INTRODUCTION: LESSONS FROM THE OCTOPUS

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The paternalistic surgery-centered model of intersex treatment has been incisively critiqued in recent years. Feminist and antihomophobic analyses have shown how traditional medical protocols privilege male genitalia and heterosexual relationships, in particular through the assumption that penis-vagina penetration within the context of heterosexual marriage is proof positive of a successful surgical outcome. And queer analyses have begun to show that the dichotomous ossification of a patient's gender identity — another clinical goal — is both unrealistic and politically objectionable. First-person testimonies by patient advocates have largely substantiated these critiques of medical practice. There seems, then, to be a clear narrative of contestation and subsequent change emerging in the treatment of intersex. In other words, we have learned "lessons from the intersexed," as Suzanne Kessler puts it, initially about genders and gonads, but subsequently about the meaning of ethical patient care.[1]

Yet, the history of intersex treatment, which now includes the recent history of its ethical critique, is marked by a curiously disjointed temporality. If there is a lesson to be learned from the intersexed, it is structured by multiple deferrals: the deferred revelation of the outcome of David Reimer's medical management, on which much intersex treatment has been based; the now seemingly self-evident barbarity of surgical procedures that for years appeared reasonable to many clinicians and parents; the difficulties of choosing treatments, even with informed consent, that will have effects at once long-lasting and unpredictable; the inherent latency in follow-up studies of clinical outcomes, with or without surgery; the dilemma of surgical improvement whereby progress for future patients requires the use of experimental techniques on patients in the present; the stubborn asynchrony between cultural change in gender politics (and sexual politics) and con-

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servative tradition in medicine; and increasingly the time lag between, on the one hand, changes in medical nomenclature and policy and, on the other, the reform of medical practice apparently expedited by new terminology and protocols. In these and other ways, I argue that the most acute "lesson from the intersexed" is that intersex treatment in the present should always be considered, paradoxically, in the light of what may come after it. Hence this special issue's title, "Intersex and After."

Accordingly, the essays published here don't constitute a manifesto for what comes after intersex; rather, they engage with the peculiar "afterwardsness" of intersex and its many lessons.[2] What happens to feminism after intersex? What happens to intersex after the shift in terminology from intersex to "Disorders of Sex Development" (DSDs)? What happens to clinical practice after multidisciplinary challenges to childhood genital surgery? What happens to the determination of sex and gender after intersex? What happens to the intersex body after surgery, and what might queer theory do about it? What happens to the meaning of ethics in intersex treatment, in the light of other types of body modification? These are some of the key questions considered by the authors of this special issue.

The first essay is "Progress and Politics in the Intersex Rights Movement: Feminist Theory in Action," by Alice D. Dreger and April Herndon, authors with experience not just of the scholarly analysis of intersex treatment but also of strategic interventions into clinical practice through patient advocacy. Their work with the influential Intersex Society of North America to change medical protocols has been substantial. Dreger and Herndon draw on this range of experience in their essay, documenting the difficult but determined rise of intersex patient advocacy in the United States during the 1990s and examining its connections to the academy, particularly feminist studies, as well as to other kinds of activism, particularly LGBT rights. While there are continuities between intersex issues and issues of gender and sexuality, Dreger and Herndon caution that there are nevertheless significant discontinuities. To this end the authors discuss their involvement in the 2005 formulation of patient-centered standards of care for what have now (by some) been termed DSDs, in an effort to focus clinical attention on those aspects of intersex that, unlike gender and sexual identities, benefit from medical care.

The relation between nomenclature, bodies, and identities is investigated in greater detail in a provocative essay by Ellen K. Feder, "Imperatives of Normality: From 'Intersex' to 'Disorders of Sex Development.'" Feder takes a longer view of the DSD terminology than Dreger and Herndon, with the aim of understanding why intersex ever seemed to be a type of identity, rather than a type of anatomy, in the first place. Building on Michel Foucault's famous analysis of the nineteenth-

century emergence of sexual identities, Feder argues that the historical association (or even conflation) of intersex and homosexuality has unhelpfully implied that intersex is a disorder like no other, for it marks a kind of person — whether the "pseudohermaphrodite" of medical diagnosis or the "hermaphrodite with attitude" of activism. Feder makes the further suggestion that just as clinicians have disciplined intersex bodies by the use of sex assignment surgery and hormonal treatments, so too may discourse be used to discipline clinicians into managing intersex differently.

The roundtable "Intersex Practice, Theory, and Activism" is notable for its participants' wide range of backgrounds: the gynecologist Sarah M. Creighton, the law professor Julie A. Greenberg, the social scientist Katrina Roen, and the visual artist Del LaGrace Volcano. Roen facilitates the discussion, in which participants tackle some of the clinical, legal, ethical, and cultural dilemmas surrounding intersex. Their thoughtful conversation reveals how it is not simply the case that sex and gender are constituted differently in different situations — as gender and sexuality studies have amply shown — but that what counts *as* a dilemma is inseparable from the material conditions under which sex and gender assignments are made. Such conditions include the power of the law to structure interactions between clinicians and families; the coexistence of lay and expert discourses about genital normality; and the cultural circulation of representations of sexual dissidence.

