AG AboutGender
International journal of gender studies

http://www.aboutgender.unige.it/ojs

Vol.2 N° 3 anno 2013
p. 114-144

Queering the Genitals
An Operation Useful for All

Daniela Crocetti

Università di Bologna

Abstract

Queer theory is often interested in the body primarily regarding its role in affective relations, reordering the genitals as participants in sex and gender, not as primary indicators of actions or categories. In this article, instead, we apply queer theory to genital materiality and practice by looking at what genitals are expected to do, and the practices that modify them (enhancing or shifting gendered category). Anxiety regarding genital form lurks outside the queer, stimulating definitions of norms and practices to enforce them. The queering of the genitals -an examination of their performative construction in the nexus of identity, desire, and privilege- touches all bodies, highlighting the instability of genital gender and normality.

Keywords: Genitals, Genital Modification, Cultural Genitals, Intersex, DSD, Transgender, Cisgender.

«Queer theory is at its heart about politics – things like power and identity, language, and difference» (Wilchins 2004, 5).

1. To pee or not to pee

In 2006, queer theory found its way into Italian politics (in the institutional sense). In the halls of the Italian parliament the honorable Elisabetta Gardini raised a stink about who could use which bathroom and why. Specifically, Gardini objected to the use of the parliamentary female bathroom by the honorable Vladimir Luxuria.

> And this is why I say you are not to use the bathroom […] There are rules. It is not that bathrooms are male and female for moral reasons. It's because there are health and hygiene norms to respect. Men and women are different, they get infections and diseases in different ways and having separated bathrooms by law is something that protects people's rights[1].

Gardini's objection is an interesting place to start a discussion about both the materiality of the genitals and cultural genitals. Vladimir Luxuria is publicly a transgendered woman. She was an activist for many years before entering the government, where she was subject to

[1] E' per questo che dico in bagno tu non vieni [...] Ci sono delle regole. Non è che maschi e femmine nei bagni è per un discorso moralistico. E' perché ci sono delle norme igienico-sanitarie da rispettare. Uomini e donne sono diversi, prendono infezioni e malattie in modo diverso e aver fatto i bagni distinti per legge è una cosa che tutela i diritti delle persone (Interview in "Corriere.it" 31/10/2006, http://www.corriere.it/Primo_Piano/Politica/2006/10_Ottobre/31/gardini.shtml, *my translation*).

constant morbid curiosity regarding the form of her genitals. Riki Anne Wilchins and David Valentine ask, «Even if you do know what someone's genitals look like, what does that mean?» (1997, 219). Luxuria's female genitals are queered by her activism and her past. Therefore in this case, her imagined genital form provoked anxiety regarding the gendered act of urination. The simple act of urination is layered with gender performance expectations and anxieties; fear of sexuality, fear of disease, and confusion regarding gender in the body.

Queer theory is interested in the body as to it role in affective relations. The genitals lose their primacy as the locus of sex, gender and sexuality in the body, slipping into their place as an integrated part of the whole. Yet, this article will apply queer theory to genital materiality and practice. Queer theory is deeply informed by science studies, as well as philosophical inquiries into the historical construction of the body. Whereas queer theory is interested in social interactions and regulation, science studies has continued to delve into the construction of the gendered body, through laboratory studies, and the investigation of the consolidation of contemporary biological knowledge.

It is quite impressive, from a biological perspective, that genital form continues to hold such intense cultural currency regarding gender. The 20th century has seen a vast explosion of knowledge regarding the multiple factors that contribute to forming the gendered body, from chromosomes to hormones to molecular markers (see Fausto-Sterling 2000; Holmes 2007). And yet the genitals continue to be loaded with gendered symbology that often trumps other descriptive modes. Gendered significance is layered onto the genitals in every move, including in the act of urination.

It would be easy to argue that urination is the primary action of the genitals. It happens several times a day and may be the only thing in any given day that directs not only the sensory laden hands, but also physical awareness, to the genitals. Science studies, medical anthropology, and most critical theory often concentrate on the boundary lines of definition. This often leads our intellectual attention towards the stigmatized, or marked, body. For instance, Margrit Shildrick reiterates the concerns of medical anthropology when she states

«[T]he body is curiously absent to us during health, and it is only in sickness that it makes itself fully felt, and then as that which unsettles the sense of self» (Shildrick 1997, 10).

Queer theory instead reminds us that sex is another moment that shocks the body into awareness of itself (Bell and Binnie 2000). The role of the genitals in the image of sexuality and the sex act reinforces the cultural script that can gender the genitals. Queer theory destabilizes the gender binary associated with the genitals, as well as the binary of sexual desire (Halberstam 2005; see Foucault 1979). Complimenting «what Tim Dean has called queer theory's "insistence on the specificity of genital contact as the basis for all political work"» (Morland 2009, 291), Iain Morland clarifies that «queer pleasure is characterized by a focus not on genitalia but on the body as a whole» (*Ibidem*).

Therefore the first tools queer theory gives us is the reminder that sexuality, like sickness, shocks us into awareness of the body, and that sexuality is not just about the genitals and the act of penetration. However, queer theory, like science studies and philosophy is attracted to the study of boundaries and otherness. This, as noted earlier, pulls our attention to queer bodies and the social regulation of such bodies. When speaking about the genitals, this attention pulls our gaze towards the modification of genitals, establishment of the "normal", and the regulation of their form, significance and gender. For part of this article I will also fall into the trap of looking at the surgically modified body.

Morland (2009) refers to surgery and body modification as yet another type of touch that impacts physical experience. The surgeon's hand, like a lover or a molester, leaves signs of its touch on the body and the psyche. The surgeons hand moves along the power lines of the "normal". Foucault indicates that «disciplinary and regulatory techniques practiced on the body exemplify the productive nature of power in that they not only set up systems of control but also call forth new desires and institute new normalities» (Foucault in Shildrick 1997, 48). However, the agency of minority groups and the randomness of results are absent from this discourse (Wilchins 2004). Foucault's position has been criticized as inscribing the 'productive force of power' onto all bio-technologies, and ignoring the agency of bio-tech users. The feminist discourse, for example, addresses both the liberating aspects of

bio-technologies such as the birth control pill[2], as well as the pill's position in the increasing medicalization of the female body (Shildrick 1997; see Oudshoorn 1994; Roberts 2007).

Wilchins, among others, notes that activists of all types have shifted the productive discourse and «that postmodernism is unable to provide a coherent account of how this came about» (Wilchins 2004, 104). Therefore, we cannot afford a singular position regarding surgery, which can liberate and control, enhance and damage, depending on the circumstance. Feminists are generally critical of body enhancement projects such as plastic surgery, referring to the construction of an inaccessible body ideal. Shildrick states that «[i]n the phallocentric order the female body can never finally answer to the discursive requirements of femininity but remains caught in an endless cycle of bodily fetishization that marks a failure of control» (Shildrick 1997, 56).

Queer theory does not appeal to the luxury of condemning the body enhancement project. Many Transgender individuals turn to bio-technologies to modify their gendered bodies. These interventions do not create the docile bodies that Foucault speaks of, but libratory queer realities. Surgical techniques to modify the genitals in particular have had unexpected cultural side effects. These side effects range from the reinforcement of the concept of the plastic body (and plastic gender) to increased discourse (and therefore agency) surrounding the construction of the gendered body.

