
Erotically Queer

A Pink Therapy Guide for Practitioners

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Chapter 6

Intersex-centred sex therapy and relationship counselling

Six commonly neglected concerns of
intersex adults

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Who are intersex people?

Intersex is an umbrella term to describe people with one or more of over 40 innate physiological characteristics. Although these characteristics are natural manifestations of human biological diversity, contemporary medical norms pathologise and marginalise people whose bodies do not fit popular definitions of strictly female or male bodies. Intersex characteristics can involve chromosomes, genitals, gonads, hormones, and aspects of reproductive anatomy, including features present at birth and innate characteristics that develop later in life, such as during puberty. Although some people's intersex characteristics may be identified at birth, intersex characteristics are often not discovered until later in life. Some intersex features are not externally visible at any stage of life. Contrary to stereotypes, it is not usually possible during regular social interactions to determine whether or not someone is intersex. This means you are likely to have met intersex people before without knowing it.

Respectful use of the term “intersex” is as an adjective, not a noun (i.e., “an intersex person”, “person with intersex characteristics”, or “person with an intersex variation”, but not “an intersex”, “an intersexual”, or “the intersexed”). The adjective to describe a non-intersex person is endosex (i.e., “an endosex person”). Although some people prefer to describe their specific intersex characteristics, research suggests that intersex is the most preferred term among actual intersex people (e.g., Jones et al., 2016). Despite this documented preference, many endosex professionals and parents continue to promote pathologising language such as “Disorders of Sex Development” (sic), which many intersex people experience as inaccurate, offensive, and harmful. “DSD” language promotes negative bias by constructing intersex people as having disordered bodies that require medical intervention to “fix” – often without actual intersex people's informed consent. Despite efforts by some clinicians to keep the initialism of “DSD” while shifting to “*Differences of Sex Development*”, this option still marginalises intersex people. It disregards scientific evidence of human biological diversity. “DSD” language is also closely linked with ongoing human rights violations against intersex people, so intersex people can experience endosex providers who use this terminology as emotionally distressing and unsafe.

One popular misconception about so-called “sex chromosomes” is that all people have either XX or XY chromosomes and that this genotype determines people’s so-called “biological sex”. This reductionist, unscientific ideology excludes people with intersex combinations such as XXY (Klinefelter’s), XO (Turner’s), and XXXY, XXXXY, and XYY (three Klinefelter’s variants). Recent scientific findings show that chromosomes alone do not determine physiological sex characteristics as commonly assumed and that so-called “biological sex” is plastic and mosaic, not static, deterministic, or dimorphic (Ah-King & Nylin, 2010; Joel, 2021; Joel et al., 2015, 2020).

Sanz (2017) critiqued the Anglocentric/Eurocentric sex binary – the belief that there are two distinct and natural sexes, female and male – as an untested epistemological framework and rejected the scientific legitimacy of “biological sex” as “a circular network that reproduces itself precisely because it has no clear referent” (Sanz, 2017, p. 3). Despite its lack of scientific validity, this sex binary and the construct of “biological sex” continue to be invoked to justify human rights abuses against intersex people. Even in regions where attempting to change people’s sexuality and gender to fit societal norms is criminalised, endosex medical professionals continue to inflict medically unnecessary and invasive psychological, hormonal, and surgical procedures on intersex people. These interventions, typically beginning during infancy and often continuing through adolescence and even into adulthood, are often justified due to heterosexist and ethnocentric assumptions about people’s psychosocial needs. Later in this chapter, I explore some specific examples of coerced and involuntary surgical interventions imposed on intersex people.

Intersex inclusion or coercive queering?

For over 15 years, I have contributed to intersex advocacy, education, and outreach initiatives in local, national, and international contexts as a professional and community member. I testified at the historic Australian Senate Committee Inquiry on the involuntary or coerced sterilisation of intersex people in Australia. I helped to develop the mental health practitioner training for the Yellow Tick accreditation initiative. During that time, I encountered many nominally “queer” publications *about* intersex people *without* input from actual intersex people (see also Ansara, 2021, on reducing bias in professional communications). Numerous queer theorists and gender studies scholars have purported to advocate on intersex people’s behalf without ever listening to – much less elevating – the communications of actual intersex people.

Given the reasonable mistrust with which many intersex people view these fields of study and the fact that many intersex people do not self-identify as “queer”, some people in intersex communities are likely to ask what a book chapter on intersex people is doing in a “queer”-themed book. This chapter has been included *precisely because* nominally queer, endosex professionals and communities need to acknowledge that being subsumed under the umbrella of “queer” can feel profoundly alienating for intersex people.

Ansara (2010, 2015) explained *coercive queering* as a practice that delegitimises people's understanding of their genders and bodies by lumping people under a "queer" umbrella without their consent. Coercive queering functions at both experiential and structural levels. For intersex people, coercive queering enacts *endosexism*, a term to describe how endosex people and lived experiences are valued and prioritised. In contrast, intersex people and lived experiences are simultaneously devalued and erased (cf. Holmes, 2016). Coercive queering often involves the non-consensual objectification of intersex people's lived experiences, such as reducing intersex people to mere tropes and rhetoric in queer theory. Including this chapter in a nominally "queer"-themed book is a strategic and pragmatic resistance to intersex erasure and coercive queering that I hope will raise awareness among endosex therapists and provide intersex people with a useful self-advocacy tool that can be shared with endosex health professionals.

Scope of this chapter

Few therapeutic publications address the specific erotic, affectional, and intimate relationship needs of intersex adults. To address this gap, I focus on only a few relevant and neglected therapeutic themes frequently raised by actual intersex people and communities in these three dimensions of lived experience. I hope other publications will fill the remaining gaps.

