PART 7: SQUARE PEGS

Affronting Reason

Cheryl Chase

"It seems that your parents weren't sure for a time whether you were a girl or a boy," Dr. Christen explained, as she handed me three, fuzzy, photostatted pages. I was twenty-one years old and had asked her to help me obtain records of a hospitalization that had occurred when I was a year and a half old, too young for me to recall. I was desperate to obtain the complete records, to determine who had surgically removed my clitoris, and why. I wanted to know against whom my rage should be directed. "Diagnosis: true hermaphrodite. Operation: clitorectomy." The hospital record showed Charlie admitted, age eighteen months. His typewritten name had been crudely crossed out and "Cheryl" scribbled over it.

Though I recall clearly the scene of Dr. Christen handing me the records and dismissing me from her office, I can recall nothing of my emotional reaction. How is it possible that I could be a *hermaphrodite?* The hermaphrodite is a mythological creature. I am a woman, a lesbian woman, though I lack a clitoris and inner labia. What did my genitals look like before the surgery? Was I born with a penis?

Fifteen years of emotional numbness passed before I was able to seek the answers to these and many other questions. Then, four years ago, extreme emotional turmoil and suicidal despair arrived suddenly, threatening to crush me. "It's not possible," I thought. "This cannot be anyone's story, much less mine. I don't want it." Yet it *is* mine. I mark that time as the beginning of my coming out as a political intersexual, an "avowed intersexual," to borrow the epithet that until recently adhered to homosexuals who refused to stay invisible.

The story of my childhood is a lie. I know now that after the clitorectomy my parents followed the physicians' advice and discarded every scrap of evidence that Charlie had ever existed. They replaced all of the blue baby clothing with pink and discarded photos and birthday cards. When I look at grandparents, aunts, uncles, I am aware that they must know that one day Charlie ceased to exist in my family, and Cheryl was there in his place.

The medical establishment uses the terms *hermaphrodite* and *intersexual* to refer to us. The word hermaphrodite, with its strong mythological associations, reinforces the notion that hermaphroditism is a fantasy, not your neighbor, your friend, your teacher, or—especially—your baby. And, because it falsely implies that one individual possesses two sets of genitals, it allows my clitoris to be labeled as a penis and the clitorectomy performed on me to be justified as "reconstructive surgery." For these reasons, I prefer the term intersexual. Kira Triea, one of many who has joined me in speaking openly about her intersexuality, also feels strongly about this point. "It irks me so when I am trying to explain to someone who I am, what my experience has been, and they begin to quote Ovid to me." For Triea—an intersexual assigned male at birth, raised as a boy, who began to menstruate through her penis at puberty, and who now lives as a lesbian-identified woman—hermaphroditism is a real presence in her life every day; she need not look to poetry penned in Latin two millennia ago.

At the beginning of my process of coming out as intersexual, I chose to examine again the three pages of medical records that I had set aside for fifteen years. The word "hermaphrodite" was horribly wounding; it drove me to the brink of suicide. I thought back to my earlier process of coming out as lesbian. The way out of this pain was to reclaim the stigmatized label, to manufacture a positive acceptance of it. This second coming out was far more painful and difficult. As a teenager recognizing my attraction to women, I visited the library, stealthily examined Del Martin and Phyllis Lyon's *Lesbian/Woman* (1991) and Radclyffe Hall's *The Well of Loneliness* (1990). I learned that other lesbians existed, that they somehow managed to live and to love women. Somehow I would find them; there was a community where my lesbianism would be understood and welcome. No such help was available to reclaim my intersexuality. The only images I found were absolutely pathologized case histories in medical texts and journals, closeups of genitals being poked, prodded, measured, sliced, and sutured, full body shots with the eyes blacked out.

For many months, I struggled to reclaim the label "hermaphrodite." I knew that I had been horribly mutilated by the clitorectomy, deprived of the experience of sexuality that most people, male or female, take for granted. What would my life be had I been allowed to keep my genitals intact? "No,"

I thought. "I don't wish to have a penis between my legs, for my body to look like a man's body. I could never relate sexually to a woman as if I were a man." The physicians who removed my clitoris considered instead performing a long series of surgeries to make my genitals look more male, to support the male sex assignment rather than changing it to female. Though I can offer little evidence to support the idea, I am convinced that, had I been kept male, I would now be a gay man.

