

Queer Theory

Readers in Cultural Criticism

General Editor: *Catherine Belsey*

The Body
Posthumanism
Theorizing Ireland
Postmodern Debates
Queer Theory

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Readers in Cultural Criticism

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Intersex Activism, Feminism and Psychology

Peter Hegarty in conversation with
Cheryl Chase

INTRODUCTION

In the 1950s John Money and his colleagues at Johns Hopkins University developed protocols for the treatment of infants born with genitalia that deviate from social norms for acceptable male and female bodies.¹ In 1990 psychologist Suzanne Kessler commented that Money's theory of intersexuality was 'so strongly endorsed that it has taken on the character of gospel' among medical professionals.² Since that time intersexed persons have begun to protest the violent and stigmatizing effects of those medical protocols on their lives. On 10 June 1999, I interviewed Cheryl Chase, the founder of the Intersex Society of North America (ISNA), the largest organization of intersexed persons in the world, at her home in northern California. We discussed the surgeries that Cheryl was subjected to as an infant, her discovery that she was intersexed, the formation of ISNA, and the relationships between intersex activism, feminism, and lesbian and gay politics. I transcribed our two-hour conversation and what follows is an edited version that Cheryl has read and commented on. [Interviewer]

INTERVIEWER (hereafter INT): Let's start by talking about your own story, and how you learned you were intersexed.

CC: When I was eight my parents admitted me to the hospital. All they said was 'Remember you used to have stomach aches? We are going to look and see if everything is OK.' I just remember that the surgery was extraordinarily uncomfortable and painful. Then when I was 10, my parents told me that I had been born with an 'enlarged' clitoris. You could hear the quotes on 'enlarged' when they said it. They said a clitoris was 'something that might have been a penis if you were a boy but you are a girl and so you don't need one'.

INT: 'You don't need one'?

CC: Yes. They said 'and since yours was "enlarged" doctors removed it when you were born. The surgery was just to check everything was OK. But don't tell anyone about this.'

INT: They wanted to cover up the medical procedures?

CC: Yes. And they explained it all in terms that I had no understanding of. Then when I was about 12 I started reading books about sex. I understood there was supposed to be some focus of pleasurable sensation in your genitals but I couldn't find it. By the time I was 19 I understood that I couldn't masturbate and I wasn't having orgasms. But until well into my 30s I held contradictory beliefs. I knew that my parents had had my clitoris removed, yet I believed that eventually I would figure out where it was on my body.

INT: Did you get any psychological care as a child?

CC: My parents took me to a psychiatrist when I was 10. She gave me IQ tests and tried to interest me in having children. She gave me a plastic toy model called 'The Visible Woman', which had abdominal organs that you could replace with pregnant ones. I guess she was trying to prepare me for a future role as wife and mother.

INT: Did she know that you were intersexed?

CC: She never mentioned it directly, but she told me that I was 'medically famous', and that I was in a lot of textbooks. When I was about 19 I decided to find out who had done the clitorotomy and why. Because that psychiatrist had said I was 'medically famous', I started reading medical journals; I came away with the hypothesis of progestin virilization.

INT: Can you explain that?

CC: Progestin is a synthetic form of progesterone; a hormone that is produced during pregnancy that maintains the uterine lining. The synthetic progestin, given to pregnant women back in the 1950s and 1960s, isn't identical to natural progesterone and sometimes it has virilizing effects on female infants. Quite a few genetic females born at that time had large clitorises and even relatively male-looking genitals because their mothers were given progestin. The solution was for the doctor to remove the clitoris. DES, a kind of synthetic oestrogen, was also marketed at that time. Then in the 1970s large numbers of cases of a rare kind of cervical cancer in young women began to appear. It turns out that DES given to pregnant women causes their daughters to have cervical cancer 20 years later. I confused DES and progestin in my mind at this time and concluded that I was at risk for cervical cancer. Anyway, I saw a gynaecologist and told him I wanted my records. When I talked to him again he told me the hospital had ignored his request and he couldn't understand why. He instructed me to ask for the records in person and gave me an undated letter to that effect. But

when I went to the hospital records department in New York City they wouldn't show them to me nor explain why. I told them that I had a legal right to those records and they said, 'so, sue us'. I broke down completely. Later I got hold of that gynaecologist's correspondence and learned that they did send him the records and he had lied to me.