Some key neglected concerns of intersex adults

The following are six key neglected concerns relevant to the erotic, affectional, and intimate relationship needs of intersex adults:

- Epistemic injustice.
- Endosexist norms and standards.
- Medical trauma, impeded interoceptive awareness, and iatrogenic alexithymia.
- Disclosure and stigma management.
- Shame, self-worth, and relationship capital.
- Barriers to erotic, affectional, and intimate relationship boundaries.

After discussing each neglected area of concern, I guide sex therapists and relationship counsellors on how to adapt their existing practices.

Concern 1: epistemic injustice

Identifying concerns

The term *epistemic injustice* (Fricker, 2007) has been applied to describe how inequitable access to knowledge production and communication can perpetuate the systemic oppression of intersex people (Carpenter, 2016; Hart & Shakespeare-Finch,

2021). Fricker (2007) delineated two forms of epistemic injustice: *Testimonial injustice*, which occurs when people's accounts of their lived experiences are discounted, disbelieved, or treated as less authoritative due to their marginalised status; and *hermeneutical injustice*, which refers to challenges people face when trying to understand and communicate their own lived experiences, due to these experiences having been excluded from the collective conceptual and linguistic resources of their society.

Identifying and meeting the sex therapy and relationship counselling needs of adults with intersex characteristics can be fraught and complicated, given the manifold internal diversity among this population. Both forms of epistemic injustice affect intersex people's ability to share and validate their own lived experiences. Carpenter (2016) identified two forms of hermeneutical injustice faced by intersex people: One form occurs through societal identity discourse that, by using identity-focused language, mischaracterises intersex human rights concerns as being about sexual orientation and gender identity instead of being about bodily autonomy. Coercive queering (Ansara, 2010, 2015) of intersex people is an example of this form of hermeneutical injustice. The second hermeneutical injustice is perpetuated through "a deliberate culture of secrecy" (Carpenter, 2016, p. 79) that ensures intersex people lack the vocabulary to make sense of their everyday lived experiences and histories, combined with discriminatory clinical language that denies intersex people and their endosex parents the opportunity to discuss intersex people's bodies outside of an endosexist deficit perspective.

Carpenter quoted Holmes's (2011) analysis showing that "silencing is precisely the point of the new terminology". Holmes's article critiqued a so-called "consensus" statement that medical professionals made *about* intersex people *without* prioritising any input from actual intersex people and blatantly disregarding the consensus among real intersex people and communities. Holmes explored how this statement functioned as a systemic barrier that stigmatised intersex people's bodies and denied intersex people the opportunity to determine authoritative descriptions of their own embodiment. Attempts by endosex professionals and professional bodies to elucidate intersex lived experiences are often similarly hindered by this combination of erasure, pathologising, and refusal to accept intersex people as the best authorities about their own bodies. Intersex people are also excluded from normative curricula (Brömdal et al., 2021) and from media representations of adults with erotic, affectional, and intimate relationship needs.

Many people with marginalised innate physiological characteristics cannot safely disclose details of their lived experiences in print. Among the intersex people who spoke with me about their erotic, affectional, and intimate relationship lived experiences for this chapter, Bonnie Hart was the only person who wished to be identified by name. All other representations are anonymised composites drawn from frequently recurring clinical circumstances to address ethical concerns.

Bonnie Hart (she/her) is an intersex woman, peer worker, advocate, content specialist, and social science researcher who has investigated how people born

with intersex characteristics navigate the complex psychosocial and medical concerns involved in accessing safe healthcare and psychosocial services. Bonnie has served in leadership roles with Intersex Peer Support Australia (formerly the Androgen Insensitivity Syndrome [AIS] Support Group Australia [AISSGA]) and the Yellow Tick initiative, through which she has supported organisations and service providers to develop intersex-inclusive practices through delivery of training and policy review. Bonnie is also an original signatory of *The Darlington Statement* (2017), an intersex-led consensus statement developed by people from intersex communities in Aotearoa/New Zealand and the unceded Aboriginal lands colonially known as “Australia”.

During our interview for this chapter, Bonnie and I discussed our shared insight that practitioner acknowledgement of epistemic injustice is pivotal to understanding the therapeutic needs of intersex people. Considering the many concerns that have been silenced and how much has remained unaddressed due to the exclusion of intersex people from processes of knowledge production about their own embodiment, Bonnie (25 March 2022, by Zoom video, audio recording only) explained that

this is an onion. Where the centre of the onion lies is hard to determine because we are talking about populations of people who have limited access to knowledge about themselves, their bodies, and their experiences, and how to place those selves, bodies, and experiences within social, relationship, family, structural, clinical, and legal contexts.

Although people’s sources of knowledge about sex and sex education vary widely by sociocultural factors, media representations are often influential. Given the disproportionate gap in representations of intersex people, endosex practitioners often fail to anticipate the devastating impact epistemic injustice can have on the erotic, affectional, and intimate relationship lives of intersex people.

In addition to intersex people’s bodies being problematised, Bonnie noted that, in the absence of basic education to understand their bodies and experiences, “a lot of that responsibility comes back onto the person to have to know, advocate, and discuss these difficulties with whoever they’re engaging with”. This responsibility can be challenging to accept “if your body isn’t stereotypically male or female, if you actually have an experience of those differences being pathologised earlier in life, and if discussions around sex exclude you, because you don’t often know where you stand in that scenario”.

Hart and Shakespeare-Finch (2021) shared some examples of epistemic injustice from *Our collective story* (2017), a collection of reflective writings developed during AISSGA Intersex Peer Support meetings:

It was always a day filled with mixed emotions she couldn’t quite name. . . . She didn’t have the words to describe to her mother how this felt. Instead,

she wouldn't mention it, in the hope that this would minimise or erase what had just happened.