"Never mind, just don't think about it," was the advice of the few people to whom I spoke, including two female therapists: "You look like a woman." There is a powerful resistance to thinking about intersex. Because they look at me and make a female attribution, most people find it impossible to imagine that my experience and my history are not female. The resistance to thinking about what my sexual experience might be is even more profound. Most people, including the two therapists mentioned above, are paralyzed by the general prohibition on explicit sex talk. But sex radicals and activists are little better. They assume that I am having "vaginal orgasms" or even "full-body orgasms." If I persist in asserting my sexual dysfunction, many patronize me. "I am completely confident that you will learn how to orgasm," one man told me, then continued his explanation of how male circumcision was just as damaging as clitorectomy, my experience to the contrary.

What is most infuriating is to read, nearly every day in popular media, denunciations of African female genital mutilation as barbaric abuses of human rights, which fail to mention that intersexed children's clitorises are removed every day in the United States. Such writers occasionally note that clitorectomy has been practiced in the United States but always hurry to assure the reader that the practice ended by the 1930s. Letters to these authors receive no reply. Letters to editors pointing out the inaccuracy are not published. In 1996, Congress passed H.R. 3610, prohibiting "the removal or infibulation (or both) of the whole or part of the clitoris, the labia minor, or the labia major" (p. H11829). However, the next paragraph specifically excludes from prohibition these operations if they are performed by a licensed medical practitioner who deems them necessary. As early as 1993, Brown University Professor of Medical Science Anne Fausto-Sterling had joined intersexuals to ask Congresswoman Pat Schroeder, in drafting the prohibition, not to neglect genital surgery performed on intersexed infants. Ms. Schroeder's office made no reply. Newspaper accounts in 1996 lauded the bill's passage as an end to clitorectomy in the United States.

It took months for me to obtain the rest of my medical records. I learned that I had been born, not with a penis, but with intersexed genitals: a typical vagina and outer labia, female urethra, and a very large clitoris.

Mind you, "large" and "small," as applied to intersexed genitals, are judgments that exist only in the mind of the beholder. From my birth until the surgery, while I was Charlie, my parents and doctors considered my penis to be monstrously small, and with the urethra in the "wrong" position. My parents were so ashamed and traumatized by the appearance of my genitals that they allowed no one to see them—no baby-sitters, no possibility of tired parents being spelled for diaper-changing by a helpful grandmother or aunt. Then, in the moment that intersex specialist physicians pronounced that my "true sex" was female, my clitoris was suddenly monstrously large. All this occurred without any change in the objective size or appearance of the appendage between my legs.

Intersex is a humanly possible but (in our culture) socially unthinkable phenomenon. In modern industrial cultures, when a child is born, the experts present, whether midwives or physicians, assign a sex based on the appearance of the infant's genitals. They are required—both legally and by social custom—to assign the child as either male or female. Were parents to tell inquiring friends and relatives that their newborn's sex was "hermaphrodite," they would be greeted with sheer disbelief. Should the parents persist in labeling their child "hermaphrodite" rather than "male or female with a congenital deformity requiring surgical repair," their very sanity would be called into question.

Thus, intersexed children are always assigned to either male or female sex. In making these problematic sex assignments, specialist physicians are generally consulted; the assignment may not be made for several days, and it is sometimes changed, as was done with me. In fact, there are documented cases in which the sex assignment has been changed without soliciting the opinion of or even *informing* the child, as many as three times.[1]

Most people take for granted, even assume as "scientific fact," that there are two, and only two, sexes. In reality, however, about one in two thousand infants is born with an anatomy that refuses to conform to our preconceptions of "male" and "female." Few outside the medical profession are even aware of our existence. I now know that hundreds of thousands of people in the United States alone share my experience, and we are organizing ourselves through the Intersex Society of North America.[2] My ability to embrace the term hermaphrodite, at first halting and uncertain, has grown in depth, conviction, and pride, as I have met other intersexuals; we have shared our stories, our lives, and our anger.