The images by Volcano that follow the roundtable, gathered here under the darkly humorous title "The Herm Portfolio," perform multiple tasks. Selected from photographic work over a fourteen-year period, they exemplify Volcano's artistic practice as discussed in the roundtable. The images illustrate Volcano's project of making critical interventions into mainstream representations of not only sex, gender, and sexuality but also class and ethnicity. Most interestingly, the images demonstrate the material constitution of dilemmas over sex and gender assignments: the placement together of these photographs prompts viewers to query the sexes and genders of all the photographic subjects, even in images that in circumstances other than a *GLQ* intersex issue might not raise dilemmas at all. Taking the concealment and revelation of bodily differences as their theme, these images ask, who has the authority to conceal and reveal differences? And, what must such differences be, if they can be either concealed or revealed?

The question of whether cultural changes in the meaning and perception of bodily sex would be enough to prompt reform in the medical treatment of intersex remains unresolved by the roundtable and images. This question is addressed by Vernon A. Rosario. His contribution to the issue, "Quantum Sex: Intersex and the

Molecular Deconstruction of Sex," argues cogently for the redundancy of not only binary conceptions of sexual difference but also all deterministic accounts of sex differentiation. Drawing on recent scientific research that is often overlooked in medical and academic accounts alike, Rosario proposes that sex emerges probabilistically from a quantum cloud of biological and environmental processes, rather than being determined mechanistically by biology and environment in any given combination. This insight has practical implications for the genetic counseling of families and intersex patients, as well as for the meaning of clinical sex assignment and its long-term evaluation.

Of course, molecular biology is not the only discourse that can be used to challenge medical protocols, especially those relating to genital surgery for intersex. For *GLQ*'s readership, queer theory may also be useful. The question that my own essay therefore asks is, what can queer theory do for intersex? If Dreger and Herndon are correct that scholars in feminist and gender studies have sometimes overlooked the pressing issues of stigma, consent, and disclosure for people affected by intersex, in favor of celebrating the multigender or gender-free possibilities that intersex apparently exemplifies, then it is important to evaluate whether queer theory enables a better critique of medicine. Specifically I explore how queer theory might account for postsurgical bodies of diminished genital tactility. I contend that for this purpose queer theory must do more than focus on bodily sensations such as pleasure, shame, and touching.

Lastly, Nikki Sullivan's review essay, "The Somatechnics of Intersexuality," critically appraises three multidisciplinary anthologies in which the traditional medical management of intersex is, in turn, evaluated and often contested. Sullivan takes the arguments made in the anthologies—specifically those about ethical decision making—as the starting point for reconsidering how embodiment is the ground of ethics. Sullivan uses the idea of somatechnologies to indicate how original unmodified bodies do not precede the technological modification of some unusual bodies; instead, all bodies are constituted within a technological field that at once enables and constrains their sensibilities, including the capacity for ethical judgment. Consequently, Sullivan argues that one's embodied cultural location crucially makes certain somatechnologies intelligible as body modification in the first place, prior to any conscious judgment about whether such modifications are right or wrong. This challenges us to think about the embodiment of all agents in the intersex treatment controversy, not just patients. Doctors and parents have bodies, too.

To readers of *GLQ,* the medical management of intersex may now seem "constituted by the very incomprehensibility of its occurrence," as Cathy Caruth

has written of trauma.[3] But as the essays in this special issue make clear, it is not without concrete determinants; indeed, these determinants are often the most effective grounds on which treatment can be critiqued. Correspondingly, although it might appear very odd that infant genital surgery — sometimes accompanied by gender reassignment and almost always accompanied by secrecy — became the standard Western treatment for intersex in the 1950s and has persisted almost until today, I don't think this happened because clinicians and families of people born with intersex anatomies have been mad or evil, as some might claim (and I write as one who has suffered from the negative effects of multiple surgeries). There are two contributory factors to the surprisingly uncontested uptake of the treatment model that I'd like to offer, in closing, alongside the explanations discussed elsewhere in this special issue.[4] While analyses of the treatment model's influence in terms of the histories of gender, sex, and sexuality are astute, they ought to be considered in relation to other intellectual and scientific contexts that at first glance seem less relevant to the medical management of intersex.[5]