(p. 10)

They never told a lie about their body, not knowingly. How was it possible to tell the truth about your body without knowing what intersex was? What language is used to describe it?

(p. 10)

It wasn't until 10 years later she learnt the whole truth, that her "ovaries" were actually testes, and that she would discover a whole community of amazing people like her.

(p. 11)

These brief examples illustrate how epistemic injustice can affect intersex people's capacity to make sense of and communicate about their embodiment and lived experiences.

What can practitioners do?

The most helpful thing practitioners can do to address epistemic injustice is to treat intersex people as the best authorities about their lived experiences. Recognising people's authority as knowers about themselves is an essential component of intersex-centred care known as *cultural humility* (Tervalon & Murray-García, 1998). Whether loving parents, concerned partners, altruistic researchers, or well-intentioned health professionals, *no one* can adequately represent intersex people *without* listening to, prioritising, and elevating what actual intersex people wish to share. By practising cultural humility, practitioners can address testimonial injustice and begin to learn about and promote the in-group intersex community language needed to rectify hermeneutical injustice. Genuinely intersex-centred care means *only* intersex people themselves are communicating on their own behalf or with consensual communication support, without uninvited proxies or substitutes. For participants who find spoken words difficult, such as people with neurodivergent and/or disability-related needs, practitioners need to integrate alternative and augmentative communication options (also known as AAC; see Chan, 2022).

The absence of shared collective resources for making sense of and communicating one's intersex lived experiences in an endosexist society requires sustained clinical attention. When establishing therapeutic relationships with intersex people, sex therapists and relationship counsellors can explicitly acknowledge epistemic injustice. To rectify epistemic injustice, practitioners can do the following:

- Evaluate the extent to which people's current language feels affirming and accurate for them.

- Explore whether people are familiar with the intersex-affirming language to describe their own bodies and lived experiences.
- Connect people with intersex community resources that use affirming language to describe their bodies and experiences.
- Guide intersex people to develop their own affirming and accurate language to describe their bodies and lived experiences.
- Model the use of intersex-affirming language with therapy participants and in professional spheres when communicating with colleagues and professional bodies.
- Encourage endosex intimate partners of intersex adults to use the affirming language intersex people prefer for themselves.

Concern 2: endosexist norms and standards

Identifying concerns

Practitioners' use of endosexist conceptual frameworks in sex and relationship therapy disadvantages intersex people by treating endosex people as the standard reference point against which all people's bodies and experiences are evaluated. One widespread endosexist norm is invoked when therapists conflate people's sex characteristics with concepts such as "sexual orientation" and "gender identity". This conflation has resulted in the failure of human rights frameworks such as the *Yogyakarta Principles* to protect actual intersex people's human rights (Carpenter, 2020). When this conflation occurs, therapists misconstrue intersex as a matter of *identity* and can inaccurately evaluate intersex people as having confusion about their gender and sexuality when they do not. Intersex people have many different ways of describing their bodies and lived experiences. Intersex people can have any sexual orientation, including straight/heterosexual. Despite the continued misrepresentation of intersex people as a so-called "third gender", intersex characteristics are distinct from gender. Many intersex people have fixed, binary genders and identify unambiguously as women or men. Many non-binary and agender people are endosex. Unfortunately, the conflation of intersex people with non-binary gender erases the diversity of both intersex and endosex people's lived experiences and, in so doing, contributes to harmful public policy and legislation (see Carpenter, 2018). In addition, a national study from the unceded Aboriginal lands colonially known as "Australia" found that most intersex respondents (55.3%) did *not* consider themselves to be part of "the LGBTIQ community" and over a third (38.3%) reported that they did *not* consider participating in "the Australian LGBTIQ community" to be a positive experience (Hill et al., 2020). Even this small sample of intersex people highlighted that referring intersex people to intersex-specific community organisations is crucial.

The distinction between identity and embodiment for intersex people is vital for practitioners to grasp due to its *clinical* implications. For example, many intersex people who have achieved clarity about their sexuality and gender do not automatically

have a comparable degree of clarity about their *embodiment*. They may seek therapeutic support to help them to make sense of and communicate about their bodies, and to achieve erotic satisfaction alone or with other people. Endosex practitioners need to be aware that intersex people who have a well-developed understanding of their sexuality and gender and no struggle with their *identities* can still struggle to achieve a comfortable relationship with their *bodies*. Bonnie explained that

even if you do have a binary gender, which most intersex people do, understanding if you have some variations in your sex characteristics and how that information applies to you can be difficult, particularly if it's being talked about in binarised terms or heteronormative terms as well.

This heteronormative view around the treatment model that people subscribe to and parents subscribe to presupposes a particular type of sexual orientation, presupposes what people would want to do with their bodies, and what will be important to them.

(personal communication on Zoom, 25 March 2022)

Many endosex medical professionals still use endosexist standards like those Bonnie described to justify non-consensual interventions during childhood (Holmes, 2016; Davis, 2011). Endosexist standards can affect people's view of their own bodies, their erotic communication skills, and their erotic lives. The lack of open discussion with key attachment figures during puberty and the lack of intersex-inclusive sex education (see Brömdal et al., 2021) can inhibit the capacity of intersex people to discuss their erotic lives with therapeutic professionals, who may be accustomed to working with endosex people who have typically been given far more information about their own bodies.

What can practitioners do?