Struggling to understand why society so utterly denies the phenomenon of intersexuality, I read widely in such diverse fields as philosophy, history, psychology, and ethnography. I was excited to discover that in recent years a number of scholars in these fields have begun to examine the ways

in which sex and gender are socially constructed (Butler, 1990; Foucault, 1980b; Kessler and McKenna, 1978; Laqueur, 1990; Vance, 1991). These and related works constitute a recognition that the paradigms of previous investigators have caused them to overlook information about nonreproductive sexual conduct, practices, and categories. Data that were at odds with their culturally determined, heterosexist, dimorphic point of view were ignored because they could not be accounted for.

In many other cultures, however, the phenomenon of intersexuality is well known, and an intersexed child may be recognized and assigned as such at birth. Unfortunately, interpretations by ethnographers have been straightjacketed by the absolute sexual dualism that has dominated Western thinking since Darwin. Recently though, ethnographers have given us examples of cultures in which intersexual assignment confers high status, low status, or even condemns an infant to death by exposure, as an evil omen (Edgerton, 1964; Furth, 1993; Herdt, 1994; Nanda, 1994; Roscoe, 1991). The Jewish Talmud discusses hermaphrodites in many locations and lays out regulations governing matrimony, priesthood, inheritance, and other matters for intersexuals (Berlin and Zevin, 1974). The Talmudic sages held variously that the hermaphrodite was: of uncertain sex, but in some essential way actually either male or female; part male and part female; definitely male, but only in respect to certain laws. And, in an eerie echo of modern medical practice, one Talmudic writer even differentiates the hermaphrodite, whose sex can never be resolved, from the *Tumtum*, whose sex is ascertainable through surgery.

Americans, though, are apt to express disbelief when confronted with evidence of intersexuality. Modern Western culture is the first to rely upon technology to *enforce* gender dichotomy: since the 1950s or so, surgical and hormonal means have been used to erase the evidence from intersexed infants' bodies. Medical literature speaks with one voice on the necessity of this practice, even when it concedes that surgical intervention may damage sexual function (Conte and Grumbach, 1989; Emans and Goldstein, 1990; Hendricks, 1993). Silence has been considered evidence of patient satisfaction.

For over forty years, some form of clitorectomy or clitoroplasty has been used to treat little girls with adrenogenital syndrome (one of dozens of reasons why an infant may be born intersexed). The only indication for performing this surgery has been to improve the body image of these children so that they feel "more normal" . . . *Not one has complained of loss of sensation even when the entire clitoris was removed. . . . The clitoris is clearly not necessary for orgasm* (Edgerton, 1993, p. 956).[3]

What are genitals for? It is my position that *my* genitals are for *my* pleasure. In a sex-repressive culture with a heavy investment in the fiction of sexual dichotomy, infant genitals are for discriminating male from female infants. It is very difficult to get parents, or even physicians, to consider the infant as a future adult and sexual being. Medical intersex specialists, however, pride themselves on being able to do just that.

For intersex specialists, male genitals are for active penetration and pleasure, while female genitals are for passive penetration and reproduction: men have sex; women have babies. Asked by a journalist why standard practice assigns 90 percent of intersexed infants as females (and surgically enforces the assignment by trimming or removing the clitoris), one prominent surgical specialist reasoned, "you can make a hole, but you can't build a pole" (Hendricks, 1993, p. 15). Notice how John Gearhart, a noted specialist in genital surgery for intersex children, evades questioning about orgasmic function following the presentation of his paper on additional surgeries for repair of vaginas surgically constructed in intersexed infants. (Dr. Frank, in attendance at the presentation, shares a professional interest in such surgery; the discussion was published in the *Journal of Urology* along with the paper.)

> *Dr. Frank:* How do you define successful intercourse? How many of these girls actually have an orgasm, for example? How many of these had a clitorectomy, how many a clitoroplasty, and did it make any difference to orgasm?
>
> *Dr. Gearhart:* Interviews with the families were performed by a female pediatric surgeon who is kind and caring, and who I think got the maximum information from these patients. Adequate intercourse was defined as successful vaginal penetration. . . . (Bailez et al., 1992, p. 684)

Gearhart has since condemned outspoken intersexed adults as "zealots" (Angier, 1996, p. E14), and minimized reports by former patients of damaged sexual function after clitoral surgery because "some women who have never had surgery are anorgasmic" (Chase, 1996, p. 1140).

