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## *Letter to the Editor*

*To the Editor:*

While a long-term psychological evaluation of intersex children is a most welcome development, we would like to point out several problems with the report of Slijper *et al.* (1998).

Most notably, the authors incorrectly claim that if early genital surgery is not performed, "the child should neither be raised as a boy nor as a girl, but as an intersex person." The reviewers even erroneously ascribe such a recommendation to Diamond & Sigmundson (1997b), who in fact recommend that children be labeled with a sex but not subjected to early surgery. Labeling a sex without inflicting surgery on an infant or child (who cannot provide informed consent) is the practice advocated by the member consensus of many intersex support groups, including the Intersex Society of North America, the Intersex Society of Canada, the Intersex Society of New Zealand, and Peer Support for Intersexuals (Japan).

History shows that before cosmetic genital surgery became widely practiced—around 1960—children with ambiguous genitals were labeled and raised as boys or girls and that many of these people enjoyed productive family, work, and intimate lives (Dreger, 1998; Reilly and Woodhouse, 1989; van Seters and Slob, 1988; Young, 1937). In addition, today there are individuals born with ambiguous genitals who are labeled with a sex but not subjected to surgery, either because their parents rejected medical advice, or because they "slipped through the cracks." Many such individuals express profound gratitude to have escaped early surgery (Chase, 1997a; Diamond, 1997).

As Dreger documented, some intersexuals raised as male or female without surgery were quite unaware of their difference: In the late Victorian period, an expanding medical literature "made it absolutely clear that pseudohermaphrodites often married persons of the same gonadal sex," which distressed physicians more than hermaphrodites or spouses (p. 120).

Quite a few intersexuals seen by Young (1937) at Hopkins in the early 20th century explicitly rejected surgical and hormonal normalization. Case 13, Young recorded, was raised female, "decided to be male" at age 14, married and "enjoyed sexual life both as male and female," resisted addi-



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tional medical examinations and rejected "an operation to determine sex" (p. 137). Emma T., a "'snappy' young negro woman with a good figure" and a large clitoris, was married to a man but found her passion only with women. Emma refused surgery to "be made into a man," because it would entail removal of her vagina and thus loss of her "meal ticket," i.e., her husband (pp. 139-142).

Although no comparison of long-term psychological outcome with and without early genital surgery has ever been performed, since the late 1950s medical practice has insisted that intersex infants must be surgically "normalized," rendering a controlled study impossible. It is therefore ethically incumbent upon investigators to familiarize themselves with the information available on outcomes without surgery, including the historical and contemporary narrative material mentioned above (Dreger, 1998 forthcoming).

We are also troubled by Slijper *et al.*'s suggestion that a child of age 4 would be considered capable of making an informed decision about clitoral surgery—which necessarily involves extensive dissection and removal of genital tissue that may irreversibly damage her sexual function. In a recent review of a dozen girls ages 11 to 15 who had undergone clitoroplasty and vaginoplasty, pediatric urologist Thomas concluded "The results are indifferent and, frankly, disappointing" with reconstructions showing visibly different appearance from the original cosmetic result, clitorises withered and obviously nonfunctional (1997; Scheck, 1997). Intersex patient-advocate Angela Moreno recounts that modern clitoroplasty, performed on her at age 12 by experienced surgeons, destroyed her orgasmic function (Chase, 1997b, p. 12). Chronic genital pain has also been documented in adults subjected to clitoroplasty years earlier (Chase, 1996).

Finally, the reviewers write that the aim of their team was to avoid development of cross-gender identification, and that in their treatment of children assigned female who developed gender identity disorder of childhood, they focused upon "[making] the patient aware of the conflict between the fantasy of being a boy and the reality of having the female gender." Development of cross-gender identification is it painful experience, as is change of sex role. But these children have been assigned a sex on the basis of a controversial theory of psychosexual development: If not for medical intervention, the "fantasy" might have been a reality. A significant minority of patients do change sex role during adolescence or adulthood, even if surgically sex assigned during infancy (Diamond and Sigmundson, 1997a; Meyer-Bahlburg, *et al.*, 1996; Money *et al.*, 1986; Reiner, 1996; 1997a, 1997b).

We believe that intersex patients would be better served by psychotherapy which encouraged them to openly explore all options including change of sex. A change of sex negotiated during adolescence, before pro-

found secondary sex changes have occurred, may be less painful than submitting—perhaps only until early or middle adulthood—to the medical team's insistence upon "the reality" of the sex assigned by that same medical team.

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