6 Suzanne J. Kessler

Defining and Producing Genitals

Obstetricians do not stand at the delivery table with ruler in hand, comparing the genitals they see with a table of values. They seem to know ambiguity when they see it. In the medical literature on intersexuality, where physicians communicate their findings and their assumptions, the phrase "ambiguous genitals" is used freely with no apparent need to define what "ambiguous" means in this context. One could say that ambiguous genitals are described ambiguously. It is not uncommon to read statements like, "Their [intersexed] external genitals look much more like a clitoris and labia than a penis or scrotum." One surgeon writes, without further specification, that the tip of the phallus should be the "expected size for the patient's age." Another states that the need for surgery "must be judged on the basis of the size of the shaft and glans of the clitoris in relation to the size of the patient and the interrelationship of the labia, mons veneris, and pubis."

One way to interpret this vagueness is that the ambiguity is so obvious that a physician who has seen scores of genitals has no need to validate the obvious. But the nonmedical reader is left wondering to what extent genitals must be ambiguous before they are seen to be in need of "correction." There are, of course, normative data on genital size, shape, and location, but I will delay a discussion of specifications in order to consider the meaning of genital variations for physicians, as projected through their justifications for surgery and their descriptions of aberrant genitals.

Genital Intolerance

Physicians describe all genital surgery on intersexed infants as necessary. Yet there are at least three categories of distinguishable genital surgery:

1. that which is *lifesaving*—for example, a urethra is rerouted so that the infant can pass urine out of his or her body;
2. that which *improves the quality of life*—for example, the urethral opening is redesigned so that a child can eventually urinate without spraying urine on the toilet seat; and
3. that which is *aesthetic*—for example, the small penis is augmented so that the (eventual) man will feel that he looks more manly.

Nowhere in the medical literature on intersexuality are these different motivations alluded to. In fact, although variant genitals rarely pose a threat to the child's life, the postdelivery situation is referred to as a "neonatal psychosexual emergency," seeming to require life-saving intervention.

Few arguments are put forth in defense of performing a surgery on intersexed infants. When pressed for a reason, physicians assert that "normal" genitals will maximize the child's social adjustment and acceptance by the families. Physicians claim they are acting in the interest of parents, who are motivated by a desire to protect their child from teasing.

Teasing is not an insignificant construct in theories about gender. Philosopher Ellen Feder exposes the way psychiatry uses testimony about teasing not only to justify treatment of Gender Identity Disorder in children but also to define it. Feder notes that what alarms teachers and parents about a child's cross-gender behavior is not the behavior per se but the other children's reactions to it. Teasing and name-calling are one of the manifest symptoms of a child gender disturbance. Children on the playground are treated "as a kind of natural tribunal," and the medical profession imbues this with authority, rather than treating the teasing and the institutions that tolerate it as in need of correction. Obviously, the same could be said of the management of intersex. Much is made of the possibility of teasing, but documentation is not provided for how teasing has negatively impacted those rare people whose intersexed genitals were not "surgicalized." Nor is there a discussion in the medical literature about procedures for counteracting (or curing) the teasing.

One endocrinologist and intersex specialist, in defending current practices, says that not doing surgery would be unacceptable to parents because "some of the prejudices run very deep." Implicit in this defense is that the genitals themselves carry the burden of evoking acceptance. There is no sense that the burden is or ought to be on people to learn to accept the genitals. As one intersexual said, "It's difficult to be Black in this culture, too, but we don't bleach the skin of Black babies."

An argument for surgery that is grounded in prejudice overlooks the fact that many bodily related prejudices have been moderated. More people than ever before discuss their cancer histories in public, are open about their AIDS status, and admit to having had an abortion. These changes have required a different way of talking, and it can be argued that the mere fact of talking differently has helped create changes in the way people think about cancer, AIDS, and abortion. Rather than assuming that physicians (like anyone else) are primarily motivated by greed and the power to impose their definitions on the ignorant, we could be more generous and assume that they (like anyone else) find it difficult to imagine new ways of talking in familiar situations. . . . I propose some new ways for physicians to talk differently about intersexuality, predicated on more comfortable attitudes about variant genitals.

Current attitudes about variant genitals are embedded (not too deeply) in medical reports and offer insight into the late-twentieth-century medical management of intersexuality. Feelings about larger-than-typical clitorises are illustrated by these representative quotations (my emphasis):

> The excision of a hypertrophied clitoris is to be preferred over allowing a *dis-*

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figuring and embarrassing phallic structure to remain.

The anatomic *derangements* [were] surgically corrected. . . . Surgical techniques . . . remedy the *deformed* external genitals. . . . [E]ven patients who suffered from major clitoral *overgrowth* have responded well. . . . [P]atients born with *obtrusive* clitoromegaly have been encountered. . . . [N]ine females had persistent phallic enlargement that was *embarrassing* or *offensive* and incompatible with satisfactory feminine presentation or adjustment. [After] surgery no prepubertal girl . . . described *troublesome* or painful erections.