Foucault (1980, 52) states «the exercise of power perpetually creates knowledge and conversely knowledge constantly induces effects of power». Discourses ranging from queer theory and disability theory, to bio-sociality and patient group production of knowledge (see Rabinow 1999; Rabeharisoa and Callon 2002), highlight the unpredictability that knowledge and power will produce. The history of the genitals is marked by the history of surgery and the performative expectations for the genitals.

Both power and knowledge are overlaid by privilege. The preferred or privileged, genital form is re-constructed in visual media. However, anyone can be captured by anxiety re-

[2] In 1972 Loretta Lynn of country music fame wrote the controversial song *The Pill*, celebrating the libratory effects of chemical birth control.

garding personal genital form. The obsession of otherwise privileged cis-gendered individuals (they have the same gender identity they were assigned at birth) with transgendered individuals genitals form, reflects cis-gender anxiety regarding the instability of their own genital privilege.

In the beginning of the 21st century the Italian political structure accepted a woman into their ranks who would draw morbid attention to her genital form[3]. The earlier comments regarding hygiene, gender and bathrooms belie a confusion regarding genital function and gender. The extension to disease risk implies sexually transmitted diseases, which sexualizes the act of bathroom sharing. One may posit that the heart of the argument lies in the gendered act of urinating standing up, which may lead to urine spillage on both the seat and floor of the toilet. Gardini reads «real» (biological) male genitals under Luxuria's female cultural genitals. Luxuria is subject to both a morbid sexualization as well as inappropriate comments regarding her genital form due to the fact she has socially transitioned from the gender category assigned to her at birth.

Gardini does not ask, 'what do your genitals do?', but rather 'how do they do it?'. Queer theory posits that identities are constantly being rewritten, and therefore gender categories are not only cultural constructs, but also mutable and transient. There is a separation between what the subject does (role-taking) and what the subject is (the self) (Warner 1993). The queering of the genitals proposes to examine the interaction between what the genitals *do* and what they *are*. However, body parts are not subjective entities, what they *do* and what they *are* remain socially defined categories.

What genitals *are* is context based, like most identities, and may have different meanings in the same temporal moment based on the position of the interpreter. Disability theory and science studies also contextualize the consideration of what the normal/healthy body *does* is in itself a socio-cultural construction (see Davis 1997; Koyama 2006). The interpretation of

[3] Vladmir Luxuria brought many issues regarding the body, identity and sexuality to parliament. See http://legxv.camera.it/cartellecomuni/leg15/include/contenitore_dati.asp?deputato=d301519&tipopagina=&source=%2Fdeputatism%2F240%2Fdocumentoxml.asp&position=Deputati\La%20Scheda%20Personale&Pagina=/CartelleComuni/Leg15/Deputati/Composizione/SchedeDeputati/deputatoiniziativalegislativa.asp%3Fdeputato=d301519&Nominativo=GUADAGNO%20Wladimiro%20detto%20Vladimir%20Luxuria

what the genitals *do* and what they *are* is often exquisitely overlapped. Genitals pass urine, participate in sexual acts, itch, produce lubricants, pass diseases, participate in reproduction, have varying form and size, and are expected to directly correspond aesthetically to a social gender category. These are not mutually exclusive categories. The gendered names we give them can be based on their form, or based on the gender of the person who possesses them.

The queering of the genitals is useful for all bodies, not only for bodies marked as queer or different. The hypothesis is that cis-gender hetero-normative individuals are the main subjects of genital normality policing, constantly at risk of becoming queer. «Queer is by definition whatever is at odds with the normal, the legitimate, the dominant. There is nothing in particular to which it necessarily refers. It is an identity without an essence. 'Queer' then, demarcates not a positivity but a positionality vis-à-vis the normative.» (Halperin 1995, 62). Disability theory critique defines disability as «a product of social institutions that divide human bodies into normal and abnormal, privileging certain bodies over others» (Koyama 2006). Queer bodies can be seen in much the same light. Queering the genitals therefore involves identifying, analyzing and ultimately subverting the dominant model.

2. Thinking about the genitals

In 1997 Wilchins and Valentine wrote, «the time has come to think about genitals» (Valentine and Wilchins 1997, 215). Their position was directly influenced by the growing Intersex patient rights movement that criticized early childhood genital surgery. In the late ‘90s the frequency, and traumatic results, of ‘corrective’ genital surgery for Intersex syndromes was just coming to light. In the past 15 years the Intersex movement has grown into a diversified international movement with differing goals, from gender normalization critique to medical reform (see Dreger and Herndon in Morland 2009, 199-224).

Wilchins and Valentine’s article was also posed as a challenge to the American feminist discourse that deconstructed gender as a socio-political category, but often left the body un-

touched (if not in regards to reproductive issues). In the US, the Intersex movement originally allied itself with the Transgender movement, claiming a position that deconstructed gender norms, as well as the direct correlation between genital form and gender identity. At the time, American feminists were unclear on their position towards Trans people, often seeking to exclude trans-women from all-women venues such as the Michigan women's music festival.

In Italy as of yet, however, Intersex patient groups have largely avoided identity politics movements, seeking to focus on medical reform[4]. Two important issues inform the AISIA's position that Intersex is not a trans-gender experience. All of AISIA group members are cis-gendered[5]. Intersex patients often fight against the imposition of the 'surgical fix' (Dreger 1998) and normalizing medicalization that can be detrimental to both mental and physical well-being. The Trans political agenda has often had opposite goals, seeking to access the right to modify ones body[6]. In Italy, however, due to the strict medicalized regulations for legal gender change (that includes sterilization), the Trans struggle has also become one against regulatory medicalization. Queer theory re-centers the critique on the enforcement and standardization of the gender binary, and therefore finds a similar battle to define and make choices for ones own gendered body[7].

While having extremely different live trajectories, both Intersex and Trans people are subject to a morbid curiosity regarding the form of their genitals. I would argue however that cultural anxiety surrounding genital form is far from a fringe issue. The locker room trope is the prime example of semi-public enforcement of insecurities regarding genital

[4] The primary Italian Intersex patients rights group, AISIA (Associazione Italiana Sindrome da Insensibilità agli Androgeni; KIO – Klinefelter Italia Onlus – suspended activities in early 2012), is directly focused on issues regarding the syndrome AIS (Androgen Insensitivity Syndrome). They also give support to individuals and families with other Intersex/DSD syndromes, focusing primarily on medicalization. There is the possibility of future collaboration, as an Italian Trans activist (diagnosed and medicalized for DSD in early childhood, involved in the Intersex activist project organized by sociologist Michela Balocchi through Arcigay Florence) was recently invited to participate at an AISIA event.

[5] There are a handful of young children in the group whose gender assignment was changed early in life by their parents in response to displayed gender identity. These individuals are still young children and therefore their parents are group members.

[6] Italian citizens won the right to change their legal gender in 1982 following a state funded protocol that included modification of the gendered body. See Marcasciano, LaTorre, Pasquino 2012.

[7] See Balocchi 2012, Busi 2012.

form. The genitals raise strange moral ambiguities, we are supposed to keep them covered, and yet we need their form to be standard. Even the controversial 1991 Benetton genital collage did not risk showing genitals that might be considered ambiguous or altered.