Intersex specialists often stress the importance of a heterosexual outcome for the intersexed children consigned to their care. For instance, Slijper and colleagues state, "parents will feel reassured when they know that their daughter can develop heterosexually just like other children" (Slijper et al., 1994, p. 15). Dr. Y, a prominent surgeon in the field of intersexuality, agreed to be interviewed by Ellen Lee only under condition of anonymity. He asserts that the ultimate measure of success for sex assign-

ment of intersexed children is the "effectiveness of intercourse" they achieve as adults (Lee, 1994, p. 60). Intersexuals assigned female who choose women as sexual partners, and those assigned male who choose men as sexual partners, must then represent failures of treatment in the eyes of our parents and of intersex specialists. Indeed, my mother's reaction upon learning that I was sexual with women was to reveal to my siblings, but not to me, my hermaphroditism and history of sex change and to regret that she had allowed physicians to assign me female, rather than male.

My mother and father took me into their room one day to share a secret with me. I was ten years old, still utterly ignorant about sexual matters. "When you were a baby, you were sick," they explained. "Your clitoris was too big; it was *enlarged*." The way they spoke the word *enlarged*, it was clear that it was being given some special, out of the ordinary, meaning. "You had to go into the hospital, and it was removed." "What is a 'clitoris'?" I asked. "A clitoris is a part of a girl that would have been a penis if she had been a boy. Yours was *enlarged*, so it had to be removed. Now everything is fine. But don't ever tell this to anyone else."

Who am I? I look at my body. It *looks* female. Yet I have always harbored a secret doubt. I remember myself as a withdrawn, depressed adolescent, trying to steal a glance of a woman's genitals. Do hers look like mine? I had never seen a naked woman up close. I had no idea that my genitals were missing parts. In fact, one cannot discern the difference between my genitals and those of any other woman without parting the outer labia. I do recall learning, from a book, about the phenomenon of masturbation. Try as I might, I could not locate a focus of pleasurable sensation in my genitals, couldn't accomplish the trick that I had read about. I wasn't able to associate this failure with the secret about the *enlarged* clitoris that had been removed. I simply couldn't take in that such an irreversible harm had been done to me and by adults who were responsible for my well-being. I often woke from a nightmare in which my life was in danger, my gender in question, and my genitals were somehow horribly deformed, spilling out of me like visceral organs. It wasn't until I became a young adult that I was able to make the connection between the removal of my clitoris and my feeble sexual response and inability to experience orgasm.

Who am I? I now assert both my femininity and my intersexuality, my "not female"-ness. This is not a paradox; the fact that my gender has been problematized is the source of my intersexual identity. Most people have never struggled with their gender, are at a loss to answer the question, "How do you know you are a woman (a man)?"

I have been unable to experience myself as totally female. Although my body passes for female, women's clothing does not fit me. The shoulders

are too narrow, the sleeves too short. Most women's gloves won't go on my hands, nor women's shoes on my feet. For most women, that wouldn't be more than an inconvenience. But when the clothing doesn't fit, I am reminded of my history. Of course, men's clothing doesn't fit either. The straight lines leave no room for my large breasts or broad hips. Still, I experience something about the way that I work and move in the world as relatively masculine. And when a man expresses an intimate attraction to me, I often suspect that he may be wrestling with a conflicted homosexual orientation—attracted to a masculine part of me, but my feminine appearance renders his attraction safely heterosexual.

As woman, I am less than whole—I have a secret past; I lack important parts of my genitals and sexual response. When a lover puts her hand to my genitals for the first time, the lack is immediately obvious to her. Finally, I simply do not feel myself a woman (even less a man). But the hermaphrodite identity was too monstrous, too other, too freakish, for me to easily embrace—a medical anomaly, patched up as best the surgeons could manage. I had an article from a medical journal that stated that only twelve "true hermaphrodites" (the label applied to me by my medical records) had *ever* been recorded (Morris, 1957, p. 540).

