3. The Intersex Movement of the 1990s

Speaking Out Against Medical and Narrative Violence

3.1 THE PARADIGM SHIFT FROM MEDICAL NARRATIVES TO NARRATING PERSONAL EXPERIENCE

Intersex voices had been silent (or rather, silenced) for the most part in the history of intersex. The end of the 20th century however marked a change in intersex representations: autobiographical accounts of intersex lives, conveyed from the perspective of intersex individuals, have appeared in considerable numbers and produced a new discursive space that has challenged the monolithic medical discourse on intersex. Several factors have contributed to the emergence of first-person accounts of intersex experiences. First, the civil rights movement, feminism and sexual minorities movements have paved the way for all kinds of minorities whose voices had been considered as nonauthoritative and consequently been suppressed within mainstream cultural discourses. The gradual emancipation from dominant cultural notions about sex, gender, sexuality, 'race,' class, etc. has opened up possibilities for marginalized identity groups and individuals to represent their life stories, or their selves from their own perspectives and to gain access to and inclusion into a cultural collective.

Second, the emergence of illness narratives in postmodernism, written or told by people who suffer from some disease or are in one way or another recipients of medical treatment, has been considered as a form of resistance to medical authorities' appropriation of patients' bodies and autonomy. As Alice Dreger observes, "the modernist conception of the active physician-hero – a strictly rationalistic, brave, selfless savior who treats a silent, passive, unambiguously grateful patient – has given way to postmodernist challenges of the doctor-patient balance of power and to challenges to the 'doctor as savior' motif" (Dreger 1998: 172). Through the narrating of their own experiences with illnesses or other conditions affecting their bodily integrity, the 'patient' (an identity category itself produced by medical discourses) no longer remains in the role of the powerless 'victim' of medicine but can develop a sense of mastery over their body and gain in confidence and self-determination. While many intersex individuals today do not consider their bodily variations as a medical condition, a large number of intersex persons have undergone (nonconsensual or forced) medical treatment related to their intersex variation at some point in their lives and as such were subjected to medical authority over their bodies. In fact, most intersex first-person accounts that were produced in the 1990s heavily criticize the medical establishment's practices performed on them, and on intersex individuals in general.

Third, the postmodern critical attitude towards master narratives and the postmodernist theoretical conception of identity, gender, and corporeality as constructions contingent on cultural, historical, social and linguistic contexts have enabled intersex persons to reclaim both the definitions of their identities and bodily self-determination. The first-person intersex narratives constitute legitimate alternative or counter-narratives to hegemonic medical narratives and to other dominant narratives about sexed embodiment and gender, and thus challenge the notion of one 'truth' regarding intersex. The quest for 'truth' and authenticity regarding one's own corporeality and sense of gender is a structuring principle of many intersex narratives. While notions of truth and authenticity are problematized in the individual narratives, these narratives nevertheless refer back to the idea of a 'true self' which has been appropriated or corrupted by medical and other authorities.

A number of other factors can be identified that have benefitted the rise of individual intersex voices and the emergence of an intersex cultural collective. The internet plays a crucial role in distributing multi-perspective information about intersex, in connecting with other intersex individuals and in organizing, and in accessing historical archives of knowledge on intersex that have been digitalized and made available online (although the process of selecting what information is worth being digitally stored is itself problematic). Moreover, the academic and activist work of and about genderqueer, transgender and other gender-nonconforming individuals and groups has provided a 'queer space' in which identities and bodies that do not, or do not want to, conform to cultural sex and gender standards get a platform to live out their own sense of (gender) realities (within and against the normative gender and sex constructions and the vocabularies that are available). While there are themes and needs that are specific to intersex persons and cannot be appropriated or ignored by an umbrella category of gender nonconformity, many intersex people have found support and a small space for themselves within various queer or trans communities. The initial increase in personal intersex accounts, however, can be largely attributed to the foundation of the Intersex Society of North America (ISNA).

ISNA was the first intersex organization that operated on a larger scale in North America. Cheryl Chase founded ISNA in 1993 with the declared goal of "systemic change to end shame, secrecy, and unwanted genital surgeries for people born with an anatomy that someone decided is not standard for male or female" (isna.org).

ISNA provided the superordinate narrative context in which many of the early first-person accounts of intersex individuals were embedded. Many of these narratives were published in ISNA's newsletter *Hermaphrodites with Attitude* between 1994 and 2005 (in 2001 the title was changed to *ISNA News*) and in the special issue of *Chrysalis, 'Intersex Awakening'* (2.5, 1997/1998), whose guest editors were Chase and Martha Coventry and which "reflects the groundbreaking work of ISNA" (Denny 1997/98: 3).

Most of the stories claim to represent authentic experiences of the narrators; some pieces of fiction and poetry were also featured. While the majority of the narrators are intersex persons, there are a few stories narrated by partners of intersex persons, effecting a shift in perspective. Beside the first-person narratives, *HWA* contained articles primarily about ISNA's work and medical themes, and occasional texts about intersex-related support groups, media coverage on intersex, and book reviews. The bulk of the personal narratives in the newsletter was published in the first four issues between 1994 and 1996. As a consequence, the scope within which these narratives were published was rather narrow, and the audience addressed highly selective: the newsletter was distributed among allies of Chase and other people who were more or less familiar with the issue of intersex, and the readership consisted mainly, while not exclusively, of intersex people (*Chrysalis* addresses readers with all sorts of "transgressive gender identities"). Since ISNA served as an important point of reference for a (very specific and young) cultural intersex collective in 1990s North America, many of the early first-person narratives reflect their agenda.

The publication of works on intersex as experienced by intersex persons themselves, as opposed to medical accounts of intersex, can be considered as a first and crucial step towards ending the silence of intersex voices and the invisibility, or erasure, of intersex bodies within society, and as a form of resistance to the medical establishment's authority over their bodies and lives. The personal narrating of selves and experiences provides the intersex individual with a sense of mastery over their life which was often taken away from them by authorities (medical doctors and/or parents), and enables them to come to terms with their often traumatic bodily experiences. The editors of *HWA* describe the personal motivation for coming out as intersex via the writing in a public forum as the anger about the social and medical violation of their bodies and their self-determination: "Most of us [...] feel rage over how we have been treated. At times it is hard to know where to focus this anger. Our common enemy is the society that denies the individual the right to decide for themselves who they are and how they want to live their life" (Nevada and Chase 1995: 11). Moreover, the individual, personal motivation is transformed into a political force in this process, and the forming of community structures and communication networks based on a shared experience is crucial for the development of an intersex collective: "Finding others serves to contextualize intersexuals' medical experiences as social, rather than individual problems. Learning that others had undergone similarly alienating medical procedures led to an ability to recast the personal as political, rather than as an individual failing" (Preves 2003: 123). Reclaiming the power of language can serve as a tool to rearticulate one's own sense of self; however, almost all narratives reiterate in some way the medical discourse and its hierarchical power relations. I argue that these narratives can nonetheless possibly contribute to a deconstruction of hegemonic intersex narratives as they contain inherent moments of resistance and expose internal contradictions and inconsistencies within the medical narratives.

The sample of intersex narratives under consideration in this chapter comprises a total of sixteen pieces of writing, ten published in *Hermaphrodites with Attitude*, five in *Intersex Awakening* and one in *Genderqueer* (eds. Nestle et al 2002), an anthology of essays about gender nonconforming lives. Out of these, twelve are narrated by intersex individuals and three by partners of intersex persons. One is a fictional short story. Several interrelated major themes can be identified which the narratives under consideration negotiate: medicalization and pathologization; 'normalization' processes involving genital surgery (mutilation) and hormone treatment, resulting in sexual dysfunction; mental health issues; invisibility, silencing, erasure and negation; the gender/sex dichotomy and biologist-essentialist accounts of sex and gender; and organizing and/or sharing individual experiences. There is hardly a story in *HWA* or in *IA* that does not address one (or in most cases, several) of these themes. I argue that the reiteration of the specific discourses, motifs, strategies, and narrative plots by and within these narratives both produces very particular representations of intersex subjects and at the same time opens the intersex subject up to the possibility of its contestation and resignification (to borrow Butler's phrasing, Butler 1993: 10). My selection of the texts is based on the following thematic aspects of lived intersex realities, according to which the particular narratives are categorized in my analysis (of course, these aspects are interrelated, and the selected narratives often discuss several aspects, thus the categorization was based on the particular narrative's main focus): the 'normalizing' of intersex bodies, the medico-cultural erasure of intersex, and the refusal to accept the terms of recognition provided by medical discourses; the cultural/medical construction of genitals through visualization practices, normative notions of sexuality, and the counter-gaze claimed by intersex narrators for processes of self-invention; the problematic aspects of sexual experiences of intersex individuals who had undergone nonconsensual genital surgery, and the redefining of sexual pleasure; narratives from partners' perspectives; and the role of an intersex community for a collective cultural rearticulation of intersex.

Despite their different foci, the narratives generally follow a similar plot. A 'typical' story is structured as follows: it begins with the narrator's early feelings of not fitting into the sex/gender dichotomy, memories of some surgical intervention or other medical treatment during their childhood and/or adolescence, the subsequent silencing of the existence of an 'atypical' body, later the gradual realization of being intersex and, quite often, the development of mental health issues in reaction to it, the mourning of sexual dysfunction, and finally the awareness of the existence of 'other' intersex individuals and a possible emancipation from dominant (medical) discourses, often combined with deep gratefulness toward ISNA for publicly articulating intersex issues. While many of the narratives adhere to this storyline, there are other stories that involve single themes, the primary issues being the medicalization and 'normalization' of intersex bodies. In *HWA* and *IA* there exists virtually no single narrative that does *not* deal with medical issues.

At first glimpse, most narratives seem to tell a similar story about a medicalized, postoperative, genitally mutilated intersex body. The relationship between intersex patients and medical doctors is central to the medicalization of intersex: this specific relationship is simultaneously produced by the medical discourse on intersex and functions as the major structuring principle and affirmation of that discourse. The discursive power mechanisms at work within this narrative construct intersex persons and physicians as 'patient' and 'doctor,' respectively. Previous to the emergence of personal intersex narratives which produced intersex counter-discourses, medical practitioners have been considered as the chief authorities in regulating sex 'transgressive' bodies. Their authority over 'deviant' bodies is exercised mainly by surveillance: hierarchical observation, normalizing judgment and the examination are the means by which the intersex body is subjected to disciplinary control (Foucault). The hegemonic gaze possessed by medical authorities has been inextricably involved in the processes of the 'normalizing' of sex or gender 'deviance.' There is a risk of conceiving of the intersex narrators of individual stories as already 'constructed' by this hegemonic medical narrative even before they are constructed through their individual narratives. The narrators' perpetuated references to the medical narratives' conception of 'the' intersex body as a pathological body renders a counter-discourse to the dominant medical discourse on intersex problematic. Since the medical narratives on intersex seem to motivate the majority of individual intersex narratives, how is it possible to talk about intersex without resorting to medical terminology?

In the ensuing chapter, "Fragmented Bodies, Fragmented Realities: First-Person Narratives of Intersex Lives, 1994-2002," I interrogate the paradigm shift in the narratives about and their representations of 'intersex' (i.e. intersex individuals, intersex collectives, and intersex as a cultural category) that took place at the beginning of the 1990s, which was effected by the personal narratives of intersex individuals or activists that have emerged in response to the need for alternative narratives on intersex. Thereby I interrogate the processes of reaffirmation and challenging of hegemonic conceptions of intersex and the resignification of intersex through the autobiographical narratives and their intertextual references and interaction not only with medical discourses, but with other cultural discourses, including human rights and ethical debates, discussions about gender, sexed embodiment, and sexuality, and activism. I argue that these autobiographical texts renegotiate intersex subjects as sites of contestation over normative sexed and gendered modes of being, and over the constitution of humanness and cultural identity. I analyze the strategies of resistance to the hegemonic discourses on intersex and moments of (productive) indeterminacy within the first-person narratives under consideration, and their production of a narrative/cultural space from where to collectively "articulate an alternative, minority version of sustaining norms or ideals" (Butler 2004: 3) that provides the conditions for intersex subjects, with their diverse forms of intersex embodiment, to be/come recognizable, and hence intelligible.

3.2 FRAGMENTED BODIES, FRAGMENTED REALITIES: FIRST-PERSON NARRATIVES OF INTERSEX LIVES, 1994-2002

3.2.1 'Normalizing' Intersex Bodies: The Medico-Cultural Erasure of Intersex and the Renegotiation of 'Loathsome Options' of Recognition

The first-person narrative of ISNA founder Cheryl Chase's "Affronting Reason" (originally published in 1998, reprinted 2002) can be considered as an 'archetype' first-person account of intersex experience, in particular with regard to the narrative's negotiation of the historical invisibility of and the conditions of intelligibility for intersex. Chase's narrative is constructed through the interrelations between her embodied experience and the cultural production of sexed bodies, genders, and sexualities in accordance with prevailing social norms. Within an extremely narrow space, "Affronting Reason" renegotiates basically all negative signifiers that renders intersex unintelligible, in an effort to dismantle or challenge the hegemonic medical narrative's intersex construction. This intersex narrative seems to be defined by negativity, lack and absence, it connotes an 'impossible' narrative: "*It's not possible,* I thought. *This cannot be anyone's story, much less mine. I don't want it. Yet it* is *mine*," Chase comments on her intersex narrative (Chase 2002: 205). Her own narrative intersex construction is predicated on a paradox of presence/absence, its very coming into existence already entails a deconstructive moment. By telling and writing down her story, she makes this 'impossible' story 'real.' "Affronting Reason" begins with the establishment of Chase's corporeality as intersex by medical authorities:

> "'It seems that your parents weren't sure for a time whether you were a girl or a boy,' Dr. Christen explained as she handed me three fuzzy photostats. I was 21 years old and had asked her to help me obtain records of a hospitalization that occurred when I was 1 ½. I was desperate

> to obtain the complete records, to determine who had surgically removed my clitoris, and why. 'Diagnosis: true hermaphrodite. Operation: clitorectomy.'" (Chase 2002: 204)

"Affronting Reason"'s intersex narrative constitutes a narrative of negation that operates on several levels. To begin with, Chase denotes the story of her childhood as "a lie" (2002: 205): the identity of "Charlie," the baby born as a "true hermaphrodite," was erased and replaced by the identity of "Cheryl," a surgically constructed "girl." The medicalization and mutilation of intersex bodies are interrelated with the invisibility and silencing of intersex individuals within the story. All evidence of intersex existence is virtually annihilated. In the medical texts, intersex objects are deprived of their individuality, subjectivity and humanity by blacking out their eyes and only exhibiting their genitalia. The prevalent images of intersex subjects are constituted by fragmented bodies and mutilated body parts: "The only images I found were pathologized case histories in medical texts and journals, close-ups of genitals being poked, prodded, measured, sliced, and sutured – full body shots with the eyes blacked out" (Chase 2002: 206). Here, intersex denotes not a viable, whole and real mode of being, but is defined by its sexed body parts, and moreover, its pathologized genitals, so that the intersex body becomes not only fragmented but is made up entirely by the pathologized sexed body fragments. The medical gaze produces a mutilated, fragmented and dehumanized intersex subject, claiming this to be the only intelligible intersex subject position, which is however "socially unthinkable" in our culture (Chase 2002: 207).