Evidence indicates that cis-gendered anxiety over genital form is increasing, as the genitals become yet another site in the body for aesthetic insecurity. Popular sex-education texts for girls have started including discussions on labia size, trying to dissuade anxiety[8]. Genital plastic surgery for cis-gendered individuals is on the rise. An obvious, yet superficial, explanation for this phenomenon is the increased access to digitally altered images of the genitals through the rise of genitally focused pornography. Feminists, and gynecologists, have called for monitorization and evaluation female genital cosmetic procedures and claims (ACOG-Committee Opinion No. 378). Like many Intersex 'normalizing' procedures, advertisements often make health claims that confuse form, function and ideas surrounding what the genitals are imagined to do.

3. What do genitals do?

As we hinted at earlier, discussing what the genitals do is a complex and contextual operation. On one hand the genitals are implicated as the material symbolism of sex and gender, and on the other the material of the genitals can be involved in certain actions and tasks. As we will discuss in further detail later on, queer theory argues that it is the expressed gender of the individual that genders the genitals, not the genitals that gender the individual (Whittle in Morland and Willox 2005, 115-129). Generally, without ever being verified, the form of one's genitals are *imagined* based on social cues (Butler 1990; Halberstam 1998; Monceri 2010).

Kessler and McKenna (1978) developed Harold Garfinkle's (1967) concept of cultural genitals to refer to the genitals that one is assumed or imagined to have. Kessler and

[8] Such as *My body, My Self for Girls* 2000 Newmarket Press; The Internet is increasingly populated with discussions expressing anxiety regarding labia size, as well as those defending large labia.

McKenna join the science studies analysis that deconstructs the black box of biological *sex*. They believe that any elaboration of gender difference is socially motivated, even when speaking about biological components of the body. Therefore they use the term gender also when speaking about the biological components of the body.

This argument was also motivated by the rise of the Intersex debate. In the same period that the contemporary standards of medical gender 'normalization' were coming to the light, academics were investigating the conception of the gendered body (see Foucault 1979; Fausto-Sterling 1985; Laqueur 1990). Dreger (1998) elaborates the medical obsession with the Hermaphroditic body from the end of the 18th century. Dreger cites the gendering of the gonads as a turning point in the establishment of medical authority over gender assignment. As the 20ith century unfolded, hormones were 'discovered' and gendered as well (Oudshoorn 1994, Sengoopta 2006). The developmental model of the body created a directional framework of biological sex, based on the also newly 'discovered' sex chromosomes. Departures from the genotype[9] were explained by variations at the molecular level through genes, which lead to differing hormonal levels and gendered development.

The end of the twentieth century was ripe with biological explanations for behavior, morality and health. Eugenics equated inherited physical difference and disability with the moral degradation of society (Davis 1997; Feder in Morland 2009, 225-247). Scientists such as Calori and Lombroso sought the physical basis of female and racial inferiority. Pioneering gay rights activists such as Hirschfeld described inversion or homosexuality as a biological variance. However, Foucault points out the ambiguous nature of these operations. «The appearance in nineteenth-century psychiatry, jurisprudence, and literature of a whole series of discourses on the species and subspecies of homosexuality, inversion, pederasty, and "psychic hermaphroditism" made possible a strong advance of social controls into this area of "perversity"; but it also made possible the formation of a "reverse" discourse: homosexuality began to speak in its own behalf, to demand that its legitimacy or

[9] In 1911 Johannsen described the difference between genotypes and phenotypes, in which the genotype refers to the genetic make-up and the phenotype to the developed organism. See Jablonka and Lamb 2005.

"naturality" be acknowledged, often in the same vocabulary, using the same categories by which it was medically disqualified.» (Foucault 1998/1976, 101)

Despite the complex model that was developing, the genitals remained the focal point for gender assignment. Only when the genitals were considered 'ambiguous' would science step in to investigate the other components of the gendered body. In addition, both Foucault and Reis note that sexual orientation was a key point in the medical obsession with the hermaphrodite. Foucault references Antide Collas as the last hermaphrodite killed (in 1599) for the simple fact of having a hermaphroditic body[10]. In later cases the punishable crime became alleged homosexual behavior (Foucault 1999/2003, 67). Elizabeth Reis indicates that treatment was not uniform, but that in most 19th century cases a doctor would do what he could to establish the patient as a heterosexual body (Reis 2009). A heterosexual body, to borrow from Foucault, is a 'useful body' to society, which produces legitimized social products.

In the 1950s psychologist John Money decided that genital form was one of the most important aspects of gender identity formation. His research was based on a handful of Intersex patients, and older patient files (Karkazis 2008). This began the legacy of early genital surgery for Intersex children as medical protocol. As through the 19th century, up until the late 1990s, homosexuality in Intersex adults was taken as a potential mistaken gender assignment[11].

Medical literature quickly reveals the dominant view of genital function. Size was the primary factor. Doctors were expected to measure children's genitals on the Prader scale (Prader 1954) and then adapt them to one gender or the other. However, in real practice, most children were assigned the female gender because «you can make a hole but you can't build a pole» (Hendricks 1993). Of the many potential functions of the genitals - pass urine, participate in sexual acts, produce lubricants, participate in reproduction – their symbolic

[10] Throughout the middle-ages physical difference and dis-ability were seen as bad omens or indications of evil and were punishable also by death (see Foucault 1999).

[11] Particularly in CAH (Congenital Andrenal Hyperplasia), stereotypical male play behavior (energetic) and same-sex sexual objects were confused with expressed gender identity. See Fausto-Sterling 2000, 73-75; Karkazis 2008, 80-86.

aesthetic function was given priority. Ignoring the sexual-nerve function, the genitals of the majority of Money's young patients were redesigned to assume a penetrable female form, often without labia, based on hetero-normative sexual practices (that do not include female orgasm).

Surgeons consider the lengthening of the phallus and the corpus cavernous to be a less successful operation: «a functional vagina can be constructed in virtually everyone [while] a functional penis is a much more difficult goal» (Catlin in Dreger 1998, 183). A historically male population of surgeons set higher sexual performative standards for the male organ, and thereby did not make the same success claims they made for the female body. Parents of female-assigned children will be pushed to surgically reduce the clitoris and lengthen the vaginal canal (requiring continuous penetration with dilators in primarily pre-sexual children). The parents of male-assigned children will be pushed to surgically reposition the urethra to the tip of the phallus, but lengthening or surgeries regarding length and erectile function are not on the priority list. At one of the primary Italian DSD (Disorders/Divergence of Sex Development[12]; see Reis 2009, 153-162) centers[13], a male gender assignment will often directly correlate to the postponement of surgery. A child's smaller than average phallus is often treated with topical hormone ointment. Phalloplasty could be a valid option, yet it's success is interpreted differently. Doctors will not necessarily push to modify children's male genitals with the same frequency or in the same manner as females (Dreger 1998; Fausto-Sterling 2000; Mattioli, Jasonni 2004). These positions are perhaps reflection in legal regulation of social gender change, which often requires vaginoplasty for the female body, but not phaloplasty for the male (as in Italian regulation). This provides increased

[12] In 2006, through the consensus convention in Chicago (attended by intersex activists, academics and medical practitioners) both the new term DSD (Disorder of Sexual Development) and the Patient Centered Care Model were developed. The new terminology is both hailed useful, for moving away from the gender and surgery centered model, and criticized for increasing medicalization and stigmatization through the word disorder (prompting others to propose divergence; see Reis 2009, 153-162). For opposing views see http://oii-usa.blogspot.it/; http://www.intersexinitiative.org/articles/intersextodsd.html. The terms used in the text reflect auto-identification and/or a medical diagnosis.