INT: Your gynaecologist lied to you?

CC: Yes. They sent him the records twice. I think he lied to me because he saw how distressed I already was. He didn't want what was going to happen to me to happen in his office. He wanted it to happen on their watch.

INT: It seems like more than one person tried to deny you this information.

CC: Everyone I turned to did. Next I found that psychiatrist I had seen as a child. I asked for her help in getting the records. She said: 'You don't need them.' Then she asked me if I had a boyfriend.

INT: Sounds like she was only interested in normalizing you.

CC: I told her I didn't have a clitoris and couldn't orgasm and she said 'Oh that's childish. Adult women prefer vaginal orgasms.'

INT: This was in the 1970s, even after Masters and Johnson?

CC: Oh yes. This is post-, post lots of women's writings about sex. So I retreated from that interaction in tears too. Around that time I decided to move to San Francisco because I heard there were lesbians there and I had understood I was lesbian from quite a young age. A couple of years later in San Francisco I consulted a female gynaecologist, told her what I knew, and asked for her help in getting the records. She obtained a three-page summary and gave it to me, saying 'it seems as if your parents at first weren't sure if you were a boy or a girl.' The records showed that I was actually legally and socially a boy for the first year and a half of my life.

INT: Was that the first time you learned of this?

CC: Yes. There was a name I had never heard before in the records, 'Charlie', with my parents' names and address, and with my date of birth. That boy was admitted at a year and a half to the hospital for 'sex determination', and Cheryl was dismissed. The records say things like 'true hermaphrodite' and 'pseudo hermaphrodite' and 'ovo-testes' and 'clitorrectomy' and 'phallus'; things that were utterly shocking to me. That was in the 1970s in San Francisco. There was a lesbian community, but lesbian separatism was popular and men were supposed to be evil. In that context I wasn't about to explain to another lesbian that I didn't have a clitoris because I had been a boy for a year and a half! No way! I got those records when I was about 21. I didn't talk about it again until I was 35.

INT: So that female gynaecologist gave you the information but didn't help you deal with it.

CC: She discounted the meaning of it. She pretended that it wasn't going to hurt. Later I got hold of her correspondence with the hospital. After she saw me, she wrote to tell them they should be really proud and that I was doing great as my 'true sex, i.e., female'.

INT: It seems that doctors are very unprepared to deal with intersexed adults.

CC: Doctors refer to adults as 'formerly intersexed'. Once they have done the surgery, intersexuality is over. There are no sequelae. One member of ISNA, Angela Moreno, had her clitoris chopped off when she was 12.³ Afterwards her parents asked the doctors explicitly, 'Shouldn't we go and get her some counselling about this?' The doctors said: 'Don't do that because then she'll find out she has a Y chromosome and she'll commit suicide.' That's only 10 years ago. The doctors believe that your experience is so horrible, nobody could possibly own it. That's their position.

INT: If people are kept so much in the dark about their own bodies, how did you come to form this organization and meet people with such similar histories?

CC: I spent the next dozen or more years occupying myself with work. I studied at MIT and Harvard; I moved to Japan and started a high-tech company there. I was successful, but I was terribly depressed and I realized that my life wouldn't have meaning without a radical change. So I volunteered for a telephone counselling service in Tokyo. They had an intensive training with role-playing and speakers talking about personal emotional crises. The more that I did the training, the more I fell apart completely in my personal life. Eventually I told part of the story to the person in charge and she sent me to see their professional therapist, but this psychologist couldn't even deal with the fact that I was lesbian! I told her how I didn't feel like a woman; I said that when I went to buy gloves that women's gloves didn't fit me. She said, 'Well you know, I'm small and they're all too big for me.' But she didn't understand that she doesn't have a history of sex change for her small hands to remind her of. I told her I was unable to masturbate, that sex is always emotionally difficult, and that my partners always leave me. 'Well, everybody has their ups and downs', she said.

