



Silvia García Dauder, Nuria Gregori

Designing the margin of feasible bodies

Truths and binary oppositions in the construction of sexes–genders–sexualities

The controversy around the gender of the South African athlete Caster Semenya is by no means unprecedented. As Nuria Gregori and Silvia Garcia Dauder write, the world of sport is a social microcosm that reveals much about the role of assumptions concerning biological sex in a psychosocial logic in which gender identity, sexual orientation or sexual practice exerts maximum authority.

I recall one night lying in bed after having made love to my partner. I remember that my clitoris still felt the heat and the dampness of the inside of her vagina. I felt good. But I wondered, perhaps I will be the only woman who will have done this? Am I the only woman lucky enough to have a clitoris which knows the feeling of penetrating? (Kim, 1999:99).¹

It is in this very clear and provocative way that Kim introduces her contribution to the anthology *Intersex in the Age of Ethics*, one of the first publications to talk about the experiences of people who were previously stigmatized and condemned to silence. Kim's transgression lies not only in the fact that she reveals and narrates her lesbian relationship, but in that, as a woman, she narrates how her clitoris is capable of penetrating a vagina. Biomedicine considers Kim's clitoris to be "ambiguous", "deformed", "abnormal", or "offensive"; it is treated as a hypertrophic clitoris, a mega clitoris or a phallic clitoris. All of these terms imply that there is something unacceptable about the fact that their size exceeds the limits of what is expected of a woman in our society.

Kim's essay, along with many other testimonies, gave a voice and legitimized "other" bodies and "other" experiences in a move towards the recognition of human plurality, in doing so departing from traditional ideas and presumptions about sex–gender–sexuality in the West. Her experience, like those of many others, forces us to review and question the truths and the limits imposed by our particular social, medical and legal constructs of sex, gender and sexuality. Formerly described as aberrations, chimeras, monstrosities, or more recently as syndromes, disorders or ailments, the variability represented in these bodies has been classified as hermaphroditism, pseudo–hermaphroditism and intersexuality, or more recently as "abnormalities of sexual differentiation" (ASD). The many different syndromes or disorders under this umbrella term cannot be detailed here, nor is it possible to list all the situations in which a woman might fail to have all the ingredients deemed necessary by western medicine to determine a person's "biological sex".

Chromosomes, gonads, internal structures, enzymes, hormones and their development into external genitalia are the elements that determine the conundrum of norms and dualities of biological sex. With this logic in mind, if you are born with an XY karyotype, you possess male gonads or testes with their corresponding ducts, prostate and so on, as well as an enlarged penis that has a certain size, morphology and structure that leads into the tip of the urethra.

In such cases, certain levels of testosterone must accumulate in order for known male secondary sexual characteristics to develop, be it muscle development, deep voice, a beard or growth of body hair. As for women, the formula consisting of XX chromosomes, female gonads or ovaries, Fallopian tubes, a uterus, vagina and internal structures, as well as a wealth of hormones and enzymes (oestrogen, progesterone, etc.), together creates female bodies with genitals that reveal an "invisible" clitoris, vaginas that are capable of containing a penis, breast development with some fat cells, as well as an endless number of other traits associated with femininity.

Apart from the linear coherence between these different sexual components, in biomedical literature the same logic is also applied when each of these elements is examined separately. Thus, the chromosomes or hormones are described and interpreted according to the stereotypes of masculinity and their opposite, and so begins a frantic game of binary, complementary and exclusive categories. For example, hormones such as oestrogen, progesterone or testosterone are often considered separate from the other elements that affect the way a body functions. According to psychobiologists, their effects explain particular kinds of social behaviour, such as aggression (testosterone), empathy (oestrogen) or antipathy and rejection (progesterone).

It is assumed that only a certain quantity and combination of these biological variables can ensure adequate social adjustment. In other words, it is hoped that people will prescribe socially to a fixed and stable gender throughout their lifetime and that, ultimately, they will behave in accordance with the social expectations pertaining to their gender.

When there are doubts and uncertainties over the "visible"² and "invisible"³ features of the body, people are increasingly monitored and examined before these "bodies" might have some kind of impact or influence on their identities, expectations and desires. For example, if a male child diagnosed with ASD is interested in dancing or dolls, then his parents might be reminded of his two X chromosomes and question whether the medical diagnosis was in fact mistaken. In other cases, one woman's desire for another will cause us to remember her Y chromosome karyotype as well as the effect that this could have on her affections. One of the most widespread concerns within the scientific community is that there is no certainty about the effects that certain hormones and chemical substances can have on gender identity and sexual orientation in the early stages of development.

