes on intersex individuals act a vehicle for society's regulatory forces. Even when confronted with the presence of the two sexes, the doctor must decide which was the (one) true sex that lied beneath. It was imperative that an individual be categorized as one sex or the other in order to fully participate within society that operates on strict dualisms. The body possessing ambiguous genitalia is the antithesis for accepted binaristic modes of thought. To merely recognize the presence of ambiguous genitalia is not sufficient; the doctor has a duty is to treat the individual, a process that involves using medical authority to assign a person's sex. In *Fixing Sex* Karkazis argues that "assigning a single true sex became more complex in the early twentieth century, as the markers of and methods for this true sex became multiple, diverse, conflicting, and negotiable" (38, 2008). With the advancement in medical techniques, determining the sex of an individual no longer solely relied on the outward appearance of the genitalia, but on gonadal composition, chromosomal makeup, and secondary sex hormones and characteristics. These additional components allowed the body's materiality to exist as more than just an individual's phenotype, and allowed sex to be materialized through increased medical interpellation.

In order to 'care' for bodies with ambiguous genitalia intersex, individuals became the subjects of increased medical intervention. For Foucault, *biopolitics* and its fixation with the sex of an individual was necessary for regulation to take place. He states,

the notion of "sex" made it possible to group together, in an artificial unity, anatomical elements, biological functions, conducts, sensations, and pleasures, and it enabled one to make use of this fictitious unity as a causal principle, 'an omnipresent meaning, a secret to be discovered everywhere: sex was thus able to function as a unique signifier and as a universal signified (Foucault 1978, 154).

The grouping together of 'anatomical elements' made it possible for *biomedicine* to create arbitrary measures of what female and male genitalia should look like in order to be categorized as either. Sexual assignment into the sex binary of intersex bodies was necessary in order to control cultural conceptions of sex by holding bodies to the Platonic ideal of physical dimorphism. In *Bodies that Matter*, Butler makes a similar argument, stating:

Such attributions or interpellations contribute to that field of discourse and power that orchestrates, delimits, and sustains that which qualifies as "the human". We see this most clearly in those who do not appear properly gendered; it is their very humanness that comes into question. Indeed the construction of gender occurs through *exclusionary* means[...] (Butler 1993, 8).

With ambiguous sex, their 'true' sex was a secret to be discovered, a process afforded to biomedicine, an institution entrenched with binaristic ideas of sex and gender.

Treatment for intersex conditions often involves surgery when the individual is very young. These procedures assume an "agreement among a series of somatic characteristics and more phenomenological processes, such as gender identity, gender role, and sexuality. In this model, gender identity and behavior derive unproblematically from assigned sex" (Karkazis 2008, 99). Intersex children and others with atypical genitalia are incompatible with Western preconceived notions of sex and gender. With seemingly 'unnatural' combinations of the 'two' sexes, the presence of ambiguous genitalia is excluded from cultural perceptions of normalcy. Intersex people and their bodies fail to conform to cultural expectations, their very existence questioning the 'naturalness' of physical dimorphism. As a result, individuals with ambiguous genitalia have their realities excluded and erased through modes of medical treatment and intervention, and are usually treated before they are old enough to give or withhold consent.

These surgeries are specifically in response to perceived disagreement in somatic characteristics, and are a response to being confronted with evidence of a faulty assumption. Surgeries and other forms of *biopolitical* care for intersex people are often perceived by intersex people as violent and traumatic. Famous intersex activist Cheryl Chase famously states,

[...]there is no justification for early genital surgery other than doctors' quest for normalcy. This is wrong. Its torture. These children are subjected to involuntary surgery. Intersex people are not sick, they are not in need of care, but so-called rational medicine is coming after these kids with knives in their hands (Karkazis 2008, 1).

Sexual assignment allows medical experts to regulate the body at both the individual level and the institutional level. Treatment of intersex bodies is predicated on the notion that gender follows an individual's sexed body. Since western societies do not officially recognize the presence of more than two genders, ambiguous genitalia necessitate medical intervention in the form of corrective genital surgery. Chase makes a point to emphasize that these forms of care are often involuntary, since corrective surgeries are often performed when the individual is very young.