Practitioners working with intersex adults need to discuss people's intersex characteristics in terms of both their *embodiment* *and* their lived experience of the intrapersonal, interpersonal, systemic, and societal dimensions of that *embodiment*. Intersex-centred practice avoids relying on identity-based constructs created by endosex people (e.g., “coming out”, “identity development”, etc.) and prevents coercive queering by distinguishing between sexuality, gender, and *embodiment*. Clinicians can then initiate open conversations that many intersex adults have not had with parents and caregivers about their fertility and the erotic, affectional, and intimate relationship dimensions of their lives. Endosex clinicians will also need to examine and address their own endosex privilege and accountability for challenging endosexist forms of systemic injustice.

By creating safe, affirming spaces for this exploration, clinicians can begin repairing ruptures caused partly by what Bonnie described as “the gold standard for clinical outcome, which is heterosexual intercourse”. While engaging in these open conversations, practitioners can challenge endosexist norms and standards

by ensuring that they discuss intersex characteristics as part of natural human biological diversity. This means not using endosex people as the standard reference point (e.g., not referring to endosex people and bodies as “normal” or “regular” people or bodies), as well as being careful to avoid pathologising language (e.g., “Disorders of Sex Development”, “DSDs”, or “intersex conditions”).

Some key tasks early in therapy are to help people to develop an intersex-centred standard that uses intersex embodiment as the standard reference point and to find affirming and authentic ways to communicate about their bodies and lived experiences. When discussing partners, refer to endosex partners and intersex partners instead of only mentioning the sex-associated characteristics of the intersex partners or calling the endosex partners’ bodies “normal” – this is offensive, as it implies that intersex people’s bodies are abnormal. Applying intersex-centred language is particularly important when endosex partners struggle to understand and support their intersex partners. Attempts at “neutrality” in this context reflect the practitioner’s unexamined endosex privilege, have an inequitable effect, and constitute collusion with endosex norms.

Concern 3: medical trauma, impeded interoceptive awareness, and iatrogenic alexithymia

Identifying concerns

The term *interoception* describes internal bodily sensations that include pain, temperature, hunger, thirst, and other important information about one’s physiological condition. *Interoceptive awareness* is the conscious awareness of this information that can inform actions (Craig, 2003). Many intersex adults who have been denied safe opportunities to know their bodies and explore their erotic responses can struggle to develop interoceptive awareness. As Bonnie explained:

I know from my personal point of view, I didn’t ever really feel free to fall into my body and to actually openly explore my body and openly understand my body because there was so much that wasn’t known, the body was pathologised before I even started to ask questions about what my body did. And then my body was changed. Irrevocably changed before I really understood what the implications of that were to be and how that would impact the way I felt about myself and the way I felt about myself in relation to other people.

Many people in intersex communities have described feeling unable to relate to their own bodies. Intersex people often report signs of *alexithymia*, a term that describes having limited or no ability to recognise or define the nuances of one’s feelings and determine one’s feelings and needs based on somatic stimuli. Research suggests that greater alexithymia is associated with lower interoceptive awareness (Berenguer et al., 2019). However, researchers continue to explore the nature of the relation between these two variables, and current evidence has

established a correlational rather than causal relation. *Iatrogenic alexithymia* is a form of alexithymia caused by medical providers, such as the medical abuse and clinical culture of silencing and erasure to which many intersex people have been subjected.

Alexithymia is not a personal failing of intersex people. It is a reasonable adaptation and coping response to unreasonable treatment, such as the medical abuse and epistemic erasure to which intersex people are commonly subjected. Alexithymia can also affect people's ability to notice and identify what they are experiencing during an erotic encounter and to communicate their sensory and erotic desires to others. Alexithymia in sensory and erotic contexts can inhibit communication about one's own erotic and relational needs, which can in turn contribute to relational ruptures and impede people's capacity to enjoy a fulfilling erotic life.

Recent sexological research has documented how greater alexithymia and lower interoceptive awareness can be associated with lesser arousal, reduced lubrication, more difficulties in achieving orgasm, more dissatisfaction, more pain during erotic activities, and greater sexual distress for participants categorised as "female" (Berenguer et al., 2019). This research also showed that greater interoceptive awareness was associated with stronger desire in participants categorised as "female". A key finding of this research was that self-awareness of internal bodily states and emotions is pivotal to sexual functioning. Unfortunately, like many studies that focus on the nuances of adult erotic functioning and satisfaction in general, this study appears to have assumed participants' biology based on reported gender, omitted information on whether participant gender was assumed or self-reported, used biased phrases like "both sexes" and "opposite sex", and excluded adults with intersex characteristics. Unfortunately, researchers who consider intersex adults' erotic functioning and satisfaction often do so only tangentially to gather evidence to promote or critique medical interventions. Intersex-centred research will prioritise intersex people's functioning and erotic satisfaction.

Despite the research gap in this area, extensive anecdotal evidence from intersex communities illustrates how having one's body alternately demeaned and fetishised can make it challenging for adults with intersex characteristics to determine whether an erotic activity feels pleasurable, painful, or uncomfortable. One example that illustrates this effect came from Lina, an intersex woman who experienced medical abuse repeatedly while growing up, and who described feeling unable to discuss her body or communicate about her erotic needs and desires as a result. She felt these traumatic earlier experiences had damaged her ability "to know myself as an erotic being". The first images Lina saw of people with "bodies like mine" in books were

these white hands with gloves on them coming into the sides of pictures of genitals. So the idea of hands near genitals, for me growing up, was linked to medical literature photography, which when I tried to learn about myself was the first and only image of people like me out there. For many years, I had to

do a lot of work to let people put their hands near my genitals because it was an association that was just not pleasurable. I also grew up with clinicians on a regular basis putting their fingers inside of my genitals.