Ultimately, this biological construct functions in response to a social need that assumes a type of coherence between a natural order and a social order. As Foucault stated in his book dedicated to Herculine Barbin, a famous hermaphrodite in nineteenth-century France, "the phantasmagoria of nature can promote confusion of debauchery".⁴ In order to fit into a particular heterosexual and patriarchal social order, one must display either established masculine or feminine traits; any physical ambiguity, whether apparent or potential, is perceived as a threat to that order. Although perhaps just a fear of

the unknown, it is probable that society simply does not want to learn more about these ambiguities.

However, the regulation of "sex truths" does not only reside in the medical field. The world of sport is a social microcosm that reveals much about these assumptions concerning biological sex and the part they play in a psychosocial logic in which gender identity, sexual orientation or sexual practice exerts maximum authority. It is interesting to explore the metaphors and mechanisms of exclusion generated by the discussions and practices of sporting authorities when faced with people who are considered sexually ambiguous.

Within the social space of sport, the sex–gender of people is strongly scrutinized, and a whole range of monitoring devices have been created in order to eliminate any trace of ambiguity over gender. Above all, in elite sporting events athletes "suspected of ambiguity" are subjected to gender tests. Also noteworthy are the mechanisms of inclusion/exclusion affecting individuals undergoing testosterone treatment. For example, in the case of the German athlete Balian Buschbaum, formerly Yvonne Buschbaum, both the press and the athlete herself agreed that her decision to take testosterone injections would mark a logical end to her sporting career — had she not retired from sport, she would have tested positive for drug abuse.

The testosterone molecule represents power, triumph, physical force and ability and therein lies its threat. According to gender expectations, anyone considered to be female by birth that possesses unusually high levels of testosterone appears particularly threatening and should be expelled from the competition. Paradoxically, this does not happen in reverse: athletes who convert from male–to–female (MtF) undergo feminizing hormone therapy with oestrogen and/or anti–androgen medication that allows them to carry on competing. When the Brazilian judoka Edinanci Silva removed his "male sexual organs" and testicles, thus reducing his levels of testosterone by 80 per cent, this was enough for the International Olympic Committee (IOC) to allow him to participate in the women's category in the 2008 Beijing Olympics. Nonetheless, the athlete continued to face criticism regarding his chromosomal structure, which was the XY formula in this case: "Undoubtedly, the hardest match for Esther San Miguel was when she faced Edinanci Silva. She had to be careful not to make any mistakes and to overcome her tremendous 'force'. The Spanish athlete said candidly: 'I felt as if I was competing against a man.'"⁵ It appears that the genetic map with XY chromosomes grants males guaranteed success and superiority.

Despite being banned by the International Olympic Committee in 1999, in 2008 the Beijing Olympics Committee created a laboratory specifically designed to carry out the classic "gender tests" or "female tests" for "suspect cases". Curiously enough, doubts surrounded only people suspected of being "men" who then participated in tests to prove they were "women". These alleged "men–women" were subjected to blood tests to examine their hormone levels and sex chromosomes. There have been a number of controversial cases, including that of Indian athlete Santhi Soundajaran in the 2006 Asian Games and Spanish athlete María José Martínez Patiño in 1986. Despite the fact that both had clear social identities as women, the test results revealed they both had XY chromosome configurations — a structure that is medically assigned to a man's biology — and led to their disqualification from the competition.

In response, one might ask the Olympic Committee and sporting authorities whether we need to design a new type of games with new rules so that these

people have the right to participate in the competitive sporting arena. What type of Olympics is designed for people like Santhi Soundajaran or Balian Buschbaum?

The lives of many of these people whose bodies are continually rejected are negotiated and debated according to the masculine/feminine dichotomy, and their autonomy presents symptoms of illness: of a body that reveals contradictions, paradoxes and that ultimately reveals the arbitrary, historic and prescribed nature of social categories. The body is measured in dichotomous terms and is classified as good/bad, right/wrong, healthy/ill, normal/abnormal, hideous/beautiful, generating very negative consequences for anyone who falls into the "incorrect" category, in other words "different", "abnormal" or "aberrant". Experiences such as that of David Brager reveal the danger of continuously building up dichotomies:

During puberty, children go through many changes: they develop muscles, grow body hair, their voice grows deeper, their emotions are all over the place, they become more aggressive and their genitals mature. My puberty was different: I got fatter and my chest got bigger, I had no body hair, my voice was still high, I remained calm, hair did not grow around my genitals and they were smaller than ever.⁶

In the same way as other aspects of nature, all the components determining sex-gender are arranged, in the words of the anthropologist Lévi-Strauss,⁷ in binary opposition. As Levi-Strauss explains, although many phenomena are constant rather than separate or disjointed, the mind, given its need to impose order, treats them as if they are more different than they are in reality. Shades of variation become inequalities, asymmetries, power relations and the superiority of some categories over others, of "healthy" over "sick", of "normal" over "abnormal, different, disabled or "damaged", of "men" over "women", and so on.

