Intersex Australians and their relationships and identities

by

Stephen Craig Kerry PhD.

Freelance Researcher

sckerry@lycos.com
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Abstract

This paper presents the findings of a PhD which is the first to specifically target intersex Australians and their relationships and identities. When Intersex Australians have drawn the attention of study it is often through the medical gaze. This paper views this population through a sociological lens. A large portion of the current state of affairs of Australian intersex can be attributed to effects of cultural globalisation. As a respondent in the study stated; in Australia there is the perception of a U.S. style intersex. This conflation of local and international socio-political and legal matrices of intersex is in no small way attributed to the success of the Intersex Society of North American and accessibility to the Internet. While this paper falls short of suggesting there is a distinctive ‘Australian style intersex’ it is the intention of this paper to present for the first time in a public forum the key narratives as shared by the intersex Australians in this study. It offers up voices that are rarely heard in the discipline of Sociology and introduces intersex Australians’ views on their relationships and their identities.
Intersex Australians and their relationships and identities

Are you a boy or a girl? At our birth it is the medical gaze that determines the answer. It is the looking at our genitals that will guide all future relationships and identities. For approximately 1% of the population it is the indecision brought about in no small way by the ‘ambiguity’ of genitals that can problematise all subsequent relationships and identities. This paper introduces, some for the first time, Intersex Australians’ view of their relationships and identities through the lens of their intersex status. In addition this paper will discuss how Australia has been at the centre of some significant changes to the public perception of intersex, for example the 2000 Sydney Olympics did away with four decades of invasive sex testing of female athletes and the inclusion in the national passport system of a third ‘sex’ option. Firstly, it is important to recap some of the more relevant issues pertinent to the current medical management protocols, the nascent intersex movement, and some of the reasons why intersex is ignored outside the medical profession.

Intersex 101

Historically referred to as hermaphroditism the contemporary term ‘intersex’ has emerged in the past decades to stand in as an umbrella term for a range of physical configurations that blur the hitherto impassable gulf that separates male and female, men and women. The five more common variations include: Androgen Insensitivity Syndrome (AIS), Congenital Adrenal Hyperplasia (CAH), Klinefelters Syndrome (KS),
Turners Syndrome (TS) and 5 Alpha-Reductase Deficiency (5ARD). While not all intersex ‘conditions’ have at-birth genital ambiguity as an identifiable marker it is this situation that has provoked the greatest interest and reaction from the modern medical profession. When confronted with a situation where a child’s sex is not ‘obvious’ the medical gaze falls back on a decades-old paradigm of investigating, diagnosing and surgically assigning a ‘true’ sex. This surgical assignment is based on John Money’s Gender Role Theory and the John/Joan case. When a boy had had his penis burned off during a circumcision procedure Money advised the parents that ‘John’ could be successfully raised as a girl if the genitals were surgically altered to mirror that gender identity. Henceforth known as ‘Joan’ the child was raised as a girl, and apparently to the outside world this re-assignment of ‘John’ as ‘Joan’ was a success. Money’s theory argued that prior to a “gender identity gate” (Colapinto 2000: 51) of two and a half years any child could be successfully raised as either a boy or a girl providing that their genitals and subsequent socialisation reinforced the assignment. However, in 1997 David Reimer aka ‘John’ was convinced to go public and counter John Money’s repeated claims that his re-assignment as a girl had been a success.

Despite the fact that the John/Joan case was obviously not a successful example of the theory John Money maintained that it was. Moreover, to this day surgeries on infants born with ambiguous genitals are being performed based on it with little to no follow-up studies. Like many other parts of the western world Australia has been at the forefront of a movement of vocal intersex individuals challenging these medical protocols. The challenge is on several fronts. Firstly, the surgeries are invasive and physically damaging,
secondly surgical assignment is not always correct, and thirdly, the medical profession insists that intersex individuals (and their families) should not be told the truth about their intersex status, because this ‘truth’ would cause psycho-social trauma.