(anonymous personal communication shared with permission)

Some intersex adults subjected to coerced and involuntary medical abuse during infancy, childhood, and/or adolescence experienced these intimate violations as societally sanctioned forms of child sexual abuse. In addition to psychological and emotional distress, intersex adults commonly report a range of physiological effects of this abuse, include scarring, painful urination, painful genital arousal, painful frontal enveloping (what in heteronormative and cisgenderist contexts is described in phallogentric terms as “penetration”), urinary incontinence, and little to no pleasurable sensation from genital contact (Jones et al., 2016). Some intersex people have expressed ambivalence or discomfort regarding any genital touch. Although some intersex people enjoy genital stimulation, practitioners need to be aware that this ambivalence or discomfort can stem from medical abuse. Many intersex adults subjected to medical trauma may avoid or become distressed by some or all forms of erotic activity that can trigger traumatic affective, cognitive, and sensory memory fragments and aggravate existing attachment injuries. People unable to identify and communicate their internal reactions during erotic activities due to impeded interoceptive awareness or iatrogenic alexithymia can experience re-traumatisation and increased dissociation.

What can practitioners do?

After establishing emotional safety, practitioners can communicate their awareness that many intersex people might experience difficulty with identifying and sharing how they feel in their bodies due to traumatic past medical experiences. By explicitly acknowledging the legitimacy of these experiences upfront, practitioners can establish a safer environment for later exploration of how impeded interoceptive awareness and iatrogenic alexithymia might affect intersex people’s erotic lives and their capacity to articulate their erotic needs in therapy. Although narrative details of traumatic medical experiences are less likely to be shared before practitioners have earned people’s trust, communicating one’s receptivity to this topic can ensure practitioners establish an optimal therapeutic space for receiving such disclosures. Identifying the physiological effects of medical abuse reported by many intersex adults can also be essential to developing a viable therapeutic plan.

Many intersex people have described finding sex therapy and relationship counselling unhelpful when practitioners did not ask questions designed to help them find words to describe their erotic lives and challenges. For many intersex people, healing and recovery from medical abuse, stigma, and erasure may also involve seeking reparations and holding those responsible for these abuses accountable.

Addressing the impacts of medical trauma and iatrogenic alexithymia can be crucial to achieving desired outcomes in sex therapy and relationship counselling

and can improve intersex people's erotic lives. Consider the following therapeutic concerns:

- Kumiko described to her therapist how she wanted to take sexy selfies to share with one of her partners, Yasmeen, but found herself unexpectedly distressed by seeing a picture of herself partially nude, as this triggered the memory of the medical photos that doctors had taken of her as a child and teenager without her consent or knowledge at the time.
- Ari noticed that they avoided genital contact with partners and felt uncomfortable with certain kinds of genital touch. When being touched genitally, they noticed that they often felt unable to ask for what they wanted. This resulted in an “orgasm gap”, where they would touch their partners in ways that resulted in orgasms with relative ease, while Ari began to feel disgruntled and frustrated that their partners did not seem able to reciprocate. During conversations with their sex therapist, they realised that specific elements of the touch reminded them of the medical child sexual abuse they experienced during interventions to which they were subjected during childhood. Ari realised that these triggers made them feel small and silent, like the child they had been during these experiences.

In the many similar real-life situations that I have encountered as a therapist, participants achieved beneficial therapeutic outcomes only through addressing these concerns in terms of medical trauma, impeded interoceptive awareness, and iatrogenic alexithymia. There is no one-size-fits-all approach to helping people to recover from the impact of medical and societal trauma. A detailed clinical response is beyond the scope of this chapter. However, by integrating these concerns into routine investigations, practitioners can establish conditions conducive to addressing these key concerns.

Concern 4: disclosure and stigma management

Identifying concerns

Many intersex adults have had lived experiences of rejection, ridicule, and fetishisation by endosex partners. Medicalisation of intersex people's bodies can produce or increase loneliness and abandonment (e.g., Jones, 2022). Endosex partners often terminate intimate relationships upon discovering their partners are intersex. It is a common experience for intersex people to express anxiety and fear about disclosing their intersex characteristics to therapists. This hesitation is partly due to the many intersex people who have expressed dissatisfaction with endosex queer therapists' inability to conceptualise their lives beyond the limitations of identity-focused concepts like “coming out”. This conceptual failure undermines therapists' capacity to support intersex people with figuring out to whom

they could safely disclose their intersex characteristics, and how to manage their stigma about what many intersex people consider deeply personal and sensitive information that is poorly suited to the high visibility of a public pride parade or a “coming out” post on social media.

Disclosure can involve context-specific physical and emotional safety risks for intersex adults who identify as heterosexual and those who belong to conservative religious and cultural communities. Some religious and cultural communities are homosocial, with entirely gender-segregated spaces and events. In contexts where the socially constructed categories of sex and gender are conflated, disclosure of being intersex can result in an intersex person being ostracised, vilified, or rejected by the entire community. In addition to the violence by medical practitioners mentioned earlier, community environments governed by cultural traditions and religious laws can also be violent or hostile toward people known to be intersex. Where gender-specific traditions and laws determine what constitutes acceptable conduct, intersex people may face massive barriers to achieving equitable access to intimate relationships, social roles, and community activities. For therapists living in cultural contexts with fewer gender-based rules and restrictions, it is essential to avoid imposing ethnocentric assumptions or making blanket recommendations to either “come out” (sic) or leave the community entirely. Intersex people from minoritised cultural and religious communities can often feel unwelcome, both in intersex community spaces dominated by secular, Christianised, white Anglo cultural norms and in white Anglo-dominated therapeutic environments that do not recognise and address people’s intersecting cultural and religious needs.