For whose benefit does this mechanism of medical erasure and social silencing operate? Certainly, it does not benefit intersexed children. I have been brutally mutilated, left to wonder and to search for the truth in utter silence and isolation. When at age thirty-six, I finally confronted my mother, I asked her how she could possibly have kept her silence for all those years, left me to learn my history as Charlie and the label of hermaphroditism from medical records. Her response? "Well, you could have *asked* me." (I wonder what other improbable questions I should be certain to ask while she is alive . . .)

At first, I was horribly vexed by this issue of identity. My earlier experience of coming out as a lesbian helped me to see the solution to my predicament. The terms homosexual and lesbian, as with the term intersex, were inventions of medical discourse used to pathologize disapproved sexualities. I must proudly assert my identity and insist that the medical construction of intersexuality as disease is oppression, not science. I must find others who share my experience—others who will speak out with me. A community can provide emotional and logistical support for its members and mount a much more powerful resistance than individuals acting alone.

It wasn't easy to overcome my feelings of intense shame. I remember furtively using the printer, copier, and fax machine at the office, heart pounding with the fear that someone would see the documents that I was working with—medical records, articles from medical journals, a journal

of my emotional progress. I still believed that intersexuality was so rare that I might never find another whose experience was similar to mine. Instead, I first sought out and spoke with transsexuals. Alice Walker had just published *Possessing the Secret of Joy*, a novel which focused Western attention on the African cultural rite euphemistically referred to as female circumcision. I thrilled to read the elderly midwife, whose long life had been spent performing clitorectomies, castigate her former victim for suggesting clitorectomy might be justified for hermaphrodites, if not for females. "It's all normal, as far as that goes, says M'lissa. You didn't make it, so who are you to judge?" (Walker, 1992, p. 257) I located and spoke with African women mutilated in this way, who are now organizing in the United States against the practices of their homelands. The examples of all these brave people helped me to deal with my shame.

I began to speak, at first indiscriminately, with friends and acquaintances about what had been done to me. Within a year, I had turned up half a dozen other intersexuals; most of them were also genitally mutilated; two were living with their atypical genitals intact. A woman clitorectomized during her teens, though she knew from masturbation that her clitoris was the focus of sexual pleasure, she was unable to express this or otherwise resist the pressure of parents and doctors; a child who had been clitorectomized just two years previous (in 1990); a woman who was grateful that her mother had resisted years of medical pressure to remove her daughter's large clitoris; a man who had been raised as a girl, switched to living as a man (with intact intersexed genitals) after he developed a masculine body at puberty; a man whose penis had been severely damaged by repeated surgeries to "correct" the position of his urethral meatus;[4] a man who had discovered that the childhood surgery which no one would explain to him had actually removed his uterus and single ovary. None of these people had ever spoken with another intersexual.

Surgeons assert that the reason why they fail to provide us with counseling is that they cannot locate mental health professionals with experience in dealing with intersexuality (Lee, 1994). Yet, surgeons perpetuate this situation by mutilating, traumatizing, stigmatizing, and silencing us, their intersexed patients. We grow up with so much shame that as adults we are not able to discuss our experience openly, and the phenomenon of intersexuality remains invisible. Indeed, as recently as 1996, one entrant in a medical ethics contest won a cash prize for her essay encouraging physicians to lie to their intersexed patients in order to prevent them from knowing their diagnoses (Natarajan, 1996). In adulthood, many who were treated as children by medical intersex specialists feel so betrayed that they shun all medical care.

What do I see when I look in the mirror? I see a female body, though scarred and missing some important genital parts. When I interact in daily life with others, though, I experience a strange sort of bodily dissociation—my perception of myself is as a disembodied entity, without sex or gender. I view healing this split as an important element of personal growth that will allow me to reclaim my sexuality and to be more effective as an intersex advocate. My body is not female; it is intersexed. Nonconsensual surgery cannot erase intersexuality and produce whole males and females; it produces emotionally abused and sexually dysfunctional intersexuals. If I label my postsurgical anatomy female, I ascribe to surgeons the power to create a *woman* by *removing* body parts; I accede to their agenda of "woman as lack"; I collaborate in the prohibition of my intersexual identity. Kessler quotes an endocrinologist who specializes in treating intersexed infants: "In the absence of maleness, you have femaleness. . . It's really the basic design" (Kessler, 1990, p. 15).