Female babies born with an *ungainly* masculine enlargement of the clitoris evoke grave concern in their parents. . . . [The new clitoroplasty technique] allow[s] erection without cosmetic *offense.*

Failure to [reduce the glans and shaft] will leave a button of *unsightly tissue.*

[Another surgeon] has suggested . . . total elimination of the *offending* shaft of the clitoris.

[A particular surgical technique] can be included as part of the procedure when the size of the glans is *challenging* to a feminine cosmetic result.

These descriptions suggest not only that there is a size and malformation problem but that there is an aesthetic and moral violation. The language is emotional. Researchers seem disgusted. The early items on the list suggest that the large clitoris is imperfect and ugly. The later items suggest more of a personal affront. Perhaps the last item says it most transparently: the clitoris is "challenging."

A social psychologist should ask: How were embarrassment and offense displayed? If the clitoris is troubling, offending, and embarrassing, who exactly is troubled, offended, and embarrassed and why? Not only are these questions not answered by intersex specialists, they are not even asked. A comment from an intersexed adult woman about her childhood is a relevant counterpoint: "I experienced the behavior of virtually everyone towards me as absolutely dishonest, embarrassing." Her comment reminds us that objects in the world (even non-normative organs) are not embarrassing; rather, people's reactions to them are. Another intersexual woman's "uncorrected" clitoris was described by her sexual partner as "easy to find." Whether a clitoris is easy to find is arguably of some importance in sexual interactions, but it is not a criterion that physicians use for determining the suitable size for a clitoris.

An unexceptional quotation about the clitoris further substantiates the physicians' attitude:

> The clitoris is not essential for *adequate* sexual function and sexual *gratification* . . . but its preservation would seem to be *desirable* if achieved while maintaining *satisfactory* appearance and function. . . . Yet the clitoris clearly has a relation to erotic stimulation and to sexual gratification and its presence is desirable, even in patients with intersexed anomalies if that presence does not interfere with *cosmetic, psychological, social and sexual* adjustment. (my emphases)

Using my emphases as a guide, the alert reader should have some questions about the above quotation: Is "adequate sexual function" the same as "gratification"? If not, then which refers to the ability to orgasm? Why is the presence of the clitoris only desirable if it maintains a satisfactory appearance (whatever that is) and does not interfere? Lastly, how are the four different adjustments assessed and ranked, and is the order accidental?

Compared to language describing the larger-than-average clitoris, the language describing the small penis is less emotional but no less laden with value judgments. Common descriptors for the small penis are "short, buried, and anomalous." Sometimes there is a discussion about whether the microphallus is normally proportioned or whether it has a *"feminine stigmata* typical of intersexuality" indicative of *"arrested (feminine) development"* (my emphases).

The emotionality in the case of the small penis is reserved for the child "who cannot be a boy with this insignificant organ. . . . They *must* be raised as females. . . . They are *doomed* to life as a male without a penis." This last quotation suggests . . . that if the penis is small enough, some physicians treat it as though it does not actually exist. Given its size, it does not qualify as a penis, and therefore the child does not qualify as a boy. "Experience has shown that the most *heartbreaking* maladjustment attends those patients who have been raised as males in the vain hope that the penis will grow to a more masculine appearance and size 'at a later date'" (my emphases).

Physicians do not question whether a large clitoris ill prepares a girl for the female role. The emphasis is more on its ugliness. In contrast, physicians' descriptions of the micropenis are tied quite explicitly to gender role (my emphases): "Is the size of the phallus . . . *adequate* to support a male sex assignment? [If not], those patients [regardless of genotype] are *unsuited* for the masculine role." A ten-year-old boy (with a microphallus) considering sex change was given testosterone ointment, after which he *"reaffirmed his allegiance to things masculine."* "The sexual identification of the patients by their parents seemed less ambiguous following [testosterone] treatment, and the parents encouraged *more appropriate male behavior* in the patients following treatment." After Barbara's sixteenth birthday, her penis developed erections, she produced ejaculations, and she found herself feeling a *sexual interest in girls.*"

The penis needs to be large enough to support masculinity (in the eyes of the parents and the child). If it is really a penis, it will push the child toward the "male" gender role, even, as the last example shows, if the child is a girl.

Given the pejorative language used to portray the large clitoris, and the pitying language applied to the child with the small penis, it is not surprising that genital surgery in these cases is described as necessary. It is affirmed as necessary, though, not because anyone (or any one profession) has deemed it so but because the genital, itself, required the improvement. The quotations below (my emphases) establish that the organ carries the message itself; there is no messenger:

> Given that the clitoris *must* be reduced, what is the best way to do it?
>
> When the female sex is assigned, an operation on the clitoris together with other *necessary* procedures to modify the genitalia becomes *necessary* for the establishment of proper psychological and social adjustment.
>
> The size of an enlarged clitoris *demanding* clitorectomy cannot be stated in exact measurements.

