

What Is Sex? What Is Gender?

READING 5

The Five Sexes

Why Male and Female Are Not Enough

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In 1843 Levi Suydam, a twenty-three-year-old resident of Salisbury, Connecticut, asked the town board of selectmen to validate his right to vote as a Whig in a hotly contested local election. The request raised a flurry of objections from the opposition party, for reasons that must be rare in the annals of American democracy: it was said that Suydam was more female than male and thus (some eighty years before suffrage was extended to women) could not be allowed to cast a ballot. To settle the dispute a physician, one William James Barry, was brought in to examine Suydam. And, presumably upon encountering a phallus, the good doctor declared the prospective voter male. With Suydam safely in their column the Whigs won the election by a majority of one.

Barry's diagnosis, however, turned out to be somewhat premature. Within a few days he discovered that, phallus notwithstanding, Suydam menstruated regularly and had a vaginal opening. Both his/her physique and his/her mental predispositions were more complex than was first suspected. S/he had narrow shoulders and broad hips and felt occasional sexual yearnings for women. Suydam's "feminine propensities, such as a fond

ness for gay colors, for pieces of calico, comparing and placing them together, and an aversion for bodily labor, and an inability to perform the same, were remarked by many," **Barry** later wrote. It is not clear whether Suydam lost or retained the vote, or whether the election results were reversed.

Western culture is deeply committed to the idea that there are only two sexes. Even language refuses other possibilities; thus to write about Levi Suydam I have had to invent conventions-- and *his/her*--to denote someone who is clearly neither male nor female or who is perhaps both sexes at once. Legally, too, every adult is either man or woman, and the difference, of course, is not trivial. For Suydam it meant the franchise; today it means being available for, or exempt from, draft registration, as well as being subject, in various ways, to a number of laws governing marriage, the family and human intimacy. In many parts of the United States, for instance, two people legally registered as men cannot have sexual relations without violating anti-sodomy statutes.

But if the state and the legal system have an interest in maintaining a two-party sexual system, they are in defiance of nature. For biologically speaking, there are many gradations running from female to male; and depending on how one calls the shots, one can argue that along that spectrum lie at least five sexes--and perhaps even more.

For some time medical investigators have recognized the concept of the intersexual body. But

the standard medical literature uses the term *intersex* as a catch-all for three major subgroups with some mixture of male and female characteristics: the so-called true hermaphrodites, whom I call herms, who possess one testis and one ovary (the sperm- and egg-producing vessels, or gonads); the male pseudohermaphrodites (the "merms"), who have testes and some aspects of the female genitalia but no ovaries; and the female pseudohermaphrodites (the "ferms"), who have ovaries and some aspects of the male genitalia but lack testes. Each of those categories is in itself complex; the percentage of male and female characteristics, for instance, can vary enormously among members of the same subgroup. Moreover, the inner lives of the people in each subgroup—their special needs and their problems, attractions and -repulsions—have gone unexplored by science. But on the basis of what is known about them I suggest that the three intersexes, herm, merm and ferm, deserve to be considered additional sexes each in its own right. Indeed, I would argue further that sex is a vast, infinitely malleable continuum that defies the constraints of even five categories.

Not surprisingly, it is extremely difficult to estimate the frequency of intersexuality, much less the frequency of each of the three additional sexes: it is not the sort of information one volunteers on a job application. The psychologist John Money of Johns Hopkins University, a specialist in the study of congenital sexual-organ defects, suggests intersexuals may constitute as many as 4 percent of births. As I point out to my students at Brown University, in a student body of about 6,000 that fraction, if correct, implies there may be as many as 240 intersexuals on campus surely enough to form a minority caucus of some kind.