This invisibility and social silencing renders intersex bodies ghostlike, and an intersex subject position is problematized. The absent, lacking corporeality is reinscribed into Chase's intersex body, and she experiences a bodily dissociation in the interaction with others: "my perception of myself is as a disembodied entity, without sex or gender" (2002: 213). The medical and social rendering of intersex individuals to a ghostlike, "disembodied entity" and Chase's initial subjection to it constitute intersex as an unintelligible mode of being, and the intersex narrative as an impossible, "unthinkable" narrative that negates its own existence through its narration. This repeated paradox of narrative presence/absence deconstructs the narrative's negation of its existence as the storytelling itself simultaneously presupposes and produces the presence of a narrative voice. In her theory of the performativity of gender and the sexed body Butler conceives of gender as the persistent repetition of cultural conventions on the body which is not an individual choice but operates within an already existing cultural and historical framework. The body, however, is not a site passively inscribed with cultural codes (Butler 1997a: 411f). Chase's constant reiteration of the medical and cultural conventions of 'normalization' constitute her intersex reality as an absence, i.e. an absence of these normative conventions. Her narrative constructs her intersex body as the non-female body through the absence of normative 'female' genitalia, thereby simultaneously perpetuating and challenging the medical narratives' naturalistic notions of sexed embodiment which imply a sex binary and coercive heterosexuality.

Genitalia are the primary signifiers that connote a sex, and the lack or mutilation of genitalia disqualify a sex from being intelligible: "my genitals were missing parts" (Chase 2002: 210); "I now assert both my femininity and my intersexuality, my 'not female'-ness. This is not a paradox; the fact that my gender has been problematized is the source of my intersexual identity" (2002: 211). Chase's refusal to accept the medical gender assignment allows for a change in perspective within this narrative and functions as a moment of intersex subject formation that deconstructs the hegemonic intersex narratives' assertion of distinct, binary sex and gender categories:

> "What do I see when I look in the mirror? A female body, though scarred and missing some important genital parts. [...] My body is not female, it is intersexed. Nonconsensual surgery cannot erase intersexuality and produce whole males and females; it produces emotionally abused and sexually dysfunctional intersexuals. If I label my postsurgical anatomy *female*, I ascribe to surgeons the power to create a *woman* by removing body parts. I accede to their agenda of "woman as lack." I collaborate in the prohibition of my intersexual identity." (2002: 213)

A possible interpretation of these passages is ambivalent. Chase's own conceptions of 'female' and 'intersex' bodies and her self-perception as female and/or intersex are contradictory: she perceives her body as a scarred and 'deficient' female body but immediately rejects this female embodiment in favor of an intersex embodiment. This intersex body, however, is a violated and 'deficient' body as well; yet she chooses to reclaim this intersex body. Both corporealities, according to her reasoning, are not viable corporealities. The narrative problematizes Chase's intelligibility as a sexed (and gendered) subject, for she cannot be a 'woman' (as her intersex corporeality cannot be 'made' into a 'whole,' i.e. viable, female body), and although she can define herself as 'intersex,' 'intersex' is not an intelligible mode of being. Chase faces the dilemma of intelligibility, as her "options are loathsome": she has "no desire to be recognized within a certain set of norms" (Butler 2004: 3), i.e. the doctors' "agenda of 'woman as lack,'" and for her self-chosen 'intersex identity' no category of recognition exists. On the other hand, Chase's rejection of the medical construction of her intersex body as 'female minus relevant sexed body parts' "opens the way for a more radical form of self-determination" (Butler, in Williams 2014) and allows her to reclaim the authority to define her body as intersex. In asserting both her intersex corporeality and identification *and* her femininity, she challenges cultural notions of distinct, normative genders and sexed embodiment. Moreover, in asserting her lesbianism she undermines the medical agenda to produce heterosexual subjects and disputes the ostensible 'success' that was to be achieved by surgically making her a (heterosexual) woman.

The primary motivation for many narratives is a previous negative experience with the medical establishment, mostly during infancy or adolescence. It is above all the perceived powerlessness towards medical authorities and feelings of being at their mercy that cause feelings of distress and rage in the narrators. In addition, many narrators express their anger about both doctors' and parents' lies about medical interventions, followed by a silence maintained about the intersex state of the child's body. In most cases, no explanation was given by doctors about surgical interventions and their long-term consequences. Many intersex narrators feel deprived of complete control over what had happened to their bodies and of the choice in determining what their sex should be. Some feel that their parents were complicit in the doctors' decisions, some find the behavior of their parents excusable. In her narrative about her experiences as an intersex child at Buffalo Children's Hospital as a response to an article by a medical doctor featured in *HWA* (fall/winter 1995/96), "Physically Screwed by Cultural Myth: The Story of a Buffalo Children's Hospital Survivor," Heidi Walcutt directs her anger towards the practitioners at Buffalo, whom she accuses of a complete disregard of her needs and feelings and of constructing her whole medical history around silences and lies:

> "I can't tell you what my diagnosis was – because no one ever told me. But I do know that I was raised as a girl, and first admitted to Buffalo at age 5 in 1966, where surgeons operated on my enlarged clitoris. In my recollection, it was a fully-formed, functioning penis. [...] No one explained anything to me before or immediately after the surgery [...] And, based on my reading of some of John Money's books, and ISNA literature, I now suspect that I have androgen insensitivity, that surgeons at Buffalo Children's removed my *testes*, and that all the staff there conspired to lie to me, telling me that I was female, but my (nonexistent) ovaries and uterus were 'underdeveloped.'" (Walcutt 1995/96: 10)

Walcutt begins her story with a sense of uncertainty about her sexed body. She conceives of this uncertainty principally as the doctors' distorted presentation of her medical diagnosis. Her narrative seems to be informed by the quest for her 'true' diagnosis, rather than her 'true' sex or gender. She attributes this uncertainty, and in particular her previous inability to speak about her intersex body, to the doctors' behavior and actions at Buffalo Children's Hospital. Not only did the medical authorities exclude her from any decision-making process regarding the treatment of her sexed body and thus denied her informed consent and self-determination. What is more, the doctors' definition of her sex conflicts heavily with her own perception of her sexed reality, hence she perceives their treatment as fundamentally wrong since her "fully-formed, functioning penis" was made into a flawed "clitoris." Her perception of her surgically created 'female' organ as not (entirely) 'functioning' is articulated in terms of sexual availability: although she has some clitoral sensation, she is not sure whether she is orgasmic, and her vagina is "just a pocket, about half an inch deep, with flaps of skin on either side" (Walcutt 1995/96: 10), and as such not deep enough for being penetrated. The fact that she, as a lesbian, is not interested in having "normal sex with [a] husband" (1995/96: 10) – the doctors' reason for the planned surgery which was intended to increase the depth of her vagina – causes her disinterest in a vagina 'made' for heterosexual intercourse. So while Walcutt seems to be deeply annoyed with the children's hospital's misrecognition of her intersex variation and her exclusion from the decision-making processes regarding her sexed body, she manages to reclaim the defining power for herself. She educates herself about intersex with various sources, including not only medical textbooks but also works which convey the perspectives of intersex individuals, and arrives at her own diagnosis: androgen insensitivity. At this point in her narrative, her quest for her 'true' diagnosis – i.e., a diagnosis that she herself arrived at and that she can accept as being 'true' – is completed. However, Walcutt is not content with arriving at her own conclusions about her sex. She states that she "feel[s] in between male and female" (1995/96: 11) and identifies as "entirely lesbian" (10) – her new diagnosis changes neither her gender identification nor her sexuality. The main reason for her rage against the medical establishment is her exclusion from the discourse about her sexed body, her gender, and her sexuality, which has led, for her, to the inability to express her feelings about these issues. The counseling at Buffalo was exclusively controlled by a psychologist, and Walcutt had to submit to the rules of the medical discourse:

> "The counselors just laid out for me what was going to happen to me, but I really couldn't talk about how I felt, or ask them questions. I was always uncomfortable in the counseling sessions, I would tell them almost anything so that I could just get out of there. [...] those sessions always followed the counselor's agenda. She would just explain what was going to happen to me. Occasionally she would tell me, 'we want to know what you're experiencing, what you're feeling.' But there just wasn't a space there to talk about these kinds of things." (1995/96: 11)

Walcutt is neither legitimated to participate in the medical discourse about intersex, nor has she the ability, at this moment, to produce a discursive space for herself in which she would be allowed to speak. The medical discourse on intersex in this narrative in fact both conceives of and consequently marks intersex as unintelligible by referring to sex only in terms of male vs. female sexes. This intersex discourse is marked by absence, or erasure, and the intersex individual has no discursive possibilities to articulate her sense of being intersex as an intelligible mode of being. The only thing she can do is tell them what they want to hear – i.e. use the language of the authorities. Her own voice is silenced and her feelings stifled. Her personal experiences have no validity since her voice – like the voices of all 'patients' – is considered as non-authoritative within the hegemonic discourse. Since the 'correction' of 'deviance' from the norm is its structuring principle, Walcutt's intersex embodiment is subdued by femaleness and her lesbianism by heterosexuality. Neither could she talk with her parents about her feelings, as they were conservative Christians. Consequently, she was never able to develop her own voice and to find the adequate words for her intersex embodiment and her gendered sense of self: "I kept things to myself. Questions. Problems. Shame. I've spent my whole life with my feelings so bottled up, it's really hard to change now" (1995/96: 10). However, Walcutt finds a way out of her silence when she learns about ISNA, and reclaims her voice by writing and publishing her letter in *HWA*, in which she is able to produce a counterpoint to and articulate her own feelings about the medical establishment. Thereby, she emerges as an intelligible intersex (and lesbian) subject, by refusing the gender assignment made by medical authority and positioning herself in a critical relation to the norms that constitute the conditions of her intelligibility (see Butler 2004: 3).

That the exclusion of intersex individuals from medical discourses and the denial of their intersex variation will almost inevitably lead to the persons' feelings of shame, fear, isolation and emotional as well as bodily suffering becomes apparent in a number of other intersex narratives. In "In Amerika They Call Us Hermaphrodites" (*IA* 1997/98), Angela Moreno writes about her personal experiences with the medical establishment and the consequences of the violation of her bodily integrity. Moreno, who was assigned female and raised as a girl, underwent a clitorectomy at twelve, but was neither informed by the doctors nor her parents about the details and the consequences of this surgery. At the hospital, the doctors "didn't mention the part where they were going to slice off my clitoris. All of it. I guess the doctors assumed I was as horrified by my outsized clit as they were, and there was no need to discuss it with me. After a week's recovery in the hospital, we all went home and barely ever spoke of it again" (Moreno 1997/98: 11f). A follow-up counseling for her or her parents was discouraged by the doctors, denying them any further chance of participating in the medical discourse.

The doctors' normative judgment is expected to be tacitly consented to by the patient. Moreno did not have a say whatsoever in this decision regarding her genitalia. While she herself refers to her clitoris as "that wonderful location of pleasure for which I had no name but to which I had grown quite attached" (1997/98: 11), her own assessment of her bodily and sexual well-being was subdued by the doctors' normative ideas of sex and gender and their arrogant and paternalistic attitude towards the patient. The power relation between 'doctor' and 'patient' becomes obvious in the doctors' strategy of hierarchical observation: their assessment of what size of a sex organ is to be considered as 'adequate' for males and females defines any person's genitalia as either 'normal' or 'deviant.' This judgment can only be made by doctors for they, as authorities, have both the almost exclusive view into people's genitalia and the defining power to which the patient has to submit unconditionally.

While the doctor-patient relationship has slightly shifted by now, in the 1980s when Moreno's surgery was performed, this relationship was still relatively strictly organized, in particular with regard to intersex 'patients.' While the surgeon who performed Moreno's clitorectomy "summarized the outcome as 'tolerated well,'" Moreno herself conceives of the clitorectomy as "the unspeakable assault that I experienced under the guise of medical treatment" (Moreno 1997/98: 12). The medical records, of course, convey only the perspective of the doctor, while Moreno's perspective is completely absent. Consequently, the removal of the clitoris is defined as a successful medical outcome and the patient's personal negative experiences dismissed as irrelevant. Thirteen years after the clitorectomy she writes: "I am horrified by what has been done to me and by the conspiracy of silence and lies. I am filled with grief and rage" (1997/98: 12).

As a result of her treatment, she has developed serious mental-health problems including eating disorders, depression, and intense body-hatred. She considers her bulimia as representing her attempts to express the fear, shame and rage caused by this assault on her bodily integrity, for which she has been lacking the language. Her medical records were at first incomprehensible for her – the medical terminology again excluded her from participating in the discourse surrounding her intersex variation. Knowledge becomes power here quite obviously: those who possess the relevant knowledge are all powerful (medical authorities), those who do not are powerless (intersex patients). However, Moreno was no longer willing to submit to her perceived powerlessness towards the medical establishment and asked her gynecologist to explain her records to her. When she could finally make more sense of the confusing medical verbiage, she started to feel more confident that someone had taken her questions seriously and that she was now able to take part, though still restrictedly, in the medical discourse about her body. Yet while she was not completely powerless anymore, she still lacked her own voice to productively cope with her situation and her intersex corporeality.

