Gender assignment for infants with ambiguous genitalia: Are there alternatives?

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One’s gender is much more than the assemblance of chromosomes, hormones and genitalia. From before a baby is born, sex and gender have already begun their development. Throughout history, boy or girl have been the only two ways to complete the doctor’s proclamation, “It’s a ...”. The importance of this classification in our society is never more clear than when it cannot be made. Yet this classification is not an easy one for children born with ambiguous sex. This paper shall investigate the debate regarding the appropriateness of gender assignment and gender assignment surgery in infants born with ambiguous gender.

It is postulated that one child in every 1500-2000 born will be of ambiguous gender (Intersex Society of North America, http://www.isna.org). Historical documentation reveals that this condition is not only a contemporary issue (Kessler, 1990), but has been an issue for decades. There are a plethora of mechanisms that can be responsible for gender ambiguity including nondisjunction[1], abnormal crossing-over[2] or hormone exposure in the womb. The observed outcome of these mechanisms can vary but most result in a diagnosis of intersexuality[3]. Intersexed individuals are characterized by display of both male and female sexual features (Intersex Society of North America, http://www.isna.org/). These characteristics encompass all of that we consider to make-up gender including chromosome type and make-up, gonad development, hormone excretion, internal and external genitalia presence and personality.

Although the aforementioned prevalence might appear low, there are a number of other conditions, which are far less prevalent that receive more media and medical coverage. For example, a child is approximately 300 times more likely to be born with ambiguous genitalia than to be born with muscular dystrophy (Professional Guide to Diseases, 8th Edition). Even though such congenital conditions are viewed as victims of circumstance, conditions resulting in a difference of personality or mental state beget judgement (Baas, van’t Wout, Aleman & Kahn, 2008; Nehls, 1998). Exploration into current, popular perceptions of such controversial issues may allow researchers and scholars to elucidate which procedures demonstrate the most positive results, bringing us one step closer to increased acceptance and integration of those with intersex conditions.

Traditional Approach to Infantile Gender Assignment

Imagine, for a moment, that you are the attending doctor of an intersex birth. As a physician, you know the impact of this news is going to greatly affect both the parent’s and the child. You also know that the bulk of research suggests that you choose the sex of the gender yourself and perform the suitable gender assignment surgery. You are to focus on maintaining or enhancing the function of the child’s genitalia but also you know that you must attempt to make the child as male or as female as possible. This was the situation faced by doctors only a few decades ago. Although this process may sound simple, the current research suggests that results with the best possible prognosis must attend to 6 variables: (a) reproductive potential, (b) sexual
function, (c) minimal medical procedures, (d) gender-appropriate appearance, (e) psychosocial well-being, and (f) stable gender identity (Zucker, 2002).

Dr. John Money of the Johns Hopkins Hospital asserted that one’s gender was tabula rasa[4] at the time of birth. If gender assignment occurred before 18 months of age, a child would go on to adopt whatever gender had been assigned (Money, 1957; Money, 1972). Whereas few contemporary ethics committees would make such a decision without great debate, the result of this assertion was a proliferation of gender assignment and subsequent surgeries on infants born with ambiguous genitalia (Money, 1975; Money & Ehrhardt, 1972). Additionally, the factor that determined which gender was to be assigned was predominantly the presence of, or size of, the phallus (Diamond & Sigmundson, 1997a; Kessler 1990; Money, 1975). Supporting doctors understood that a sex must be assigned (Daaboul & Frader, 2001; Money & Ehrhardt, 1972) and this premise guided their decision to conduct countless genital surgeries on infants, often without informing parents.

These decisions were made because of the belief that without the assignment of a gender, an individual is left “not knowing what [they] are” (Callahan, 2009). This lack of self-knowledge impacts how the individual views themselves as well as how the world views that individual. One’s gender is an integral part of one’s identity. At the age of 18 months, a child is beginning to discern between “you” and “I” as separate, cognitive entities (Slater & Lewis, 2007), a process that could be disrupted without a firm sense of “I”. Additionally, while one’s personality is influenced by one’s genetic make-up (Bouchard, 1994), it is the intricate interplay between nature and nurture that is responsible for the bulk of what makes each of us the unique individuals we become (Collins, Maccoby, Steinberg, Hetherington & Bernstein, 2000). While little research has focused on the consequences of not assigning a gender to a child, the confusion that may arise based upon this premise could have negative consequences.

