

The “Normalization” of Intersex Bodies and “Othering” of Intersex Identities in Australia

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Abstract Once described as hermaphrodites and later as intersex people, individuals born with intersex variations are routinely subject to so-called “normalizing” medical interventions, often in childhood. Opposition to such practices has been met by attempts to discredit critics and reasserted clinical authority over the bodies of women and men with “disorders of sex development.” However, claims of clinical consensus have been selectively constructed and applied and lack evidence. Limited transparency and lack of access to justice have helped to perpetuate forced interventions. At the same time, associated with the diffusion of distinct concepts of sex and gender, intersex has been constructed as a third legal sex classification, accompanied by pious hopes and unwarranted expectations of consequences. The existence of intersex has also been instrumentalized for the benefit of other, intersecting, populations. The creation of gender categories associated with intersex bodies has created profound risks: a paradoxically narrowed and normative gender binary, maintenance of medical authority over the bodies of “disordered” females and males, and claims that transgressions of social roles ascribed to a third gender are deceptive. Claims that medicalization saves intersex people from “othering,” or that legal othering saves

intersex people from medicalization, are contradictory and empty rhetoric. In practice, intersex bodies remain “normalized” or eliminated by medicine, while society and the law “others” intersex identities. That is, medicine constructs intersex bodies as either female or male, while law and society construct intersex identities as neither female nor male. Australian attempts at reforms to recognize the rights of intersex people have either failed to adequately comprehend the population affected or lacked implementation. An emerging human rights consensus demands an end to social prejudice, stigma, and forced medical interventions, focusing on the right to bodily integrity and principles of self-determination.

Keywords Intersex · Disorders of sex development · 17-beta hydroxysteroid dehydrogenase 3 · Discrimination · Health policy · Human rights

Introduction

In 2015, the UN Office of the High Commissioner for Human Rights named Australia and Malta as countries that have made demonstrable progress in recognizing the human rights of intersex people. Australia had held the first parliamentary inquiry on involuntary or coerced medical interventions, implemented a federal third gender classification (Attorney General’s Department 2013), and laid claim to “some of the most advanced laws in the world, including on intersex status” (Department of Foreign Affairs and Trade 2017, ¶15). Yet the report of the parliamentary inquiry has not been

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implemented and forced early medical interventions continue with the imprimatur of the Family Court of Australia. Malta had enacted legal protections for children's bodily integrity (*Gender Identity, Gender Expression and Sex Characteristics Act 2015* [Malta]).

The coexistence in Australia of both legal inclusion and surgical "normalization" indicates a disjunction between a rhetoric of inclusion and the reality of human rights violations and, specifically, a lack of connection between policies and practices designed to protect people with non-normative identities and policies and practices affecting people born with non-normative bodies. This paper reviews these developments, citing Australian and international sources. It summarizes a chapter to be published in *The Legal Status of Intersex Persons* by Intersentia in 2018 (Scherpe, Dutta, and Helms 2018).

Background

Since 2006, a medical model has constructed "congenital conditions in which development of chromosomal, gonadal, or anatomical sex is atypical" as "disorders of sex development" (Hughes et al. 2006, 554). This medical model regards intersex variations as physical "malformations" that can be "fixed" to ensure the healthy physical and psychological development of intersex persons as either female or male; to ameliorate stigma and mitigate parental and societal antipathy.

In contrast, a "third sex" model constructs intersex people as people who should be marked as having a non-standard sex. This is succinctly described by Noël Wise, a judge in the California Superior Court, in *Time* magazine in 2017:

Many individuals are born with sex chromosome, endocrine or hormonal irregularities, and their birth certificates are inaccurate because in the United States birth records are not designed to allow doctors to designate an ambiguous sex. (Wise 2017, ¶3)

Both medical and third sex models describe the same population, but both are to some extent ahistorical, reflecting new technologies and social constructions.

In the West, intersex people, "hermaphrodites," have been regarded in early canon (church) and common law as either male or female, depending on predominant characteristics (Greenberg 1999). For example, Edward

Coke, in his 16th century *Institutes of the Laws of England* described heirs as male, female, or hermaphrodites, where a hermaphrodite can be heir either as male or female, "according to that kind of the sexe which doth prevaile" (Greenberg 1999, 277).