> The child with hypertrophy of the clitoris will *require* corrective surgery to achieve an acceptable functional and cosmetic result.

Where does the clitoris get its right to demand reduction? Presumably from nature. If it is an affront to nature, it is understandable why the language used to describe it is so emotional. Unlike the large clitoris, which is too big for its own good, the micropenis is too small for its own good and "demands" to be made into a clitoris. However, although it is widely assumed that men with micropenises are unhappy—and should these men be lucky enough to have female partners, they, too, will be unhappy—there is evidence to the contrary. The physicians' assertion that penises of insufficient length are "inadequate" implies that penises that fall within the measurement range are adequate. Adequacy as a physical measurement rather than an interpersonal negotiation is a neat way of side-stepping a difficult social-psychological determination. (It is probably not irrelevant that the vast majority of genital surgeons are male.)

To summarize, the medical point of view is that large clitorises and small penises are wrong and need to be, in the words of medical management, "corrected." The term "correction" not only has a surgical connotation but a disciplinary one as well. In this, as in all important enterprises, words matter. An intersexed woman chastised me for the title of a paper I wrote, "Creating Good Looking Genitals in the Service of Gender." "Fact is," she said, "they don't create, they destroy."

Who has the power to name? Physicians talk about "medical advancements in surgical correction," but some people subjected to such surgeries refer to them as "genital mutilations." Those opposed to male circumcision contribute to the argument about the power to name genital interventions. They refer to the penis with a foreskin as the penis in its natural, *intact* state and write about circumcision as *amputation*. In their graphic descriptions, they refer to the "*stripping* of the glans" and even "*skinning* the infant penis alive" (my emphases), instead of the benign "snipping" of the foreskin. If, as happens on rare occasion, a male is born without a foreskin, it is noted in his records as a birth defect called aposthia, suggesting that the foreskin should have been there all along. It is a peculiar body part that should have been there only to be removed. Why, too, does the medical profession refer to the natural bonds between the foreskin and the glans of the newborn as "adhesions," since the ordinary meaning of adhesions is "unwanted and unhealthy attachments which often form during the healing process after surgery or injury"? Why do physicians write about "a more natural appearance of a penis without the foreskin," when what they really mean is "nicer looking"?

"Mutilation," a word we usually apply to other cultures, signals a distancing from and denigration of those cultures, and reinforces a sense of cultural superiority. One culture's mutilation is another's ritual. The manner in which intersex management is medically ritualized protects it from claims of mutilation until one moves outside the medical culture and takes a different perspective.

7 Catherine Lord

Subject
Her Baldness Meets Beth and Gets High on Gender

Wednesday/September 27, 2000

In a message dated 9/27/00 CBLORD@UCI.EDU writes to FOCL'SRB:

Subject: Her Baldness Meets Beth and Gets High on Gender

American Airlines, flight 19, JFK to LAX, last Sunday

10:30 a.m., Eastern Standard Time. Her Baldness, upgraded by her gracious and generous and very GIRL (that particular morning) friend from coach to business class and loving her wide window seat with her own blanket and her own pillow says Perrier please while giving the flight attendant her black leather jacket and spilling the Sunday *New York Times*, the real one, the big one, out of a plastic bag, not to mention two thick unillustrated academic books on the history of food, which will of course go unread during the flight, and the latest issue of *Vanity Fair*, which will not.

10:45 a.m. Flight 19 takes off, on time.

11:00 a.m. The flight attendant distributes menus. Pasta involving cream sauce and a lot of cheese, chicken involving a lot of butter, and salad involving a lot of cold beef.

11:15 a.m. The flight attendant, the same flight attendant, a thin white woman in her forties, offers her a choice of drinks. Kim takes club soda with ice and lime. What would you like, sir? the flight attendant inquires of Her Baldness. As Her Baldness has previously encountered gender misidentification, she adopts the pedagogical strategy of nonconfrontation. She manifests enormous indecisiveness about goodies, wavering between mixed nuts and oyster crackers, or both, or neither, or lemon or lime, or ice or not, or flat or sparkling. She settles on club soda, ice, no lime. She is so anxious to give the flight attendant an opportunity to reflect on gender possibilities that she asks for tomato juice in addition to club soda. The flight attendant is amicable, cooperative and patient. Her Baldness congratulates herself on her maturity in using details such as the temperature of a warmed cashew to give the flight attendant an opportunity to reconsider the social construction of gender

Catherine Lord, "Subject: Her Baldness Meets Beth and Gets High on Gender," from *The Summer of Her Baldness: A Cancer Improvisation* (Austin: University of Texas, 2004), 117–123. Copyright © 2004. By permission of the University of Texas Press.

NOTE: In this excerpt from Catherine Lord's photo memoir on cancer, she refers to herself as "Her Baldness."