In reality though, few such students would make it as far as Brown in sexually diverse form. Recent advances in physiology and surgical technology now enable physicians to catch most intersexuals at the moment of birth. Almost at once such infants are entered into a program of hormonal and surgical management so that they

can slip quietly into society as "normal" heterosexual males or females. I emphasize that the motive is in no way conspiratorial. The aims of the policy are genuinely humanitarian, reflecting the wish that people be able to "fit in" both physically and psychologically. In the medical community, however, the assumptions behind that wish—that there be only two sexes, that heterosexuality alone is normal, that there is one true model of psychological health—have gone virtually unexamined.

The word *hermaphrodite* comes from the Greek names Hermes, variously known as the messenger of the gods, the patron of music, the controller of dreams or the protector of livestock, and Aphrodite, the goddess of sexual love and beauty. According to Greek mythology, those two gods parented Hermaphroditus, who at age fifteen became half male and half female when his body fused with the body of a nymph he fell in love with. In some true hermaphrodites the testis and the ovary grow separately but bilaterally; in others they grow together within the same organ, forming an ovo-testis. Not infrequently, at least one of the gonads functions quite well, producing either sperm cells or eggs, as well as functional levels of the sex hormones—androgens or estrogens. Although in theory it might be possible for a true hermaphrodite to become both father and mother to a child, in practice the appropriate ducts and tubes are not configured so that egg and sperm can meet.

In contrast with the true hermaphrodites, the pseudohermaphrodites possess two gonads of the same kind along with the usual male (XY) or female (XX) chromosomal makeup. But their external genitalia and secondary sex characteristics do not match their chromosomes. Thus merms have testes and XY chromosomes, yet they also have a vagina and a clitoris, and at puberty they often develop breasts. They do not menstruate, however. Ferms have ovaries, two X chromosomes and sometimes a uterus, but they also have at least partly masculine external genitalia. Without medical intervention they can develop beards, deep voices and adult-size penises

Intersexuality itself is old news. Hermaphrodites, for instance, are often featured in stories about human origins. Early biblical scholars believed Adam began life as a hermaphrodite and later divided into two people—a male and a female—after falling from grace. According to Plato there once were three sexes—male, female and hermaphrodite but the third sex was lost with time.

Both the Talmud and the Tosefta, the Jewish books of law, list extensive regulations for people of mixed sex. The Tosefta expressly forbids hermaphrodites to inherit their fathers' estates (like daughters), to seclude themselves with women (like sons) or to shave (like men). When hermaphrodites menstruate they must be isolated from men (like women); they are disqualified from serving as witnesses or as priests (like women), but the laws of pederasty apply to them.

In Europe a pattern emerged by the end of the Middle Ages that, in a sense, has lasted to the present day: hermaphrodites were compelled to choose an established gender role and stick with it. The penalty for transgression was often death. Thus in the 1600s a Scottish hermaphrodite living as a woman was buried alive after impregnating his/her master's daughter.

For questions of inheritance, legitimacy, paternity, succession to title and eligibility for certain professions to be determined, modern AngloSaxon legal systems require that newborns be registered as either male or female. In the U.S. today sex determination is governed by state laws. Illinois permits adults to change the sex recorded on their birth certificates should a physician attest to having performed the appropriate surgery. The New York Academy of Medicine, on the other hand, has taken an opposite view. In spite of surgical alterations of the external genitalia, the academy argued in 1966, the chromosomal sex remains the same. By that measure, a person's wish to conceal his or her original sex cannot outweigh the public interest in protection against fraud.

During this century the medical community has completed what the legal world began—the

complete erasure of any form of embodied sex that does not conform to a male-female, heterosexual pattern. Ironically, a more sophisticated knowledge of the complexity of sexual systems has led to the repression of such intricacy.

In 1937 the urologist Hugh H. Young of Johns Hopkins University published a volume titled *Genital Abnormalities, Hermaphroditism and Related Adrenal Diseases*. The book is remarkable for its erudition, scientific insight and open-mindedness. In it Young drew together a wealth of carefully documented case histories to demonstrate and study the medical treatment of such "accidents of birth." Young did not pass judgment on the people he studied, nor did he attempt to coerce into treatment those intersexuals who rejected that option. And he showed unusual even-handedness in referring to those people who had had sexual experiences as both men and women as "practicing hermaphrodites."

