

# The History of Intersexuality: The Emergence and Control of Intersexuality in Medical Discourse

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## **Abstract**

Many writers have looked upon instances of intersexual births as problems for the binary model that they have identified in western understanding of sex and gender. This paper challenges that interpretation of intersexuality, recognising the place of the concept in an exclusivist taxonomy contrived by those medical professionals that inaugurated the term “intersexual”. The birth of the treatment of “intersexuality” was a culmination of a century long conceptual movement that eradicated the “true hermaphrodites” of the pre-medical era and interpreted such anatomies as ambiguous problems to be solved and corrected with infant surgical intervention. This paper will trace the emergence of the concept of intersexuality and the usurpation of human double-sexed hermaphroditic biology and suggest that the political agendas of those aforementioned writers would be best realised by revival of the possibility of the “true hermaphrodite” and a subsequent objection to the normalising surgery of paediatricians of intersexuality.

**Keywords:** Intersexuality, medical discourse, gender.

## Essay

Do we *truly* need a *true* sex? With a persistence that borders on stubbornness, modern Western societies have answered in the affirmative. They have obstinately brought into play this question of a “true sex” in an order of things where one might have imagined that all that counted was the reality of the body. (Foucault 1980, vii)

The status of being intersexed that I refer to as “intersexuality”<sup>1</sup> is described by the Intersex Society of North America (ISNA) as ‘a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of female or male’ (see ‘What is intersex?’, The ISNA webpage). Intersexuality has by some writers been seen as ‘quite literally queer or “culturally unintelligible”’ (Preves 2002, 523) and thus intersexual individuals heralded as ‘exceptions in a world where most people are “biologically normal”’ (Kessler 1985, 23). The aim of this paper is to trace the emergence of intersexuality in Western medical discourse and investigate how, under the scrutiny of ‘medical men of the nineteenth century’ (Dreger 1998, 54), it was used not as a term that transgressed the categories of the medical profession, but in control of those hermaphroditic physiologies that had preceded intersexuality in the form of ‘the human monster’ (Foucault 1997, 51). I argue that the revival of the possibility of “true hermaphroditism”, by means of objecting to normalising surgery, would be a more appropriate way of subverting ‘a binary notion of gender’ (Hird and Germon 2001, 172) riters such as Sharon Preves have seen the existence of intersexuality as problematic for the ‘overarching and largely unexamined social expectation that all humans belong to one of two clearly delineated sex categories, female or male’ (Preves 2002, 523). In the discourse prevalent not only in medical treatment of intersexuality but broader cultural perspectives of “sexual ambiguity”, commentators have perceived ‘a binary notion of gender’ that is said to be ‘*the* necessary code’ (Hird and Germon 2001, 172). It is thought that the intersexual body, in being ‘sexually ambiguous’, challenges ‘prevailing understandings of sex’ as a mutually exclusive binary (Preves 2002, 523). To highlight

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<sup>1</sup> The term “intersexuality” is used by few authors on the subject of intersexed bodies, presumably in an attempt to avoid confusing biological sex with sexual orientation. I should make it clear that my use of the term does not intend to imply a necessary connection between the physiology of intersex people and their sexual orientation.

the naivety of such attitudes towards intersexuality and what its ramifications are for the sexual status quo, I wish to expose the origins of the term “intersex” as it is understood in the literature of gender theory and medicine.

The source of the term “intersex” is difficult to determine; whilst Hird and Germon trace it to 1920 (Hird and Germon 2001, 175 n.1), Alice Dreger (Dreger 1998, 31) writes that ‘Richard Goldschmidt was the first biomedical researcher to use the term “intersexuality” in his 1917 paper ‘Intersexuality and the endocrine Aspect of Sex’, and was responsible for initiating the growth of the term’s usage in the biomedical profession. However, antecedent to the study of ‘sexual ambiguities’ (Dreger 1998, 31) is a history of medical expertise that stretches far beyond intersexuality into the documentation of hermaphroditism. According to Foucault, hermaphrodites ‘who occasioned...problems in the seventeenth and eighteenth centuries’ were preceded by the ‘half human, half-animal being’ of the Middle Ages and the ‘double individualities’ of the Renaissance (Foucault 1997, 51). During these pre-medical eras the anatomically ambiguous individual was instead conceived vis-a-vis a hermaphroditic duality that originated nearly two millennia before its incorporation into the broader “intersex”. This “double individuality” can be traced to Ovid’s *Metamorphoses* when Hermaphroditus, who ‘in his face showed father and mother and took his name from both’ (Ovid 1998, 83), was bound inseparably to the lustful Salmacis:

...both bodies merged

In one, both blended in one form and face. (*Ibid.* 85)