Psychosocial emergencies and biomedical technologies

When the logic behind biological sex suffers any type of setback or surprise, emergency legal and healthcare action is taken. The detection of ambiguous genitalia is one of the first characteristics that alerts the scientific community to the fact that "something is wrong", primarily because it is noticed at birth, a moment that is highly institutionalized in our society. In other cases, the discovery will take place during puberty, before atypical genitalia develop, such as boys developing breasts, girls not menstruating, or later in life when women realise they are unable to conceive. At odds with what nature presents us with, in the cultural imagination there are morphological opportunities to speak about "normal" genitals. There are numerous tables, graphs and standards listed in medical textbooks that are considered normal parameters; anything that does not fall within these parameters is scrutinized. Scales for measuring ambiguous genitalia indicate different states in which the morphology of genitals becomes unacceptable. The frequently used Prader and Lucks⁸ scale specifies different phenotypes (external appearances) in five grading scales, which range from normal female genitalia to normal male genitalia to any other variation beyond and between. The purpose of these graphs is to diagnose the "degree of virilization", in order to plan and direct subsequent surgery and create genitals that have a standardized form and dimension.

Thus, efforts are more focused on ensuring that technological advances, in the form of surgery or hormones, can modify biology in accordance with social expectations of what is thought to be feminine and what is thought to be masculine. The resulting bodies are easier to manipulate to the established social expectations of a particular gender: "We have discovered the artificial manipulation of natural sex and the established naturalization of cultural gender."⁹ As a result, as the natural variability from one body to another becomes something abnormal and impossible; what is considered "normal" and "natural" becomes at once possible thanks to biomedical technology. The intersexual body is "normal" but not normative, "natural" but not recognized. Ambiguous bodies are modified by adjusting hormone levels and by surgery known as genital corrective surgery (clitoroplasty, vaginoplasty or phalloplasty) in order that they correspond to the utopian dichotomy of gender.

Biomedical technology seeks to respond to the need to create certain ideas about the compatibility between the sexes, as a heterosexual model of sexuality with intercourse-focused practices. Within this model, a woman will be questioned or will question herself if she does not have a vagina with a diameter and length that is sufficient to contain a penis. As regards the clitoris, as much as possible is done to preserve the woman's ability to have a response, but in this case the resulting aesthetic criteria — "a clitoris that is not visible" — will be prioritized over the possibility of experiencing pleasure. As for men, everyone is aware of the symbolic value that society attributes to the qualities of the penis. Therefore, when establishing a priority criterion of "sexual response and function", this translates into a penis that is both capable of achieving an erection and of penetration. For intersexuals, surgery will continue to be the only base upon which they can build a firm gender identity. Without clitoral reconstruction surgery, it is considered impossible for an intersexual to identify themselves clearly as a woman. In the case of males, the size and functionality of the penis — a penis capable of staying erect and penetrating a vagina is more likely to urinate correctly — determines the success of his masculinity.

Although biomedical technology (surgery and hormonal treatment) has been refined and the results have improved considerably in recent years, it is not without its risks. These include infections, scarring, loss of function and sensitivity, and ultimately, chronic problems. Nonetheless, for many medical professionals the emotional pain emanating from the social rejection that may result from possessing an unusual physical appearance or an unusual sexual anatomy is much greater than the potential physical damage that might arise from the iatrogenic effects of plastic surgery or the potential side effects of hormonal treatment. As Suzanne Kessler writes, medical intervention is justified in favour of producing socially adjusted individuals: "A social problem is 'cured' medically."¹⁰ Hence, when biology mars social expectations of gender, rather than causing us to question the significance and the meaning of our own expectations, as well as the consequences of these expectations for those who cannot meet them, every effort is made to monitor and control this "unnatural" and "antisocial" natural order.