In following centuries, the meaning of the term hermaphrodite narrowed to take on a more precise biological meaning, and doctors sought to identify humans with such characteristics and otherwise determine the "true sex" of their patients (Reis 2012). Reis describes how clinicians were preoccupied with ideas of sexual deviance and dishonesty. A nascent medical model was juxtaposed against an abject otherness:

Physicians in the 1880s and 1890s wanted their patients to understand their hermaphroditic conditions as deformities and not as a physical license to commit sexual immorality. (Reis 2012, 68)

An example was provided by J.W. Long, in 1896:

I believe that we owe it to these poor unfortunates to impress upon them, as well as upon others, that they are *not* part man and part woman ... The peculiarities which make them appear mixed, are only deformities like hair-lip or club-foot. (Long 1896, 244)

While diagnostic terms have changed, intersex advocates hear the same comparisons made by clinicians today.

Medical Model

Early surgeries to modify sex characteristics were institutionalized in the mid-twentieth century, in part due to the work of John Money. These interventions, based on ideas that infants' gender identities were malleable (Diamond and Sigmundson 1997), became so pervasive that, by 1969, Dewhurst and Gordon reported that the lives of those not subjected to surgery had to be imagined. They continue to be practiced wherever Western medicine is accessible.

To ensure normative psychological development, medical histories were often withheld from patients with a consequential loss to follow-up and poor-quality evidence supporting medical interventions (Lee et al. 2016). Key decisions about gender assignment were based on technical aspects of surgery and

heteronormative function, including the idea that “you can make a hole but you can’t build a pole” (Hendricks 1993, 10). This approach remains evident in the World Health Organization’s draft International Classification of Diseases 11; for example, gender assignment in children with 17-beta hydroxysteroid dehydrogenase 3 is based on likely outcomes of masculinizing genitoplasty, with early feminizing surgery and gonadectomy otherwise stipulated (World Health Organization 2017).

From the 1990s and early 2000s, early interventions were vigorously challenged, leading to a clinical “consensus” meeting in Chicago in 2005 that, according to Davis, reasserted clinical authority over intersex bodies (Davis 2011). Pressure for the meeting may also have arisen from public reports on Alex MacFarlane, an Australian who may have been the first to receive a non-binary passport and birth certificate (Meyer-Bahlburg et al. 2004).

The invite-only meeting was notable for the omission of clinicians who opposed early interventions and the presence of two community group representatives amongst fifty clinicians. One of them, Barbara Thomas, has remarked that they were marginalized, but their presence has been employed to validate a new nomenclature of “disorders of sex development” agreed at the meeting (for example, O’Connor 2016, 533); this was proposed to distinguish a biological state from “identity” or “the person as a whole” (Thomas 2006, 2). The meeting also promoted referrals to multidisciplinary teams, in order to provide families with specialized, experienced healthcare.

The resulting “consensus” statement outlined the available evidence on cancer risks, albeit frequently based on limited studies and small samples, recommending actions including gonadectomies or monitoring. Regarding cosmetic “normalizing” practices, the statement is notable for use of terms like “felt” and “belief”; necessary given a lack of systemic evidence to underpin clinical practice (Hughes et al. 2006). Rationales for intervention belie aspirations of distinguishing biological states from issues of identity; they include “minimizing family concern and distress, and mitigating the risks of stigmatization and gender-identity confusion of atypical genital appearance” (Houk et al. 2006, 755).

Within the Australian context, the global statement was given effect by a 2010 set of principles. These principles appear designed to direct children’s identity formation and promote family integration. They outline

“psychosocial risks” minimized through medical interventions including “reduced opportunities for marriage” (until recently a heterosexual institution) and “stigma associated with having genitalia which do not match the gender in which the [child] lives” (Gillam, Hewitt, and Warne 2010, 415).

By 2013, these principles had been widely disseminated across Australia and incorporated into derivative Victorian principles and pressure brought to bear on policymakers by intersex and disability advocates led to a Senate inquiry on involuntary or coerced sterilization. A public submission to that inquiry by Hewitt, Warne, and others for the Australasian Paediatric Endocrine Group claimed that “consensus statements ... describe recommended indications for genital and gonadal surgery” (APEG et al. 2013, 2). Despite “particular concern” regarding post-surgical “sexual function and sensation,” the Group justifies interventions for reasons of appearance including:

... for functional reasons [sic] such as to allow a male individual to urinate while standing, and for psychosocial reasons such as to allow the child to develop without the psychosocial stigma or distress which is associated with having genitalia incongruous with the sex of rearing. (APEG et al. 2013, 4)

The resulting Senate report found that “surgery is intended to deconstruct an intersex physiology and, in turn, construct an identity that conforms with stereotypical male and female gender categories” (Senate 2013, 69). It also reported that “there is no medical consensus around the conduct of normalising surgery” (Senate 2013, 68).