[13] As part of the ethnographic project, all participants and centers were rendered anonymous.

space for male individuals who do not posses genitals of standard male form or size, yet perform male cultural genitals.

4. To pee or not to pee. Part 2

The majority of male DSD genital surgery regards the gendered performance of urination. In 0.8% of XY men, the urethra is not positioned at the tip of the phallus, diagnosed as the medical category of hypospadias. While hypospadias was not always included in the medicalized category of Intersex[14], due to the correlation between XY chromosomal material, 'male' gonads and male gender assignment, the new category of DSD[15] opens the door to ever increasing syndromes. The inclusion of hypospadias diagnosis in DSD nearly doubles the statistics of people who are considered to deviate from the standard gendered body. The normal is an ever-shrinking category.

Hypospadias variation does not disturb the passage of urine in more than three-quarters of the cases (Mattioli and Jasonni 2004). What is medicalized in the majority of cases is not the function of urinating, but the gender manner of urinating. Parents are advised to move the urethra to the tip of the phallus for psychosocial reasons, despite the high risk of repeated infections, interventions and eventual urethral collapse. The gendered performance of urinating standing up is read to be important enough to risk eventual urethra function failure. Parents are asked to make these decisions in high-pressure situations, often without adequate information regarding outcomes and risks (as in most early childhood genital surgeries). Qualitative evidence indicates that the fear of bullying and lock-room stigmatization often is raised first by the medical practitioners, not the families (see Dreger 1999, Kessler 1998).

A quick search on the Internet indicates both male anxiety regarding normal urinating behavior, as well as a common preference that men urinate sitting. The Internet is a growing

[14] Coined in 1917; Dreger 1998, 31
[15] Coined in 2006; see Morland 2009

ethnographic resource, where both the general public and interest groups publicly discuss their ideas and concerns (Garcia et al. 2009). One website, called 'is it normal?', asks if it is normal for a man to urinate sitting down[16]. 77% respond that it is normal. However, of the 195 comments only seven (3.6%) express negative comments regarding sitting and urinating, three (1.5%) of which are homophobic in nature. Five comments indicate health benefits to the prostrate and kidney regarding urinating sitting[17], three indicate that the majority of German men sit to urinate, and one comments that most Muslim men sit to urinate[18]. The majority of the comments not only normalize urinating sitting down, but advocate it.

The act of urinating is also inserted in the gender-relation power binary[19]. Being asked to sit while urinating is seen as a threat to autonomy, and in this context some objectors indicate fear that urinating sitting down symbolically queers the male body. However, the majority of the responses refute the claim that that urinating sitting is un-manly, reframing the issue regarding hygiene and power dynamics. «Just tell her you'll clean and wipe after you pee […] The problem isn't that you pee standing, the problem is that the bathroom is unclean. So solve the real problem» (MidasGirl).

5. Pleasure and Shame - modifying the genitals

The medicalization of childhood genitals is complicated by the multiple issues of missing autonomy, cultural constructions of normality, informed consent, statistics on long-term satisfaction and the malleability of the body in the hormone flooded periods of early childhood and puberty development. The medical standard of the normal genital often rests on size, penetrability for females and urination standing-up for males. This standard links the aesthetics of the genitals to gender identity, but also eventual sexual well-being and pleas-

[16] http://isitnormal.com/story/peeing-sitting-down-920/

[17] A quick search in Italian for urinating while sitting "urinare seduto" indicated instead 6 health related articles in the top ten sites.

[18] The Sunnah indicates regulations for male urination regulation that includes not using the right hand and crouching to hide the genitals. See http://islamqa.info/en/ref/2532

[19] See also http://www.stevepavlina.com/forums/social-relationships/34622-do-real-men-pee-sitting-down-adult.html

ure through a distorted construction of self-esteem. Intersex activists instead indicate that many of the 'normalizing' operations reduce or obliterate sensation, as well as leaving a lasting legacy of shame regarding ones body.

Queer analysis of sexuality deconstructs sexualities beyond mere penetration or genital arousal. Sexuality includes multiple forms of touch and multiple forms of desire, in which the genitals may take on both a physical and symbolic role. Iain Morland (2009), in his article, *What Can Queer Theory do for Intersex?*, points out that a queer analysis of desire and sexuality is incomplete without attention to shame, as well as pleasure. One could easily argue that shame is a primary social aspect of the genitals, a normative expectation, a potential constant reflected by our efforts to keep them covered in all public situations. Pleasure on the other hand, is not a given, and, as we look closer, will emerge as *not* one of the fundamental expectations for the genitals.

Both queer and normative expectations for the genitals are formed of a complex web of social constructions regarding gender roles, sexuality, aesthetic form, physical function, pleasure, shame and identity. Our social genitals and our physical genitals are implicated in the delicate act of identity expression. They help us express not just what binary gendered category we live in, but what type of gendered person we are, and it which situations, shifting in and out of queer categories. What are non-queer sexualities, or non-queer genitals? We can roughly sketch various attempts to define the normal genitals and their relationship to the social genitals. The line between the dominant and the queer, just like the line between the normal and the pathological, is made up of multiple shifting definitions.

How genital function is defined is situational, different disciplines and subjectivities prioritize differing objects, from nerve function to gender presentation. The cis-gendered body is naturalized, expected to correspond aesthetically to the genital norm. Yet even the cis-gender body is subject to constant re-construction, at the edge of queerness. The continuous potential for shifting definition is hidden in the genitals, either through socio-linguistic operations or the surgical manipulation of tissue.

Even medical literature on the success of DSD genital modification surgery indicates that in the majority of cases, nerve sensation is damaged. Yet interpretations of sexual and geni-

tal function remain broad. A study of 8 women with DSD who underwent vaginal surgery in Milano indicated the majority of the patients were satisfied with their sex-life (Lesma 2006). Looking closer at the data, however, 6 did not have sexual relations and all had difficulty achieving orgasm.

AISIA[20] members report negative results with vaginal lengthening surgery, which often creates scar tissue in otherwise elastic vaginal tissue. Many of the members who have had corrective surgery continue to be blocked sexually, convinced that the surgery would be evident to their sexual partner. The older members of the group were often led to believe they were 'freaks' and to feel deeply ashamed of their bodies. One member was directly told that she should not have sex due to her diagnosis (she had 'normal' female genitals but XY chromosomes).