Some research suggests that intersex people may be more likely than endosex people to have disability needs. For example, Jones et al. (2016) found that 27% of intersex people reported having disabilities, while other studies found only 17% of transgender people and 18.5% of the broader Australian population reported having disabilities. Some intersex people with disability-related needs rely on support workers for basic functions such as feeding, toileting, and bathing. In this context, disclosure may raise existential threats about potential mistreatment or service denial, particularly when intersex people appear more likely than endosex people to be affected by intersecting forms of ableism.

What can practitioners do?

Practitioners need to educate themselves about intersex-specific cultural safety protocols and the existential and practical risks of self-disclosure when working with intersex people from racialised cultural backgrounds or religions and intersex people with disability needs. As the stakes of rejection from disclosure may be dangerously high, endosex practitioners need to educate themselves about the practical dimensions of a person’s everyday life and reflect on their unexamined endosex privilege before developing a therapeutic response.

Concern 5: shame, self-worth, and relationship capital

Identifying concerns

Endosexist media norms about the “ideal” body and its capacities can limit intersex people’s sense of having a “normal”, functional, and physically desirable body. Consequently, many intersex people, particularly those subjected to medical abuse, grow up with an innate sense of being flawed and unattractive. For example, Declan was a sub who explained to the relationship therapist that he had wanted to engage in exhibitionist play with Marco, his endosex Dom. Even though it was Declan’s fantasy to be paraded around the dungeon showing off his body for Marco, Declan had not anticipated the wave of shame and embarrassment that he experienced as a result of having learned that his genitals were hideously ugly and should remain hidden.

One intersex variation called hypospadias (singular and plural form) describes people’s bodies that endosexist medical taxonomy describes as having the urethral opening situated on the underside of “the penis”. According to this terminology, people with hypospadias are born with a urethral opening located somewhere between the area directly below “the penis and the scrotum”. Infants with hypospadias are typically subjected to surgical intervention due to unsubstantiated claims that they will have psychosocial problems with standing urination and “penile penetration” later in life (Carmack et al., 2016). These medical claims contain unexamined ethnocentric, cisgenderist, endosexist, sexist, and heterosexist biases.

In many countries, it is widespread for endosex men to prefer urination while seated. For the past fourteen centuries, men from Muslim societies and cultures have preferred urination while seated (Nawab et al., 2006). Even in countries where prior sanitation options required standing urination, increased access to seated urination options can result in changing preferences. For example, Suzuki et al. (2022) found that 38.6% of Japanese endosex men urinated while seated, with 54.5% citing maintaining bathroom cleanliness as the reason for this preference. Given that standing urination had been a well-established norm among Japanese men only several decades earlier, this finding demonstrates the culture-bound and malleable nature of this supposedly essential biological norm.

Regarding medical claims that hypospadias causes adult sexual dysfunction, Carmack et al. (2016) noted that hypospadias is relatively common and that recent evidence suggests that many individuals with hypospadias do not experience the functional or psychosocial difficulties commonly claimed by endosex medical professionals. The researchers also explored evidence showing high rates of parental regret for hypospadias “repair” surgeries and noted that these surgical interventions have a substantial risk of adverse outcomes. The authors reviewed published outcomes data and conducted an in-depth analysis of typical rationales for hypospadias surgery, examining potential benefits, harms, and non-surgical alternatives. They found that “most childhood surgeries for hypospadias

are performed for anticipated future problems concerning function and cosmesis, rather than extant physical and/or psychosocial problems that are adversely affecting the child's well-being" (p. 1047). Noting that surgery to address hypospadias "can be safely performed after an age of consent without increasing the absolute risk of surgical complications to an ethically meaningful degree" (ibid.), the authors concluded that such procedures should be performed "only if requested by the affected individual, under conditions of informed consent" (ibid.).

Although medical professionals justify surgical interventions for hypospadias as a supposed medical emergency requiring "repair" to provide "normal" function, people subjected to these non-consensual medical procedures have raised serious concerns about this practice. Orr (2019) explored how the violent medical abuse inflicted on intersex boys with hypospadias often resulted in shame, physical and emotional pain, trauma, and coercive reinforcement of hegemonic, hetero-masculine behaviour. Orr noted that this behaviour damaged these boys' sense of gendered belonging and turned the act of urination into a distressing and harmful experience.

The sense of shame many intersex people have internalised

can significantly impact people's sense of self-worth, and place in the world, and also role in society. If people don't have access to clear role models of how to live with bodies that aren't typically male or typically female they'll rely on stereotypical role models to play out. And if you have low self-worth, and if you are, say, from my point of view, if I was a woman, a young woman growing up with a body that wasn't typically female, that didn't menstruate, that couldn't bear children, my perceivable relationship capital going into a heterosexual relationship was already at a deficit.

(Hart, personal communication, interview conducted by Zoom, audio recording only, 25 March 2022)

This concept of "relationship capital" and intersex characteristics reducing one's worth as a potential intimate partner has far-reaching consequences that can increase the risk of intersex adults being subjected to coercively controlling partners. While preparing this chapter, I spoke with intersex people from multiple genders and sexualities who described how having their bodies stigmatised, problematised, and subjected to medical scrutiny from a young age had made them more susceptible to sexual abuse and consent violations from childhood through adulthood.

What can practitioners do?

After establishing a therapeutic relationship that feels safe and comfortable for intersex participants, explore whether they have concerns related to their relationship capital and whether this has been associated with shame or limited self-worth. Where relationship capital is a current issue, it can be beneficial to identify possible ways that intersex partners may feel they have felt coerced into accepting

unfavourable conditions or boundary violations to offset their perceived deficits. It is important to notice and address situations in which intersex people appear habituated to mistreatment by endosex intimate partners due to perceived lack of relationship capital.