A recent 2016 global update to the earlier clinical “consensus” concurs, finding that there is still no “consensual attitude” towards clinical practices, including their “indications, timing, procedure and evaluation of outcome,” nor evidence on “risk of stigmatization” (Lee et al. 2016, 176). Writers for the Committee on Bioethics of the Council of Europe report that:

... “quality of life” studies on patients into adulthood are lacking and are “poorly researched”, (2) the overall impact on the sexual function on children surgically altered is “impaired” and (3) the claim that gender development requires surgery is a “belief” unsubstantiated by data. (Zillén, Garland, and Slokenberga 2017, 43)

Available clinical data lacks adequate sample sizes, independence, and often lacks relevant control groups. It is often framed around clinical preoccupations with, for example, genital appearance, heterosexuality, and gender conformity (Houben et al. 2014, 482). Studies have asked leading questions (Baratz and Feder 2015), while patient views have been cherry-picked. In some reports, patient views may simply reflect a lack of informed consent and unsubstantiated claims. For example, a Chinese study cited by Meyer-Bahlburg (2015) reported that clinicians and their patients favoured early surgeries (Zhang et al. 2013). At the same time, many individuals remain unaware of their medical history and are lost to follow-up, with consequences for their health and sexuality (Kirkland 2017; Lee et al. 2016; Blackwood 2018).

However, policymakers such as a former Australian Capital Territory Chief and Health Minister have unwisely appeared satisfied that “consensus” implies agreement about clinical practices, with national and international consistency (Gallagher 2014a).

Clinical practitioners have “not responded well” to criticism (Zillén et al. 2017, 43). In 1993, Edgerton stated that no individuals “complained of a loss of sensation, even when the entire clitoris had been removed” (Edgerton 1993, 956). Just three years later, complainants were dismissed in *The New York Times* as “zealots” and “the unhappy ones” (Angier 1996, ¶12–13). Similar claims were made by Australian clinicians to the Senate in 2013 (APEG et al. 2013, 4), while attempts have also been made to marginalize intersex advocacy groups as holding isolated, unsupported beliefs (for example, Department of Health and Human Services, Victoria 2016).

Claims of changed or improved medical practices have been made since at least 1987 (Lobe et al. 1987), often expressing a narrative of continuous technical improvement. The effect is to dismiss dissenting testimonial, advocacy, and clinical reports as describing obsolete medical practices. Such claims of change fail to address the more fundamental issue of necessity, but they also lack evidence.

Where statistical evidence exists, it does not support claims of change to clinical practices, including U.K. data (Creighton et al. 2014), German data (Klöppel 2016), and mixed reports from the United States (Human Rights Watch 2017).

Australian data lack transparency. Reports of surgery numbers in specific Victorian (Bock 2013) and New South Wales (O’Connor 2016) hospitals do not fit well

with procedures data published by the Australian Institute of Health and Welfare (2017) or the Department of Health (2014). Overall, Australian procedures data are limited by the scarcity of related diagnostic data and a lack of information on claimed indications, but they do not support claims of clear or systemic change to clinical practices. Recent Australian Family court cases also do not support claims of change to clinical practices.

The 2017 case of *Re: Carla (Medical procedure)* ([2016] FamCA 7 [20 January]) was taken by parents to sterilize their child. Born in 2010, “Carla” was said to have 17-beta hydroxysteroid dehydrogenase 3 deficiency, “a sexual development disorder,” with XY sex chromosomes, testes, and predominantly female genitalia. A Queensland government department appeared as a friend of the court; members of the hospital multidisciplinary team provided affidavits.

Justice Forrest stated Carla could be sterilized by parental consent, justified in part due to potential cancer risk. This was inadequately substantiated. Referencing a “consensus statement,” the judge cited a now-dated “intermediate” risk factor of 28 per cent, claiming it would be “virtually impossible to regularly monitor [testes] for the presence of tumours” (20). However, the “consensus” source (Hughes et al. 2006) advises that clinicians should “monitor” gonads. A 2010 clinical review (Pleskavoca et al. 2010) reduced risk levels to 17 per cent, while a representative of a German multidisciplinary team has stated that, “cancer risk even for the high-risk groups is not so high. We can monitor with ultrasound and for tumour markers” (Amnesty International 2017, 28). The case demonstrates a failed narrative of continuous technical improvement.

Re: Carla is notable for its extensive disclosure of gender stereotypes as rationales for sterilization, including parental descriptions of female gender identity development and reference to the child’s “Barbie bedspread,” “fairy stations,” “Minnie Mouse underwear,” and long blond braids (15). The child was, however, not in a position to freely exercise choice about such accoutrements. The Court explicitly ordered surgery prior to her capacity to understand the procedure (30), itself implicitly acknowledging a lack of urgency, while noting that Carla might need further surgery to facilitate (heterosexual) intercourse (18).