One of Young's more interesting cases was a hermaphrodite named Emma who had grown up as a female. Emma had both a penis-size clitoris and a vagina, which made it possible for him/her to have "normal" heterosexual sex with both men and women. As a teenager Emma had had sex with a number of girls to whom s/he was deeply attracted; but at the age of nineteen s/he had married a man. Unfortunately, he had given Emma little sexual pleasure (though *he* had had no complaints), and so throughout that marriage and subsequent ones Emma had kept girlfriends on the side. With some frequency s/he had pleasurable sex with them. Young describes his subject as appearing "to be quite content and even happy." In conversation Emma occasionally told him of his/her wish to be a man, a circumstance Young said would be relatively easy to bring about. But Emma's reply strikes a heroic blow for self-interest:

Would you have to remove that vagina? I don't know about that because that's my meal ticket. If you did that, I would have to quit my husband and go to work, so I think I'll keep it and stay as I am. My husband supports me well, and even though I

don't have any sexual pleasure with him, I do have lots with my girlfriends.

Yet even as Young was illuminating intersexuality with the light of scientific reason, he was beginning its suppression. For his book is also an extended treatise on the most modern surgical and hormonal methods of changing intersexuals into either males or females. Young may have differed from his successors in being less judgmental and controlling of the patients and their families, but he nonetheless supplied the foundation on which current intervention practices were built.

By 1969, when the English physicians Christopher J. Dewhurst and Ronald R. Gordon wrote *The Intersexual Disorders*, medical and surgical approaches to intersexuality had neared a state of rigid uniformity. It is hardly surprising that such a hardening of opinion took place in the era of the feminine mystique—of the post-Second World War flight to the suburbs and the strict division of family roles according to sex. That the medical consensus was not quite universal (or perhaps that it seemed poised to break apart again) can be gleaned from the near-hysterical tone of Dewhurst and Gordon's book, which contrasts markedly with the calm reason of Young's founding work. Consider their opening description of an intersexual newborn:

One can only attempt to imagine the anguish of the parents. That a newborn should have a deformity . . . [affecting] so fundamental an issue as the very sex of the child . . . is a tragic event which immediately conjures *up* visions of a hopeless psychological misfit doomed to live always as a sexual freak in loneliness and frustration.

Dewhurst and Gordon warned that such a miserable fate would, indeed, be a baby's lot should the case be improperly managed; "but fortunately," they wrote, "with correct management the outlook is infinitely better than the poor parents—emotionally stunned by the event—or indeed anyone without special knowledge could ever imagine."

Scientific dogma has held fast to the assumption that without medical care hermaphrodites are

doomed to a life of misery. Yet there are few empirical studies to back up that assumption, and some of the same research gathered to build a case for medical treatment contradicts it. Francies Benton, another of Young's practicing hermaphrodites, "had not worried over his condition, did not wish to be changed, and was enjoying life." The same could be said of Emma, the opportunistic hausfrau. Even Dewhurst and Gordon, adamant about the psychological importance of treating intersexuals at the infant stage, acknowledged great success in "changing the sex" of older patients. They reported on twenty cases of children reclassified into a different sex after the supposedly critical age of eighteen months. They asserted that all the reclassifications were "successful," and they wondered then whether reregistration could be "recommended more readily than [had] been suggested so far."

The treatment of intersexuality in this century provides a clear example of what the French historian Michel Foucault has called biopower. The knowledge developed in biochemistry, embryology, endocrinology, psychology and surgery has enabled physicians to control the very sex of the human body. The multiple contradictions in that kind of power call for some scrutiny. On the one hand, the medical "management" of intersexuality certainly developed as part of an attempt to free people from perceived psychological pain (though whether the pain was the patient's, the parents' or the physician's is unclear). And if one accepts the assumption that in a sex-divided culture people can realize their greatest potential for happiness and productivity only if they are sure they belong to one of only two acknowledged sexes, modern medicine has been extremely successful.