Though intersex individuals have been subject to *biopolitical* forms of care since the eighteenth century —evidenced by the forced sexual reassignment of Herculine Barbin— John Money's theories surrounding gender and sexuality shifted the modes of treatment for intersex bodies in the twentieth century. Using clinical data mostly on intersex people, John Money argues that childhood gender socialization was the most significant factor in explaining an adult's gender identity (Davis 2015, 58). Further utilizing the predominant model that gender identity follows from biological sex, Money argued that babies could live happily regardless of their genitalia since “prenatally determined traits or dispositions can be incorporated into the postnatally differentiated schema, whether it be masculine or feminine” (Davis 2015, 58). Here, bodies have come to matter to *biomedicine* through the postnatal regulation of sexual differences.

Money's theories transferred even more authority to medical professionals, who could now treat the reality of the intersex body instead of merely observing and playing 'the waiting game', to see what sex and gender an intersex individual would choose. As a result, genital corrective surgery is often performed before the individual is eighteen months of age, due to John Money's influence. Clinicians could reasonably assign a sex and gender to a child, and expect them to develop and conform to the constraints of dictated by Western culture and society. The surgical modification of genitalia allowed intersex infants to live 'normal' lives, including participating in penile-vaginal intercourse.

Though *biomedicine* and *biopolitics* regulates intersex bodies as to create a cisnormative and heteronormative subject for Western society, it is not only intersex individuals who are subject to these specific regulatory forces and its modes of care. Atypical genitalia occur in many individuals, including those without intersex conditions, such as those who are born with hypospadias¹ and micropenises². These conditions are often confused with other intersex disorders, such as congenital hyperplasia³ and androgen insensitivity syndrome⁴. The presence of atypical genitalia does not necessarily mean the individual has an intersex condition, but rather that the genitalia does meet a number of arbitrary factors, such as phallus size. Corrective genital surgery has been recommended to individuals without an intersex condition when the phallus is

¹ Any opening of the meatus other than the tip of the penis (eg. located on the glans, shaft, scrotum, or perineum), categorizing the phallus as a microphallus rather than a micropenis (Karkazis 2008, 298).

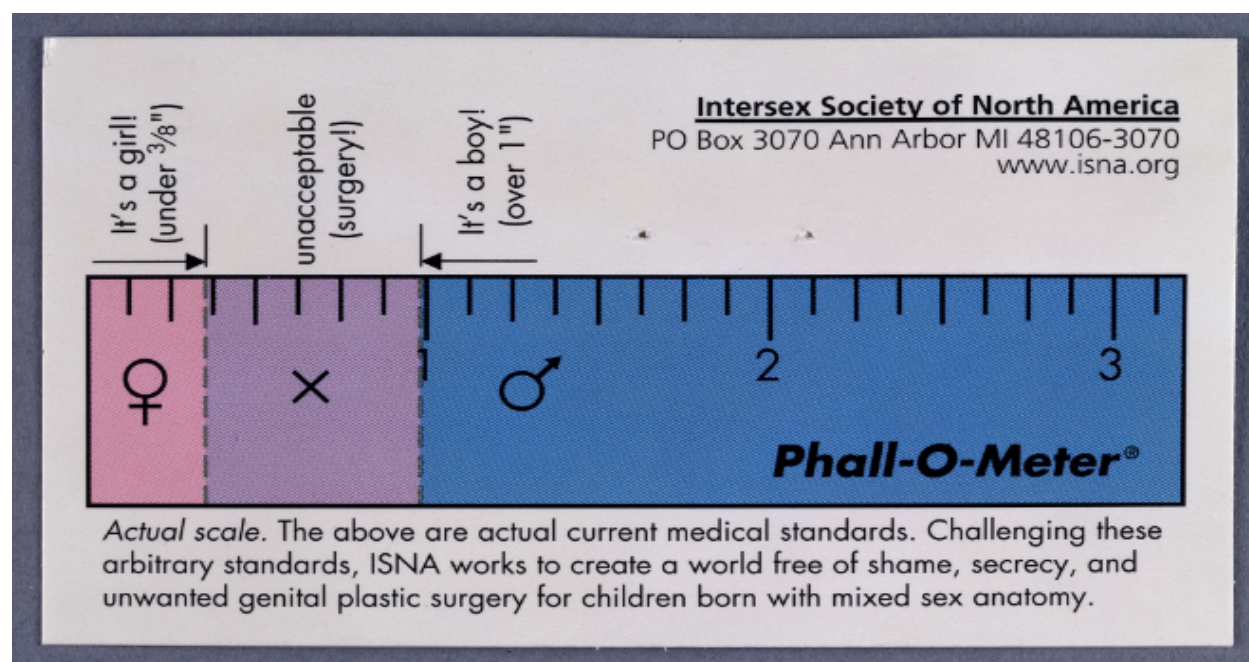
² A micropenis is a 'normally' formed penis, except for its small size. John Money and his collaborators defined a micropenis as two and half standard deviations below the mean for the infant's stage of development when stretched (Karkazis 2008 101). To qualify as a micropenis, the organ must have a medium raphe, a foreskin, and a urinary hole at the tip of the glans, which is what allows a boy to urinate standing up. There are other penile abnormalities that are not considered grounds for for gender (re)assignment (Karkazis 2008, 297-298). However some medical professionals recommends reassigning males to females when the phallus is too small. Threshold for a 'too small' penis ranges from 2.5 cm., 2 cm., 1.9 cm. and 1.5 cm in infancy (Karkazis 2008 102).