Carla’s sterilization was set in train by an earlier clitorrectomy and labioplasty (16), disturbingly described by the judge as having “enhanced the appearance of her female genitalia” (2).

Children assigned female with this intersex traits are known to later change sex assignment at a rate of between 39–64 percent, according to a clinical review (Cohen-Kettenis 2005). When clitoral and phallus tissues are homologues, it is not possible to unambiguously ascertain the kind of “congenital malformation” that has been ascribed to Carla.

In the 2017 Family Court case *Re: Kaitlin* ([2017] FamCA 83 [22 February]), an adolescent with hypopituitarism required hormone treatment to undergo puberty. Raised as male, “Kaitlin” had always identified as female but began testosterone treatment without her informed consent, resulting in her non-compliance. The case was taken by her parents because judicial approval was necessary for “cross-sex” hormone treatment. The judge described as “fanciful” the idea that court approval might have been required for her testosterone treatment (19) but made no comment on its appropriateness.

Each of these medical interventions may now take place without judicial oversight. The clitorrectomy and labioplasty in *Re: Carla* never required such oversight, and the judge enabled parental authorization of her sterilization. Following a full Family Court judgment in *Re: Kelvin* ([2017] FamCAFC 258 [30 November]), judicial approval for “cross-sex” hormone treatment is no longer required.

Third Sex Model

The Western canon and common law approach to hermaphrodites has broken in the model period. In part, this may reflect the consignment of intersex bodies to the imagination (Dewhurst and Gordon 1969) but it also reflects the imagining and construction of new concepts of gender and of non-binary or third gender. Historical and non-Western anthropological texts have since been reinterpreted, including to demonstrate a perceived superiority in systems that allow for a third gender (Holmes 2004). These include the memoirs of Herculine Barbin, a nineteenth-century intersex woman interpreted by Foucault as illustrating “a happy limbo” of non-identity (Foucault 2013, 17–18), despite a self-understanding as “an *exceptional* female” (Holmes 2004, 6).

Money claimed to first describe gender as identity (Downing, Morland, and Sullivan 2014). Sullivan describes how he presented “gender identity” and “gender

role” as ways of encapsulating sometimes discordant aspects of embodiment into a masculine or feminine whole (Downing, Morland, and Sullivan 2014). This Cartesian separation of bodies and identities enabled Money to understand the identities of intersex people, and it enables feminists and LGBT people to distinguish cultural gender-specific roles and norms from biology.

Gender, and the existence of intersex people, have been utilized to support human rights demands by marginalized populations. However, such claims have often neglected to consider their impact on an intersex population or have displayed pious hopes about such claims. In doing so, they fail to comprehend that whether a society is divided into two or three categories is of less import than how the various groupings are valued (Holmes 2004).

To illustrate the problem, Kondratenko (2016) has claimed:

... countries, like Germany, Malta, Australia and New Zealand, added the third box corresponded to gender on the birth certificates. It gives parents of intersex infants the right to choose the third option: marking the sex category “X” or “other”. By doing so, parents and doctors are not forced to put intersex babies through surgeries that would turn them into male or female. Thus, as intersex children grow up, they have the right to realise their identity by themselves. (§8)

Indeed, some intersex (and non-intersex) people have non-binary or other non-normative gender identities. A 2015 Australian sociological convenience sample of 272 people born with atypical sex characteristics found that 19 per cent favoured “X” or non-binary classifications, yet 60 per cent use the term intersex to describe themselves (Jones 2017).

However, an assumed consequential relationship between non-binary classifications and an end to “normalizing” medical interventions lacks evidence. Third sex models of intersex assume homogeneity in identity and fail to explain how new classifications interact with medical practices. Indeed, new classifications for infants and children have been opposed by intersex-led organizations in Australia and Europe, for adding to pressure promoting medical interventions in order to avoid perceived uncertainty and public disclosure.

Instead, Kondratenko’s analysis (like that of Wise [2017]) homogenizes and naturalizes intersex bodies

as “others,” assuming that a natural and singular identity realized by intersex people is necessarily non-binary. The same broad claims are true of policymakers. Writing on a third classification for birth certificates, the former Chief and Health Minister of the Australian Capital Territory made the same assumption, claiming that a new classification would address parental rights and a “risk that parents will force their child to conform to a particular gender or subject them to gender assignment surgery or other medical procedures to match the child’s physical characteristics to the chosen sex” (Gallagher 2014b). To date, no children have been so classified.