Towards the end of her narrative, Moreno, like other intersex individuals who begin to narrate their personal experiences, learns about ISNA and other intersex people who might share her experiences. She realizes that she is "not the only one" (Moreno 1997/98: 12), and this new awareness and the change in perspective, through reading articles written by intersex persons and by ISNA, also lead to her own self-diagnosis, "Partial Androgen Insensitivity Syndrome." This diagnosis still refers to a term that had been produced within medical discourses and is a construction by medical authorities. Moreno's reappropriation of this term, however, changes its meaning for her, for two reasons: first, her diagnosis is for the first time clearly articulated and her intersex variation, about which the doctors had kept silent before, acknowledged. Second, her diagnosis is the result of her own research, which does not primarily rely on the medical records but on 'alternative' knowledge provided by first-hand accounts of other intersex persons with whom she can identify.

Butler argues that “all of us [...] are in the active position of figuring out how to live with and against the constructions – or norms – that help to form us. We form ourselves within the vocabularies that we did not choose, and sometimes we have to reject those vocabularies, or actively develop new ones” (Butler, in Williams 2014). Thus, while Moreno needs to refer to medical terminology to articulate her sense of self, and cannot articulate her intersex embodiment ‘outside’ of the medical discourse, she is finally able to create a discursive space within, yet in critical relation to, the dominant discourse that challenges dominant normative notions of sex and gender and thus enables a viable, intelligible intersex subject position that was previously not possible.

In his personal journal, which was in part published in the first issue of *HWA* 1994 under the title “I Am Not Alone!” David writes about the erasure, silencing, and invisibilization of intersex by medicine and culture:

> “It is a terrible perversion of the healing arts to attempt to destroy the unique gender identity of intersexual infants – to instill fear and shame in them by considering them to be some sort of sexual freaks to be tampered with. And, considering the cultural taboo of not talking about sexual differences, we surround hermaphrodite children with the poison of secrecy about themselves and what has happened to them.” (David 1994: 5)

To him, intersex is nipped in the bud for its visibility entails its own undoing or erasure. Since a person’s intersex corporeality is nullified most often in infancy, their intelligibility as intersex can never reach a viable adult status but is suppressed by a culturally enforced gender assignment (either male or female). This enforcement is carried out through instilling shame and fear in the “helpless infant” (David 1994: 5) – a shame and fear experienced by the family and society –, in order to ensure the child’s assimilation to their assigned normative gender. David experiences these practices as “legally and scientifically sanctioned traumatic sexual abuse” (1994: 5) and himself (and by extension, other intersex individuals) as a victim who is at the mercy of the abusive powers that “manipulat[e] our bodies to meet its own needs of conformity” (1994: 5). Abuse is conceived as both the manipulation of intersex bodies and gender identities and the displacement of intersex to the realm of non-existence.

David’s narrative ends with a determined announcement and a challenge to medicine and society: “It really pisses me off. I will not be silent about this!” (1994: 5). In fact, his narrative itself already contributes to the resistance to medical and cultural practices of erasing intersex subjectivity: his realization that he is not the only intersex person and that there are many others who share his experiences undermine the medico-cultural claim that intersex people do not exist. With the publishing of his personal journal, he breaks the taboo and secrecy about himself and other intersex persons which was imposed on him as an infant. David not only manages to emancipate himself from this taboo but is also working towards a viable adult intersex identity.

Jane Carden's personal story "Learning to Speak at 36" (*HWA* 1995) revolves around secrecy and her attempts to overcome the silence maintained about her intersex variation. Her narrative, too, starts with a sense of her sexed body as an 'unreal' corporeality: "Twenty five years ago [...] I was told a lie. [...] From that day forward, no one in my family has ever again spoken to me about my medical condition" (Carden 1995: 2). Like in Moreno's and David's narratives, Carden conceives of the secrecy and fear about her intersex body as really being the doctors' and parents' fear imposed on her: "Not once was I asked how I felt about any of what had transpired. I was a patient with a terrible secret that even the doctors and my own mother couldn't or wouldn't discuss" (1995: 2f). Carden is denied any possibility to either participate in the medical discourse or express her own feelings about her intersex corporeality. She cannot participate in the medical discourse because she does not have the authority to do so and lacks relevant knowledge. Intersex simply does not exist within this discourse, only in the form of an unspeakable absence.

At age 20, however, Carden begins to do her own research in an effort to resolve the secrecy about her sex. She reads medical texts in the medical school library and finally comes up with the diagnosis "testicular feminization," about which her parents had lied to her. From the medical books she learns that she is a "male pseudo-hermaphrodite." Again, her self-identification relies on the terms which the medical discourse provides for her. At this moment, she still cannot identify as a 'real' intersex person but must be content with being 'pseudo,' not 'authentic,' and not really existing. The search for her own 'true' sexed 'reality' ends for the moment in an identificatory dead end, the repeated negation of her intersex body. The only thing affected by her discovery is the subsequent cessation of medical care, which she finds unnecessary due to the new information regarding her genital surgery. When she decides to resume medical care, she is again confronted with prior lies about her medical treatment and the ignorance of medical practitioners regarding her bodily condition. The perpetual lies and silence about her intersex variation and the resulting inability to talk openly about her intersex body drive her into isolation and cause mental-health problems. At 36, she still needs to "learn to speak," in her own voice with her own words. However, by refusing to accept the silence about her intersex variation, and hence positioning herself critically towards the medical and social practices of rendering intersex (subjects) unrecognizable, Carden recognizes and points to the unrecognizability of intersex and thereby (temporarily) "emerges at the limits of intelligibility, offering a perspective on the variable ways in which norms circumscribe the human" (Butler 2001: 635). Carden is still in a process of rearticulating her (sense of) self, which (can) entail(s) both the rejection of the terms that define her (against her will) and the development of new terms. While she still needs to "figur[e] out how to live with and against the constructions – or norms – that help to form" her (Butler, in Williams 2014), Carden's intervention into the doctors' and her parents' agenda of 'intersex as non-existing' is a crucial step towards constituting intersex not only as existent, but, eventually, as recognizable and an intelligible way to live out her sense of sexed reality.

"Finding the Words" is also Martha Coventry's designated goal in her narrative with the same title (*IA* 1997/98). When she was six years old, she underwent a clitorectomy, and the loss of the clitoris is followed by a silence that lasts for twenty-five years:

> "Not a word of explanation was ever given for the surgery, and when they cut out my clit, they cut out my tongue. I could not cry out to save myself, and that stifled scream wedged in my throat, blocking my voice. Endless fears about who and what I was took the place of words and they settled like darkness over me." (Coventry 1997/98: 27)

The 'unspeakability' of intersex, i.e. the unintelligibility of intersex, translates quite literally as the excision of sexed body parts classified as intersex. The juxtaposition of cutting out her clitoris (physically) and her tongue (symbolically) signifies the inextricable interdependency of social and corporeal constraint that delegitimizes intersex as real and constitutes the basis for the attempted 'normalization' of intersex. The secrecy maintained about Coventry's clitorectomy and her intersex variation had a devastating effect on her whole life throughout childhood, adolescence, and adulthood. Her constant struggle with her sexed body and her gender identity used to be defined by insecurity, shame, denial, and pretending. Her permanent feelings of being not 'authentic' as a woman haunt her and cause nightmares that last for years: "When I was growing up, and well into adulthood, I used to have a waking nightmare that a squad of men in uniforms would arrive at my door, take me into the night and execute me for not being a real woman. In my mind, they were always justified and I never raised my voice in protest" (1997/98: 27). Even in her dreams, she is unable to break the silence about her sex or to articulate her own sense of self. The nightmare mirrors her feelings of being completely powerless against the authorities in her real life – both the medical authorities and her parents – and of being forced to submit to their judgments about her body and identity. They have the legitimation to define her sex and assign her a gender, while she feels she has no (defining) power. The hegemonic construction of her sex/gender as female clashes heavily with her perceived sex and gender; however, her own judgment is informed by normative cultural notions of maleness and femaleness, which results in her perception of herself as being "in drag" and "a fraud" (1997/98: 28). Her fear of completely losing her identity causes Coventry to stop asking questions for the moment and "frighten[...] [her] back into total and terrified silence" (28). What follows is a continued odyssey of doubts and emotional break-downs, an unsuccessful marriage and perceived "sexual failure[s]" (1997/98: 28), and isolation.

At some point in her life, close to self-destruction, Coventry begins to love herself and her body and to gradually embrace her difference. A short time later, the death of her father enables her to live her own life independently from his defining power over her sexed embodiment – by deciding to erase her intersex corporeality in favor of a female sex and to withhold this truth from her – and to finally come to terms with her intersex body and her sexual desires. She explores her medical records together with a gynecologist in order to understand the full dimension and the meaning of the surgery and begins to write down her own experiences of growing-up and her sex and gender struggles. Moreover, she finally acts out her lesbianism which she has suppressed since adolescence. Like virtually all intersex narrators under discussion here, she ultimately realizes the existence of other intersex people who share her experiences, and begins to find her own words for her intersex embodiment: "I will never find the words of my six-year old self, and that is fitting. Today I have the reasoned and educated voice of a grown woman who knows harm when she sees it and is increasingly growing strong enough to name it and try to stop it" (29). Coventry manages to emancipate herself from the authorities' power over her and to resist their normalizing judgments about her sexed body and her sexuality by finding her own voice. This voice is authoritative, grown-up and educated, hence powerful, in contrast to her infant voicelessness and powerlessness.

The analysis of intersex narratives demonstrates that most narrators' negative experiences with medical authorities are a direct result of a perceived powerlessness, a lack of mastery over their own lives and bodies, and the lies about medical treatments and the silencing of their intersex corporeality. Joan W. writes in a letter addressed at her doctor who treated her as an intersex child, "Dear Dr. M" (published in *HWA* 2001), about doctors' dismissal of patients' experiences as irrelevant for studies on the results of genital surgery: "The few studies that have been done have emphasized the cosmetic result; the physical and emotional impact on the patient is given little consideration" (W. 2001: 4). The intersex 'patient' has no right to speak within medical procedures and is relegated to "assuming the role of a research subject" (4).

Intersex individuals are made objects within the medical discourse not only by denying them an active role in the process of subject formation and the autonomy over their bodies, by excluding them from the dominant discourse on intersex. Equally important are the visualization practices through which the intersex body is constructed as 'pathological' and the medical perspective affirmed as the (only) legitimate perspective. The intersex narratives negotiate the hegemonic gaze of medical authorities, which serves the control and the 'normalizing' of sex or gender 'deviance.' The questions of who possesses the gaze within a specific narrative and how the privilege of being in the active gazing position is used play major roles in the construction of intersex bodies and subjects (and other subject positions such as medical doctor). Visualization practices can be detected within the narratives that resists, challenge or subvert the hegemonic gaze. These processes involve a reclaiming of an 'anarchic,' or deconstructive gaze, which is opposed to the hegemonic gaze, by intersex individuals who previously were not authorized to possess the gaze, thus effecting a decentering of the gaze. I will now analyze how the gaze is utilized for processes of self-invention and the rearticulation of intersex subjecthood, and how specific strategies of visualizing in the intersex narratives refuse or challenge hegemonic medical visualization practices.

3.2.2 Medical Gaze vs. Visual Self-Invention: The Performativity of Genitals and the Construction of Sexuality

The stories primarily revolving around representations of genitalia make up the bulk of all narratives in *HWA* and *IA* and include, beside non-fictional and fictional accounts, medical photographs of genitalia. A 'normalizing' of 'ambiguous' genitals is identified as the main – in fact the only – reason for genital surgery. Normalizing judgments passed by doctors, informed by cultural ideas about bodies and genders which are translated into standard medical practice, are an integral technique in the process of hegemonic gazing. The intersex infant's precarious state, the threat of being/becoming unintelligible, is determined by the appearance of the genitals in the first place – which really means, not by the appearance of the genitals *per se*, but by their 'inconceivability,' their claimed disruption of normative binary notions of sexed embodiment:

> "Physicians whose careers are dedicated to erasing intersexuality (by performing invasive medical procedures on non-consenting infants) characterize the birth of an intersexual infant as a 'social emergency,' and a traumatic emotional shock for the parents. In fact, by their own admission, plastic surgery on intersexual infants' genitals is a form of psychosurgery." (Chase 1994: 6)

The notion of indeterminate sex in the newborn as a "social emergency" is firmly established in the treatment protocol: in instructional texts and articles on intersex produced primarily by surgeons in the 1980s and 1990s, doctors declare a state of emergency when they fail to immediately determine whether the infant is a girl or a boy. This perceived threat to the gender binary urges them to seek a 'remedy' for the 'problem' as quickly as possible, to reassure the parents that their child's sex will be 'unambiguous.' The coercive measures are often executed without sufficient consultation with the parents, and always without the consent of the patient (Fausto-Sterling 2000: 45). In his personal journal, intersex narrator David writes: "we somehow terrify and threaten the culture to the extent that we are almost universally destroyed as infants. 'Fixed' and made to fit in" (David 1994: 5). This 'fixing' is implemented in response to the perceived threat to the culturally established strict demarcation between male and female genders, and thus to compulsory heterosexuality:

> "Because our society demands a world in which heterosexuality is the norm and there are only two possible sexes, those born intersexual must be considered pathological. Medical procedures which remove perfectly functioning body parts (i.e., mutilation) can thus be justified by the insistence that it is a 'cure.'" (Holmes 1994a: 5)

In the 19th century, doctors' most important justification for genital surgery performed on an intersex individual was the patient's future marital prospects. The primary goal of the surgery was to make the person 'marriageable,' i.e. making female sexual organs fit for being penetrated (through the creation or dilation of a vaginal opening) or male sexual organs fit for penetrating, as Elizabeth Reis notes:

> "In deciding the sex of their patients, doctors sought [...] happy endings, hoping to see their patients embrace at least one element of womanhood (or manhood): marriage. The early cases of interventionist surgery on genitalia were designed to make the genitals serve the doctor's perception of patients' sexual and marital requirements." (Reis 2005: 432)

Doctors' considerations concerning the desired surgical outcome generally privileged a 'normal' appearance of genitalia over the person's sexual desires and genital sensation. Normal-appearing genitalia would ensure that the person, at least visually, would be able to meet the sexual requirements vis-à-vis prospective sex partners – who should be, of course, persons belonging to the 'other' sex (depending on the doctor's own estimation of the person's 'true' sex). Medical practitioners were usually worried about the intersex person's (potential) development of homosexual desires and considered it as their duty to prevent the person from pursuing sexual partners of the 'same' sex through surgical interventions. If this implied a damaging or even destruction of the person's genital sensation or sexual satisfaction, doctors expected the patient to tacitly consent to the intervention for the sake of their marriageability. As expected, there was a gender bias inherent in this practice: women's sexual desires were by far less appreciated or even acknowledged than men's, so that as a result doctors' (who were almost exclusively male) contemplations of genital adjustment dismissed female sexuality as irrelevant when a certain case required the doctor's decision about whether to make the intersex person a sexually dysfunctional 'man' or a sexually mutilated 'woman.' This practice seemed to suggest, "[b]etter a woman with no sexual desire than a man unfulfilled" (Reis 2005: 433).