INT and CC: [Laugh]

CC: Eventually I decided to fire her. I also decided to confront some of the intersex doctors, based, in part, on what I had learned in the counselling class. Those three pages of medical records were in an ex-girlfriend's basement. I asked her to send me the records and they came the day after I broke off with my therapist. When I looked at the papers and saw this boy again and 'true hermaphrodite' and 'clitorrectomy', I realized that those papers had much more power to hurt me than I had realized. I saw

another therapist once but she was way over her head too. I didn't know what I was going to do. I thought about killing myself. I thought about cutting my throat and planned just how to make the cut. Then I decided that if I was going to have such a messy death, at least I wanted to do it in the office of the surgeon who had mutilated me. At that point I decided that I needed to work harder at getting help. So I talked to some therapists in the US and eventually was referred to someone trained in sexuality, who practised in Japan. I saw him several times a week for some months, and it helped. He didn't know anything specifically about intersexuality, but he didn't deny my experience, that my parents and doctors had defaulted on their responsibility to take care of me. I decided to find out everything I could about what happened. The records didn't describe how people thought and felt about me, or how they made decisions about me. I flew to the US to see my mother and I asked her lots of questions. She answered me in a way that was incredibly frustrating. She said that it hadn't been painful, it wasn't shocking or embarrassing, she hadn't had anything to do with any of it, the doctors had been completely in charge, and she had never given any of it a second thought. I believe that it was still so painful for her that she couldn't stand to acknowledge it.

INT: Are you in contact with your family now?

CC: No. My mother's dead; she broke off contact with me after that. My father is also dead and my sisters don't talk to me. After that I realized that the US would be a better place to get help than Japan so I moved back to San Francisco. I knew that what doctors did to me in the 1950s was barbaric, but I assumed that what they do to intersexed kids now has to be very different. So I looked for doctors who dealt with intersexed children.

INT: You still thought there must be a logic in this system somewhere?

CC: Yes. Back in the US I got in touch with intersex specialists, but they were shockingly ignorant. One woman surgeon said to me, 'My goodness, you have received really excellent care.'

INT: What did she mean?

CC: The only thing she could hear was that they didn't remove my ovaries. I asked another doctor, one of the most famous men in the whole field, if he knew any therapists. He said: 'No, but if you find a good one ...'

INT: '... let me know?'

CC: No, he didn't even say 'let me know?' he just said 'hang on to him'. He didn't want to know about providing therapy for intersexed adults. Plus they couldn't tell me anything about sexual function. I realized that doctors were still no smarter than they had been in the 1950s. I was lucky enough to find a great therapist, a man who is himself intersexed.

And I started talking about my history to everybody, indiscriminately and badly, but within a year I found six others.

INT: And the stories are like yours?

CC: Yes. That's when I decided to start the Intersex Society. I came across Anne Fausto-Sterling's *Myths of Gender*. Anne had mentioned this girl who was about to be clitorctomized to make her 'look like other girls'. And she wrote: 'If the surgery results in genitalia that looks like those shown in Money and Erhardt's book, then these particular psychologists are in need of an anatomy lesson!'⁴

INT: [Laughs]

CC: She also had written that males impregnate; females gestate and lactate and menstruate. So I called and told her that I thought that was wrong because intersex was a complex phenomenon, and that there are counter-examples to any binarizing definition that she can come up with. 'You are right,' she said, 'and since I wrote that I have changed my mind.'

INT: Great.