In the case of childhood normalizing surgeries, the imposition of 'correction' can actually be the root of physical shame (Parens 2006). At the root of Money's protocol was the idea that eventual sexual pleasure rested on a clear gender identity, which could only be provided by a 'corrected' genital form. However, the medical event – the medical stripping, the intimate invasion of the surgeon into the body – creates the negative stigma of difference that has a strong impact on sexual identity (not sexual orientation). Morland agrees with Holmes that «intersex surgeries make bodies more intersex than they started out» and that «[t]he lived experience of this is that one's sexual anatomy seems both glaringly unusual and yet brutally normalized – one reason why postsurgical individual may be fearful of sexual relations» (Morland 2009, 300). AISIA member experience highlights this affirmation; those who have been surgically touched are physically reminded of the diagnosis in the sexual moment.

Sexuality is a complex phenomenon that is not just about orgasm, but also about desire and the legitimacy to desire. Queer theory contextualizes the legitimacy to desire as part of continuum of power, indicating that «queer pleasure is characterized by a focus not on genitalia but on the body as a whole» (ivi, 291). Morland sites Califia in order to contextu-

[20] Associazione Italiana Sindrome da Insensibilità agli Androgeni, see http://www.aisia.org/home.html; Crocetti 2010.

alize cis-gender desire as a hidden factor in the spectrum of sexual perversions: «a belief in sex differences and a dependence on them for sexual pleasure is the most common perversion», that is however «overlaid by privilege» (ivi, 290).

Morland re-centers the queer touch on the infinite possibilities for desire and sexuality that shift in and out of moments of privilege. He states: «a queer understanding of the postsurgical body need not attend to the genitalia on which the surgery operates…A queer understanding ought to attend instead to the desires that exceed such naming». In addition, Morland highlights the role of the queer discourse in «transmuting otherwise unpleasant experiences of social degradation into experiences of pleasure» (Halperin in Morland 2009, 287). Queer theory, like disability theory, redefines the stigmatized difference as a legitimate position of desire and desirability, that is however outside clear structures of privilege.

Shame in sexuality or regarding the genitalia is not by any means a defining factor of intersex. Instead shame is a significant factor in the construction of dominant sexuality[21] that is imposed onto Intersex medicalization. Heterosexual and cis-gendered sexuality is not necessarily «straightforwardly pleasurable» as Morland puts it, nor do people necessarily like it (Morland 2009, 292). Queer theory positions itself to recognize both the importance and variety of sexuality, as well as the stigma, shame and difficulty that sexuality presents. The queering of sexuality relocates the origin of sexual shame in cis-gendered heterosexual anxiety. The anxiety surrounding genital form and its relationship to gender can similarly be traced to cis-gender instability.

In situations other than imposed childhood surgeries, the modification of genital material can be a positive, liberating intervention. Genital surgery is seen in very different light if it is imposed institutionally as in the case of most DSD surgeries, chosen by trans-gendered individuals, or chosen by cis-gendered individuals. In all three cases the tissue modification responds to the overlap of genital function with genital form. However, all three instances

[21] Laqueur in *Making Sex* (1990, 31) indicates that in ancient Greece young athletes would tie down their genitals to make them seem smaller and like the feminine version. He uses the word pudenda instead of genital. Pudenda comes from the future passive participle of pudeo (shame). Pudenda indicates the part for which one feels shame.

have a different relationship to constructing either a docile privileged body, or body that re-situates knowledge regarding gender privilege.

6. Perfecting the cis-gendered body

Genital modification techniques are now increasingly used in body enhancement and plastic surgery. The language of enhancement implies that the modification is conducted outside of a medicalized context (either DSD diagnosis or GID diagnosis[22]). Vaginoplasty and labioplasty for cis-gendered women is a new controversial frontier of plastic surgery. This is the Italian version of an Italian website, which contains some extra text on pathology not present in the English version:

> If up until recently female genital surgery was only conceivable in the case of a pathology, today more and more women ask surgeons to operate on their intimate parts to redesign their vulva, reduce the dimension of their vagina, increase the muscle tone of their perineum. The scope of these types of surgeries is both esthetic and functional (feel more sexual pleasure), and is the same as any other type of operation; help women feel better about how they look[23].

This blurb highlights most of the interesting aspects of the evolution of the consideration of the genitals. It indicates the historical process of medicalizing genital form, and gender, through the genitals. It indicates the desire to use technology to transform the body to conform to ideological standards that are better than well. It uses the same psychological justi-

[22] The debate surrounding the medicalization of gender identity is far too complicated to outline here. Let is suffice to say that in certain countries medicalization allows access to health services, while in others it is merely displacing the social obsession with fixed-gender on to the «deviant« individual as a mental disorder.

[23] Se fino a non molti anni fa gli interventi chirurgici sui genitali femminili erano concepibili solo in presenza di una patologia, oggi sempre più donne chiedono al chirurgo di intervenire sulle loro parti intime per ridisegnare la vulva, diminuire il diametro della vagina o migliorare il tono del perineo. La finalità di questo tipo di interventi è sia estetica che funzionale (provare maggior piacere sessuale), ed è la stessa di qualunque altra operazione del genere: riconciliare le donne con la propria immagine. Translation author DC. http://www.vaginoplastica.net/

fication as most plastic surgery: «help women feel better about how they look», a commercialization of insecurity. And in the end, it continues to define the aesthetic form of the genitals as their primary function.

We must not forget that in the history of the modification of the gendered body, female genitals were not seen in very high regard. Potential sexual pleasure was ignored in order to privilege an ideal form. The surgical premise that female genitals were just a hole to be penetrated is not promising. We continue to find differing performative expectations for the male and female body, and male and female sexuality that impose the classic gendered discoursive binary on the genitals in the form of passive/active, private/public, insignificant/relevant etc (Cameron 2007). And yet, the female request for genital surgery does not clearly reflect this binary structure. What do cisgendered people think their genitals are supposed to do?

Psychologist Liao and gynecologist Creighton indicate that, in the UK, requests for genitoplastic surgery have doubled in the last 5 years. They interviewed patients in order to uncover their subjective motivation. The two main motives mentioned were the discomfort created by the labia in tight clothes or during sporting activities, or pure esthetics. They note that male patients do not seek plastic surgery for discomfort created by genitals size and clothing tightness.

They found that the ideal female esthetic sought by patients mirrored digitally modified media, not average occurring genitals or medical representations. «Patients consistently wanted their vulvas to be flat with no protrusion beyond the labia majora ... some women brought along images to illustrate the desired appearance, usually from adverts or pornography that may have been digitally altered» (Liao and Creighton 2007). The modified media reflects an esthetically easily penetrable vagina by reducing the surrounding labial tissue, much like the early ideals of intersex surgeons.

Gynecologists note that there is a lack of scientific data regarding “normal” female genital dimensions, despite the wealth of practices to create them (Lloyd et Al. 2005, 643–646). «Although lay representations vary according to historical and cultural conditions, scientific work is supposedly screened of such influence. There are demonstrable shifts in the

scientific representation of female anatomy and it is notable that even some recent text books of anatomy do not include the clitoris on diagrams of the female pelvis» (ivi, 643). This study indicated a large range in genital variation.

Table 1. Measurements of genitalia

	Range	Mean [SD]
Clitoral length (mm)	5 – 35	19.1 [8.7]
Clitoral glans width (mm)	3 – 10	5.5 [1.7]
Clitoris to urethra (mm)	16 – 45	28.5 [7.1]
Labia majora length (cm)	7.0 – 12.0	9.3 [1.3]
Labia minora length (mm)	20 – 100	60.6 [17.2]
Labia minora width (mm)	7 – 50	21.8 [9.4]
Perineum length (mm)	15 – 55	31.3 [8.5]
Vaginal length (cm)	6.5 – 12.5	9.6 [1.5]

Source: ivi, 644

Regarding cis-gender genital surgery the research team states: «Reasons for such requests are far from understood. But 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» (ivi, 643).