Researchers of social psychology have called attention to the sociological ramifications of leaving a child without a gender label or giving them an atypical label. The categories and symbology used by our species during social interaction allow for efficient and effective communication. However, there can be negative consequences when an entity is met that does not comfortably fit into one of such classifications. Stigmatization, discrimination and bullying are common social reactions to such entities. These reactions can have detrimental psychological effects upon a child. One extreme example of negative public reaction to the atypical is that which ensued upon the debut of homosexuality as a sexual orientation. Even the reactions of scholars was misguided leading homosexuality it to be viewed as a mental illness during that time (Green, 1972; DSM-IV-TR, 2000).

Surgical assignment of gender raises a question about the actual need for concern if a mistake in gender assignment is made. Although much of the post-intervention information from intersex individuals is anecdotal and a relation of individual experiences (Ahmed, Morrison & Hughes, 2004; Boyle, Smith & Liao, 2002), some experiences are positive. These reports relate stories of those who have adapted to the sex assigned to them despite the individual feeling that it may have not been the most correct decision (Callahan, 2009). Additionally, there are a number of individuals that respond positively to the re-assignment of gender in later
years. Research has shown that individuals can not only recover from extreme and harsh circumstances, but also thrive under great strain such as experiencing the death of a loved one or being abused (Masten, Best & Garmezy, 1990). It is likely that the same can be true for these individuals if allowed to demonstrate their true resilience.

Issues with the Traditional Approach to Infantile Gender Assignment

When considering the fate of intersex children, it seems critical to question why the traditional view which insists upon the assignment of one gender seems so popular. In fact, one may even wonder if scholars and doctors have asked themselves why they believe in gender assignment. For example, the reasons a doctor may believe in immediate gender assignment may be influenced by personal beliefs or demographics. Similarly, the gender of the doctor may play a role, as well as the doctor’s ethnicity. There are a great number of scholarly articles now devoted to investigating the issues surrounding gender assignment. It appears that as our understanding of intersex conditions continues to grow, and as more reports are received from intersex adults post-surgery, there is scepticism on the surgical assignment of gender in infants (Ahmed, Morrison & Hughes, 2004; Boyle et al., 2005; Brinkmann, Schuetzmann & Richter-Appelt, 2007; Creighton & Minto, 2001; Greenberg, 2003; Holmes, 2002; Kessler, 1990; Kuhnle & Krahl, 2002; Meyer-Bahlburg, 1998; Thomas, 2004). Additionally, this scepticism often leads to the criticism of the procedures and practices of the past, suggesting a need for further investigation and possible alternatives.

It is not enough to take only the physical condition of the intersex child into consideration while assigning a gender. This is, however, the traditional practice taken by physicians when faced with an intersex infant (Diamond & Sigmundson, 1997). The child’s family constellation, cultural views and religious upbringing are also integral parts of what is to help mould the child’s identity (Holmes, 2002; Kuhnle & Krahl, 2002). Consider, for example, the intersex child of Asian descent. If the family is without a son, pressure may be exerted on choosing male as the child’s sex as it is the male that is to eventually hold responsibility for the family (Kuhnle & Krahl, 2002). Alternatively, once the decision has been made, the stronger family constellation common in collectivist countries might support the child differently than had the child been of American decent. These factors influence the likelihood and strength of gender identity acceptance. The acceptance of one’s gender is, in fact, primarily derived from societal factors rather than biological factors (Kessler, 1990; Kuhnle & Krahl, 2002). These issues increase the difficulty in assigning a gender and subsequently increase the likelihood of making an error.

As mentioned previously, gender assignment surgery is the dominant medical practice for intersexed infants and emphasizes the need for unambiguous physical gender identification (Druger, 1998). However, contrary to this emphasis, the empirical literature fails to support any one, concrete stratagem for how gender is to be chosen (Diamond & Sigmundson, 1997a; Diamond & Sigmundson, 1997b). The literature also lacks an outline regarding when or what surgeries ought to be performed. Yet, despite such ambiguity in the gender assignment process, it has become the norm. However, not surprisingly, intersex adults are often left discontent with the results of the choices made by their doctors and/or families (Creighton, Minto & Steele, 2001; Minto, Laio, Woodhouse, Ransley & Creighton, 2001; Wisniewski, 2001); a
discontentment rarely outlined in those articles supporting surgical gender assignment in infants. In the end, it is the grown neonate that is left to endure the consequences of a decision made without proper consent despite being the individual that gains to be most affected.