Surgeries on infants with ambiguous genitals often occur prior to the ‘gender identity gate’. These surgeries often result in scarring, tissue sloughing and/or life-long sensation loss or pain. Vaginoplasties (surgeries to construct a vagina) must be accompanied by life-long medical check-ups and use of dilators. Phalloplasties (surgeries on the phallus) often are to ‘repair’ hypospadias; that is where the urethra opens along the shaft of the phallus. These surgeries result in heavy scarring, loss of sensation and complete failures result in urine passing through holes anywhere along the phallus. Due to the difficulty in phalloplasties 90% of infants with ambiguous genitals are assigned female (Hendricks cited in Chase 1998b: 210; Newman 1991 cited in Holmes 2002: 169; Creighton and Minto 2001: 1265; Preves 2003: 56). According to one oft-quoted physician: “you can make a hole but you can’t build a pole” (Chase 1998a: 192; Holmes 2002: 169; Preves 2003: 56).

In addition to the surgical viability of the tissue the assignment to female stems from certain expectations placed on the phallus as a penis. Will the child be able to urinate in the standing position? Can the phallus penetrate an average-sized vagina? Is it sufficient to compete in the locker-room? (Fausto-Sterling 2000; Kessler 1998). As has been pointed out in the literature these are social considerations not medical ones (Fausto-Sterling 2000: 58; Crouch 1999: 32; Groveman 1999: 35; Kessler 1998: 12). This
seemingly arbitrary assignment of sex and gender based on social expectations ignores
the individuals’ own views, desires or sense of self. One of the most vocal views
expressed by adult intersexed individuals is the fact that their gender assignment was
wrong. While not all intersex individuals express this view the intersex movement
suggests that it certainly adds weight to the argument that John Money’s Gender Role
Theory is not working. Moreover, for those who transition as adults they face the reality
that the genital surgeries they had as infants is irreversible.

Many adults may not know about their intersex status. At the centre of the Gender Role
Theory is the insistence that for a child to be successfully raised as a boy or a girl there
must be no indication that their gender is anything but that which it is assigned. Those in
their immediate social sphere are told to encourage gender-appropriate play and at no
time is the child (or adult) to be told of their genital ambiguity or surgical history. To do
so would cause psycho-social trauma. This has lead to what the Intersex Society of North
America (ISNA) has dubbed a “conspiracy of silence” (ISNA 2002) and intersex activist
Sherri A. Groveman calls a “paradigm of deceit” (1999: 27). Ironically it is the surgical
procedures and institutionalisation of lies that has led to psycho-social trauma and it is
this trauma that has drawn intersex individuals out of their closets over the past two
decades. They have coalesced into a movement that offers peer support and challenges
the medical management of their intersex status.
Australian Intersex and their relationships and identities

In conducting interviews with eight (8) Intersex Australians it was clear that no one theme or quote could capture the breadth of their lived experiences. The participants lived in a range of familial relationships and came from various demographic backgrounds and they possessed different intersex statuses and life histories (Table 1). Several findings are of note, however not all of these issues are central to the premise of this paper. For example intersex Australians turned to religiosity as a means of coping with the psycho-social trauma and understanding the intersex status itself (Author forthcoming). Presently, emphasis is placed on familial and sexual relationships and gender and sexual identities.

Table 1 Here

Familial Relationships

Intersex individuals do not live in a social vacuum. For a child to be successfully raised as male or female it is expected that those in their familial surroundings will support the assignment through gender-appropriate reinforcements. It is not uncommon therefore for people in the family, notably the parents, to participate in the ‘conspiracy of silence’ and ‘paradigm of deceit’ and thereby destroyed or seriously hindered the parent-child relationship. Chris’ relationship with their mother has been “irreparably damaged” by the events surrounding their intersex status. Jamie was estranged from their family for seven years, a separation that appears to have been recently ended. Yet, to suggest that parents and familial members were willing participants omits some comments given by intersex
Australians. Kerry for example suggests that their mother “feels guilt” over the fact that Kerry was born that way, such that this ‘guilt’ remains a barrier to their relationship and has prevented them from discussing Kerry’s intersex status. Contrary to this view some intersex individuals appeared to have an open, rewarding and successful relationship with their parents, family members and sexual partners. As the youngest of those interviewed Leigh has benefited from recent openness in the management of intersex and subsequently has had a life-long history of being informed and supported by their parents: “My mother was very open and told me from the start everything she could”.