Concern 6: barriers to erotic, affectional, and intimate relationship boundaries

The ubiquitous and intersecting forms of epistemic injustice, endosexist norms, medical trauma, impeded interoceptive awareness, iatrogenic alexithymia, and societal stigma to which intersex people are often exposed can produce conditions unfavourable to the development of a sense of high self-worth. In this societal context, many intersex people have described the challenges they faced when trying to establish safe and affirming interpersonal boundaries. Despite substantial anecdotal evidence, intersex people continue to be neglected, under-identified, or entirely excluded from most intimate partner and domestic violence research. As Bonnie explained,

I think from a therapeutic point of view, what's really dangerous for people with those types of lived experiences is often they are disconnected from peers. They don't have access to other types of narratives about how to be in relationships. So they fall into these relationships in order to get their intimacy needs met and their connection needs met, and these things happen to them in those relationships because they haven't got to practice speaking affirmatively about their bodies, they haven't got to ever explore how to enjoy a body as a natural, sensual, full thing.

A national study found that more than three-fifths (61.7%) of participants with an intersex variation had experienced insufficient authority over medical decisions about their own bodies, and over half (54.4%) had undergone an intersex-related medical intervention (Hill et al., 2020). Among those who had undergone this intervention, almost seven in ten (68%) occurred during childhood, and only 24% of those who had undergone intersex-related medical intervention reported having been mostly or completely able to give full and informed consent to this intervention (ibid.). Many intersex adults find that the repeated privacy violations to which they were subjected during childhood result in reduced capacity to assert their boundaries when confronted with similar boundary violations by endosex intimate partners. Bonnie described how this process occurred in her own past relationships. Due to the impact of having her boundaries violated by medical professionals while she was growing up,

as a result, I felt less empowered to maintain my effective boundaries. I let myself, let my body be used as a currency to be able to maintain an emotional connection. And as a result, I experienced abusive situations, and abusive

relationships, and remained in those abusive relationships because I thought at a fundamental level, I probably deserved to be in that environment. And beyond that, I suppose I didn't have the worth to think that there would be another way of being in the world, because it hadn't been explained to me. And because often this, all of this dynamic that I'm talking about exists in a space where there is absolutely no psychosocial support offered to people. It's not offered at the very get-go, when people are making decisions in clinical spaces. And if it is provided in that space, it's really time-specific and discreet, and not the type of age-appropriate, longitudinal support that people need to be able to reassess situations as they develop and as their ideas develop around what their body is and what it's capable of doing.

Bonnie's experience highlights the long-term damage caused by health professionals' failure to treat her and her body as valuable and worthy of respect. Had they connected her with intersex-led community support sooner, Bonnie would have been able to meet other intersex people who could affirm her worth. Instead, the absence of supportive relationships that affirmed her body made her more susceptible to boundary violations in her intimate relationships and less able to identify and leave abusive relationships.

What can practitioners do?

Sex and relationship therapists need to consider how epistemic injustice, endosexist norms, medical trauma, impeded interoceptive awareness, iatrogenic alexithymia, and societal stigma may have affected intersex people's capacity to determine their limits, communicate those limits in the form of interpersonal boundaries, and respond to situations that endanger those boundaries. It may be valuable for clinicians to support people to develop their self-worth, gain skills in communicating their needs and limits, and identify and seek repair and accountability for attachment injuries and interpersonal ruptures.

Practitioners working with one or more intersex partners may need to explore options for improving communication about their erotic, affectional, and relational needs, desires, and boundaries. In addition, helping intersex people to access non-clinical spaces run by and for actual intersex people can provide the crucial peer support needed to acknowledge their own worth and establish safe and affirming erotic, affectional, and intimate relationship boundaries.

Conclusion

Intersex-centred practice means attending to the six neglected concerns discussed in this chapter: epistemic injustice; endosexist norms and standards; medical trauma, impeded interoceptive awareness, and iatrogenic alexithymia; disclosure and stigma management; shame, self-worth, and relationship capital; and barriers to erotic, affectional, and intimate relationship boundaries. By attending to

these under-recognised concerns, sex and relationship therapists can gain essential therapeutic insights from intersex people's *own* wisdom and insights. By applying intersex-centred practice, sex and relationship therapists can support intersex therapy participants to achieve pleasure, satisfaction, and liberation in their erotic and affectional lives.