CC: She had an article in press in *The Sciences* called 'The Five Sexes', where she wrote about this stuff.⁵ She sent it to me and I wrote a letter to the editor talking about my experience, because there weren't first-person narratives of medicalized people out there. The letter came out in *The Sciences* two issues later and announced the formation of the Intersex Society. Right away the mailbox started to fill up with letters from people whose stories are very much like mine. Not in the exact details, but in terms of being treated as shameful, lied to and being subjected to surgeries which they, as adults, deeply regret happening.

INT: How big is the membership now?

CC: Our mailing list is about 1500 and we are six years old.

INT: And there are other intersex organizations too?

CC: Yes, there are more than a dozen now around the world, and all have pretty similar things to say.⁶

INTERSEX ACTIVISM AND FEMINIST POLITICS

INT: ISNA is somewhat of a success story. Relatively quickly the organization has grown, gained some media attention, and even had an impact on the medical establishment. What lessons do you think other feminist activists could learn from ISNA?

CC: Don't bother with feminism!

INT: Tell me more.

CC: Back in 1991 or 1992, there was a lot of media attention about African clitorctomies. I figured, 'great, the press is going to be all over this'.

So I tried to talk to feminists who worked on that issue and they wouldn't speak to me or cover what we were doing.

INT: Have you been in touch with any African feminists?

CC: I've talked to some Africans working in the US who were much more receptive. Soraya Mire is a Somali filmmaker working in the US. She told me, 'Alice Walker's been helping me and we're going to get her to help you too.' Soraya and I had met, had looked at each other's genitals, talked about sex and cried together. She spoke to Alice Walker about me, but Walker still won't talk to me. Walker has never acknowledged that clitorotomy continues in the US.

INT: In a recent article you pointed out how Western doctors used to make analogies between intersex clitorotomy and African clitorotomy.⁷

CC: Yes. There was a medical article on intersex from the 1960s which described how to do a very deep clitorotomy. The article editorializes that clitorotomy doesn't harm sexual function, as evidenced by the fact that it is performed universally in parts of Africa.⁸ Up until the early 1970s Western doctors always called it 'clitorotomy'. Now they call it 'clitoral reduction' or 'clitoral recession' or 'clitoroplasty' because the word 'clitorotomy' has come to be equated with barbarism, child abuse and mutilation. However, doctors still remove extensive clitoral tissue. 'Ectomy' means 'to cut' - if you cut on something, it's an -ectomy, whether you remove 100 per cent of the tissue or less. Clitorotomies in Africa do not remove 100 per cent of the structure, nor do most surgeries performed on intersex children. The distinction between African 'clitorotomy' and Western 'clitoroplasty' is purely political.

INT: Is there anything in feminist thinking that you have found helpful or useful?

CC: There is, but it's often not practised in feminism. Feminist theory prides itself on politicizing personal experience. But the first article I wrote about intersex, I sent to the journal *Signs* and they rejected it without review because it contained some personal narrative.⁹

INT: So that is quite the opposite of 'the personal is political'.

CC: Right, the personal is ... is prohibited!

CC and INT: [Laugh]

INT: What stake do feminists have in changing the medical treatment of intersex infants?

CC: The surgeries are incredibly sexist. They're based on the idea that men have sex; women are penetrated by men and have babies. For instance, when doctors are presented with a boy whose penis is very small and pees from the underside rather than from the tip, they ask themselves: 'What can we do about this boy's pain? That's going to be an emotionally painful thing to live with.' And I agree that's going to be painful to live with. Then they say: 'We'll chop off his dick and cut out

his balls and tell everybody he's a girl and give him oestrogen and then stitch a piece of colon into his crotch and have him live as a woman. That will be less painful.' What you produce is somebody who has a body that is vaguely female, is infertile, doesn't menstruate, probably doesn't have any sexual function, might have genital pain, and has been lied to and shamed. That is supposed to be less painful than having a small dick? I think it is taken to be less painful because female pain is discounted. Once it has been transformed into female pain it doesn't bother us so much.

INT: Do most intersexed kids end up being sexed as female?

CC: Doctors acknowledge that they make nine out of ten kids with ambiguous genitals females because you can dig a hole but you can't build a pole.¹⁰

INT: So femaleness is defined as the absence of maleness.