On the other hand, the same medical accomplishments can be read not as progress but as a mode of discipline. Hermaphrodites have unruly bodies. They do not fall naturally into a binary classification; only a surgical shoehorn can put them there. But why should we care if a "woman," defined as one who has breasts, a vagina, a uterus and ovaries and who menstruates

ates, also has a clitoris large enough to penetrate the vagina of another woman? Why should we care if there are people whose biological equipment enables them to have sex "naturally" with both men and women? The answers seem to lie in a cultural need to maintain clear distinctions between the sexes. Society mandates the control of intersexual bodies because they blur and bridge the great divide. Inasmuch as hermaphrodites literally embody both sexes, they challenge traditional beliefs about sexual difference: they possess the irritating ability to live sometimes as one sex and sometimes the other, and they raise the specter of homosexuality.

But what if things were altogether 'different? Imagine a world in which the same knowledge that has enabled medicine to intervene in the management of intersexual patients has been placed at the service of multiple sexualities. Imagine that the sexes have multiplied beyond currently imaginable limits. It would have to be a world of shared powers. Patient and physician, parent and child, male and female, heterosexual and homosexual—all those oppositions and others would have to be dissolved as sources of division. A new ethic of medical treatment would arise, one that would permit ambiguity in a culture that had overcome sexual division. The central mission of medical treatment would be to preserve life. Thus hermaphrodites would be concerned primarily not about whether they can conform to society but about whether they might develop potentially life-threatening conditions—hernias, gonadal tumors, salt imbalance caused by adrenal malfunction—that sometimes accompany hermaphroditic development. In my ideal world medical intervention for intersexuals would take place only rarely before the age of reason; subsequent treatment would be a cooperative venture between physician, patient and other advisers trained in issues of gender multiplicity.

I do not pretend that the transition to my utopia would be smooth. Sex, even the supposedly "normal," heterosexual kind, continues to cause untold anxieties in Western society. And certainly a culture that has yet to come to grips religiously and, in some states, legally—with the

ancient and relatively uncomplicated reality of homosexual love will not readily embrace intersexuality. No doubt the most troublesome arena by far would be the rearing of children. Parents, at least since the Victorian era, have fretted, sometimes to the point of outright denial, over the fact that their children are sexual beings.

All that and more amply explains why intersexual children are generally squeezed into one of the two prevailing sexual categories. But what would be the psychological consequences of taking the alternative road—raising children as unabashed intersexuals? On the surface that tack seems fraught with peril. What, for example, would happen to the intersexual child amid the unrelenting cruelty of the school yard? When the time came to shower in gym class, what horrors and humiliations would await the intersexual as his/her anatomy was displayed in all its nontraditional glory? In whose gym class would s/he register to begin with? What bathroom would s/he use? And how on earth would Mom and Dad help shepherd him/her through the mine field of puberty?

In the past thirty years those questions have been ignored, as the scientific community has, with remarkable unanimity, avoided contemplating the alternative route of unimpeded intersexuality. But modern investigators tend to overlook a substantial body of case histories, most of them compiled between 1930 and 1960, before surgical intervention became rampant. Almost without exception, those reports describe children who grew up knowing they were intersexual (though they did not advertise it) and adjusted to their unusual status. Some of the studies are richly detailed—described at the level of gym-class showering (which most intersexuals avoided without incident); in any event, there is not a psychotic or a suicide in the lot.

Still, the nuances of socialization among intersexuals cry out for more sophisticated analysis. Clearly, before my vision of sexual multiplicity can be realized, the first openly intersexual children and their parents will have to be brave pioneers who will bear the brunt of society's growing pains. But in the long view—though it could take generations to achieve—the prize might be a society in which sexuality is something to be celebrated for its subtleties and not something to be feared or ridiculed.