References

- Ah-King, M., & Nylin, S. (2010). Sex in an evolutionary perspective: Just another reaction norm. *Evolutionary Biology*, 37(4), 234–246. <https://doi.org/10.1007/s11692-010-9101-8>
- Ansara, Y.G. (2010). Beyond cisgenderism: Counselling people with non-assigned gender identities. In L. Moon (Ed.), *Counselling Ideologies: Queer Challenges to Heteronormativity* (pp. 167–200). Aldershot: Ashgate.
- Ansara, Y.G. (2015). Challenging cisgenderism in the ageing and aged care sector: Meeting the needs of older people of trans and/or non-binary experience. *Australasian Journal on Ageing*, 34, 14–18. <https://doi.org/10.1111/ajag.12278>
- Ansara, Y.G. (2021). Disrupting professional myths about “the mainstream”: Diversity, inclusivity, and bias reduction are paramount in conventional publication standards. *Psychotherapy & Counselling Journal of Australia*, 9(2). <https://pacja.org.au/volume-9-no-2-november-2021/>
- Berenguer, C., Rebôlo, C., & Costa, R.M. (2019). Interoceptive awareness, alexithymia, and sexual function. *Journal of Sex & Marital Therapy*, 45(8), 729–738. <https://doi.org/10.1080/0092623X.2019.1610128>
- Brömdal, A., Zavros-Orr, A., Lisahunter, Hand, K., & Hart, B. (2021). Towards a whole-school approach for sexuality education in supporting and upholding the rights and health of students with intersex variations. *Sex Education*, 21(5), 568–583. <https://doi.org/10.1080/14681811.2020.1864726>
- Carmack, A., Notini, L., & Earp, B.D. (2016). Should surgery for hypospadias be performed before an age of consent? *The Journal of Sex Research*, 53(8), 1047–1058. <https://doi.org/10.1080/00224499.2015.1066745>
- Carpenter, M. (2016). The human rights of intersex people: Addressing harmful practices and rhetoric of change. *Reproductive Health Matters*, 24(47), 74–84. <https://doi.org/10.1016/j.rhm.2016.06.003>
- Carpenter, M. (2018). The “normalization” of intersex bodies and “othering” of intersex identities in Australia. *Journal of Bioethical Inquiry*, 15(4), 487–495. <https://doi.org/10.1007/s11673-018-9855-8>
- Carpenter, M. (2020). Intersex human rights, sexual orientation, gender identity, sex characteristics and the Yogyakarta Principles plus 10. *Culture, Health & Sexuality*, 23(4), 516–532. <https://doi.org/10.1080/13691058.2020.1781262>
- Chan, T. (2022, April 4). Position statement on autistic communication. *Reframing Autism Website*. <https://reframingautism.org.au/position-statement-on-autistic-communication/>
- Craig, A.D. (2003). Interoception: The sense of the physiological condition of the body. *Current Opinion in Neurobiology*, 13(4), 500–505. [https://doi.org/10.1016/S0959-4388\(03\)00090-4](https://doi.org/10.1016/S0959-4388(03)00090-4)
- Darlington Statement. (2017, March 10). *Darlington Statement*. <https://darlington.org.au/statement/>
- Davis, G. (2011). “DSD is a perfectly fine term”: Reasserting medical authority through a shift in intersex terminology. In P.J. McGann & D.J. Hutson (Eds.), *Sociology of Diagnosis*

- (*Advances in Medical Sociology, Vol. 12*) (pp. 155–182). Bingley: Emerald. [https://doi.org/10.1108/S1057-6290\(2011\)0000012012](https://doi.org/10.1108/S1057-6290(2011)0000012012)
- Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. New York: Oxford University Press.
- Hart, B., & Shakespeare-Finch, J. (2021). Intersex lived experience: Trauma and posttraumatic growth in narratives. *Psychology & Sexuality*. <https://doi.org/10.1080/19419899.2021.1938189>
- Hill, A.O., Bourne, A., McNair, R., Carman, M., & Lyons, A. (2020). *Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia*. ARCSHS Monograph Series No. 122. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University. <https://genderrights.org.au/wp-content/uploads/2020/11/Private-Lives-3-National-Report.pdf>
- Holmes, M. (2011). The intersex enchiridion: Naming and knowledge. *Somatechnics*, 1(2), 388–411. <https://doi.org/10.3366/soma.2011.0026>
- Holmes, M. (2016). *Critical Intersex*. Oxon and New York: Routledge.
- Joel, D. (2021). Beyond the binary: Rethinking sex and the brain. *Neuroscience & Biobehavioral Reviews*, 122, 165–175. <https://doi.org/10.1016/j.neubiorev.2020.11.018>
- Joel, D., García-Falgueras, A., & Swaab, D. (2020). The complex relationships between sex and the brain. *The Neuroscientist*, 26(2), 156–169. <https://doi.org/10.1177/1073858419867298>
- Joel, D., Berman, Z., Tavor, I., Wexler, N., Gaber, O., Stein, Y., . . . Assaf, Y. (2015). Sex beyond the genitalia: The human brain mosaic. *Proceedings of the National Academy of Sciences*, 112(50), 15468–15473. <https://doi.org/10.1073/pnas.1509654112>
- Jones, C. (2022). The harms of medicalisation: Intersex, loneliness and abandonment. *Feminist Theory*, 23(1), 39–60. <https://doi.org/10.1177/14647001211062740>
- Jones, T., Hart, B., Carpenter, M., Ansara, G., Leonard, W., & Lucke, J. (2016). *Intersex: Stories and statistics from Australia*. Cambridge, UK: Open Book Publishers. <https://hdl.handle.net/1959.11/18556>
- Nawab, B., Nyborg, I.L., Esser, K.B., & Jenssen, P.D. (2006). Cultural preferences in designing ecological sanitation systems in North West Frontier Province, Pakistan. *Journal of Environmental Psychology*, 26(3), 236–246. <https://doi.org/10.1016/j.jenvp.2006.07.005>
- Orr, C.E. (2019). Resisting the demand to stand: Boys, bathrooms, hypospadias, and interphobic violence. *Boyhood Studies*, 12(2), 89–113. <https://doi.org/10.3167/bhs.2019.120206>
- Sanz, V. (2017). No way out of the binary: A critical history of the scientific production of sex. *Signs: Journal of Women in Culture and Society*, 43(1), 1–27. <https://doi.org/10.1086/692517>
- Suzuki, M., Shiratori, T., & Naito, A. (2022). Relevant predisposing factors for voiding in a sitting position among Japanese male adult patients. *Continence*, 2, 100030. <https://doi.org/10.1016/j.cont.2022.100030>
- Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2), 117–125. <https://doi.org/10.1353/hpu.2010.0233>