Surgical solutions to psychosocial emergencies: the role of mind/body dualism in the medical treatment of sexual "abnormality"

The diagnosis and treatment of so-called "intersexual states" have been analysed within feminist theory, in order to contextualize the emergence of the concept of "gender identity" and to question the dualism that equates sex with

the natural–biological sphere and gender with the social–cultural sphere. Feminist theory has concluded that relegating sex to the pre–discursive field involves neglecting fundamental aspects of women's bodies. In cases of "incoherence", where opting for one or other of the "sex" components (chromosomes, hormones, gonads or genitalia) as a privileged sexual attribute is considered a social choice, it is clear that the person has built up their own sexual duality. The same goes for cases of sexual "ambiguity", where intervention has been mainly oriented towards "corrective" surgery and hormonal treatment in order to adjust the dichotomous form, rather than psychosocial intervention oriented towards recognizing the range of differences. It has become clear that the process of naturalizing gender dualism seems to be less open to variation than the sexual body itself.

It is in this context that discursive and deconstructionist approaches emerge, questioning the naturalization of sexual dichotomy and criticizing attempts to scrutinize those bodies not clearly identified as being of one sex or the other. Nonetheless, as with other approaches to this issue, they stem from the unease generated by dichotomous rules and the urgent demands for normalization from parents and adult patients. Surgical intervention, while medically unnecessary, is considered psychosocially urgent in order to create a life that is psychologically bearable. This demonstrates that we need different ways of manoeuvring within dualisms — that we need to problematize the naturalization of sexual dichotomy. In turn, we need to take into account the experience of living in a body that does not correspond to dualist social schemes.

The "classic" protocol by John Money (1995)¹¹ for the treatment of particular syndromes falling within the "intersexual state" established a sex/gender dualism based on a mind/body dualism. On one side is a sexual body (with its various components) and the other, the mind's idea or gender identity — that is, the subjective experience of feeling either male or female. In cases of "ambiguity", surgical and hormonal treatment is foremost (in most cases "women" underwent "reconstructive surgery") and every effort was made to focus on family socialization that adequately constructs complete gender identities. In these situations, bodies were and continue to be described as alien to these people (in their minds), or these people are described as being trapped or imprisoned in bodies that do not conform to their true gender identity.

Today, both diagnoses have been exclusively separated and defined on a medical and legal level. "Intersexuality" (in legal terms) or "abnormal sexual differentiation" (in medical terms) is considered a *physical* condition, a problem associated with the development of the sexual body; related surgical and hormonal treatment is covered by health insurance. "Transsexualism" (in general terms) or "sexual identity disorders" (in psychiatric terms) is considered a *mental* condition that, aside from some regional exceptions, is not covered by the Spanish health system. Both of these are medical categories that regulate ambiguities and apply to both sexes/genders, with medical and converging technologies that bring together the same group of experts (surgeons, endocrinologists, geneticists and psychologists or psychiatrists).

However, as indicated, intervention differs in several very important ways. Most fundamentally, with regard to surgical intervention, intersexuality is considered an "emergency" and transsexualism a "luxury" or an "aesthetic whim". The same rules apply to surgery for the purpose of repairing a wound or injury or surgery for cosmetic purposes. It is thought that "sex–change" operations for transsexuals respond to a *psychological need* that does not fall

under state medical insurance, since the surgery is "aesthetic" and chosen by adult patients. By contrast, genital reconstruction surgery, which is not physically harmful in the case of ASD, are considered "necessary" to prevent either parents' social anxiety or the child's psychological distress as he or she grows up. In the latter case, it is recognized that the purpose of restoring or repairing genitalia by surgery is not biologically motivated, but rather culturally motivated, and is often related to the expectations held by the parents themselves. As far as public healthcare coverage is concerned, however, while transsexualism is considered a mental illness, intersexuality does not fall under the category of physical illnesses.

Medical insurance's prioritization of the physical over the mental seems to cast doubt upon the assumption of, on the one hand, *determinism* with regard to genetic problems associated with sexual development ("genital malformations") and, on the other, the *choice* to have a sex change. This has incited a new wave of research on the biological, genetic and deterministic origins of transsexualism. The paradox that this system creates is that the design of either a genetic or determinist explanation for transsexualism is undermined by transgender people themselves, a response justified by a desire for greater autonomy for making decisions about what is covered by medical insurance.¹² Many groups and associations of transgender people reject this classification of transsexualism as a syndrome or an "intersexual neurological condition" (Harry Benjamin). What this essentially means is that, on both a medical and legal level, such people are recognized as intersexuals and, as far as the Spanish public health service is concerned, both surgery and treatment for sex changes are covered by insurance.