Perhaps due to the framing of such new classifications, the inclusion of “intersex status” in Australian anti-discrimination law, has typically been imputed as a matter of gender recognition (Yoosuf 2015), even though this was not intended or sought by either government or community advocates (House of Representatives 2013; OII Australia 2012). This interpretation has been reinforced by poorly-drafted guidelines on recognition of sex and gender that simultaneously include intersex within the definition of a non-binary category “X” and recognize that intersex people may identify as female, male, or neither (Attorney General’s Department 2013). An NGO consortium requested that “X” be redefined as non-binary in 2015 (Sex and Gender Advisory Group 2015), and recent changes to Australian Standards appear to move towards this position.

Imputations of intersex as a third sex have been deployed to support legal recognition of non-binary persons (DLA Piper Australia 2014). Failing to recognize the distinctiveness and heterogeneity of intersex populations and often medicalizing intersex bodies in the process (Colangelo 2017), such actions paradoxically reinforce ideas that gendered identities need to match sexed bodies in order to be valid.

Misconceptions around intersex as a third sex help to sustain medical authority over “disordered” female or male children by maintaining a boundary between medical jurisdiction over bodies and socio-political influences over classifications of identities. By failing to reflect the heterogeneity of intersex identities and bodies, a coming to knowledge of children and adults with intersex variations, and their families, is interrupted. Instead of facilitating self-determination, associating

intersex with any single legal sex classification constrains that ability.

New risks have been created, including concepts of deception that were reported when hermaphrodites were first medicalized. In the 1979 Family Court case *In the Marriage of C and D (falsely called C)* ([1979] FLC 90–636), the marriage of an intersex man, assigned and raised male and who had undergone medical interventions to reinforce his male characteristics, was annulled on the basis that he was not a man and that his wife was unable to consent as she “was mistaken as to the identity of the husband” (iv). A third identity may have been unavailable at the time, but similar rhetoric surrounding “deviation in sex characteristics” is evident in sport (Jordan-Young, Sonksen, and Karkazis 2014, 1) and in legal cases regarding consent in relationships with transgender people (Gross 2015).

These issues are made more complex not only by a lack of Australian resourcing for affirmative peer and family support and systemic advocacy, substituted by representation by “LGBTI” organizations offering services for queer adult sexual health, HIV prevention, and gender affirmation. This complexity is deepened by individuals promoting a contested, medicalized conception of “transsexualism” as both “intersexual” and a “disorder of sexual development,” in order to relieve stigma arising from a psychological diagnosis and reflecting a perceived ease of access to medical intervention by which intersex children are “fixed” (National Foundation for Australian Women 2016).

A Third Way

Clinical practices are known to result in loss of sexual function and sensation, a need for repeat surgeries, incorrect legal sex assignment, infertility and lifelong need for hormone replacement, genital examinations, loss of bodily integrity, and trauma (Office of the High Commissioner for Human Rights et al. 2016). The naturalization of a third sex promotes pious hopes, while the existence of intersex people is instrumentalized for the benefit of other, overlapping, populations. These reinforce associations between being intersex and being LGBT, yet these forms of biological essentialism also underpin forced medical interventions and create risks associated with claims of deception.

These circumstances create a complex, challenging environment. In response, the intersex rights movement

has steadily turned towards the human rights system and in particular principles recognizing rights to bodily integrity and self-determination. Informed by testimonies and international and local community statements (Third International Intersex Forum 2013; AISSGA et al. 2017), human rights institutions are acknowledging the physical and psychological harm caused by unnecessary deferrable medical interventions on children with intersex variations (Office of the High Commissioner for Human Rights et al. 2016) and recognizing the heterogeneity of intersex populations (Office of the High Commissioner for Human Rights 2015). A new legal framework around “sex characteristics” is emerging (Yogyakarta Principles 2017) associated with new, non-stigmatizing definitions of intersex (Office of the High Commissioner for Human Rights et al. 2016; Office of the High Commissioner for Human Rights 2015).

Conclusions

Medicine constructs intersex bodies as either female or male, while law and society construct intersex as neither female nor male. This conflict arises from fundamentally different ideas about the meaning of intersex variations and how to name them, even while there is agreement about their fundamental characteristics. In response to this complex situation, an emerging advocacy and human rights consensus focuses on simple core demands, for self-determination and the right to bodily integrity, demanding an end to forced and coercive medical interventions, social prejudice, and stigma.

Actions to recognize the rights of intersex people in law should address the core human rights issues and refrain from exacerbating contradictory demands. Examples of good practice include implementation of protections from violence, harmful practices, and discrimination on grounds of sex characteristics and of universally available non-binary sex markers.

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