Hermaphroditus is a figure of perfect coalescence of both the male and female form, given the name that incorporates both father (Hermes) and mother (Aphrodite) who were ‘themselves “the embodiments of ideal manhood and womanhood”’ and thus fixing in ‘the Western imagination the long-standing image of the hermaphrodite as a tragicomic, double-sexed creature’ (Dreger 1998, 31). The duality of Hermaphroditus is echoed in the writings of, for example, John of Salisbury, who used the metaphor of the hermaphrodite to refer to the ‘double-natured position of a court philosopher’ and his ‘contradictory (hence “hermaphroditic”) loyalties’ (*Ibid.* 32). Whilst it must be noted, to avoid romanticising pre-medical perspectives on hermaphroditism, that antiquity and the

Middle Ages held little sympathy for such “half humans” who ‘were often put to death’ (Epstein 1990, 107), the consistent attitude towards this precursor to the intersexual was a perception not of an ambiguous or problematic anatomy, but of the physiology of both man and woman ‘blended in one form and face’ (Ovid 1998, 85). Such an anatomy would constitute, if the phenomenon were to be understood as such in contemporary gender theory, a ‘cultural unintelligibility’ (Preves 2002, 523) that would transgress the mutually exclusive boundaries of the insistent ‘binary notion of gender’ (Hird and Germon 2001, 172) that the aforementioned writers have identified. The belief that the human body belongs to ‘one of two clearly delineated sex categories’ would be subversively contradicted by any notion of a human body possessing both male and female anatomy (Preves 2002, 523).

This possibility of hermaphroditic duality began to dissipate with the introduction of ‘gender assignment...based on the physician’s expert declaration of the individual’s *true sex*’ (Hird and Germon 2001, 163. Italics in original). The 1830s witnessed Isidore Geoffroy Saint-Hilaire’s introduction of teratology (defined by *The American Heritage Steadman’s Medical Dictionary* as ‘the biological study of malformations and monstrosities’), a discipline that incorporated anomalous anatomies not as hermaphroditic “double individualities” but as ‘variations from normal development’ (Dreger 1998, 34). Problems for teratology emerged thereafter in the identification of which “normal” sex the hermaphroditic patient had “deviated” from. To use Susan Kessler’s analogy, if ‘it is a fact that someone is a man or woman, just as it is a fact that the result of a coin toss is either heads or tails’ then teratology was based on that observation that ‘the coin may be worn and we may have to inspect it very closely’ (Kessler 1985, 1). One should note, however, that the new indeterminacy of hermaphroditism was not due to the wearing down of a historically existing coin; it came with the invention of that mutually exclusive binary which engendered the ambiguity of the anatomy of those “human monsters” whose identity had previously been unproblematic (see, for example, Dreger 1998, 55: ‘the posthumously famed Italian hermaphrodite Maria Arsano spent her eighty-year life as a woman, never having been suspected of being otherwise’).

The ostensible problem of identifying “true” sex was thought to be solved by the concurrent system of James Young Simpson, whose fundamental demarcation consisted of the bifurcation of hermaphroditism into the ‘spurious and true’:

The spurious comprehending such malformations of the genital organs of one sex as make these organs *approximate in appearance* and form to those of the opposite sexual type...true hermaphroditism including under it all cases in which there is an *actual mixture or blending together*...[of] both the male and female organs (Simpson in Dreger 1998, 143. Italics in original)

The increased specification of the criteria for “true hermaphroditism” was thenceforth to be the model for theorising what was now seen as genital *ambiguity*. Moreover, identification of “true hermaphroditism” enabled the search for those “spurious” individuals who masqueraded as hermaphroditic and concealed their “true” status as male or female. Thus the medical profession at the end of the nineteenth century, continuing Simpson’s paradigmatic taxonomy, created a tripartite classification scheme using the labels of Lawson Tait’s *Disease in Women*: true hermaphrodite, male pseudo-hermaphrodite and female pseudo-hermaphrodite (Tait 1879).

It was at this point that the eradication of the hermaphrodite began. The dual aspect of hermaphroditism, evident in its understanding before the “medical men”, was reinterpreted in the mid nineteenth century as ‘a would-be male or female [i.e. pseudo-hermaphrodite] gone wrong in the womb’ (Dreger 1998, 34). This was followed by late Victorian taxonomy that allowed the likes of Blacker and Lawrence (1896) to ‘clean the historical record of any alleged cases of true hermaphroditism’ (Dreger 1998, 146), rereading the history of “double individuality” as, mostly, a case of mistaken identity. Their work also insisted that new gonadal and histological (tissue-based) criteria for sex identity meant ‘the necessity of a *microscopical examination*’ (Blacker and Lawrence in Dreger 1998, 147. Italics in original), an amplification of the technicality of anatomical classification handing the authority over individual sex to the “expert”. Why was it felt necessary to eliminate the hermaphrodite and “reveal” the “true” sex of the individual? Dreger suggests that ‘it cannot be a coincidence that at the same time other historians find the emergence of the homosexual, I find the virtual extinction of the hermaphrodite’ (Dreger 1998, 153) whilst Epstein

reminds us of the Victorian ‘centrally organising concern to bar same sex alliance’ (Epstein 1990, 101). The implication is the influence of homophobia on a classification system that fathered contemporary biomedical theories of intersexuality.