³ Congenital hyperplasia is defined as an autosomal recessive genetic condition affecting both male and females. Excessive production of steroids such as cortisol, androgens, and aldosterone can cause virilization of the genitals. Overall affects puberty and growth in children, infertility, and other symptoms (Karkazis 2008, 294).

⁴ Androgen Insensitivity Syndrome causes individuals with a Y chromosome to be completely or partially insensitive the androgens the body produces due to a mutation on the individual's X chromosome (Karkazis 2008, 24).

too small for 'normal' sexual function, defined as penile-vaginal intercourse (Karkazis 2008, 102). Even though some of these individuals are not considered to possess an intersex condition, their atypical genitalia must be corrected to ensure that these infants conform to the cultural roles that arise from sex and gender. For example, John Money worried that an inability to insert the phallus into a vagina would cause an individual to have their gender and sex identity disrupted, feminizing them and making these individuals more likely to become homosexuals (Karkazis 2008, 101). Sex assignment to female early on in infancy would allow these individuals to avoid an atypical gender identity and sexual orientation.

Figure 1: Phall-O-meter⁵



Above is an example of arbitrary standards used to pinpoint signs of gender in the body through material differences. To be considered one gender or the other hinges on the ability to

⁵ Phall-O-meter', Intersex Society of North America
Wellcome Library, London. Wellcome Images
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http://wellcomeimages.org
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www.isna.org PO Box 3070 MI 48106-3070

engage in the practices and behaviors society has constructed and deemed appropriate for that gender. Such practices and behaviors include ‘normal’ sexual activity, where a phallus is inserted into a vagina. If a penis can be mistaken for a clitoris because of its size or vice versa, such genitalia would have profound implications on the cultural notions of sexual orientation, sexual activity, and gender. Surgeries are conducted with a specific notion of intercourse in mind. Often infants with a small ‘blind’ vagina undergo vaginal expansions and dilation throughout the course of their lives. The feminization of infants through surgery often necessitates reducing the size of their phallus, a procedure called a clitoroplasty. Since these surgeries are performed on young infants and children, multiple surgeries are often necessary as growth occurs. Often done without explanation or under deceptive circumstances, these genital corrective surgeries and other forms of *biopolitical* treatment result in long-term emotional, physical, and psychological complications.