In the 20th century, the gender binary has not lost its importance as a, or maybe even *the*, keystone of modern and contemporary culture. Thus, the decision of whether to assign an intersex infant as a girl or a boy is a process heavily informed by cultural conceptions of maleness and femaleness. Whereas maleness is linked to "proper penile function" and phallus size, femaleness is defined by its "reproductive function" (Fausto-Sterling 2000: 59), which led to the following common rule within medical practice of managing intersex in the 1990s: "Genetic females should always be raised as females, preserving reproductive potential, regardless of how severely the patients are virilized. In the genetic male, however, the gender of assignment is based on the infant's anatomy, predominantly the size of the phallus" (Donahoe et al. 1991: 527). In short, intersex males need a penis that is large enough both to compete with non-intersex boys/men and to vaginally penetrate a woman during sexual intercourse. Intersex females should be able to bear children. The emphasis in the case of male sexuality is on appearance and performance, the emphasis in the case of female sexuality is on procreation.

This unequal disposition regarding female and male sexuality reveals a lot about the perceived (ir)relevance of women's sexual desires in American culture. For intersex women in particular, their reproductive capability is considered the crucial factor of 'real' womanhood. In her attempt to trace the 'truth' about her sex, intersex narrator Martha Coventry is confronted with common stereotypes about gender and sexuality that are inherently misogynist. The answer she receives from both her father and her male gynecologist can be summarized as, "I had children, wasn't that proof enough?" (Coventry 1997/98: 28). As both male authorities define her femaleness, and by extension her female sexuality, in terms of fertilization, which ostensibly requires heterosexual intercourse, they justify the clitorectomy performed on her as harmless to her sexuality. Her subsequent inability to experience clitoral pleasure and her potential homosexuality are ignored. While in the 1950s clitorectomies were performed relatively frequently on intersex infants with an 'enlarged' clitoris, suggesting that "female orgasm was vaginal rather than clitoral" (Fausto-Sterling 2000: 61), from the 1960s on, medical doctors have gradually revised their ideas about female sexuality and acknowledged the clitoris as a relevant part of female sexual pleasure. This shift of cultural notions about female sexuality affected the surgical treatment of intersex infants assigned as girls, and replaced the clitorectomy (i.e. the complete removal of the clitoris) with clitoral reduction or recession (i.e. the clitoral shaft is downsized or hidden under a fold of skin). Additional surgeries that are also quite frequently performed on female-assigned intersex infants include the construction or widening of a 'vagina' and the reduction of the labia (Fausto-Sterling 2000: 60f). Although medical practice has changed to less radical methods, contemporary treatment is still generally motivated by cultural notions about gender stereotypes. Women's genitalia should be designed to both visually and physically please a male sex partner: their vagina should be able to be penetrated by a penis (i.e. to guarantee heterosexual intercourse and male sexual satisfaction) and both their clitoris and their labia should be *petite* enough not to resemble the male phallus or in any other way be obstructive to penile penetration.

In a recent medical study about variations in female genital appearance, surgeons comment on non-intersex women's putative reasons for surgically altering the appearance of their genitalia:

> "implicit in a woman's desire to alter genital appearance may be the belief that her genitals are not normal, that there is such a thing as normal female genital appearance, that the operating surgeon will know what this is, that he or she will be able to achieve this for her and that this would somehow improve her wellbeing or relationships with others." (Lloyd et al 2005: 643)

Lloyd et al attribute women's embarrassment about their genital appearance and concern about their partner's reaction primarily to the pervasiveness of cultural misconceptions of normative genital appearance via the media, particularly pornography: "With conspicuous availability of pornography in everyday life, women and their sexual partners are increasingly exposed to idealized, highly selective images of the female genital anatomy" (2005: 645). As a result, these idealized images have also informed surgeons' and other doctors' notions of what normal genitals are supposed to look like and consequently affected the treatment of persons whose genital development is considered unusual, i.e. intersex infants first and foremost. Recent studies have found that generally, information on clitoral size and vaginal length, labial size or other aspects of female genitalia is far from exhaustive. Descriptions of 'normal' female genitalia are poorly documented in medical literature (compared to the relatively vast availability of medical measurements for male genitals). Quite the contrary, the study conducted by Lloyd at al demonstrates wide variations relating to the external appearance of female genitals, including labial and clitoral size and vaginal length. These findings have important implications for the treatment of intersex persons, which has constantly been aiming at creating a 'normal' genital appearance via surgery. Lloyd at al contend that "given the variety of normal female genital appearance and lack of normative data, it can be surmised that decisions regarding the amount of reconstruction needed are entirely subjective. It is therefore surprising that surgeons feel confident that surgery has the potential to achieve a 'normal' female genital appearance" (2005: 645).

Quite a few intersex first-person narratives address this problem that many intersex individuals are faced with, namely, the fear of being rejected by a sex partner because they feel that they cannot measure up to the demands of normative looking genitalia. Joan W. holds her clitorectomy responsible for her failed sexual relationships, as the surgery damaged her clitoral sensation and mutilated her genitalia: "I have never enjoyed sexual or romantic intimacy in my life, with men or with women. I believe that this is a direct result of my treatment. The clitoral surgery that was performed on me damaged my ability to experience sexual pleasure and it failed in its putative purpose of creating 'normal' appearing genitalia" (W. 2001: 4).

Her reasoning relates to two distinct aspects: what or how she feels (or does not feel), and how she looks. While the first aspect is primarily self-referred, the second one involves also others, particularly prospective sex partners. Joan W. perceives her discomfort regarding her genital appearance as a result of the normalizing judgments made on her sexed body inherent in the medical gaze which she was subjected to as a child. Many intersex individuals who were assigned female at birth refer to the relations between the clitorectomy/clitoral reduction performed on them and a social 'normalizing' of their sexuality in their narratives. In stark contrast to doctors' and parents' assessments of what is for the child's own good, almost all narrators are deeply troubled by the consequences of genital surgery.

Many intersex narrators have undergone repeated medical examinations of their genitalia as children and adolescents. These examinations are experienced by all intersex narrators as humiliating, traumatizing and confusing, as they are unprotectedly subjected to the medical gaze. In many cases, the young 'patients' are confronted not with the gaze of one, but a group of doctors who are curious to see an 'extraordinary' case, a medical 'spectacle.' As Angela Moreno recalls it, "my doctors made a traumatizing hospitalization even more traumatizing by putting me on show for parades of earnest young residents with 'you're-a-freak-but-we're-compassionate' grins on their faces. This, all without nurses or my parents anywhere around" (Moreno 1997/98: 12). This hegemonic medical gaze was especially in the past predominantly male; nurses (who are traditionally mostly female), even if they were/are present in the examining situation, did/do not possess the hegemonic gaze.

The procedures of medical inspection of intersex genitalia always involve doctors' judgments based on normative notions about sex organs, which define the intersex body as 'deviant' and thus 'pathological.' Joan W. experiences the examinations following the clitoral surgery performed on her as being on trial, with medical authorities judging her sex and convicting her of failing to meet their normative standards of sexed corporeality: "The inspection of my genitals at each checkup was hard enough to endure, but having groups of doctors, interns and medical students present at those examinations made it quite clear to me that I was not and would never be like other girls" (W. 2001: 4). The presence of interns and medical students strengthens the conception of the intersex child as a study subject, and above all, a rare study subject that cannot be withheld from the sight of inquiring practitioners and experts. Joan's perception of her sexed body is conflicting with the image of her body as deviating from 'normal' girls' bodies, which is mediated through the medical gaze. While she feels that her clitorectomy "damaged [her] ability to experience sexual pleasure and [...] failed in its putative purpose of creating 'normal' appearing genitalia," her doctors consider her surgery as a "success" (4). Joan now positions herself in a critical relation to the doctors' perception of her body as an abhorrent condition that justifies even an unsatisfying treatment, a perception that she herself had internalized as a teenager: "I must have been truly repulsive to my parents and doctors if the result of the surgery performed on me could be considered an improvement" (4). For her environment, a damaged female body still seems to be preferable to an intact intersex body.

Joan later eludes the medical gaze by refusing to participate in a follow-up interview in order to avoid repeated humiliation, and thus resists the perpetuated objectifying and normalizing judgments about her body. By refusing the medical interrogation that seeks to define the terms of her sexed embodiment and her sexuality, and to render her own sense of sexed and gendered reality irrelevant and unintelligible, she eludes being "fully recognizable, fully disposable, fully categorizable" by the medical hegemonic power, and by this elusion, her "humanness emerges," according to Butler's reasoning (Butler 2001: 634). However, she does not fully manage to create a positive body image on her own terms. She is still traumatized by her treatment and as a result suffers from depression and suicidal feelings. However, her narrative conveys a flicker of hope, as she can at least openly articulate her counter-perspective to the medical establishment by writing a letter to her doctor. Although 'Dr. M' neither has to meet nor is directly subjected to her gaze, he or she becomes Joan's 'study subject' in her own examination of him and his colleagues' practices.

Quite often medical judgment is rendered without words. In fact, nonverbal judgments are all the more indicative of a perceived bodily 'deviance.' The intersex person is confronted with the result of an examination of their body that is not explicitly spoken out; as a result, the patient is not able nor authorized to respond to the doctors' statements. The communication process is one-sided as the doctors draw their conclusions through observing the patient, but a patient's counter-gaze that wields the same power is not possible in the examination situation. This power divide within medical visualization practices is amplified by medical photographs of intersex study subjects. Morgan Holmes describes her experience with the hegemonic gaze as extremely imbalanced and objectifying:

> "I've seen quite a few such photographs in medical texts on intersexuality. They are usually extreme closeups of genitals, or full body shots with the *eyes* blacked out. How many doctors, med students, and archivists have been able to inspect my genitals without having to confront my gaze because my eyes were conveniently blacked out of the photo?" (Holmes 1994a: 6)

The medical perspective produces a depersonalized, almost dehumanized intersex subject, by crossing out their eyes, erasing the intersex person's individuality and humanity. As a consequence, doctors can treat intersex persons as study subjects and disregard their personal feelings, needs, and opinions. Moreover, they can conveniently stare at the intersex object and make their judgments without reciprocation.

It seems paradoxical that the medical perspective is quite frequently appropriated by intersex persons for their own conceptualizations of their intersex corporeality. In an effort to find out the 'truth' about her sex that has been obfuscated by both her parents and doctors, Jane Carden uses medical photographs of other intersex persons to define her bodily variation: "After several weeks of poring over medical texts and comparing the appearance of my body with the clinical photographs, I reached a firm diagnosis: testicular feminization" (Carden 1995: 2). Not only does she refer to the visual markers of intersex as produced by medical practices but also to medical terminology as she conceives of her corporeality in terms of a pathological condition.

Medical visual accounts of intersex bodies are often reappropriated by the intersex narrators in order to reclaim their preoperative, intact body: "My medical records refer to a clinical photograph before the surgery. I have tried to obtain it, but the clinic insists that it was destroyed. [...] If I had the photograph it would be a way for me to re-member my stolen body" (Holmes 1994a: 6). While this photograph of the uncorrupted infant's body is likewise taken from a medical perspective, it is understandable that Holmes wants to take hold of this picture, as it refers back to her bodily state prior to medical intervention. What is more, the change in perspective produces a radically different meaning: through the doctors' gaze, the preoperative intersex infant body is constructed as a "pathological condition" which justifies the subsequent clitorectomy as a necessary "cure" (Holmes 1994a: 5). In contrast, for Holmes this very same body signifies a viable corporeality and the removal of "perfectly functioning body parts" a "mutilation" (5). Holmes' medicalized infant body may not cease to exist or not even be replaced by her humanized infant body construction, but the medical construction of her body is at least challenged by her counter-gaze.

The hegemonic gaze inherent in the medical intersex narrative becomes destabilized by first-person narratives' change of perspective, which allows for alternative intersex conceptualizations and the resignification of intersex bodies. In her personal narrative "My Beautiful Clitoris" (*IA* 1997/98), Annie Green turns the medical perspective on her clitoris completely upside down. As a child she underwent a clitorectomy, which she experiences as a deprivation. Because she was too young to be able to recall her preoperative body, she has to rely on a medical report to know what her clitoris looked like:

> "I have only one connection to the clitoris that I was born with: a pathologist's report on the bit of tissue the surgeons sent him for analysis:
> *The specimen consists of a soft pinkish piece of tissue measuring 2.8 cm in length and approximately 1 cm in average outside diameter. The distal 1.2 cm. of the specimen is covered with wrinkled, pinkish tissue resembling prepuce. Section shows the specimen to consist of 2 soft, pinkish-white, somewhat shiny, half cylinders, each outlined by a thin rim of shiny whitish tissue and entire complex is covered by a thin rim of soft, shiny, pink tissue.*" (Green 1997/98: 12)

Through the pathologist's gaze, the clitoris is made a disembodied object ("specimen") rather than a viable body part belonging to a human being. The measuring hints at the relevance of the size of the genital as the primary signifier for a distinctive male or female sex. In the last thirty years, common medical practice for the treatment of infants and children with 'ambiguous' genitalia has strictly regulated 'acceptable' clitoris/penis sizes: "Medical standards allow penises as short as 2.5 cm to mark maleness, and clitorises as large as 0.9 cm to mark femaleness. Infant genital appendages between 0.9 cm and 2.5 cm are unacceptable," as Suzanne Kessler sums it up (quoted in Laurent 1995/96: 12).[1] Despite the existence of medical studies that show clitoris/penis size at birth as a continuum, rather than two constants, many physicians rely on their personal ideas, informed by their cultural background, about the 'appropriate' appearance of female and male genitals and then seek to surgically adapt the sex organ to their ideas – rather than the other way around.[2]

In the pathologist's report, only implicit assumptions about gender can be identified, through the emphasis on the phallus' size. The organ is not even referred to as "clitoris" but as "specimen"; it is described in technical terms and framed within a medical context. Both the circumstance that the organ is dead tissue, as it was amputated, and a pathologist's examining of the amputated organ mark it as pathological and useless. The report's deliberately clinical tone adds to its extremely dehumanizing effect. This dehumanizing process however is undone in the very next sentence following the quote, by Green's own commentary: "It sounds beautiful, doesn't it?" (Green 1997/98: 12).