On the other hand, from a legal point of view, the medical diagnosis of ASD as a "psychosocial emergency" is what determines whether insurance cover for such treatments is economically justified or not. This is not the only factor; but despite the importance given to psychosocial considerations, trained experts — surgeons, geneticists and endocrinologists — intervene principally to modify the body, relegating any psychological or social aspects or even abandoning them altogether.

This could be related to the fact that the social sciences have a secondary role in our health system. It is also due to the contradictions generated by medical diagnosis. Although based on the recognition of the fact that there is a psychosocial dimension to the illness, intervention reverts to a dualist conception of the mind/body, failing to take into account the experience of different bodies, along with the psychosocial conditions under which parents of children with ASD or adults with ASD opt for genital surgery.

From our point of view, the basis for all these contradictions is the primacy of the dualist mind/body model, where, paradoxically, intervention takes prevalence over the fragmented body, paying scarce attention to the subjective experience of bodies in the process of transformation. The concept of the body as a disembodied object, that can be altered, modified and corrected to become a version of a perfect masculine or feminine identity, is unattainable. It is assumed that there is a genuine possibility of obtaining an unambiguous sexual identity/gender — as if to say that if intersexuals are not treated either surgically or hormonally, then they will not have a clear identity, or as if "typical" men and women never experience identity crises. The formula gender=genitals assumes that it is impossible to have a gender if you have abnormal genitalia. The ideal morphology of genitalia is based on heterosexual sexuality, and hence the satisfaction of purely physical penetration (in the case

of women, having a vagina that can be penetrated, and in the case of men, having a "normal" sized penis).

Although the psychological term "gender identity" has its origins in the classical treatment of "intersexuality", and despite the qualifying "psychosocial emergency", John Money gives psychological intervention secondary importance in comparison to surgical and hormonal treatment. Until now, it has been used as a complement to surgery, in order to regulate and correct the assigned masculine or feminine gender. Surgery is considered "urgent", after which a degree of monitoring of the individual's psychological adjustment was required. Today, this protocol is subject to various revisions, resulting in changes in both terminology and treatment.

In the Spanish context, the term "intersexual states" has been substituted by "anomalies of sexual differentiation", due to its pejorative connotations. This change has not been accompanied by debates and discussions in other countries, however. Having deepened society's understanding of identities, debates over the effects of diagnostic categories are both subject to and being subjected to medical intervention; debates have arisen about concealing them under the term ASD, about the rigid regulation of gender identity in treatments, or about the proliferation of genetic research and eugenic practices derived from new technological advances in prenatal diagnosis.

Medical "advances" in Spain have focused on new research in the fields of genetics, endocrine systems and molecular biology, as well as in the perfecting of surgical techniques. Yet there has hardly been any research into psychosocial intervention and the social shortcomings that make it impossible for certain bodies to continue to have a life and have desire. Following hormonal or surgical treatment, psychological treatment is limited to monitoring the rate of satisfaction, considering any dissatisfaction — either with the medically assigned sex or with the medical intervention itself — to be a result of the individual's inability to adapt.

In these protocols, health experts use arguments based on accessible justifications, echoing what was previously considered both feasible and reasonable. In many cases, this rhetoric depends on the organization of the particular health service itself. In the Spanish public health system, psychosocial intervention is barely catered for and psychological, social and cultural aspects are neglected; in other cases, doctors find them difficult to treat if they do not have the correct training. In the majority of cases, there are very stereotypical ideas about both gender and sexuality. Given the "psychosocial urgency", surgical and hormonal normalization are the only forms of intervention which physicians and parents are willing to consider. The suffering caused by social norms is perceived as an individual and physical problem. The question is whether technological progress is the solution to social intolerance, or rather, whether it is aiding false dualist assumptions, hence simply aggravating the experience of stigma and shame felt by people who have different genitalia.

Those who work within in the health system draw attention to the practical ineffectiveness of "social solutions". The deconstruction of social discourse is of little use in relieving people's suffering and their desire to be accepted, as opposed to the "immediate efficacy" of modifying or "normalizing" bodies. However, if we try to break away from the dualist concept of the mind/body, individual/society and so on, we come to realize that not only are surgical interventions also "social", but also that it is possible to think about another

kind of intervention, whether medical or otherwise. Such an intervention is directly oriented towards people's real-life experiences of living with different sexual bodies, and goes beyond surgical and hormonal normalization. In the first instance, this implies a reconsideration of "emergency" treatment, since "psychosocial" considerations will never be handled urgently. The changing concepts of the individual and society concerning sexual bodies and embodied differences require a process that isn't dependent on immediate action. This does not prove that surgery is incapable of solving problems of stigmatization, nor that expectations for normality disappear (Alderson, Madill and Balen).¹³