Must things be this way? In all cultures, at all times? Anthropologist Clifford Geertz contrasted the conceptualization of intersexuals by the Navajo and the Kenyan Pokot—"a product, if a somewhat unusual product, of the normal course of things"—with the American attitude. "Americans . . . regard femaleness and maleness as exhausting the natural categories in which persons can conceivably come: what falls between is a darkness, an offense against reason" (Geertz, 1984 p. 85). The time has come for intersexuals to denounce our treatment as abuse, to embrace and openly assert our identities as intersexuals, and to intentionally affront that sort of reason which requires that we be mutilated and silenced.

Even before intersexuals began to speak out, there were a few stirrings of awareness that something fishy was going on at the boundaries of the sexes. In 1980, Ruth Hubbard and Patricia Farnes pointed out that the practice of clitorectomy was not limited to the Third World but also occurs "right here in the United States, where it is used as part of a procedure to 'repair' by 'plastic surgery' so-called genital ambiguities" (Farnes and Hubbard, 1980, p. 9). Reacting to intersex specialist John Money's explanation to a three-year-old girl that clitorectomy "will make her look like all other girls," Anne Fausto-Sterling wryly noted, "If the surgery results in genitalia that look like those shown in [Money's] book, then [he is] in need of an anatomy lesson!" (Fausto-Sterling, 1985, p. 138). Five years later Suzanne Kessler, whose work has been influential in motivating the current discourse on gender as a social construction, interviewed physicians who specialize in managing intersexed children. She concluded that genital ambiguity is treated with surgery "not because it is threatening to the infant, but because it is threatening to the infant's culture" (Kessler, 1990,

p. 25). Finally, Fausto-Sterling suggested that genital surgery should not be imposed on intersexed infants (Fausto-Sterling, 1993).

A letter to the editor in which I responded to Fausto-Sterling's article, announcing the formation of the Intersex Society of North America (ISNA), brought emotional responses from other intersexuals (Chase, 1993). One, Morgan Holmes, has completed an extended analysis of the reasons why medical technology has been used to erase intersexuality in general, and from her own body in particular (Holmes, 1994). Until she contacted me, Holmes shared her experience of intersexuality with no living being. The only other intersexual in her universe was Herculine Barbin, the nineteenth-century French hermaphrodite whose journals were edited and published by Foucault (Foucault, 1980a). Barbin's life ended in suicide. By 1996, ISNA had grown to include more than 150 intersexuals throughout the United States and Canada, and several in Europe, Australia, and New Zealand.

In Britain, as well, intersexuals have begun to speak out against the extreme secrecy, shame, and freakishness surrounding their condition. The British movement was given a boost when the respected *British Medical Journal* carried an exchange that led to publication of an address for a support group.

> Mine was a dark secret kept from all outside the medical profession (family included), but this is not an option because it both increases the feelings of freakishness and reinforces the isolation. (Anonymous, 1994b)

> It's not that my gynecologist told me the truth that angers me (I'd used medical libraries to reach a diagnosis anyway), but that neither I nor my parents were offered any psychological support but were left to flounder in our separate feelings of shame and taboo. (Anonymous, 1994a)

Both writers have androgen insensitivity syndrome (AIS). During gestation, their XY sex chromosomes caused them to have testes, and their testes produced testosterone. But because their cells were incapable of responding to testosterone, they were born with genitals of typical female appearance but having a short vagina, without cervix or uterus. Raised as girls, with bodies that develop many adult female characteristics at puberty, women with AIS are often traumatized to read in medical records or texts that they are "genetic males" and "male pseudohermaphrodites." The publication of these letters led to a swell of visibility and participation in Britain's AIS Support Group, which by 1996 had chapters in the United States, Canada, the Netherlands, Germany, and Australia.

In Germany, intersexuals have formed the Workgroup on Violence in Pediatrics and Gynecology for mutual support and in opposition of medical abuse. In Japan, intersexuals have formed Hijra Nippon, with a similar agenda. In the United States, HELP and the Ambiguous Genitalia Support Network were separately founded by mothers who opposed the drastic surgical interventions and secrecy that medical specialists recommended for their intersexed children.[5] One of these women has a suit pending against physicians who removed her son's testes against her stated wishes.