She does not have many choices other than to refer to the pathologist's words (his quote makes up one third of Green's text) to talk/write about her clitoris. But her own interpretation of his words establishes a new perspective on the object and constructs it as (her) "clitoris." She appropriates the report's terms and claims and thus reclaims both the defining power of the object in question and her subjective bodily experience, thereby effecting a re-humanizing discursive moment: "I imagine it, my clitoris, lying in the cold metal specimen tray. I can't help but think how sad – such an alive, vascular, beautiful, sensitive organ, removed from the warm body of this precious child. My body" (12).

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[1] In consequence, 'clitorectomy' in this context denotes the removal of the sexual organ considered to be too large for a clitoris and too small for a penis; while the differentiation between an 'enlarged clitoris' and a 'micropenis' is not clear-cut, it however hints to the naturalistic, dichotomous notion of sex since 'enlarged clitoris' takes as a basis a female and 'micropenis' a male person, and signifies the 'inappropriateness' of the genitalia – the size of the external genitalia is the primary signifier that connotes a distinctive sex.

[2] See Fausto-Sterling (2000: 56ff) for a detailed discussion of doctors' decision-making processes for assigning gender and the prenatal, surgical and psychological 'fixing' of intersex infants.

Green's subversive discourse operates on two strategies. First, her reinterpretation of the medical text alters the relation between signifier and signified. The same text can radically change its meaning when the privilege of possessing the gaze is appropriated by a narrator who was not authorized to gaze before and the dominant perspective thus becomes decentered. "The specimen" becomes "my clitoris," (claimed) objectivity becomes subjectivity, a dead, pathologized "bit of tissue" becomes an "alive, vascular, beautiful, sensitive organ" in its original state prior to the wrongful deprivation. The clitorectomy is experienced as a grievable "loss" (12) rather than a medical/cultural necessity or even a favor. While the medical text directly follows the clitorectomy, and thus cannot refer to the tissue as "clitoris" since the tissue did not qualify as a "clitoris" (otherwise it would not have been amputated), Green seeks to reimagine an intact body *with* the organ that qualified as a clitoris for her, thereby relating to her preoperative infant body: "Every day my thoughts touch on what it would be like, what it would feel like, what it would look like, if this had not happened to me" (12). As the narrative is conveyed from the intersex individual's perspective, the medical text itself is subjected to an 'intersex gaze,' its underlying assumptions are challenged or rejected and the medical practices it articulates under scrutiny. The traditional gazing positions – active medical gazer, passive gazed-at intersex object – are reversed.

Second, Green constructs a counter-perspective on her child self in retrospect, by using the third-person narrative perspective to refer to herself as a child. The gaze of the medical authorities constructed her child self as a 'patient' with a medical 'condition' that needed to be 'cured' with the help of surgery. Her body was considered as deviant, pathological and abhorrent, so that leaving the body in this state was not an option. Her own experiences and wishes as a child were not (culturally/medically) relevant to the doctors – and obviously, neither to her parents – and consequently could be ignored. From the hegemonic perspective, cultural conventions were more 'precious' than the child herself and her bodily integrity. Green reclaims her child body by reappropriating the third-person perspective on "this child" and making it her own. Her child self is no longer a depersonalized medical study subject but becomes a "precious child," an individual, and an intelligible human being (12). Green considers the child's clitorectomy and her future prospects after the medical treatment as "sad," "tragic," and "heartbreaking": "so many years of this child's life would be filled with anguish, confusion, and shame," "this little child would grow into a sexual being who will never know orgasm" (12).

At the time her story was written Green, as an adult, already knows that these anticipations will be fulfilled. By pointing out the devastating impact, she comments on the medical authorities' neglect to pay attention to the personal, possibly negative, consequences for the child's mental and bodily health and her future life, who instead categorically promote medical treatment as a social necessity. At first glimpse, Green's narrative creates the impression that she considers her own life as miserable, due to medicine's violation of her child body and the deprivation of her adult sexuality, and that her future will be consumed with grief. However, she does not remain in the role of medicine's helpless, silent victim and resists the medical power over herself and her intersex body. She autonomously reappropriates the privilege of the gaze and uses it for a rearticulation of her own intersex sense of self and even manages to retrospectively create an image of the child Annie as a precious little being. She has authorized herself to recreate her own narrative by resignifying the terms available to her. Green's concluding remarks on having found ISNA moreover suggest that she is now able to share her experiences with other intersex people and to overcome her feelings of being alone with her struggle.

The 'constructivity' of sexes becomes apparent in the narratives' recounting of doctors' attempts to *make* a distinct male or female sex. Born with an intersex variation and having been raised as a male, Sam, the narrator of "Becoming totally gendered" (*HWA* 1995), experiences a confusion about his sex and (gender) identity, which first causes much distress for Sam and is then followed by various medical interventions:

> "All I knew was that I was different and very ashamed socially about the way I looked physically. I knew I was O.K. with how I looked and felt. But externally I was and am fearful about how others would judge me: Am I a man? What am I? I felt and feel primarily male, but the parameters for being male excluded me. For years I lived in fear of being 'found out.' [...] I was given hormone injections, which I still take, which produced a deep voice, muscle mass, and facial hair. At age eleven surgeons implanted prosthetic testes, which the doctor told my parents 'would make me look more male in the locker room.'" (Sam 1995: 3)

The explanation for this gender dysphoria given by the narrator is ambivalent: the excluding "parameters" for being male certainly refer to cultural standards for maleness, and the expressions of his feelings such as being ashamed socially, the fear of being detected as being not 'really' male, being "terrified of being shamed in the locker room" (1995: 3) and not being able to meet societal expectations of a 'normal' male appearance, suggest the narrator's dependence on others' judgments and a strong desire of being accepted in his gender. While Sam states that the surgery to construct testes "did not make me feel or look more male" (1995: 3), he expresses an ambiguous feeling towards surgery, as the subsequent reduction of his breasts enabled him to "pass for a 'normal' male" (1995: 3). Thus, societal pressure and both parents' and doctors' willingness to find a 'remedy' for Sam's struggle with his sexed embodiment and his sense of gender in surgery can be identified as the main reasons for the narrator's distress with his intersex corporeality. The normalizing judgment usually made by medical authorities, in order to control and correct 'deviances' from the norm, is (to some extent) adopted and consequently integrated into the intersex person's sense of sexed and gendered reality.

For Sam, a 'successful' performance of his sexed body and, consequently, his gender is measured by how others perceive him: vis-à-vis his male schoolmates (in the locker room – a highly gendered space), his genitalia need to look like theirs in order to qualify as male, vis-à-vis female sex partners, his genitalia need to be fit for (hetero-)sexual intercourse. However, in the end it is not the surgeries which provide Sam with a sexed and gendered mode of being he feels right for himself: although Sam is able to pass as a male, he still feels "socially isolated" (1995: 3) and misses a sense of belonging to a community whose members share his bodily and gender experiences. His identificatory process is triggered by a sudden awareness of the existence of other intersex people, and his love for himself and his embracing of being intersex is achieved through the identification with the intersex community.

Most intersex narratives that negotiate the narrators' experiences with medical interventions, in particular surgery, represent the intersex person as having been subjected to the treatment by authorities, i.e. their parents and doctors. The decisions concerning their body, gender, and sexuality were made by others, and the intersex person was not authorized or able to give consent to or to reject treatment. In some cases, however, intersex individuals who underwent infant genital surgery damaging their ability to experience clitoral sensation, orgasms and sexual pleasure consider additional surgery for 'undoing' this damage. IQ's narrative "Thinking of more surgery?" (*HWA* 1995), explicitly addressed at other intersex people and ISNA members, negotiates her experiences with seeking a way to restore her sexual sensation through surgery. At one moment in her life, she no longer wants to resign herself to her perceived sexual dysfunction: "I decided that there *must* be some way to get back what had been robbed from me. Perhaps the sort of microsurgical techniques used to reconnect fingers severed in industrial accidents could restore the sensation of my clitoris" (IQ 1995: 9). Her desire for self-determined genital surgery is not only sparked by the prospect of improving her sexuality, but also motivated by regaining a sense of mastery over her body. The process which follows her decision demonstrates how dominant medical practices are simultaneously reiterated and challenged. To begin with, IQ initiates this process by gathering information about the prospects and the feasibility of such a surgery and locating a surgeon apparently qualified for the operation. She is also an active, and at first glance equal agent in the medical communication process with the surgeon, being able to discuss the chances of success and most importantly, the risks. Moreover, IQ herself decides to become his patient, and allows him to examine and photograph her, precisely those acts usually carried out by medical authorities without the intersex person's consent and even against their own will.

IQ's reclaiming of this active role in the medical process effects a shift in the traditional doctor-patient relationship and its underlying power mechanisms. Relevant, i.e. medical, knowledge ceases to be a doctor's exclusive privilege and can also be accessed by the patient. The patient can at any point during the process opt out or opt for a different treatment. The doctor is bound to provide truthful and detailed information about the treatment. At least theoretically, the patient is equipped with more power and autonomy within this relationship; as a result, the dominant medical discourse on intersex is undermined, or challenged.

However, while IQ's narrative constructs her as this active agent, and thus resists her perpetual subjection to medical powers, her narrative also reveals the limitations of a radical subversion of the hegemonic medical intersex narrative. The major discursive strategies of this narrative are replicated in the process related to by IQ. In the majority of cases where an intersex child is born, both the child and the parents are isolated from other intersex children and their parents, and are basically alone in dealing with the child's intersex variation. Also in subsequent treatment, not many doctors encourage patients and their parents to consult with other intersex children or adolescents, or with their parents, respectively. In many intersex narratives, narrators remember their feelings of being "the only one in the world" as intersex children (Walcutt 1995/96: 11).

In IQ's narrative, her surgeon claims to have performed the desired surgery on several other intersex women who also underwent a clitorectomy as infants. IQ is delighted at the prospect of meeting other women who share her experiences: "I would get [this surgeon] to introduce me to them! No longer alone in the world!" (IQ 1995: 9). However, she is again purposely isolated from other intersex persons, in this case because the surgeon finally has to admit that he has never done a surgery to restore the clitoris of a clitorectomized intersex woman, and hence does not know any other adult intersex individuals. Moreover, she is confronted with obfuscating and contradictory information concerning the possibilities of success and the risks involved in the planned surgery. Many intersex narratives represent the concealment of relevant information and incomprehensible medical verbiage as a 'typical' strategy employed by medical authorities to maintain their power position towards the patient.

Taking all negative aspects into account, IQ concludes that she will not have another surgery and closes her narrative with rather bleak prospects: "In the end, I decided that the likelihood of improving my erotic sensation by surgery was minute, and that there was a good chance of doing more harm. I have abandoned the idea of surgery, and know that I must live all my life without learning what a clitoris feels like" (1995: 9). IQ's attempt to have her clitoral sensation surgically restored has failed in the end. In the process of pursuing the desired surgery, she is faced by challenges that are evocative of dominant medical practices regulating the treatment of intersex infants and children. Her faith in the medical establishment is ultimately destroyed, as her advice to other intersex people who might consider surgery to restore sensation makes quite clear: "you are probably better off not letting a surgeon touch you again" (9).

Yet her narrative also demonstrates that an adult intersex person can free herself from being subjected to medical powers and might choose surgery on a voluntary basis, and more importantly, opt out of surgery if they like. IQ's decisions to both pursue and finally reject the surgery are based on knowledge she was able to gather and on a relatively equal, however biased, relationship with her doctor. Her final dismissal of medical treatment can also be read as a liberation from medicine's defining power of her sexed embodiment and her sexuality. Although she contends that she will never know clitoral sensation in her life, in dealing with the subject in a productive way – by calling on the very same practice that harmed her previously and seeking to utilize its potential for repairing the loss –, she manages to overcome both her perceived dependence on surgery/surgeons and many years of denial and emotional crises. IQ's narrative thus can be read as a form of resistance against surgical practices and as providing a counter-narrative to traditional narratives on genital surgery performed on intersex individuals.

3.2.3 Making Up for the Absence: Redefining Sexual Pleasure and the Challenging of Heteronormative Ideas of Gender and Sexuality

Sexuality and sexual relationships and their often problematic implications for intersex persons are negotiated in some narratives. To date, the sex/gender (re)assignment performed on the infant or child is almost unanimously considered as 'successful' by both doctors and parents when the person forms heterosexual relationships as an adult. Joan W. addresses the relationship between genital surgery and homophobia in a letter to her former pediatrician:

> "I have taken the time to discuss these issues with other women born with genital ambiguity, and with parents. I have found many women who, like me, never formed the heterosexual relationships that their parents desired and that doctors implied would be one of the benefits of trimming an unacceptably large clitoris. I have noticed an undercurrent of homophobia in some of the comments of parents who defend their decision to allow surgery on their infant daughters. I have spoken with many women who resent the surgery that was performed on them." (W. 2001: 4)

If parents and doctors do not seek to prevent homosexuality from the outset by means of surgery or other medical interventions, the possibility of the child becoming homosexual in adult life is basically ignored. Genital surgeries, hormone therapy, and psychological counseling both assume and are targeted at the production of a heterosexual subject. The sexed bodily characteristics are scrutinized with regard to their potential to perform heterosexual intercourse, thereby referring back to normative notions of heterosexual practices and the active/passive divide between male and female partners (i.e. the man penetrates, the women is penetrated). Medical and psychological treatments of the intersex patient involve normalizing judgments about their actual or prospective sexuality. Heidi Walcutt experienced her treatment at Buffalo Children's Hospital as largely ignorant of or even hostile towards questions of sexuality. Due to her early genital surgery, she feels her ability to experience sexual pleasure and orgasms to be severely limited, but the practitioners at the hospital kept silent about these issues: "I don't believe that anyone at Buffalo's Children ever spoke to me about genital sensation, orgasm, or masturbation" (Walcutt 1995/96: 10). Her treatment is directed towards 'normalizing' her as a girl/woman, taking physical functions of the sexual organs as the main basis for defining (normative) femaleness: "She [the psychologist] told me that I was female, but my ovaries and uterus had been 'underdeveloped,' and that I would need to take pills prescribed by Buffalo physicians if I wanted to have puberty like other girls" (10).