CC: Their idea is that if you have somebody who is not a good enough male and you cut off enough parts, whatever's left is female. The Former Surgeon General of the United States, Joycelyn Elders, is a paediatric endocrinologist and has this done to her patients. She says, 'I always teach my students you can't make a good male but you can make a pretty good female. Just take everything out and make a pouch.'¹¹ That was quoted in the *New Yorker*, and you know where the feminist outrage was?

INT: Where?

CC: Nowhere. Nobody even noticed it. Alice Dreger has written about 'monster ethics'. She argues that the ethics that have been applied to dealing with children who have atypical anatomies are ones that we would think of as ludicrous if we didn't think of the child as a monster.¹²

INT: Yes. We're strongly invested in the belief that categories like 'male' and 'female' are based in nature. When natural bodies come along that trouble the categories, there's nothing rational about people's reactions at all.

CC: So we fix the person instead of the category.

INT: It sounds as if, politically, intersexed people are caught between two poles. According to the doctors, there are no intersexed adults and so your concerns are not important. But according to some feminists, intersexed persons are not real women and so your concerns about clitorotomy are not important to them either.

CC: A good example of that last point is Germaine Greer's new book, which devotes an entire chapter, titled 'Pantomime Dames', to arguing that women with complete AIS are really just boys that doctors have made into girls like transsexuals.¹³ She also says that they develop a 'masculine figure - broad shoulders, narrow hips, no waist, short legs - and progressive baldness and heavy facial hair'. All of which is utterly untrue.¹⁴

INT: Even if it were true, so what?
 CC: Yes, but women with AIS are the most physically feminine of intersexed people: they lack the androgen receptor which produces masculine proportions, baldness, facial hair and so on. Greer says that because doctors have been using 'woman' as a trash category, feminists should not accept people with AIS as real women.

INTERSEX ACTIVISM AND LESBIAN AND GAY ISSUES

INT: How do you see the relationship between the treatment of intersexed infants and homophobia?
 CC: The treatment is deeply homophobic. When a child is born with unusual sex anatomy parents get freaked out that the child is going to be homosexual. Even in medical writings the homophobia is explicit. Doctors are advised in journals and textbooks to tell the parents that with surgery, their child will be normal, happy and heterosexual.
 INT: It's taken as a failure of surgery if the child grows up gay or lesbian?
 CC: It's assumed to be a likely outcome if there isn't any surgery.
 INT: Homophobia is used to motivate the surgery?
 CC: Absolutely. Yet lots of intersexed people end up homosexual, by which I mean sexually attracted to people of the social sex that they were assigned to. In other words, they are likely to be harassed and stigmatized as queer. They are vulnerable to homophobia. It would be caring to help parents deal with their own homophobia before the child grows up. Right now doctors validate the parents' homophobia by encouraging them to pray that their anxiety that the child will turn out to be queer will not come true.
 INT: So lesbian, gay and bisexual folk have a stake in the treatment of these infants.
 CC: Yes. Normalizing medical treatments deepen parents' homophobia, making it harder for those intersexed children who do end up gay.
 INT: Around the same time that medical protocols were being developed for dealing with intersexed infants, psychologists and psychiatrists claimed that it was the parents' fault when their child grew up gay or lesbian, and that sexual orientation could be changed through therapy.
 CC: Yes, they were attempting to change sexual orientations with therapy, lobotomies, shock treatments ...
 INT: ... and clitorectomies.
 CC: Yes.
 INT: In reaction to that kind of psychology, some people argue that, if sexual orientation was recognized as something biological, that homophobia would be ameliorated; straight people would then think that it's

not a person's fault if they are gay or lesbian. But intersexed infants are believed to be biologically preprogrammed to be gay or lesbian and yet homophobia pervades their lives.