Some intersexuals whose bodies resemble mine have an XX, some an XY karyotype; others have a mosaic karyotype, which differs from cell to cell. There is no possible way to discern my karyotype without sending a tissue sample to a laboratory. If the result were "XX," should this information bolster my identity as a female? As a lesbian? If "XY," should I reconceptualize myself as a heterosexual man? It is ludicrous that knowledge of the result of a laboratory test in which cell nuclei are stained and photographed under a microscope should determine the perception of anyone's sex or gender.

The International Olympic Committee has learned this the hard way. Since the IOC began to karyotype women in 1968, one in 500 female athletes tested have been rejected because of their unusual chromosomes; in some cases, the decision was made only after the event, and the woman was stripped of title and barred from future competition. To this writer's knowledge, only one person treated in this way has thus far been willing to speak openly about her experience. When meet officials presented Maria Patino with the news that she was "genetically male," they advised her to fake an injury and leave quietly (Pool, 1994).

When I first began to seek out other intersexuals, I expected, I wanted, to find people whose experience exactly matched mine. What I have discovered is that in one sense we are very different—the range of personalities, politics, and anatomies in our nascent intersexual movement is broad. Some of us live as women, some as men, some as open intersexuals. Many of us are homosexual, if that term is narrowly understood in terms of the social gender roles of the partners. Some of us have never been sexual. But, in another sense, our experiences are surprisingly coherent: those of us who have been subjected to medical intervention and societal invisibility share our experience of it as abuse.

I claim lesbian identity because women who feel desire for me experience that desire as lesbian, because I feel most female when being sexual, and because I feel desire for women as I do not for men. Many intersexuals share my sense of queer identity, even those who do not share this homosexual identity. One, assigned female at birth and lucky enough to escape

genital surgery through a fluke, has said that she has enjoyed sex with both women and men but never with another intersexual. "I'm a heterosexual in the truest sense of the word" (Angier, 1996, p. E14).

Healing is a process without end. The feeling of being utterly alone may be the most damaging part of what has been done to us. My work as an activist—listening to, counseling, and connecting other intersexuals, and working to save children born every day from having to repeat our suffering—has been an important part of my own healing and of feeling less overwhelmed by grief and rage.

NOTES

1. Money describes a child who was assigned male at birth, female a few days later, male at age three weeks, and female at age four and a half. She was clitorectomized in conjunction with the final sex change. Her history of sex reassignments was kept secret from her, tabooed from family discussion, although she recalled it in dreams (Money, 1991, p. 239).

2. Intersex Society of North America, P.O. Box 31791, San Francisco, CA 94131. E-mail info@isna.org.http://www.isna.org.

3. Although this statement was written in connection with an article about "clitoroplasty without loss of sensitivity," the authors provide no evidence that this standard procedure, which removes nearly the entire clitoris and relocates the remainder, leaves sexual sensation intact. On the other hand, Morgan Holmes, who was subjected to it as a child, characterizes it as a "partial clitorectomy" (Holmes, 1994). Another woman, who had the procedure performed as an adult and is able to contrast her sexual experience before and after the surgery, calls it "incredibly desensitizing" (Chase, 1994, p. 3).

4. Approximately one in three or four hundred infants is born with a condition called hypospadias, in which the portion of the urethra that traverses the penis is partially or completely open. This condition is rarely harmful; it looks unusual, and the boy or man may have to sit to urinate. Hypospadias "correction" surgery is probably the second most common form of cosmetic genital surgery performed in the United States, following "routine" male circumcision.

5. AIS Support Group US, 4203 Genessee #103-436, San Diego, CA 92117-4950. E-mail <aissg@aol.com>. AG Gewalt in der Padiatrie and Gynecologie, Brandtstrasse 30, Bremen 28 215, Germany. E-mail <aggpg@t-online.de>. Hijra Nippon, Suita Yubinkyoku Todome, Honami cho 4-1 Suita shi, Osaka T564, Japan. HELP, PO Box 26292, Jacksonville, FL 32226. E-mail <help@jaxnet.com>. Ambiguous Genitalia Support Network, P.O. Box 313, Clements, CA 95227.

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