The psychologist's statement seems to suggest that in order to function as a 'real' woman, the intersex girl needs to have fully developed reproductive organs (size and function both matter here) – and since these aspects are not 'naturally' given in Walcutt's body, the cultural demands on femaleness need to be simulated via medicine. In particular with regard to her future sexuality and marital prospects, medical treatment is aimed at simulating 'appropriate' female sexual functions, i.e. surgically creating a 'vagina' fit for performing heterosexual intercourse. Since Walcutt's vagina which the doctors created through a first vaginoplasty is not deep enough for penile penetration, she would need to have another surgery "if [she] ever want[s] to have normal sex with [her] husband" (10). Walcutt's supposed heterosexuality is never questioned and the assumption that all heterosexual women want to marry a man and be penetrated by a penis goes completely unchecked. The second planned vaginoplasty is cancelled, but Walcutt does not seem to be bothered by her small vagina since she is a lesbian. She also relies on normative notions about both hetero- and homosexuality in saying that "if I were interested in sex with men, I might feel differently" about her impenetrable vagina (10). This statement, together with the reason she gives for not regretting the cancellation of her vaginoplasty, i.e. her lesbianism, are based on the assumption that all heterosexual women want to be penetrated while homosexual women always and universally reject being penetrated. At age 27, she had never formed sexual relationships with another person because of her inability to accept her attraction to women. Although she attributes her past denial of her lesbianism largely to her parents, who, as conservative Christians, condemned homosexuality, her closetedness might be in part a result of the homophobia inherent in her medical treatment ("I hoped to marry, adopt children, as the counselors at Buffalo Children's suggested" [11]).

Narratives that deal with an intersex person's sexuality and sexual relationships are strongly linked to the destruction, or at least impairment, of their sexuality due to genital surgery. A significant structuring principle of these narratives is absence: the removal of the clitoris, the lack of sensation, the inability to orgasm, unfulfilled sexual pleasure, and sexual dysfunction. For sexuality and sexual experience to be considered satisfying it has to realize specific culturally established standards defining a normative sexuality. This normative model of sexuality relies on compulsory heterosexuality and the assumption that men gain sexual pleasure by penetrating and women by being penetrated. The fulfillment of sexual experience is very often measured in terms of the ability to reach orgasms. In heteronormative notions of female sexuality, it is the ability to have vaginal orgasms that defines sexual pleasure for women; however, in many intersex narratives, clitoral orgasm becomes the central signifier of sexual pleasure, and consequently the inability to reach clitoral orgasm is perceived as a failure to achieve sexual pleasure at all. Many narratives at first glance seem to deny intersex persons a satisfying sexual experience that derives its fulfillment from sexual stimulation other than (clitoral) orgasm. The absence of a clitoris is always conceived of as a wrongful deprivation executed by medical doctors in order to create 'normal' appearing genitalia, and its brutal loss inevitably leads to psychosexual damage and mental-health issues:

> "As a consequence of 'reconstructive genital surgery' during infancy, I have no clitoral sensation, and have never been able to experience orgasm. After many years of denial, I had a severe emotional crisis, with suicidal feelings. I decided that there *must* be some way to get back what had been robbed from me." (IQ 1995: 9)

> "Thirty-two years have passed since my clitoris was taken from me. Though I was too young to be able now to recall the event, I feel that I will be grieving the loss for the rest of my life. Every day my thoughts touch on what it would be like, what it would feel like, what it would look like, if this had not happened to me. [...] How tragic that this little child would grow into a sexual being who will never know orgasm. How heartbreaking that so many years of this child's life would be filled with anguish, confusion, and shame." (Green 1997/1998: 12)

In relation to sex partners, quite a few of these narrators perceive their intersex body as dysfunctional since it cannot measure up to the cultural demands of a fulfilling sexual experience, and a satisfying sexual performance is not only determined by the sexual pleasure experienced by the intersex person but also by her sex partner. As Cheryl Chase concedes in "Affronting Reason": "As a woman, I am less than whole. [...] I lack important parts of my genitals and sexual response. When a lover puts her hand to my genitals for the first time, the lack is immediately obvious to her" (Chase 2002: 211).

For a sexual performance to be successful it has to meet specific culturally established requirements, thereby taking the bodily experiences of 'others,' i.e. male or female but *not* other intersex individuals as the basis for one's own bodily experience: "I knew that I had been mutilated by the clitorectomy, deprived of the sexual experience most people, male and female, take for granted. What would my life be had I been allowed to keep my genitals intact?" (Chase 2002: 206). This narrative does not allow for an intersex person to experience her own sexual pleasure, since sexual pleasure is assessed exclusively in terms of the ability to have clitoral orgasms. Chase does not use the term "clitoral orgasm" explicitly, but she insists in making a distinction between various forms of orgasms like "vaginal orgasm" and "full body orgasm" and seems to privilege "clitoral orgasms" over other forms – which cannot be realized (without a clitoris due to clitorectomy): "If I persist in asserting my sexual dysfunction, many patronize me" (2002: 206).

Moreover, the constant infantilization of intersex bodies problematizes an adult intersex mode of being. The intersex body exists in its original form only in the preoperative newborn's body and ceases to exist after genital surgery performed on the infant. Since intersex signifies an absence, the postoperative body is signified by absence too, since it cannot possibly assume an intersex/absent sex. The construction of the sexed body repeatedly and exclusively relies on genital signifiers, taking infant genitals, 'uncorrupted' by cultural conventions, as the original signifiers for a 'natural' sex: "In a sex-repressive culture with a heavy investment in the fiction of sexual dichotomy, infant genitals are for discriminating male from female infants. It is very difficult to get parents or even physicians to consider the infant as a future adult sexual being" (Chase 2002: 209). Although Chase's narrative criticizes the medical establishment's and the parents' ignorance with regard to the intersex person's future adult sexuality and their ability to experience sexual pleasure, and thus provides a counter-perspective on matters of sexuality, it fails to construct a positive, pleasurable intersex sexuality. Chase seems to reject alternative options to reclaim her sexual pleasure, and the narrative ends without a hint that this will change in the future.

Chase's narrative of her personal experiences with her sexuality provokes a juxtaposition with one of her fictional narratives that allows for an intersex person to experience her own sexual pleasure. In Chase's short fiction story "(Not) Another Clit Story" (*IA* 1997/98), the sexual experience of a female-identified intersex person, Karen, is juxtaposed to that of an African woman, Zara, who both underwent a clitorectomy as infants. The narrative seeks to resist the dominant narrative of intersex sexuality by rejecting accounts of sexual dissatisfaction and painful intercourse. Against this dominant narrative, Chase seems to construct a sexual narrative that has a positive outcome in terms of sexual pleasure. A positive reclaiming of intersex sexuality is complicated by the narrative's own discursive strategies. The sexual encounter between the two women is problematized from the start by the narrative's introduction of the protagonists as genitally mutilated. The juxtaposition of the mutilated body and the eroticized body structure the whole narrative, and sexual pleasure is inextricably intertwined with an effort to compensate for the perceived lack:

> "Gradually Karen's tears subsided, she pushed her grief back down to its usual hiding place, and another feeling rose up in its place. She rubbed her cheek against Zara's, pressed her lips, moist and swollen from crying, against Zara's. [...] Now Karen ran her tongue down the crease between belly and thigh, used one hand to urge Zara's thighs apart wider. Avoiding the broad pad of scar in the center, she lapped along the sensitive flesh outside what remained of Zara's lips. A moan escaped from deep inside of Zara, and Karen pressed on, down and back, tonguing the intact flesh behind her vaginal entrance as she brought both hands under buttocks and around hips, stroked the other woman's belly. [...] She slid a finger at the same time gently into Zara's vagina, pressed and swirled it, careful to avoid too much pressure against the scarred entrance." (Chase 1997/98: 32)

At first glimpse, this sexual experience seems to revolve around an absent clitoris, and as a result the clitoris is very present, symbolized by the scar, hinting at something that once was there, and still *should* be there, but is not anymore. The narrative's construction of the sexed body again relies on genital signifiers, and since the loss of the clitoris signifies an absence, this sexed body is marked as unintelligible and therefore a viable intersex sexuality is rendered problematic. However, the narrative enables alternative sexual experiences to be satisfying for clitorectomized women and intersex persons. During the sexual act, other body parts are eroticized and pleasure is achieved through sexual practices other than clitoral stimulation. A focus on the clitoris as the exclusive source of sexual pleasure becomes decentered and the sexual attention is instead refocused on the whole body, not only on the genitals. The sexualization of the lovers' bodies is not simply a result of sexual intercourse but of the way in which their bodies are constructed through each other's touch and perception. The narrative follows the exploration of their bodies through the perspective of the lover – mostly through Karen's perspective on Zara –, the body materializes before the lover's and the reader's eyes by tracing the contours of its flesh with the lover's own hands, tongue, and other body parts, thereby bestowing a new meaning on them. Each body part is given special consideration, which first effects a fragmentation of the bodies and then a recomposing of the fragments to a new bodily wholeness.

The better part of the short story is dedicated to the course of lovemaking and the de- and reconstruction of the sexed bodies involved in it. By projecting the intersex woman's experience of sexuality onto the African woman and vice versa, both Karen's and Zara's bodies not only become whole again in the end, but moreover "[t]heir bodies intertwined" (Chase 1997/98: 32), both undone and reunited by their shared sexual experience. This narrative not only challenges notions of intersex sexuality (and by extension, any clitorectomized person's sexuality) defined by lack and hurt. While the story begins with a reference to the loss of genital parts, this loss becomes incorporated into the narrative and into the sexual encounter, and is finally resolved into a sexual gain. Moreover, its representation of lesbian sexuality resists conventional cultural notions of sexuality and undermines the inherent heteronormative basis of medical treatments of intersex individuals, exposing the intended 'corrective' surgery as a failure. The narrative achieves a reclaiming of an intersex woman's sexuality as pleasurable, and thus stands in contrast to Chase's non-fictional account of how she experiences her sexuality.

The different ways to experience and to reclaim a fulfilling sexuality Chase seems to reject in her real life are tried out in her fictional narrative, which gives her more space for the construction of a desired intersex experience than a non-fictional account. Thus, while Chase does not seem to experience a satisfying sexuality at the time "Affronting Reason" was written – this remains speculative, however, as we have only been given fragments of her sex life –, a fulfilled sexual experience seems at least imaginable for her, despite her clitorectomy. The question of representation is also a question of activist and political strategies. While "(Not) Another Clit Story" appeared in the *Chrysalis* special edition about intersex, which was intended to raise intersex voices to empower other intersex people, an empowering account of intersex sexuality, even if fictional, can help others who have similar experiences with their sexuality as a result of a clitorectomy to reimagine their own sexual pleasure. In contrast, communicating toward the public (and especially toward the medical establishment and policy makers) that a person who underwent nonconsensual genital surgery can nevertheless experience sexual pleasure involves a certain risk, as such positive accounts can potentially be interpreted as an affirmation of (the 'success' of) the medical practice of 'normalizing' treatment. This aspect might also be a reason why intersex persons are, and especially were at the outset of intersex activism, cautious in which way they communicate their sexual experiences.

However, some non-fictional first-person accounts represent an intersex person's love and sexual relationships in positive terms, allowing for a satisfying sexual experience. Martha Coventry's sexual trajectory takes her from compulsory heterosexuality and her self-perception as a "sexual failure" (Coventry 1997/98: 28) to sexual fulfillment in lesbian sexuality. Sexuality has always played an important role in her life, and has been intimately involved in her struggles with her sense of gender. Her first orgasm at age eleven or twelve triggers her quest for her 'true' sex, when her clitorectomy had previously confined her to silence and fears about who and what she was: "Perhaps it was this new and powerful experience of pleasure from a place that held so much pain that made me determined to find out the truth about my body" (Coventry 1997/98: 28). Although she does not receive an answer at this point, she continues exploring her sexuality as a teenager. Her perceived genital 'deviance,' however, results in a disturbed adolescent sexuality: "wreaking havoc with my budding sexual self was the constant reminder that I was a freak. I was not right in the place where everyone else was perfect. I wanted to be normal. I wanted to fuck" (28). She subsequently avoids sexual encounters out of a fear that sex partners would find her mutilated genitals repulsive.

Coventry's self-perception as a woman relies on normative cultural gender notions, and her ideas about a fulfilled sexuality depends increasingly on heteronormative imperatives, both interrelated social requirements she is not able to meet. She then falls in love with a man whom she later marries, but self-doubts about her body and normative ideas about heterosexual intercourse make it impossible for her to enjoy her sexuality. Although she and her husband find other ways than vaginal penetration to be sexual, she cannot deal with her perceived "sexual failure" as a woman: "in this society, and in my mind, it was the old in-and-out that counted. It was my measure of a woman and I was lousy at it. My vagina was shut tight and there was nothing that could be done about it. Not even my children could pass easily trough that opening" (28). Her failure to sexually satisfy her husband is juxtaposed to her failure to give vaginal, i.e. 'natural,' birth to her children. Coventry has so deeply internalized society's misogynist conceptions of female sexuality as restricted to reproduction and pleasing men that she is devastated by shame for not being able to live up to the ideas of normative womanhood. She considers her life up to this moment as a pretense and a continual failure of being 'normal,' holding her difference responsible for her inability to pursue a fulfilled (love) life.