The first factor is the intersex treatment pioneer John Money's imaginative combination of classical psychoanalytic determinism and ego psychology. In the former, certain genitals must be in place, and be seen, in order for psychosexual differentiation to occur; in the latter, clinical treatment can ameliorate conflict between self and body, and in turn between individual and society. This combination produced an invidious slippage between a concern for exterior physical genitalia and the resolution of interior psychological conflict — as if the modification of infant genitalia were itself a preemptive therapeutic practice. The second factor is mid-twentieth-century scientific humanism (of which ego psychology became a part, I'd argue), which optimistically figured the "plasticity" of gender, ethnicity, and educability as an essential part of being human. The surgical assignment of gender therefore seemed to exemplify human nature, precisely because it taught the lesson that humans have no nature in particular. In these ways (and doubtless several others), the traditional treatment model straddles multiple understandings of selfhood in Western culture — a potent mix enabling the model to work as an "ideological octopus," which has appealed for many years to traditionalists and progressives alike.[6]

Future research on intersex should continue to interrogate the multidisciplinary contexts in which its medical management has emerged, octopus-like. For if such contexts have made medical protocols obdurate, they have also left intersex treatment open to critique from multiple disciplines — not just gender and sexuality studies — all with lessons to teach the octopus.

Notes

I wish to thank the *GLQ* editors and anonymous reviewers for their generous assistance, and the contributors for their expertise, diligence, and patience. I am grateful also for Peter Hegarty's stimulating comments on a draft of this introduction.

1. Formative works in the ethical criticism of intersex treatment include Cheryl Chase, letter to the editor, *Sciences*, July–August 1993, 3; Milton Diamond, "Pediatric Management of Ambiguous and Traumatized Genitalia," *Journal of Urology* 162 (1999): 1021–28; Milton Diamond and H. Keith Sigmundson, "Sex Reassignment at Birth: A Long Term Review and Clinical Implications," *Archives of Pediatric and Adolescent Medicine* 150 (1997): 298–304; Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex* (Cambridge, MA: Harvard University Press, 1998); Dreger, ed., *Intersex in the Age of Ethics* (Hagerstown, MD: University Publishing Group, 1999); Anne Fausto-Sterling, "The Five Sexes: Why Male and Female Are Not Enough," *Sciences*, March–April 1993, 20–25; Fausto-Sterling, *Sexing the Body: Gender Politics and the Construction of Sexuality* (New York: Basic, 2000); Suzanne J. Kessler, "The Medical Construction of Gender: Case Management of Intersexed Infants," *Signs* 16 (1990): 3–26; and Kessler, *Lessons from the Intersexed* (New Brunswick, NJ: Rutgers University Press, 1998). For a fuller discussion of feminist and queer analyses of medical practice, see the essays in this special issue by Alice Dreger and April Herndon ("Progress and Politics in the Intersex Rights Movement: Feminist Theory in Action"), and by me ("What Can Queer Theory Do for Intersex?").
2. The term *afterwardsness* comes from Jean Laplanche. See his "Notes on Afterwardsness," in *Jean Laplanche: Seduction, Translation, and the Drives*, ed. John Fletcher and Martin Stanton (London: Institute of Contemporary Arts, 1992), 217–23.
3. Cathy Caruth, introduction to "Psychoanalysis, Culture, Trauma II," ed. Caruth, special issue, *American Imago* 48 (1991): 419.
4. I have discussed these factors in greater depth in "Thinking with the Phallus," *Psychologist* 17 (2004): 448–50; and "Plastic Man: Intersex, Humanism, and the Reimer Case," *Subject Matters* 3–4 (2007): 81–98.
5. The role of what Bernice L. Hausman has called "the idea of gender" in the development of intersex treatment is contentious (*Changing Sex: Transsexualism, Technology, and the Idea of Gender* [Durham, NC: Duke University Press, 1995]). On the one hand, it seems clear that John Money significantly interiorized gender as something not of the body. One effect of this was to make the successful surgical assignment of gender measurable by criteria other than technical quality; postsurgical genitalia of even the most dubious appearance could be valued by Money not so much for their resemblance to "natural" genitals but for their production of alleged psychosexual normality in the form of a patient's stable gender identity. This applies to both intersex and transex surgeries. (For more on the meaning of postsurgical "normality," see

my "The Injustice of Intersex: Feminist Science Studies and the Writing of a Wrong," in *Toward a Critique of Guilt: Perspectives from Law and the Humanities*, ed. Matthew Anderson [New York: Elsevier, 2005], 60–62; and Ellen K. Feder, this issue.) On the other hand, to say that gender was interiorized in Money's psychiatric discourse is to risk suggesting that gender was or is *only* interiorized and *only* a construct of psychiatry. Vernon Rosario has fiercely challenged Hausman on this point in his review of her book (*Configurations* 4 [1996]: 243–46), and Jay Prosser's *Second Skins: The Body Narratives of Transsexuality* (New York: Columbia University Press, 1998) offers an important account of gendered embodiment that does not ascribe so much discursive power to clinicians. My aim in the context of this introduction is not to resolve the highly complex question of how gender functioned in Money's work but simply to indicate that its function is contested and benefits from consideration in relation to other historical developments.

6. I'm indebted for this phrase to Justin Lewis, *The Ideological Octopus: An Exploration of Television and Its Audience* (New York: Routledge, 1991).