Progression of the pathologisation of hermaphroditism followed from this point for almost a hundred years through the repeated introduction and subsequent usurpation of new biomedical scientific paradigms, each with their own increasingly specified measure of “true hermaphroditism”. In 1911, Samuel Pozzi’s refined nomenclature announced that ‘even so-called true hermaphrodites with ovotestes [the gonadal measure of true hermaphroditism] were not really true hermaphrodites’ in virtue of the fact that ‘only the ovarian portion of the ovotestes functioned’ (Dreger 1998, 155). Three years later, David Berry Hart insisted that the term “hermaphrodite” be removed from medical lexicon (Hart 1914) and another three years later Richard Goldschmidt made, according to Dreger, the first use of the term “intersexual” (Dreger 1998, 31).

Thus the emergence of the intersexual was not the appearance of bodies that ‘do not conform...to one of two clearly delineated sex categories’ (Preves 2002, 523). Nor is it true that ‘intersexuals have been erased historically by the enforced *choice* of one gender or the other’ (Hird and Germon 2001, 164). Quite the contrary; in their failure to recognise the historical distinction between the pre-medical hermaphrodite and the intersexual (a term incorporating and perpetuating that Victorian tripartite taxonomy of “anatomical ambiguity”) writers such as Hird and Germon confuse a classification system introduced to eradicate the nonconformist body of the hermaphrodite with that nonconformist anatomy. Intersexuality, rather than exemplifying a transgressing physiology, was a result of the final elimination of the possibility of transgressing hermaphroditic biology.

The completion of the transition from the hermaphrodite to the intersexual was followed in the twentieth century by treatment of intersexuality based primarily on the work of John Money. Money’s theory, first co-authored in 1955 (Money, Hampson and Hampson 1955) and developed in 1972 with the help of Anke A.Ehrhardt, (Money and Ehrhardt 1972) maintained that ‘gender identity is changeable until approximately eighteen months of age’ and thus recommended that ‘the genitals must be made to match the assigned gender as soon as possible’ after birth (Kessler 1990, 6-

7). As a consequence of this development, anatomical ambiguity moved to the realm of paediatrics, where it remains today. The British Association of Paediatric Surgeons, for instance, produced a paper in 2001 on the 'Surgical Management of Children Born with Ambiguous Genitalia' stating that 'standard protocols have stressed the need for early diagnosis, gender assignment and appropriate surgery in infancy' (Rangecroft, Laurence et al. 2001). The ISNA now refer to intersex not as the status of an individual but as 'a variety of conditions in which a person is *born* with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male' ('What is intersex?', ISNA webpage, italics added). Intersexuality in the twenty-first century is used as an umbrella term that incorporates a variety of 'disorders of sex differentiation' (Fugita and Denes 2001, 635) that the "medical men" of today agree must be rectified during infancy. These include Androgen Insensitivity Syndrome (AIS), Congenital Adrenal Hyperplasia (CAH) and Klinefelter's syndrome.

Still prevalent in biomedical practice, however, is the identification of male and female pseudo-hermaphroditism, now described by the online General Practice notebook as 'the situation in which an individual has ["true"] male chromosomal and gonadal gender but with *apparently* female external genitalia' ('Male pseudohermaphroditism', General Practice Notebook webpage, italics added) or 'there is ["true"] female chromosomal and gonadal gender associated with *apparently* male external genitalia' (*Ibid.* 'Female pseudohermaphroditism', italics added). The Victorian insistence in identifying the "true" sex pervades the polysemy of intersexuality; CAH, for example, is said to have a 'particularly strong influence in "masculinising" ["true"] females' whilst Klinefelter's syndrome is described as 'a congenital condition...[which] arises when the standard 46XY chromosome pattern of a *male* human is interrupted' (Stretton-Cox 2004. Italics added). Androgen Insensitivity Syndrome is said to occur when 'a person who is genetically male (has one X and one Y chromosome) is resistant to male hormones called androgens' (Hurd 2006), the hormones responsible for the development of male physicality. Consequently the AIS individual develops 'some or all of the physical characteristics of a woman, *despite* having the genetic makeup of a man' and the "true" male foetus undergoes "abnormal" growth into an adult who 'appears to be female'

(*Ibid.* italics added). Thus the ostensibly archaic “male or female gone wrong” view of the Victorian embryologists is not as outdated as intersexuality support groups have hoped it would become.