Her ideas of sexuality seem to be informed by the idea of a gender coherence involved in compulsory heterosexuality. She suppresses her early discovered and constant desire for women because she fears that her attraction to women would mean that she was really male, and even when finding out about the existence of lesbians, she cannot identify with them since they have 'normal' female bodies, in perceived contrast to hers. Her subsequent living in denial of her own sexual needs finally leads to an emotional breakdown. This crisis, however, marks a radical turning point in Coventry's life: she ends her marriage and begins to rediscover herself, finding a new, strong voice, as well as her body and her sexuality, exploring new ways of getting sexual pleasure. The reclaiming of her sexed body and her sexuality enables her to redefine her sexual self, and above all, her intersex self. Interestingly, her separation from the two most important men in her life – the breakup with her husband, the death of her father – cuts her loose to finally live her own life, allowing her to act out her lesbianism and to embrace her intersex embodiment. She now has arrived at a point where her life is coming full circle:

> "All the queerness I felt growing up finally had a home. Being a dyke fits my strangely hermaphroditic self so comfortably, so wonderfully. It feels totally and deeply right. Embracing my love for women not only makes me happy, it is the thing that I had been waiting for to give me the courage to look at my body, and at who and what I truly was, without turning away. I could never have found my intersexual self until I had found and loved my sexual self." (Coventry 1997/98: 29)

Coventry now resists the demands of a coherent, stable gender/sex and sexuality confined to normative parameters enforced by authorities; yet her own desire for an 'authentic' gender/sex – intersex signifies both her embodiment and her gender identification to her – points to a "basic, fundamental, enduring, and necessary dimension of who we are" (Butler, in Williams 2014), that cannot be reduced to a biologist-essentialist idea of sexed embodiment and its determinist relation to gender and sexuality. While the primary motivation of her narrative is the quest for her 'true' gender/sex and sexuality within a normative framework of legitimate alternatives offered by society, this quest for 'authenticity' can also be interpreted as a striving for liberation from normative categories of sexed, gendered, and sexual modes of being none of which seems to fit her sense of self.

Coventry's intersex narrative demonstrates that overcoming normative ideas of gender and sexuality is a process that requires making concessions and more often than not involves painful struggles. Eventually, her narrative subverts the hegemonic medical intersex narrative's inherent heteronormative demands on intersex persons' sexuality, which defines the 'success' of a sex and gender assignment in terms of a heterosexual outcome. Coventry's embrace of both her intersex and her lesbian self and her sexual fulfillment in lesbian practices reject the hegemonic narrative's heteronormalizing processes and expose its assertion that an intersex person's emotional well-being depends on their heterosexuality as not sustainable. Her redefinition of her sexed and gendered reality does not take place 'outside' cultural discourses that produce the conditions of intelligibility, but within or at the limits of these discourses, and hence of intelligibility. She achieves a 'different' kind of intelligibility, one that emerges as a result of her ability to "articulate an alternative, minority version of sustaining norms or ideals that enable [her] to act" (Butler 2004: 3) in reference to cultural collectives, i.e. an intersex collective and lesbians/lesbian communities.

3.2.4 Intersex in the Eyes of Lovers: Overcoming Sexual Trauma and the Eroticizing of the Intersex Body

The intersex narratives discussed so far have been exclusively conveyed from the perspective of intersex narrators, representing love and sexual relationships from an intersex point of view. Many of these accounts convey a rather pessimistic attitude towards a viable relationship and a fulfilled sexuality. Quite often, sexual and intimate relationships are complicated by the intersex narrator's previous traumatic experiences and fear of rejection by a partner, thereby largely omitting the partner's point of view in the narratives. However, a few first-person accounts were published in *HWA* and *IA* whose narrators are partners of intersex persons. These accounts, though barely representative due to the scarcity of the texts, are particularly interesting since they allow for a change in perspective and demonstrate how intersex is constituted, neither through an intersex person's perspective nor a medical gaze, but a personalized third person's gaze. Those few narratives center on closely interrelated themes like intimate relationships between the narrator and an intersex person, sexuality, and struggles with the intersex partner's mental-health problems. The relationships are presented as problematic, and the intersex partner's difficulties related to their intersex embodiment also affect the narrator. Sexuality is often the crux of the matter. As previously discussed, particularly in relation to sex partners, quite a few intersex narratives represent the intersex body as sexually dysfunctional since it cannot realize the cultural demands of heteronormative sexual experience, i.e. fails to sexually satisfy the other. In one of the partners' narratives, "The healing journey" (*HWA* 1995), Saraswati comments on "how deeply the wound of genital mutilation" of her partner impacts her life and her own sexuality. At times, the sexual loss of the intersex person becomes the loss of her sex partner:

> "I felt so vulnerable exposing my orgasm when my partner could not have orgasm. Sometimes my orgasms reminded her of what had been taken from her [...] Sometimes I feel sorrow at what has been robbed from her, robbed from us. Sometimes I wish so much she would feel desire for me, that I could see her coming to orgasm at the tip of my finger. That was taken away from me, too. It is not her wound only, I now live with it as well." (Saraswati 1995a: 8)

Sexual and emotional wounding, as a result of genital surgery, structure both the relationship and the narrative. While having sex, "[p]ain, grief, rage appear, the surgeons intrude into our private space, together with the isolation, the loss of parenting" (1995a: 8).

However, the narrative deals with this wounding in a productive way, in conceiving of it as the point of origin for a process of healing. For Saraswati, pain, healing, and sexual activity are strongly interrelated, as sexuality is both the source of the wound and the way out of it. The sexual healing is pursued in terms of a journey. Saraswati's initial function as "the sex teacher, the rescuer" (1995a: 8) of IQ, her future intersex partner, in using her sexual skills to provide IQ with a space to express her troubled feelings, moves into a different direction very fast when she becomes IQ's life partner. At first she manages to assume the role of the "healer" for her partner. Lovemaking as the cure for physical and emotional pain involves the reclaiming of a sexuality that was previously a place of shame and frustration on the intersex partner's side: "So many partners in her life had wanted her to make love to them, but could not or would not spend the time it takes for her to get aroused" (1995a: 8). In contrast, in this process of their healing journey, the couple works out alternative ways of finding sexual pleasure other than clitoral stimulation: "I had to understand that for us, making love was about giving her pleasure, regardless of what it might look like. It was not easy to remember sometimes that simply stroking her feet and shoulders for an hour might be just what she needed" (1995a: 8).

Saraswati's narrative moreover provides a partner's perspective on intersex genitalia, a perspective that is rarely found in intersex literature: "I like IQ's genitals, because they are hers. It was the first time I had seen female genitals without a clitoris. I like the way they get wet, it is my cue to know that somewhere there is arousal happening. They reassure me" (1995a: 8). This statement has several implications. First, it constitutes a counter-perspective to the medical gaze. The medical gaze on intersex genitals is strictly depersonalized, since the genitals belong to a patient (to whom a doctor usually has no personal relationship) but are at the same time detached from the rest of the body and consequently from the person as a whole, effecting a dehumanizing of the intersex person and also of the genitals. In addition, the intersex genitalia become pathologized through the medical gaze, and need to be surgically altered to make them 'appropriate,' as they were considered 'deviant,' and hence undesirable, in their original state. In most cases, the surgery's consequences for the intersex person's sexual pleasure have been ignored. Neither is true for the representation of intersex genitals through the partner's gaze. The partner, Saraswati, has an intimate and sexual relationship to the intersex person, IQ, and is interested in her as a person, as a life partner, and in her sexual pleasure. For Saraswati, IQ's genitals are desirable because she desires and loves IQ, and they are special because they belong to the beloved person.

Second, the partner's perspective also establishes a counter-perspective to the intersex person's own perception of her genitals. As already pointed out, many intersex persons perceive their postoperative genitals as sexually dysfunctional since they do not meet cultural criteria of normative sexes and ostensibly fail to perform satisfyingly during sexual intercourse. In contrast, Saraswati emphasizes the sexual functioning of IQ's genitals as she is able to get wet and experience sexual pleasure even without a clitoris. Moreover, her narrative constantly affirms her desire for IQ, their mutual lust for each other, and the great passion involved in their lovemaking. Saraswati's definition of sexual pleasure, however, remains ambivalent. While she claims that for her and IQ, sexual stimulation can be achieved by various means and thus proposes a decentering of the (absent) clitoris, she simultaneously refocuses on clitoral orgasm as the exclusive way to be orgasmic, as her comment above indicates. In doing so, she denies IQ the experience of having other than clitoral orgasms, or to define 'orgasm' for herself. This perpetual reference to absence and lack – of a clitoris, of the ability to orgasm – in combination with her own desire inevitably leads Saraswati to an eroticizing of IQ's pain, something she was trying to avoid: "A part of me had been seeing IQ as broken, in need, with few social skills, and I was getting off on it. I realized that I had fetishized her as being broken" (1995a: 8).

Her function as a "healer" for IQ increasingly poses a challenge for her and the relationship. Focusing her attention exclusively on her partner's wound and at the same time holding her own wounding at bay, Saraswati is soon confronted with her own rage and shame. She starts to articulate her own wound, questioning her own sexuality and sense of her gender. From her narrative it does not become clear whether Saraswati herself is intersex. She writes about her own wounding, “I believe that only a person who has been deeply wounded can understand the depth of the affect of sexual wounding and hang out in the well of emotions that can surface” (1995a: 8). This sexual wounding does not necessarily refer to negative intersex experiences. While there are no direct references in the text that she underwent genital surgery – apart from the statement “the surgeons intrude into our private space” during sexual activities with IQ, but this could also be related to IQ exclusively – the only hint she gives is that she had never seen female genitals without a clitoris and is able to experience (clitoral) orgasm. That does not mean, however, that a genital surgery has not taken place, but only that Saraswati chose not to be explicit about it or her possible intersex corporeality.

The healing journey, however, also becomes her journey of coming to terms with her sexual issues. Previously, “being highly sexual has been [her] survival tool” (1995a: 8); dealing with her wounding causes her sexual desire to vanish and thus threatens her sense of self. Sexuality was a means by which she had held her emotions at bay, but through her relationship with IQ she is finally able to take her sexuality to a level of deeper intimacy and love. At the end of her narrative, their relationship seems to be more balanced and the intersex partner, IQ, is no longer considered as the needy, passive part. In her second narrative “The gift of gentle healing” (*HWA* 1995), Saraswati calls her partner a “fierce warrior” and expresses her admiration for her courage: “When she decides to change something, she is relentless about it. She will put herself through the most intense fire” (1995b: 8). Now, she even acknowledges IQ’s determination to learn how to be orgasmic, a possibility she previously had denied her intersex partner. Only a couple of months later (the first narrative appeared in spring 1995, the second one in summer 1995), the roles seem to be, if not reversed, at least much more equal. The text represents the intersex partner as a brave, powerful person with a strong will. IQ seems to have emancipated herself from both medical authorities’ power over her body and her sexuality – in reclaiming her sexual pleasure – and the needy position within an unbalanced intimate relationship.

Within the framework of Saraswati’s two narratives, IQ is constructed first as a broken person who needs to be ‘rescued’ by her partner and then as a warrior figure. Although Saraswati qualifies the latter attribute by suggesting a more gentle approach to challenges than “tak[ing] a big hammer and destroy[ing] it”, i.e. a problem she is confronted with (1995b: 8), the two identities constructed for IQ represent remarkable extremes and provoke the question of the narrator’s underlying motivation. A possible reason might be Saraswati’s growth in love for IQ which causes a shift in her perspective on IQ. Another reason is certainly her own healing process that is accompanied by pain and difficulties and makes her vulnerable, so that in contrast, IQ appears to be less vulnerable than before. The narrative also suggests that Saraswati's initial perspective on IQ as needy was informed by her own "need to have a partner whom I could control" (1995a: 8). IQ's identity is thus an ambivalent construction within her partner's narrative accounts and would remain even more speculative if IQ herself had not published a narrative in *HWA* ("Thinking of more surgery?", discussed above).

Tamara Alexander's narrative "Silence = Death" (*IA* 1997/98) is likewise a story conveyed from the perspective of an intersex person's partner. Similarly to Saraswati's narratives, this narrative interrelates the themes of a problematic sexuality and healing, and describes how a relationship is affected by an intersex partner's troubled psyche and her partner's struggle to save her. The love story between the narrator and Max begins with Max's struggles with her lesbianism and her escape first into and then out of heterosexual marriage. A statement from a previous female lover during sexual intercourse, "Boy, Jude, you sure are weird," causes her to abandon lesbianism because women "would know how her body was different," and to subsequently marry a man "because men were just less sensitive to the subtleties of women's anatomy" (Alexander 1997/98: 48). This single judgment about her genitalia made by a former lover has such a deep effect on Max that she forces herself to repress her own desires for women and to marry in pretense.

The fact that one comment about Max's genitals drives her into a self-imposed compulsory heterosexuality hints at how deeply troubled and fragile her emotional and psychosexual condition really is. However, Max ends her marriage and begins a love relationship with the narrator, Tamara. Max finally confesses to her that she is intersex: "'When I was born, the doctors couldn't tell whether I was a boy or a girl.' She dictated the speech as if she'd told it many times before and all of the emotion had fallen right out of her" (48). So, Max's early and by now internalized definition of her intersex body depends in large part on the medical doctors' judgment. In this narrative, Max's own definition of her intersex corporeality is never explicitly articulated, but only mediated, or constructed by others: the doctors (who pathologize her), a female lover (who interprets her body as non-normatively female), her husband (who seems to be ignorant about her sexual needs), and her new female partner, Tamara, who is not "horrified, repulsed, or anxious" about her genital appearance, as Max had feared (48). When asked by Max what she expected her body to be like, she answers: "'I thought it would be mysterious and wonderful. [...] And it was'" (48). For the first time, Max's body is constructed as desirable through her partner's gaze. When they have sex for the first time with Max being fully naked, Tamara's sexual desire for her intersex body becomes even more explicit:

"She was terrified, and I was aware of her fear and the cost of offering herself up to me in that moment. I have never wanted to pleasure someone, never wanted to offer my hands and my

> fingers to heal and to love and to delight... I have never been so awed by the feeling of touching as I was that night. I wanted to stroke and explore and learn and know every inch of her, her large and proud clit, the lines and crevasses from scars and healings, the tight cavern of her cunt which held my fingers so tightly." (48)

The partner's eroticizing of the violated intersex body renegotiates its prior signification as a deficient, deviant, and pathologized corporeality. While Tamara's eroticizing of Max's pain seems to be more subtle than in Saraswati's narrative, their sexuality is still built around Tamara's healing of her intersex partner's sexual wounding. Her sexual desire for Max mingles with her desire to make up for her hurt and perceived losses: "I wept for the loss of what she hadn't had and the lovers who hadn't reveled in the wonder of her body, wept for what I hadn't had before I held her in love" (48). She is the active part in the relationship and also during sexual intercourse, eager to reassure Max that her intersex body is worthy of being desired. Max's perpetual suspension of completely open lovemaking only fuels Tamara's desire for her:

> "I asked: please. Please let me touch you. Please don't shut me out. Please just lie back and let me love you, the way I want to, the way you deserve to be loved. Let me know you. Let me look. Let me run my tongue into the places you haven't let me before. Let me celebrate you, because I love this, and this, and this. I don't love you despite your differences, I love you because of them. I want you to be this way. I want to enjoy your being this way, because it is good, lovely, delicious. Let me." (48)

The construction of intersex is ambivalent in this narrative. Through the lover's gaze, the intersex body becomes precious and desirable, and its differences, which have previously led to (self-) abhorrence and/or erasure, are rearticulated as positive markers. In this process, earlier perspectives are challenged and rejected: the intersex body is de-pathologized, normative notions of femaleness are abandoned, and the body's special sexual needs are handled with great care. However, such a representation ignores that *all* individuals and bodies react differently to sexual stimulation and certain sexual practices. The narrative seems to suggest that only intersex persons and bodies need special attention in sexual situations, and hence constructs the intersex body as a non-normative body in terms of sexuality, relying on a heteronormative and very problematic notion of sexuality per se. The intersex body's perceived differences are reinscribed into Max's body, again marking it as non-normative.