The forced regulation of intersex bodies and genitalia often results in psychological trauma, and there are multiple cases where these forms of care have led to an individual’s suicide. Most famously, Herculine Barbin committed suicide in Paris after being forced to live as a man (Foucault 1980, xiii). Many intersex individuals describe feeling a sense of trauma when they realized their diagnoses and the implications of forced genital corrective surgery. Due to these manifestations of trauma, it is easy to perceive these *biopolitical* interventions as ‘violent’ care. Georgiann Davis describes her discovery of her intersexuality,

I was in tears as I read what one gynecologist wrote in my medical file...I was shocked and confused. Why had my medical providers and parents lied to me for so many years? I thought I had surgery because of a health risk. Was having an intersex trait that horrible? I remember thinking that I must be a real freak if even my parents hadn’t been able to tell me the truth (2015, 4).

Instead of being told that she had intersex traits, Davis’s providers had instead told her that she was born with ovarian cancer, necessitating the removal of her ovaries and uterus. It wasn’t until

she switched providers that she found that she had complete androgen insensitivity syndrome.

Intersex advocate Pidgeon Pagonis describes a similar experience with their intersexuality, one that was permeated with deception and violent *biopolitical* forms of care. They describe one of their ‘follow-up’ surgeries:

Ten days before my twelfth birthday, my endocrinologist scheduled me for a surgery. The day of the surgery came and I was being prepared for anesthesia. The doctors came into the room to tell me what was going to happen next. "We noticed that your vagina is smaller than other girls'. While we're in the operating room fixing your urethra, we can also make a small incision in your vagina to make it larger. This way, you'll be able to have sex with your husband when you're older-Does that sound good?" I looked at my mom, who was in the prep room with me for this and wondered how to answer. I was only 11. I let out a shameful, "Yes." (Pagonis 2015).

Throughout this account, medical intervention was deemed necessary because their vaginal opening was considered too small for penetrative ‘normal’ sex. They were not told the reasoning behind the need for surgery. Like Davis, Pagonis was also told that they were born with cancerous ovaries that had to be removed. No explanation was given for the small size of their vaginal opening, only that it had to be fixed. Although the surgeries appeared to be a success, ‘normal’ sexual activity was not immediately possible. Pagonis states, “Eventually, we were successful but it hurt. Real bad. I blamed myself. Shame and denial go hand-in-hand. During sex I would silently cuss out God and go through the ways one could kill one’s self” (2015). Throughout their article, Pagonis describes their sense of exclusion stating that, “ever since junior high, I felt different. Just because no one told me the truth doesn’t mean I never felt the effects of their lies. In trying to protect me, they made me feel ashamed and isolated and the stress and trauma from those surgeries left lingering severe effects” (2015). Both Davis’s and Pagonis’s account emphasize the stigma and deception that comes from undergoing medical intervention by describing their sense of ‘otherness’ when they realized that they underwent multiple medical procedures in order to ‘fix’ their bodies. Like Cheryl Chase, they both decry unnecessary genital corrective surgery for intersex infants.

Specifically, since intersex bodies do not fit binaristic sex categories, medical professionals impose non-life-saving medical treatment to regulate intersex bodies through a violent form of biopolitical care. Children born with an intersex condition face medical intervention that is overly concerned with policing the materiality of their bodies. Despite numerous psychological and physical complications, medical professionals continue to perform genital corrective surgery on intersex infants and children. This medical intervention creates and fosters the stigma and deception that comes from not fitting within conceptions physical dimorphism that group characteristics as either exclusively ‘male’ or ‘female’. Foucault’s theory of *biopolitics* and Stevenson’s understanding of care has provided a useful lens for the analysis of corrective genital surgery and sexual assignment. Starting with a discussion of the materiality of the body, sex, and gender situated within biomedicine, it is evident that the main purposes of medical intervention surrounding intersex bodies has been to uphold normative Western cultural ideas of gender identity, sexual orientation, and sexual activity. By conceptualizing ‘care’ as a *biopolitical* regulatory force, physical dimorphism has been violently forced upon intersex individuals through and made possible through the shift in jurisdiction from the individual to biomedical experts.

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