On the other hand, psychosocial intervention has not reduced the recovery period following hormonal or surgical treatment (apart from reconsidering the criteria for success or satisfaction). It must be implemented prior to the assignment and/or medical intervention, in order that the whole decision-making process is based on the informed consent of parents or else the adult patient's free will. There needs to be an intervention that provides as much information as possible before making decisions (in contrast to the secrecy involved in traditional protocols) and training (both for parents and adults) about the value and experience of difference and about management strategies. This means, for example, examining untested beliefs about "normal sexuality", the "normal body" or "normal life" in order to reveal information about different conditions in their social relationships, especially emotional ones. This helps provide information and the opportunity to discuss alternative forms of sexuality that go beyond vaginal penetration and helps advise people on how to handle their relationships with partners and so on.¹⁴

Meanwhile, people who experience sexual variability undergo a range of contradictions, paradoxes and negotiations. Judith Butler, critic of gender norms who explores different points of view in this debate, has placed it in the context of lives as they are experienced by the people who are most affected. They must be guided by the question of what it is that maximizes the possibility of a life worth living and what minimizes the possibility of an intolerable life. It is necessary to recognize the agencies and micro-resistances in the continuous adjustments, agreements and the negotiations undertaken in the everyday tasks of bodies, genders and designs in order to conform to the status quo. It is precisely within this tension that the key to change ultimately resides.

¹ Kim "As is", in Dreger, Alice Domurat (ed.), *Intersex in the Age of Ethics*, Hagerstown, University Publishing Group, 1999.

² In referring to the external appearance of genitals and the phenotype (distribution of pubic hair and fat, muscle development and general external appearance).

³ Chromosomes (X0, XY, XXXY, XX, etc.) gonads, (ovaries and testicles), internal structures (uterus, vagina, Fallopian tube, prostate, epididymis, corresponding ducts, etc.).

⁴ Michel Foucault, *Herculín Barbin llamada Alexina B. Revolución*, Madrid, 1985.

⁵ A lot has been said on this topic in the press and on the Internet. This extract is taken from the article: "Are you woman enough to be an Olympian?", *Soitu*, 15 August 2009. See also: "The judoka with the strength of a man", in *Cadenaser*, 14 August 2008, http://www.cadenaser.com/deportes/articulo/edinanci-silva-judoca-fuerza-hombre/csrcsrpor/20080814csrcsrdep_14/Tes.

⁶ Klinefelter's Syndrome Mutual Aid Group <http://sindromedeklinefelter.es>.

⁷ Claude Lévi-Strauss, *Structural Anthropology*, Barcelona, Paidós, 1995.

⁸ On C. V. Lucio, "Real Hermaphrodites, clinical characteristics, their genotype and gonad histology", in *Medicina Universitaria*, 5(20), 2003, pp. 176-179.

⁹ Silvia García Dauder, Carmen Romero Bachiller and Esther Ortega, "Assertive bodies and genital mutilation: the techno-medical regulation of sexual bodies", en J. M. Armengol (ed.), *Masculinitats per al segle XXI*, Barcelona, CEDIC, 2007.

- ¹⁰ Suzane Kessler, *Lessons from the Intersexed*, New Jersey, Rutgers University Press, 1998.
- ¹¹ John Money, J. G. Hampson and J. L. Hampson, "Hermaphroditism: Recommendations concerning assignment of sex, change of sex, and psychologic management", *Bulletin of the John Hopkins Hospital*, 97, 1955, pp. 284–300.
- ¹² Judith Butler, *Undoing gender*, Barcelona, Paidós, 2006.
- ¹³ Julie Alderson, Anna Madill and Adam Balen, "Fear of devaluation: Understanding the experience of intersexed women with androgen insensitivity syndrome", *British Journal of Health Psychology*, 9, 2004, pp. 81–100.
- ¹⁴ Mary Boyle, Susan Smith and Lih-Mei Liao, "Adult genital surgery for intersex: A solution to what problem?", *Journal of Health Psychology*, 10(4), 2005, pp. 573–584.

Published 2009–09–28

Original in Catalan

Translation by Ruth Collins

Contribution by L'Espill

First published in L'Espill 31 (2009)

© Nuria Gregori / Silvia Garcia Dauder / L'Espill

© Eurozine