Open discussion with members of the family does help the bond. As adults both Chris and Pat have siblings who are understanding and supportive of their intersex status. According to Pat open disclosure has gone some way to explain hitherto inexplicable idiosyncrasies. Moreover, as adults intersex Australians have been able to form sexual and intimate relationships without either partners’ sexuality being brought into question. As Leigh remarks “My partner is extremely supportive, and amazingly understanding. She is open and curious about it, and very accepting”. The fact that Lou and their partner would have to adopt appeared to have been easily negotiated in their relationship. Jamie sees their relationship as being “one of the fortunate ones” indicative of the fact that not everyone finds a partner who they can discuss their intersex status with. But within this sample the stories appear to be one of open discussion and certainly not had a traumatic affect on sexual or intimate relationships, contrary to what the medical protocols insist.
Gender and sexual identities

The intersex movement suggests that surgery on ambiguous genitals should be postponed until the intersex individual can give informed consent. Criticism from within the medical profession is that the intersex movement is using these children as “radical gender experiments” (Holmes 2002: 160). However, the intersex movement clearly states in its aims that the children should be raised with a gender, but this gender identity does not need to be surgically reinforced. The fact that intersex individuals are expressing dissatisfaction with their gender assignment supports this. As Chris says

‘Coming out’ as a person with an intersex condition and then reaffirming my true self by changing to live as a male made life difficult … but it was a challenge I took on and feel I have been fairly successful

Having lived with a female body all their lives Chris’ incongruence between male gender identity and female physical configuration does not appear to have a significant effect on their new sense of self: “I live as a man in all aspects of my life, albeit with breasts and atypical genitalia”. Moreover, Chris states that “I’ve changed a lot over the years, but my sense of self has been fairly constant”. The incongruity between having a female body and a male identity is not uncommon. Devor (1997) argues that transmen are capable of living successfully as men without penises. Conversely Kerry’s intersex status has interrupted their sense of self. While reporting feeling definitely male most of the time,
“experiencing erectile dysfunction … plus having a different penis which does not look normal impacts on my feelings of maleness”.

Leigh’s somewhat overemphasised gender draws attention to a need to reinforce a sense of gendered self: “100% Prime time lean good looking healthy MALE!” Or for Lou as a ‘natural’ expression of their sense of gendered self: “Mentally I’m female. One knows this early on - 2 years old? It is in your head and not in physical sex characteristics that one knows this”. However, for others - as with Chris’ incongruence above – who saw their gendered behaviour as outside of the norm for their gender identity it did not let it impede their identity: “I was a tomboy as a child, but never thought I was male. Even though I had XY chromosomes”. Others were able to reconcile their gender with other counter-normative gendered terms and identities. Gender identities are not always binary. For example Pat explained that their self-identity is currently located as “intersex male variant”, yet adds that while “primarily male” they recognise “aspects which extend beyond the classification of male. I don’t identify as female even though I recognise that I possess feelings, emotional reactions and thought patterns often associated with women”. Some were able to reconcile their gendered behaviour in terms of contemporary fluid notions of masculinity. Terry says “I’m not inclined toward strong masculinity identities … I guess I’m a New Age Sensitive type” and Kerry also says “I look male and act male, I have stereotypical male behaviours but with a sensitive side”. But a gender identity as something to question or think about was not easy.
Tony Briffa, one of the key figures in the largest Australian organisation (AISSG Australia), clearly suggests that gender issues are not a central concern for intersex people (Briffa 2003). This is supported by some intersex individuals who are uncomfortable about discussing it. Jamie for one clearly attributes a history of shame associated with their intersex status:

> I generally do not discuss this with people. At times I find it difficult and emotional to express myself. Unfortunately I have had a lot of negative conditioning in learning to accept and cope with who I am. At times it creeps back in and my emotional walls come back up again.