The dissatisfaction with the body that fuels the consumer request is not always satisfied by the procedure. One study highlights greater psychological distress after cosmetic surgery (Honingman 2004). Those who study plastic or cosmetic surgery (see Haiken 1999; Fraser 2003; Ghigi 2008) indicate a continuum of mutual construction between culture, gender and cosmetic surgery.

One could argue that the definition of cosmetic surgery is contingent on the idea that it is not necessary, whereas other reconstructive surgeries are. Disability activists, for instance, do not criticize corrective surgery in itself, but the societal obligation and imposition of such surgeries that mark difference as wrong. Emily Sullivan Sanford thoughtfully debates her decision to have limb-lengthening surgery stating, «I cannot recall what potential benefit ultimately swayed me towards the procedures. I can recall, however, that an essential ingredient of the decision making process was my sense that the decision was my own» (Sanford in Parens 2006, 33). Sanford argues that the success of any enhancing surgery depends on the creation of a solid self-esteem during childhood. Quite the opposite from the idea that cosmetic surgery itself gives self-esteem.

None of the described surgical techniques in the Italian ad, redesigning the vulva, reducing the diameter, etc, actually increase nerve sensibility and sexual sensation, scar tissue can actually reduce it. The proposed surgical techniques and the rhetoric of the Italian ad reflect the assumption that genital form is the most important function of the genitals[24]. Sexuality is constructed outside the realm of touch and pleasure, within the projected gaze and certain sexual acts. While responding to the hegemony of the constantly shifting 'normal' body, cisgendered genital surgery inadvertently queers the normal. The normal is made to reenter in the project of gender construction.

More interestingly, and requiring further reflection, female cisgender genital surgery postulates the female body outside of the previously mentioned discoursive binary. The female genitals have been transformed in the 20th century into a public item, to be observed in detail by all. Cisgender genital surgery poses the female body as actively sexual. By seeking genital surgery, the patient is also declaring the desire to be a sexual object, redefining their previous type of femininity on the spectrum of gender. These surgeries indicate the growth of identification with a *sexual* female archetype, despite the requirement of an idealized genital form. The suspicion that gender is plastic is reconfirmed by the desire to arrive at it.

[24] For a discussion on surgery, genital form and function see Plemons 2011.

7. Queering the genitals

As mentioned earlier, any gender transgression can draw morbid attention to genital form. Transgender (transition from one gender category to another, with or without bodily modification) experience historically raised issues regarding the gendered power binary. With the rise of surgical techniques, often experimented on Intersex/DSD patients, the genitals became part of the gender project. We have little pre-operative historical data regarding transgender satisfaction with their genital form. Ethnographic research with the tradition of Indian female transgenderism, Hijras, indicates a desire to modify genital form (Herdt 1994). Other ethnographic accounts such as in Native American cultures like the Zuni (Roscoe 1991), indicate that genital form was not as important an aspect in gender role, therefore not a source of anxiety. Europe is largely silent on the issue, having instituted laws against gender shifting in the 1700s (Reis 2009).

Oyeronke Oyewumi (1998) highlights the ethnocentric tendencies in many disciplines to define gender through genital form, indicating that genital form is not a universal gender marker. Gilbert Herdt (1994) mirrors this observation, indicating that even in cultures that maintain a rigid dual social gender system, there may be three or more sex categories that are not rigidly based on genital form[25].

The importance of genital form to gender identity formation appears to be relative to both temporal culture and individual nature, as opposed to John Money's 1950's claims. Money reflected the hidden message that western culture continues to project much anxiety on genital form. Contemporary transgender subjectivity was brought to the mainstream through the work of Garfinkle with Agnes. Agnes was profoundly uncomfortable with her genital form, and sought to have it changed so that she would feel like a *real* woman (1967). In the period surrounding Agnes's experience the rhetoric of 'being born in the wrong body' with 'the wrong genitals' dominated the Transgender discourse (Hubbard 1996).

[25] Therefore the Berdache or Navajo nadleehi are not considered Transgender, they adapt consistent social gender roles as adults and live in one of the two gender roles. They are seen as belonging to third sexed category not defined solely by genital form.

Shortly after, in 1969, the stonewall riots exposed the continuation of legal punishment for clothing and behavior considered transgendered. Homosexuality was finally removed from the Diagnostic and Statistical Manual (DSM) in 1987. As homosexuality became less medicalized, gender role and identity fell increasingly under the lens. The diagnosis of Transsexualism was introduced in the DSM-III in 1980 for individuals who demonstrated at least two years of continuous interest in transforming the sex of their bodies and their social gender status. In 1994, the DSM-IV committee replaced the diagnosis of Transsexualism with Gender Identity Disorder. This medicalization of gender identity created an institutional structure that one could turn to in order to change social role legally.

The same John Money of Intersex protocol helped establish the new clinic for transsexuals at The Johns Hopkins Hospital in 1966. Money strongly believed in the positive role of surgery and the social basis of gender identity. However, even in 1994 Money expresses the opinion that «Gender coding in the brain is bipolar. In gender identity disorder, there is discordancy between the natal sex of one's external genitalia and the brain coding of one's gender as masculine or feminine.» (Money 1994).

Through the 90s, this axiom, that gender is binary, was deconstructed from every angle possible. In many countries, such as Italy, a legal gender change requires psychological therapy, hormone treatment and genital surgery (including sterilization). In the US capitalistic model, where the state will not pay for any of these procedures, a year of therapy could be enough to obtain a legal gender change. Given the possibility, many individuals in the US change legal gender status without modifying their genital form surgically[26]. Hormone treatment will shift the size of the genitals in many cases.

Queer theory began to argue that it is the gender of the individual that gives gender to the genitals, not the form of the genitals that gives gender to the individual. Putting into practice the productive form of power, particularly transgender men began to document their genital form through political art. *Body Alchemy: Transsexual Portraits* (Cameron 1996) shows various forms of genitals on male bodies. These images were not a response to mor-

[26] Hormone treatment will shift the size of the genitals in many cases.

bid obsessions with genital form, but a way of proposing new normalities, a mirror in which other people (trans and non) could see themselves reflected. Much like technology studies, queer theory proposed that visualizing the previously invisible redefines the real (Pauwels 2005).

Through the beginning of the 21st century, queer subjectivities proposed pornography as another tool to reassume the right to desire and diversity. Auto-produced queer pornography framed the small male genitals or the large female genitals as within the realm of desire. Whereas 'straight' pornography is accused of portraying an impossible ideal, queer pornography transgresses the binary of privilege.

Zimman outlines the linguistic shift in the American transman community, which apply the gendered labels to their genitals that they feel comfortable with. New terms arise and fall away as sensibilities change. «My focus here is on the way language can be employed even in absence of radical body transformation. Yet, as we shall see, trans men's transcendence of their assigned sex is enabled-not inhibited-by the realities of the flesh, as trans men skillfully draws on scientific discourses about the relationship between male and female genitals, as well as the changes that testosterone causes in their bodies, to create a different vision of biological maleness» (Zimman 2012, 8).