In 1999, the Constitutional Court of Columbia ruled that the surgical intervention of an infant would be akin to social experimentation and did not always protect the best interests of the child (Greenberg, 2003). Intersex activist organizations lobby for a moratorium on all intersex surgeries because they believe these surgeries emphasize the normalization of the genitalia based upon sex-role stereotypes (Intersex Society of North America, http://www.isna.org/). Informed consent, an ethical pillar of psychological and medical research, cannot be obtained from an infant (see Canadian Code of Ethics for Psychologists, 2000). With fundamental ethical concerns such as these, as well as the psychological consequences then to be faced (Brinkmann et al., 2007), opponents to the traditional view find it difficult to understand how cosmetic surgeries such as genitoplasty in infants, continue (Brinkmann et al., 2007; Izquierdo & Glassberg, 1993).

As alluded to formerly, there is a large body of evidence suggesting a trend toward later discontentment in surgically assigned intersex adults as a direct result of the assignment. Complaints such as lost fertility, lost sexual sensation and incorrect assignment are some of the most prevalent (Boyle et al., 2005; Holmes, 2002; Minto et al., 2003). Surgery itself carries with it its own battery of consequences including infection, post-operative procedures and preoccupations (Boyle et al., 2005). Money suggests that these “mismanagements” of the intersexed condition are a result of the lack of training the medical field within the field of sexology (1975; Kessler, 1990). Additionally, Brinkmann and colleagues (2007) found that 60% of their intersex sample experienced psychological distress post-intervention. Unfortunately, due to the generally small population of intersex individuals, it is difficult to statistically ascertain the degree to which intersex individuals are left displeased with the gender assignment they received as infants and in which ways (Ahmed et al., 2004; Kessler, 1990). The majority, however, assert that they would have, at the very least, preferred to be a part of the decision making process (Callahan, 2009; Boyle et al., 2002).

Possible Alternatives to the Traditional Approach

Firstly, those that may not support the traditional view of gender assignment acknowledge that not all surgeries performed on infants with ambiguous genitalia are unnecessary. There are a number of conditions and reasons for performing surgery on an intersex infant. Hypospadias, for example, is defined as the abnormal placement of the urinary opening and is common in those with intersex conditions. Untreated hypospadias can lead to physiological complications such as infection, compromised hygiene and later reproductive difficulties (Cendron, 1971). Additionally, undescended testes, a common result of intersex conditions, are linked to an increased risk of testicular cancer (Pettersson et al., 2007). In situations such as these, the risk posed to the child if surgery is not to be conducted must be carefully weighed. However, based upon literature reviewed, it is suggested by this writer that the reasons for surgery be carefully considered. Those surgeries not found to be relieving the
child of immediate risk could potentially then be postponed, perhaps until the child can be consulted regarding their own personal wants or needs.

As mentioned earlier, it has been acknowledged that few medical practitioners are qualified to make the informed decision on regarding gender assignment (Kessler, 1990; Money, Hampson & Hampson, 1957). “Mismanagements” or mistakes made during the gender assignment process result in both physical and psychological distress (Brinkmann et al., 2007). It is a logical deduction, then, that one possible alternative to infantile gender assignment surgery might be to not perform infantile gender assignment surgery. With the assistance of current scientific and technological proficiency, we are capable of performing many of the surgeries needed for gender assignment. Thus, it is not a large leap to assume that the same expertise and proficiency could also facilitate the postponement gender assignment surgery. For example, one pharmaceutical drug is currently used postpone the onset of puberty, delaying the expression and formation of secondary sex characteristics in children (L. Brotto, personal communication, November 2009). This vital tool can give intersex individuals the window needed to make a decision.

In order to continue the discussion regarding alternatives to infantile gender assignment surgery, it is the opinion of this writer that the possibility of a critical period for gender assignment be discussed. Eighteen months was the threshold age postulated by Dr. Money (1975), however, a review of complaints proposed by opponents to gender assignment surgery in infants as well as taking into consideration those conditions that cannot or are not diagnosed before the age of 18 months (Dessens, Sliper & Drop, 2005) suggests an alternative is desired. Puberty is a time when great change occurs to both ones physical and psychological self (Model, Furstenberg & Hershberg, 1976; Simmons & Blyth, 1987). Puberty, throughout history and across cultures, often signifies one’s “coming of age” into adulthood (Model et al., 1976). Only a few short decades ago, those of age 16 worked, reproduced and lead the lives of legal adults today. This is still the case in some undeveloped countries. King Henry II of England was given the responsibility of an entire country at the ripe age of 15 (Cannon, 2002). At the time of puberty, Gender Identity Disorder[5] or distress regarding one’s sexual identity usually begins to present itself (S. Assanand, personal communication, November, 2009). Thus, it would seem that puberty, or around that age, might serve as an ideal time for intersex children to begin considering the future of their biological sex and gender.