Fausto-Sterling suggests that a motivating force behind the medical management protocols is to prevent the creation of queers (2000: 72). As some of these narratives indicate intersex Australians are able to see themselves in blurred gendered identities, however, this doesn’t always translate into counter-normative sexualities. For example, Jamie, Leigh, Lou and Terry define their sexual orientation as “heterosexual”. Yet intersex people do identify with queer terms, Kerry describes their sexual orientation as “gay … despite my hypospadias”. On the other hand there is less quantifiable evidence. That is to say, not everyone expressed their sexual identities in recognisable terms or in either/or ways. For some coming to terms with a concrete sexuality was hindered by confusion generated by the delineation between desire and assigned sex. Chris refers to being “attracted to nice people, with a preference for women”. And Pat says
I do not possess a sexual orientation – I don’t have a sex drive, sexual awareness, nor have had much experience with sexual interaction. Attracted to males, but not sexually - not interested or inclined to express visual attraction via sexual contact. Able to establish non-sexual intimate relationships with males, more so than with females. Best described as being asexual.

Pat elaborated on the conflux between intersex status and sexuality

I was labelled as being homosexual in my late teens. Tried to accept this label, but was very unsuccessful as I did not receive satisfaction or enjoyment from sexual contact with males (or females for that matter). Experienced severe trauma when I realised that I was neither straight, gay, bi - did not have the knowledge or awareness at this time that there were alternatives. On discovering my intersex state and discussing sexual orientation/identity with other intersexed people discovered that a non-sexual identity was just as real and as valid as a sexual identity. So now I choose to identify as not having a sexual identity

While there is evidence intersex people are identifying with normative terms, others see sexual identity as fluid and problematised by their intersex status.

Intersex in Australia
Pat suggests that there is the perception by intersex Australians of a U.S. style intersex. Cultural globalisation appears to have had an impact on the intersex community whereby there is a conflation of international (i.e. U.S.) and local intersex issues. While there is little evidence to suggest that there is a distinct Australian intersex situation in the past decade Australia has been at the forefront of two major changes that add to the evidence that the medical profession is employing a more open attitude toward intersex as Leigh’s experiences demonstrate. Since the Mexico City Olympics in 1968 a Buccal Smear test was performed on female athletes to determine that genetically these females had two X-chromosomes (Author Unknown 1996; Lehrman 1999). In 1992 the test was modified using the polymerase chain reaction to SRY, that codes for male determination (Author Unknown 1996). These ‘sex tests’ were abolished at the 2000 Sydney Olympics. This is significant because AIS women may possess XY chromosomes and thereby fail the ‘sex test’ yet they have no biological advantage over XX women.

Another significant contribution made by Australia is in the Passport system. Australian intersex activist Alex MacFarlane is believed to be the first in the world to have a passport that acknowledges an intersex or intermediate identity as opposed to a male or female identity. In 2002 MacFarlane challenged the Australian Department of Foreign Affairs’ policy of having only an M or an F box. They argued that choosing either box would be lying “I should not have to commit fraud due to departmental production inadequacies” (MacFarlane cited in Butler 2003: 8). The Department initially refused because it stated that its computers could only deal with two choices. However,
MacFarlane persisted and after several months of correspondence and an enquiry from the media they relented, thereby added the option of an X.

This albeit brief introduction to the Australian intersex situation demonstrates that Australia has played and will continue to play a key role in the way that the global intersex movement makes changes to the dominant perception of intersex as something to be diagnosed and surgically silenced. The voices heard in this paper join a chorus of international intersex individuals who challenge the medical view that intersex leads to psycho-social trauma, these stories clearly indicate that open discussion about intersex enables these individuals a space to heal wounds inflicted on bodies and also social relationships and identities.
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Table 1 Interviewees' Demographic Information

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1 Participants’ names are pseudonyms