The shift in focus is also problematic in another way: Max remains completely passive in the rearticulation of her intersex embodiment, and the reclaiming of a self-affirmative conception of her body fails. As much as their shared sexuality has been problematic from the start, it remains so during the course of events, despite Tamara's constant affirmation of her love and acceptance. Max becomes depressive and attempts suicide, caused by her perception that "she was a monster and she just shouldn't be here" (Alexander 1997/98: 49). At this point, Tamara has to face the fact that her attempt to heal Max through her unconditional love has failed: "I could not erase thirty years of grief and doubt about her worth and her place in the world. [...] I had still to learn that sometimes shame and blatant evil can be stronger. I might love her with all my heart, but that was one small glow against the bitterness and dark of the rest of her experiences" (49).

The narrator attributes this failure to the medical treatment Max has undergone and both her mother's and her own shame about Max's intersex body. However, as long as the defining power over Max's intersex embodiment remains within the gaze of others and she does not manage to reclaim this power for herself, it is doubtful whether she can ever overcome her self-loathing. Still, at the end of the narrative, Max gradually recovers and starts to fight, together with her partner, for her survival "between the worlds set up by a gender-dichotomous society" (49), slowly starting to embrace her intersex self. Tamara's narrative demonstrates that a patronizing of the intersex person by medical authorities will likely be reproduced by a partner's acting as the active, dominant part towards the intersex partner, thus hazarding their self-determination in regard to their body and self. Moreover, a dichotomization of the intersex body in terms of sexual dysfunction/function perpetuates normative cultural demands on bodies' unconditional sexual availability, as well as ableist conceptions of sexed bodies. Then again, a desiring and loving gaze can also produce an intersex body as a site of pleasure, constructing a counter-gaze to the desexualizing medical gaze, and empowering the intersex person in their desirability. The three narratives conveyed by partners of intersex persons discussed here provide interesting insights into intersex persons' lived love and sexual relationships as experienced from the partners' point of view and present alternative, though ambivalent, images of intersex individuals and bodies.

3.2.5 "Sharing Our Stories, Our Lives, Our Anger": Ideas of Community and the Collective Rearticulation of Intersex

The intersex narratives discussed in this chapter evidently represent an overall narrative structure that seems to be coherent in some aspects, disruptive in others. What virtually all of these narratives have in common is the narrator's motivation for giving an account of their experiences, and the conclusions their narratives draw. One major observation that can be made about the narratives in *HWA* and *IA* is the relative homogeneity of intersex experience, as those intersex persons who are satisfied with the surgical outcome and/or their sex and gender assignment (initially) did not feel the need to share their experiences. Apart from that, a lot of people born with an intersex variation either do not know that they are intersex, or perceive their sexed embodiment as either male or female and cannot, or do not want to relate to their intersex corporeality. Consequently, early intersex narratives do not negotiate such experiences but concentrate on a possible emancipation of intersex subjects from both the state of invisibility and subjugation. This emancipation was strived for through publicly sharing their experiences and organizing with other intersex individuals. Their narratives construct 'intersex' as ambiguous, fluent, and contingent on perspective, as opposed to the seemingly stable intersex representations within the dominant medical narratives. Beyond that, they have worked together to produce a contextual (i.e. North America in the mid-1990s) cultural intersex collective.

In the welcoming column of the first issue of *Hermaphrodites with Attitude*, chief editor Cheryl Chase calls for contributions from intersex readers "so that the next issue can be even more of a collaborative effort" (Chase 1994: 1). She also explains her choice of the magazine's title and its reference to the word hermaphrodite. For many intersex persons, the term hermaphrodite "is one which has been [...] associated with deep pain and stigma" (Chase 1994: 6); it moreover denotes an image of intersex which belongs to the realm of mythology and is consequently rejected by many intersex people as a present-day intersex mode of being. Chase, however, considers a possible reclaiming of 'hermaphrodite' intelligibility, setting the tone for the subsequent intersex narratives covered in *HWA* with the goal to establish (a) (united) counter-voice(s) to the medical discourse:

> "I believe that it is time for us to counter physicians' assertion that life as a hermaphrodite would be worthless, by embracing the word and asserting our identity as hermaphrodites. This is the way to break the vicious cycle in which shame produces silence, silence condones surgery, and surgery produces more shame." (Chase 1994: 6)

Although the tone is set, it is yet worth noting that barely a narrator refers to themselves as hermaphrodite, most prefer the term intersex. Chase herself negotiates the meanings and uses of the two terms in "Affronting Reason"'s narrative of intersex subject construction. At the beginning of her process of coming out as intersex, a reclaiming or at least a positive acceptance of the terms 'hermaphrodite' or 'intersex' is rendered problematic. For Chase, the mythologization of the term hermaphrodite disqualifies it as a viable subject position as it evokes the notion of the hermaphrodite as a fantasy, a stigmatized, unreal subject. The term even has the power to affect her emotional integrity: "The word *hermaphrodite* was horribly wounding and drove me to the brink of suicide" (Chase 2002: 205). The potential of hermaphrodite or intersex as an identity is at first abandoned on the basis of its connotation of the "monstrous," the "Other," and the "freakish," a "medical anomaly, patched up as best as the surgeons could manage" (Chase 2002: 211).

Chase's initial rejection of an intersex identity is the result of the medical authorities' power over the term, and the subject position it connotes. This medicalized subject category is occupied by 'unreal' subjects, depersonalized and dehumanized entities who moreover are so rare that their existence becomes almost abstract, a hypothetical construct of the medical discourse (Chase learns about other 'true hermaphrodites' only from a medical article). In an effort to find a solution to her struggles with a positive reclaiming of a viable intersex identity, she relates to her earlier coming-out process as a lesbian: "The way out of this pain was to reclaim the stigmatized label, to manufacture a positive acceptance of it. This second coming out was far more painful and difficult. [...] There was a community where my lesbianism would be understood, would be welcomed. No such help was available to reclaim my intersexuality" (Chase 2002: 205f). A self-determined development of a positive intersex identity fails at first because she is not able to relate to a cultural intersex collective consisting of 'real' individuals. The only images of intersex subjects she has had access to are the ones construed as pathological by a medical gaze. However, in her determination to prove the medical construction of intersex as disease to be inherently oppressive, Chase begins to assert her intersex identity (2002: 211). Eventually, a community of real-life intersex individuals, which has formed within the new activist movement in the 1990s, acts as a support for this autonomous reclaiming and the resistance against medical hegemony: "My ability to embrace the term *hermaphrodite*, however halting and uncertain at first, has grown in depth, conviction, and pride as I have met other intersexuals. Together we have shared our stories, our lives, and our anger" (2002: 208). At the end of her narrative, she describes her healing as a continual process that is facilitated primarily through articulating and sharing personal experience with others.

Breaking the silence by finding their own voices and healing through sharing experiences are the structuring principles of each story. The narratives can be read as quests for finding ways to articulate their sense of their lived sexed and gendered reality, starting from genital surgery in early childhood, passing through emotional crises, problematic relationships, and disturbed sexuality during adolescence and adulthood, constantly accompanied by silence and shame. However, the journeys generally end with a sense of a new awareness, which is sometimes followed by pain, but always results in a sort of healing. The writing of the narrative itself is both the starting point and the result of articulating a new sense of intersex self. Kira Triea describes this process as an "awakening" in her narrative with the same title (*HWA* 1994). This awakening passes through several stages, in the process of which her knowledge produces her sense of self, which is always contextual and dependent on the source of knowledge: "Some time before the onset of memory, I awakened to the knowledge that I was different; when I was thirteen I learned that I was not 'a boy'… I was actually 'a girl.' Now I know that I am an intersexed person" (Triea 1994: 1).

The final affirmation of her intersex embodiment is both the result of her "awakening" and the point of departure for her narrative; her narrative both begins and concludes with the affirmation of her intersex sense of self, and above all, of her own intelligibility: "My name is Kira Triea. I am intersexed, my karyotype is XX, and I was raised as a male until age thirteen" (1994: 6). The juxtaposition of her name and her intersex variation personalizes and individualizes intersex and thus works against the depersonalizing and dehumanizing medical discourses that produce intersex as a medical category. Triea considers her realization of being intersex as a "constructive breakdown" (1994: 1) that threatens her sense of self at first but then leads to her searching for and connecting with other intersex people. In this process, her sense of self shifts from a vague feeling of being 'different,' a confusion about her sex, to a self-defined intersex identity within the context of an intersex collective.

Triea's story exemplifies the trajectory of most intersex narrators in the specific context under consideration. An assumed shared history and shared experiences formed the basis of this cultural intersex collective that became gradually organized through intersex activism. This new cultural identity needed to be articulated by a united voice, speaking up for intersex rights and against the authoritative medical voice. Individual voices merged into this collective voice:

> "My words escape me now, my universe is slowly turning, tipping up on its head, right before my very eyes. [...] There are others who feel as I do, who cry out against the torment and the unjust persecution we suffer by those who see us as freaks and monsters to be 'fixed' out of existence. My own very private little world is about to have guests, [...] long forgotten family who speak in my native tongue." (David 1994: 4)

David's identification with the emerging intersex community, which he embraces as "family" who speak in the same language as he does, hints at a desire for belonging on the basis of a shared experience. Prior to organizing, intersex individuals have been "left to wonder and to search for the truth in utter silence and isolation" (Chase 2002: 211). Quite a few narratives seem to propose an organizing in the form of social bonding. The organization, which mostly refers to ISNA in this context, is conceived as a homogeneous group with common interests. Some organizations go so far as to demand a medical diagnosis from their members in order to legitimate their affiliation to the exclusive group of intersex persons. The organizing of intersex individuals seems to have their subjugation by authorities (doctors, parents) as its founding principle. Chase seems to speak for, or rather – as ISNA's spokesperson – on behalf of, all intersex persons when she claims that "*[w]e* grow up with so much shame that as adults *we* are not able to discuss *our experience* openly, and the phenomenon of intersexuality remains invisible" (2002: 213, emphasis added). Through the appropriation of others' experiences individual, subjective experience becomes consequently a 'standardized' experience, thereby producing a temporary intersex cultural collective based on a shared, intersubjective intersex experience: “our experiences are surprisingly coherent: Those of us who have been subjected to medical intervention and invisibility share our experience of it as abuse” (Chase 2002: 216).

This assumed shared experience has ultimately produced a new dominant intersex narrative by the late 1990s in the North American context, which has denied a space for ‘other’ intersex experiences, intersex experiences that deviate from the norms established by this dominant activist narrative. While the narratives present organizing as a strategy of resistance against the dominant (medical) discourse on intersex, at the same time they risk reproducing the very same mechanisms of appropriation, exclusion, and silencing or erasure of intersex subjects and perspectives that do not conform to their own intersex narrative. However, for political reasons the leaders of ISNA and other activist groups considered it necessary to speak with a unified voice in public so as to present a consistent agenda of this newly emerging intersex community. Conflicting views on how to approach intersex themes in conversations with medical and political representatives were initially considered as counterproductive, so the intention was to act in unison.

To conclude my analysis, this early intersex collective and the (shifts in) narratives it has produced can be claimed to have functioned as a space of alternative intersex ‘realities,’ a testing ground on which the narrators were able to construe and act out their sense of sexed and gendered self, and largely elude mainstream cultural notions of gender and sex as binaries. Questions of ‘truth’ and ‘authenticity’ with regard to sex and gender are recurring motives. Yet this new conceptualization of intersex is complex, multilayered, and at times ambiguous:

> “What I am now more able to do is to say ‘yes’ to my intersexuality without having to say ‘no’ to other aspects of my reality, other aspects of myself. [...] I am saying ‘yes’ to intersex, ‘yes’ to my masculinity, and ‘yes’ to the fluid and receptive femininity that has enriched my life with its non-linearity and intuition. And this has given me an ease and comfort that did not seem possible when I tried to deny any of these parts.” (David 1995: 5)

> “If you are intersexed, listen to your heart – slowly you will emerge. It takes commitment and courage, it is frightening, but not nearly as frightening as that monster you created all those years out of your own sweet body. As you tell your story, and tell it again and again, a sort of transformation takes place. You start to speak for all intersex people who have ever lived and are yet to be born. Your intensely personal story drops into the background, and what comes forward is your story as myth, as a kind of transcendent truth. Try to love yourself enough to free your hermaphroditic voice, so we can all claim our lives, and the bodies we deserve to celebrate.” (Coventry 1997/98: 29)

The collective rearticulation of intersex both within and against the hegemonic medical discourse, the forming of intersex within and against the terms (initially) not chosen by intersex persons but by medical authorities, and the rejection of the medical, negative connotation of these terms, “open[...] the way for a more radical form of self-determination, one that happens in solidarity with others who are undergoing a similar struggle” (Butler, in Williams 2014). The continuous reiterations of personal, individual intersex stories not only effect a resignification of intersex for the individual person, but for (an) intersex collective(s). As Audre Lorde suggested with regard to the Black women’s movement, “the transformation of silence into language and action” (Lorde 2007: 40) has likewise proven to serve as a power tool for intersex individuals, as the discussion of the early intersex first-person accounts in *HWA* and *IA* has aptly demonstrated. This process is often accompanied by pain, a threat to one’s sense of self since it almost always involves “an act of self-revelation” (Lorde 2007: 42). It results in the formation of one’s own, self-determined intersex subject position and the reclaiming of one’s own intersex body.