Whatever the age determined by professionals to be “old enough” to make decisions regarding gender assignment, alternatives must be available if postponement is to be a viable option. It is the suggestion of one counsellor of those with transgender conditions that prolonged and in-depth guidance be received throughout the one’s entire lifespan (“Luca”, personal communication, November 2009). Upon the basis of literature reviewed, it is the opinion of this writer that if gender assignment, or at least gender assignment surgery, is to be postponed, the psychological well-being of the individual and those around them must be careful monitored. A number of interventions are very beneficial as psychological buffers for those with developmental conditions (Slater & Lewis, 2007). Preparing a child for how to handle discrimination and bullying, teaching a child to establish and use functional coping mechanisms and creating a strong social support system are tools that can aid children with intersex conditions.
A Third Gender?

Ahmed and colleagues (2010) propose that the creation of a third gender is not feasible due to the unequal treatment faced by gender variant communities. However, research shows that many variant or minority communities face unequal treatment without inhibiting their presence. Furthermore, there are a number of third gendered communities that are accepted and live peacefully within their communities. These include the Hijra of India (Nanda, 1998), the Fa’aafafine of Samoa (Vasey, Pocock & VanderLaan, 2007) and the Muxes of Mexico (Dreger, 2009). Within Mexico, the Guevodoces transition from girls to men publically and are still generally accepted by their families and community (Herdt, 1990). Acceptance of a third gender can be viewed in contemporary media by observing the blossoming transgender movement in the U.S. (Bolin, 1994). It appears that the infusion of a third gender is, in fact, already underway.

If social psychologists suggests that a label be given to these populations, it may be suitable to follow the lead of the bulk of the literature and use the term ‘intersex’ to encompass all conditions leading to ambiguous genitalia. While the creation of the “I” may be, in part, predicated upon one’s sexual identification, this label, together with candid, age-appropriate disclosure of information to the child might assist in easing the developmental process until the child is ready to choose a gender, if one is to be chosen at all. If an individual can be resilient throughout the gender assignment or re-assignment process, it can be assumed that such resilience might also enable them to adapt to the ‘intersex’ label instead.

While there are mixed messages reported by the intersex literature, one message is unanimous – there is still much left not understood about intersexuality. Although no clear solution has been presented, it is clear that the literature thoroughly emphasizes the role of finding an alternative to gender assignment surgery in intersex infants. Additionally, contemporary arguments carry valuable weight when considering informed and ethical treatment. Case management, it seems, is likely to remain just that: case management. Although the creation of one encompassing gender assignment guidebook is unlikely, the current dissemination of information regarding these topics and the outcomes of previous managements will eventually allow researchers to ascertain the importance of each of the 6 variables assessed in intersex infants in order to obtain a positive prognosis. Focus placed on mistakes made has gotten us this far. Redirecting our attention to finding viable alternatives is the next step in creating a more accepted and positive environment for those with intersex conditions.
References


Gender Identity Disorder. (2000). In *Diagnostic and Statistical Manual of Mental Disorders*. Retrieved from http://pn.psychiatryonline.org/content/38/14/32.full


Footnotes

[1] Defined by the Merriam-Webster dictionary as the failure of homologous chromosomes to separate subsequent to meiosis or mitosis so that one daughter cell has both and the other neither of the chromosomes.

[2] Defined by the Merriam-Webster dictionary as the interchange of genes or segments between homologous chromosomes.

[3] The Intersex Society of North America has recently advocated the elimination of this term in order to avoid conflating anatomy with identity. However, within this paper, an examination of both the anatomical and psychological ramifications of infantile gender assignment surgery will commence and the author feels this term is the most appropriate compared to the contemporary alternative of “Disorders of Sex Development” or DSD.

[4] Defined by the Merriam-Webster Dictionary as the mind in its hypothetical primary blank or empty state before receiving outside impressions.

[5] Defined by the Diagnostic and Statistical Manual of Mental Disorders as, among other indices, a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).