This can mean using male genital names when the individual is male, as in the documentary Enough Man (Woodword 2005) «I might be hung like a gerbil, but I have a cock». Or using gendered pronouns to shift gender, such as her dick and his cunt. Sometimes standard gendered terminology is avoided altogether. In a response to a query to on how people in transition call their genitals, another person writes «recently (due to listening to this awesome interview with Judith Butler: http://digital.library.unt.edu/ark:/67531/metadc40365 /m1/) I realized I can just deny anyone the ability to name my body at all: "do you have a vagina?" "No." "Do you have a penis?" "No." "Well, what do you have?" … shrug … so I say yeah, go for the nameless body, don't feel bad about not having words for parts, embrace the wordlessness & complexity if at all possible!»[27]. The four writers in this blog in-

[27] http://www.originalplumbing.com/2012/08/17/that-which-shall-not-be-named/

dicate a discomfort with genital names in general, not due to gendered labels. If we reflect on slang for a second, we find the desire to call the genitals in manners other than penis and vagina is rampant in all languages[28].

The trans population is made continuously aware of its queer, marked status. Therefore, redirecting the productive power of knowledge, it continuously drops new terminology into the mix, such as cisgender, that marks other realities under the queer lens. Zimman notes (2012, 16):

> Rather than using unmarked language to refer to non-trans men and their bodies, such as simply *men* or *dicks*, members of this community consistently use qualified phases like *non-trans dicks* and the amusing *factory direct dicks*, making clear that non-trans men's penises are only one type of genitals. By emphasizing similarities […] members of this community reframe the difference between trans genitals and normative male bodies as primarily a matter of size rather than gender.

8. Conclusion

While someone's relationship to their gender, the importance they give it, how they express it, may change over time; cisgender and transgender experience indicates that neither genital form nor genital modification have any impact on gender identity (contrary to Money's theories). Genital form may impact how one feels *within* their gender, reflecting insecurities regarding an imagined standard. The morbid obsession with genital form and its normalization reflects the slippery boundaries in which all genitals risk being seen as queer.

The queering of the genitals exposes how genital definition is constantly being re-written through the intersection of institutions with both privileged and queer realities. Modes of urinating, once tied to western constructs of gendered power dynamics, types of masculini-

[28] Cameron looks at the metaphors of genital words as carrying social subtext, «The vision of the men's list [for male genitals] offers is banal and yet terrible, an experience of masculinity as dominance, femininity as passivity, and sex as conquest» (Cameron 1998, 379)

ties and femininities, are deconstructed in popular culture even while surgeons continue to insist on its importance as a gendered social practice. And yet, the lack of confidence that surgeons have historically displayed regarding phalloplasty, translates in practice to a diminished social pressure to change male genital size. Or rather, the penile enlargement ads that fill men's magazines are targeted at enhancing the cisgender privileged body, reconfirming the constant risk of falling into the queer.

All genitals require the social operation of naming to acquire a gender. Through an attention to function and material, science studies have deconstructed the assumed direct relationship between biology and gender. Many insist on the complex variation of reproductive functions in the gendered body as the locust of biological gender. However, the debates surrounding Thomas Beatie, popularly known as the first pregnant (trans) man, belie the complexity of popular beliefs regarding reproduction and gender. No one looses gender status due to the inability to conceive; therefore conception does not inherently give gender status.

The genitals are one of the most plastic aspects in the gendered body, second only to somatic characteristics such as hair distribution and fat/muscle ratio. Medical practice both reinforces this image by acting on the body to conform it to a gendered ideal, and dismisses the possibility that people may be more comfortable in their queer bodies. The productive power of queer realities, theory and popular culture propose the genitals as *part* of the body and *part* of sexuality. An operation useful for all.

References

Balocchi M. (2012) “Sexual and Human Rights of Intersex People: the Sociological Aspects of Medicalization of Intersexuality in Italy”, in S. Antosa (ed.) *Gender and Sexuality*, Aracne Editrice, Roma, 35-50.

Bell, D. and Binnie, J. (2000) *The Sexual Citizen: Queer Theory and Beyond*, Cambridge, Polity Press.

Busi B., (2012) “Modificazioni. MGF, intersex, trans e produzione del sesso”, in S. Marchetti *et al.* (a cura di), *Femministe a parole. Grovigli da districare*, Ediesse, Roma, pp. 177-182.

Cameron, D. (1998) Naming the parts: gender, culture, and terms for the penis among American college students, in «American Speech», vol. 67, n. 4, pp. 367-382.

Cameron, D. (2007) *The Myth of Mars and Venus, do Men and Women Really Speak Different Languages?*, Oxford University Press, Oxford.

Cameron, L. (1996), *Body Alchemy: Transsexual Portraits*, Cleis Press, San Francisco.

Corriere.it (2006) *Gardini: Luxuria vuole scardinare la famiglia* in “Corriere Della Sera”, 31 October, (viewed 7 July 2012) http://www.corriere.it/Primo_Piano/Politica/2006/10_Ottobre/31/gardini.shtml

Crocetti, D. (2010) “From hermaphroditism, to intersex and disorders of sex development (DSD): shifting terminology and shifting meaning” in M. Cazzotti and G. Pancaldi (eds.), *Impure Cultures: Interfacing Science, Technology, and Humanities*, Bologna, Università di Bologna, pp. 57-86.

Butler, J. (1990), *Gender Trouble Feminism and the Subversion of Identity*. Routledge, London.

Davis, L.J. (1997) *The Disability Studies Reader*, NY, Routledge.

Dreger, A.D. (1998) *Hermaphrodites and the Medical Invention of Sex*, Harvard University Press, Cambridge, Mass.

Dreger, A.D., and Herndon, A.M. (2009) Progress and Politics in the Intersex Rights Movement: Feminist Theory in Action, in «GLQ Intersex and After», Vol. 15, N. 2, 199-224.

Fausto-Sterling, A. (1985) *Myths of Gender: Biological Theories about Women and Men*, NY, Basic Books.

Fausto-Sterling, A. (2000) *Sexing the Body*, NY, Basic Books.

Feder, E.K. (2009) Imperatives of Normality: From "Intersex" to "Disorders of Sex Development", in «GLQ Intersex and After», Vol. 15, N. 2, 225-247.

Foucault, M. (1998/1976), *The History of Sexuality Vol. 1: The Will to Knowledge*, Penguin, London.

Foucault, M. (1980) *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, C. Gordon (ed.), Brighton, Harvester Press.

Foucault, M. (1999) *Abnormal: Lectures at the College de France 1974-1975*, London, Verso.

Fraser S. (2003) *Cosmetic Surgery, Gender and Culture*, Palgrave, Macmillan.

Garcia, A.C., Standlee, A.I., Bechkoff, J., and Cui, Y., (2009), Ethnographic Approaches to the Internet and Computer-Mediated Communication, in «Journal of Contemporary Ethnography», vol. 38, n. 1, pp. 52-84.

Garfinkle, H. (1967), *Studies in Ethnomethodology*, NJ, Prentice Hall.