The multifarious means of diagnosis in twentieth century treatment of intersexuality have led to a state of affairs wherein intersex infants now draw the attention of not just one area of expertise but a variety of biomedical professionals utilising techniques in ultrasound, karyotyping (chromosome analysis), biopsy of reproductive tissue and blood tests so that ‘a correct diagnosis and determination of sex can be made’ (Turkington 2002). However, the medical profession continues to employ new ways of uncovering the truth of the individual’s sex. Developments in neurology, as Anne Fausto-Sterling observed, meant that ‘in the late twentieth century, many biologists have shifted their attention to the brain’ so that ‘the brain then gets to define the man or woman’ (Fausto-Sterling 1992, 224). Appearing on the BBC Horizons program ‘Is it a Boy or a Girl?’, Professor Richard Swaab claimed to have discovered a ‘sexually dimorphic nucleus’ and concluded from this ‘that our [“true”?] sex difference is present already very early in developments’ (‘The Boy Who Turned into a Girl’ 2000).

Neurologists share authority with, among other disciplines, genetics, the realm of sexual biology on which Germaine Greer bases her erroneous understanding of intersexed persons. If ever an explicit case of the dangerous influence of the “true sex gone wrong” ideology were needed, one should look no further than Greer’s offensive comments about AIS in *The Whole Woman*, to which the AISSG (Androgen Insensitivity Syndrome Support Group) took marked exception<sup>2</sup> Greer’s insistence on the exclusive “truth” of the ‘XX female’ lead to the following comment, referring to the case of an AIS individual:

...she was not a woman but a failed male who may pass for a female and even marry her long-term boyfriend because she was wrongly identified at birth as a female. AIS 'females' have no female organs and not a female cell in their bodies. (Greer 2000, 88)

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<sup>2</sup> Details of the objections can be found in ‘Debates/discussions’ at the AISSG website.



Articulating the ideology behind a medical practice that sees AIS as an abnormal foetal development, Greer's misguided interpretation of the AIS individual as 'a failed male' exposes the philosophy behind intersexuality as an exclusivity of sexual categories that verges on the criminally discriminatory.

The ISNA is very explicit in its aims, recommendations and agenda. Amongst these, they insist that 'parental distress should not be treated with "normalising" surgery on children' ('What does ISNA recommend for children with intersex?', ISNA webpage). Supporting this principle and following from the preceding discussion of the origins of intersexuality and its modern medical treatment, I argue that those individuals who share the experience of being 'born with an anatomy that someone decided is not standard for male or female' (ISNA homepage) undergo a processing of the body whereby the determination of their "true" sex is based on a medico-scientific tradition that began when the "hermaphrodite", with the very real possibility of "double individuality", was usurped by an ever-narrowing definition and increasing impossibility of the "true hermaphrodite". The "true hermaphrodite" is nowadays said to account 'for fewer than five per cent of all cases of ambiguous genitalia' (Kessler 1990, 5). Thus ninety-five percent of intersex births have their "true" sex determined by the experts and their pseudo-hermaphroditism revealed. The vast numbers of infants undergoing John Money's recommended corrective surgery (according to David Hester one in every thousand births (2004, 217)) are thus the culmination of a history of medicine that has aimed to diminish the number and ultimately eliminate the existence of bodies that display the possibility of more than one sexuality.

The frequency of infants diagnosed with intersex conditions does not, as Hester and others have argued, produce 'awareness of the multiplicity of factors that results in a plurality of sex categories' (Hester 2004, 215), but instead illuminates the efficiency with which the modern medico-scientific diagnosis of intersexuality has "revealed" the "true" sex hidden by anatomical "ambiguity". The development has allowed those "medical men" that owe their origins to the illiberal impositions of eighteenth century teratology to "correct" the "congenital disorders" of an ever-increasing percentage of *pseudo*-hermaphrodites captured under the pathology of intersexuality.

If this paper indicates the existence of any historical factor that can upset the mutual exclusivity of the “binary notion of gender”, it is the duality of the pre-medical hermaphrodite and its unproblematic subsistence before its reduction to “true” gender and its subsequent “correction” at the hands of the paediatric surgeon. Rather than appealing to the existence of the problematic *intersexual* body, which can be subsumed into the pathologisation of “ambiguous anatomy”, I believe that dismantling the mutually exclusive binary framework of sexual identity and freeing up anatomical possibilities lies in supporting intersexual support groups’ demands for the termination of a medical practice whose knife intervenes in infancy. On a theoretical level, this requires an emphasis on the revival of the possibility of biological duality in the “uncorrected” *true* hermaphroditic body as it was conceived before its pathologisation.

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