CC: There's an even simpler way to put it. The notion that if we could prove that sexual orientation is biologically determined then homosexuals would be granted greater civil rights is terribly naive. For most intersexed conditions, the biological basis is pretty well understood, and yet intersexed people are stigmatized and punished by the enormously powerful mechanism of the medical establishment. Why should it be any different with gay men and lesbians? One of the things that I understood on that night when I was contemplating suicide was that, as hard as it was for me to accept the body that I was born with, it was impossible for that body to have been shameful. It was my knowledge of the history of the gay and lesbian civil rights movement that brought me to understand that the shame was socially imposed, not intrinsic to my anatomy.

INT: For some lesbian and gay folk it would be easy to see a parallel between protests against the psychiatric diagnosis of homosexuality in the early 1970s and some of the actions that ISNA has taken recently.
 CC: Yes. Some sexologists tell me 'Good science will provide answers, will right these wrongs.' I think that's bullshit. They need to read Ronald Bayer's book *Homosexuality and American Psychiatry* on the history of how activism - not science - changed the psychiatric treatment of homosexuality!¹⁵

INT: It's more likely that intersexed people will change science, right?

CC: Yes. When I started ISNA I resisted people who told me to do radical things like picket and demonstrate. I believed that doctors wouldn't listen to us if we did that. Then the US Congress passed legislation prohibiting clitorectomy that was drafted in a way that tried to avoid protecting intersexed children.¹⁶ Then I said: 'OK, now we're picketing.' It turns out that my original understanding was naive. Doctors will change last, not first. Only after we change public opinion and bring pressure on doctors from the margins of their own profession will they change.

INT: Would you say that intersexed politics are 'queer'?

CC: Yes, absolutely.

INT: That term, 'queer', has been used in many ways. What does it mean to you?

CC: The value of the word 'queer' is that it talks about difference that's stigmatized or transgressive without defining exactly what that difference is. That's how it is different from 'gay and lesbian'. When intersexed people say 'my body is OK like this' and 'my identity is OK like this', those are queer things to do and to think. Intersexed

children's bodies are queer because they elicit homophobic responses in parents and doctors.

INT: The categories 'gay' and 'lesbian' depend on a binary gender system. 'Homo-' and 'hetero-' mean 'the same as' and 'different from'.

CC: And if you think about it, those terms don't mean much if the gender or the sex of either of the two people is at all in question.

8

Axiomatic

Eve Kosofsky Sedgwick

Anyone working in gay and lesbian studies, in a culture where same-sex desire is still structured by its distinctive public/private status, at once marginal and central, as *the* open secret, discovers that the line between straining at truths that prove to be imbecilically self-evident, on the one hand, and on the other hand tossing off commonplaces that turn out to retain their power to galvanize and divide, is weirdly unpredictable. In dealing with an open-secret structure, it's only by being shameless about risking the obvious that we happen into the vicinity of the transformative. In this Introduction I shall have methodically to sweep into one little heap some of the otherwise unarticulated assumptions and conclusions from a long-term project of antihomophobic analysis. These nails, these scraps of wiring: will they bore or will they shock?

Under the rule that most privileges the most obvious:

AXIOM 1: PEOPLE ARE DIFFERENT FROM EACH OTHER.

It is astonishing how few respectable conceptual tools we have for dealing with this self-evident fact. A tiny number of inconceivably coarse axes of categorization have been painstakingly inscribed in current critical and political thought: gender, race, class, nationality, sexual orientation are pretty much the available distinctions. They, with the associated demonstrations of the mechanisms by which they are constructed and reproduced, are indispensable, and they may indeed override all or some other forms of difference and similarity. But the sister or brother, the best friend, the classmate, the parent, the child, the lover, the ex-: our families, loves, and enmities alike, not to mention the strange relations of our work, play, and activism, prove that even people who share all or most of our own positionings along these crude axes may still be different enough from us, and from each other, to seem like all but different species. . . .

In the particular area of sexuality, for instance, I assume that most of us know the following things that can differentiate even people of identical gender, race, nationality, class, and 'sexual orientation' - each one of which,