Ghigi, R. (2008) *Per Piacere*, Bologna, Il Mulino.

Haiken, E. (1999) Venus Envy: A History of Cosmetic Surgery, Baltimore, The Johns Hopkins University Press.

Halberstam, J. (1998) *Female Masculinity*, Duke University Press, Durham.

Halberstam, J. (2005) In a Queer Time and Place: Transgender Bodies, Subcultural Lives, NY, New York University Press.

Halperin, D. (1995), Saint Foucault: Towards a Gay Hagiography, NY, Oxford University, Press.

Hendricks, M. (1993) Is it a boy or a girl?, in «John Hopkins Magazine», vol. 45, n. 6, pp. 10-16.

Herdt, G. (1994), *Third Sex, Third Gender: Beyond Sexual Dimorphism in Culture and History*, Zone Books, NY.

Holmes, I. (2007) *Genetic Sex; "A Symbolic Struggle Against Reality?"-Exploring Genetic and Genomic Knowledge in Sex Discourses*, Doctoral Dissertation, University of Exeter.

Honingman, R. (2004) A Review of Psychosocial Outcomes for Patients Seeking Cosmetic Surgery, in «Plastic and Reconstructive Surgery», vol. 113, n. 4, pp. 1229-37.

Hubbard, R. (1996) Gender and Genitals: Constructs of Sex and Gender, in «Social Text», vol. 14, n. 1 and 2, pp. 157-165.

Jabolonka, E., and Lamb, M. (2005) *Evolution in Four Dimensions*. Mass, MIT Press.

Karkazis, K. (2008) *Fixing Sex: Intersex, Medical Authority, and Lived Experience*, Durham. Duke University Press.

Kessler, S., and McKenna, W. (1978), *Gender: An Ethno-methodological Approach*, Chicago, University of Chicago Press.

Kessler, S. (1998), *Lessons from the Intersexed*, NJ, Rutgers University Press.

Koyama, E. (2006) From Intersex to DSD, keynote speech, Translating Identity Conference, University of Vermont, (viewed 23 April, 2007) http://www.intersexinitiative.org/articles/intersextodsd.html

Laqueur, T. (1990) *Making Sex: Body and Gender from the Greeks to Freud*, Cambridge, MA, Harvard University Press.

Lesma, A., Maccagnano, C., Bocciardi, A., Montorsi, F., Rigatti, P. (2006) *Feminizing Genitoplasty: Psychsexual Outcomes*, Abstract for International meeting on Anomalies of Sex Differentiation, Rome, Promoarch.

Liao, L.M. and Creighton, S.M. (2007) Requests for Cosmetic Genitoplasty: How Should Healthcare Providers Respond?, in «BMJ (British Medical Journal)» vol. 334, n. 7603, 1090–1092.

Lloyd, J., Crouch, N.S., Minto, C.L., Liao, L.M., Creighton, S.M. (2005) Female genital appearance: 'normality' unfolds, in «BJOG: an International Journal of Obstetrics and Gynecology», Vol. 112, 643–646.

Marcasciano, P., LaTorre, C., Pasquino, M. (2012) *Un Transito Lungo 30 Anni*, Bologna, MIT.

Mattioli, G., and Jasonni V. (2004) Il Neonato Con Genitali Ambigui: L'assegnazione Del Sesso, Rome, Conference Patologie Andrologiche Dell'età giovanile: il Ruolo della Prevenzione, http://www.ministerosalute.it/resources/static/focus/307/presentazione.pdf (viewed 7, november 2006).

Monceri, F. (2010) *Oltre l'identità sessuale. Teorie queer e corpi transgender*, Pisa, ETS.

Money, J. (1994) The Concept of gender identity disorder in childhood and adolescence after 39 years, in «Journal of Sex & Marital Therapy», Vol. 20, I. 3.

Morland, I. (2009) What Can Queer Theory do for Intersex, in «GLQ Intersex and After», Vol. 15, N. 2, 285-312

Oudshoorn, N. (1994) *Beyond the Natural Body; an archaeology of sex hormones*, London, Routledge.

Oyewumi, O. (1998) *De-Confounding Gender: Feminist Theorizing and Western Culture, a Comment on Hawkesworth's "Confounding Gender"*, in «Signs» Vol. 23, No. 4, 1049-1062.

Parens, E. (ed.) (2006) *Surgically Shaping Children: Technology, Ethics, and the Pursuit of Normality*, Baltimore, John Hopkins University Press.

Pauwels, L. (2005) *Visual cultures of science: rethinking representational practices in knowledge building and science communication*, Dartmouth, Dartmouth College Press.

Plemons, E. (2011), Envisioning the Body in Relation: Finding Sex, Changing Sex, in Kosut, M. and Moore, L.J. (eds.), *The Body Reader, Essential Social and Cultural Readings*, NY, NYU Press, pp. 317-328.

Prader A. (1954) *Der genital befund bein pseudohermaphroditismus femeninus des kongenitalen androgenitalen síndrome*, in «Helv Paediatr Acta», Vol.9, 231–48.

Rabeharisoa, V. and Callon, M. (2002) *The involvement of patients' associations in research*, in «International Social Science Journal» Vol. 171, 57-67

Rabinow, P. (1999) Artificiality and Enlightenment: From Sociobiology to Biosociality, in Biagioli, M. (ed.) *The Science Studies Reader* NY: Routledge pp. 407-416.

Reis, E. (2009) *Bodies in Doubt*, Baltimore, John Hopkins University Press.

Roscoe, W. (1991) *The Zuni Man-Woman*, Albuquerque, University of New Mexico Press.

Sanford, E.S. (2006) My Shoe Size Stayed the Same: Maintaining a Positive Sence of Identity with Achondroplasia and Limb-Lengthening Surgeries, in Parens, E. (ed.) *Surgically Shaping Children: Technology, Ethics, and the Pursuit of Normality*, Baltimore, John Hopkins University Press.

Sengoopta, C. (2006) *The Most Secret Quintessence of Life: Sex, Glands, and Hormones, 1850-1950*, Chicago, University of Chicago Press.

Shildrick, M. (1997) *Leaky Bodies and Boundaries: Feminism, Postmodernism and (Bio)Ethics*, London, Routledge.

Valentine, D. and Wilchins, R.A. (1997) One Percent on the Burn Chart: Gender, Genitals and Hermaphrodites with Attitude, in «Social Text», Vol. 15, No. 52/53, 215-222

Warner, M. (2003) *Fear of a Queer Planet: Queer Politics and Social Theory*, Minneapolis, University of Minnesota.

Wilchins, R. (2004) *Queer Theory, Gender Theory: An Instant Primer*, Los Angles, Alyson Books.

Whittle, S. (2005) Gender Fucking or Fucking Gender?, in Morland, I., and Willox, A. (eds.) *Queer Theory*, NY, Palgrave.

Woodword, L. (2005) *Enough Man*, Documentary, USA.

Zimman, L. (2012) The Discursive Construction of Sex: Remaking and Reclaiming the Gendered Body in Talk about Genitals among Trans Men, in Zimman, L., Davis, J. and Raclaw, J. (eds.), *Queer Excursions: Retheorizing Binaries in Language, Gender and Sexuality*, Oxford, Oxford University Press.