

The (In)Visibility of Childhood Sexual Abuse: Psychiatric Theorizing of Transgenderism and Intersexuality

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Abstract

Psychiatric diagnoses related to transgenderism span a wide range of terms, theories, and treatments. Similarly, intersexuality is coming increasingly under the psychiatric gaze, being incorporated into the “gender dysphoria” criteria as with or without a “disorder of sex development” (APA, 2013). Despite the diagnostic link between these two groups, histories of childhood sexual abuse within psychiatric theorizing are particularly visible within “gender dysphoria,” but markedly invisible within medical discourse on “disorders of sex development.” While sexual abuse has been problematically argued by psychiatry to play a role in the development of gender dysphoria, the potentially abusive touching of intersex children’s bodies in distressing or painful ways is legitimized and standardized. Thus pathological accounts of transgenderism and intersexuality are given prominence, whereas non-consensual touching is marginalized. The focus in both accounts is the pathologized body, rather than the normalization of sexualized violence or the experience of such touching as non-consensual and abusive. Ultimately, such discourses function to detract attention from the sexualized violence experienced by those who do not fit into the societally imposed gender binary and continue psychiatry’s framing of gender nonconformity, rather than sexual violence, as pathological.

Keywords: transgender, intersex, sexual abuse, psychiatry

There has been ample discussion and debate regarding psychiatry, transgenderism,¹ and intersexuality,² particularly in terms of related diagnoses and

¹ *Transgenderism* is not a medical or psychiatric term; it is often used interchangeably with several other terms (such as gender nonconformity, gender creativity, etc.). It refers to a diverse group of individuals whose gender identity does not match either their body or western society’s narrow definition of gender as male or female. Some choose to undergo gender affirmation surgery and/or hormonal interventions, while others do not.

² *Intersex* replaced *hermaphroditism* to describe children who are born with genitalia that is considered ambiguous by medical professionals: It does not correlate with the binary of “male” and “female” genitalia. Medical professionals consider a clitoris of “normal” size if it is below 0.9 cm and a penis to be representative of “maleness” if it larger than 2.5 cm. Any size between these two boundaries and the clit/penile tissue is ambiguous and gender cannot be “assigned” at birth (Kessler, 2000). Intersex has since been changed to “disorder of sex development/differentiation” (DSD), which has been criticized for its pathologizing terminology (Diamond, 2009).

treatment (e.g. Hegarty, 2009; Hird, 2003; Kessler, 2000; Langer & Martin, 2004; Lev, 2005; Reis, 2009). Less attention has been given to the numerous etiological theories put forward by psychiatry and how these frame trans and intersex as pathological in different ways. This paper (parts of which have been described in my doctoral dissertation; Tosh, 2013) will examine the specific theory that sexual abuse can be a causal factor in the development of “gender dysphoria”³ (e.g. Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Zucker & Bradley, 2004; Zucker & Kuksis, 1990; Zucker, 2006; 2008). This exclusive focus does not mean that I consider sexual abuse to be a causal factor, or that this is a single and uncomplicated model accepted by psychiatry. Instead, I argue that examining a narrative that is evident in psychiatric texts (that also discuss other possible causal factors) enables an important comparison of how sexual abuse is framed in one context (as an etiology for transgenderism), alternative readings of this material, and the lack of discussion of abusive touching in the experiences of intersex individuals. This examination offers an opportunity to interrogate multiple intersecting subject positions of transgender and intersex individuals related to age, gender, sex, and psychiatrization. I use a critical and intersectional analysis (Cole, 2009; Crenshaw, 1991; LeFrançois, 2013) drawing on discursive psychology (Parker, 2003) and poststructuralist theory (Foucault, 1979; Weedon, 1996). I analyze the way sexual abuse is constructed in the form of discourse with an appreciation of the multiple and conflicting meanings attributed to these terms and experiences. I examine why particular constructions are foregrounded and others marginalized, with aims to promote discussion around psychiatric and medical authority over the definition of what does and does not constitute “abusive” bodily contact.

Diagnosing Gender

Psychiatric constructions of transgenderism have undergone numerous changes, additions, and deletions for well over a century (Tosh, in press). In contrast, intersexuality lacks a long history within psychiatric nomenclature. It was the “revolutionary” (Mayes & Horwitz, 2005) third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III*; American Psychiatric Association, 1980) that introduced the vastly extended section on sexual and gender identity disorders, and with it “transsexualism,” “gender identity disorder in childhood,” and the first mention of intersex. “Transsexualism” was introduced due to medical developments enabling surgical intervention for those who wanted to change or affirm their gender. This was in addition to the increasing awareness of individuals who wanted to pursue such surgeries (Bullough & Bullough, 1993). The term was ultimately replaced with “gender identity disorder” in the *DSM-III-R* (APA, 1987), but transsexualism remained a descriptive term for a “severe” form of “gender identity disorder” (APA, 1994, p. 771). The adult and childhood versions of “gender identity disorder” remained in the *DSM-IV* (APA, 1994) and *DSM-IV-TR*

³ I use quotations marks here to indicate that I am discussing a discursive concept or category produced by psychiatry, rather than embodied experiences of gender-related distress.

(APA, 2000) until the fifth edition of the *DSM* changed the diagnosis to “gender dysphoria” in 2013.

The first mention of intersex in the *DSM-III* (APA, 1980) was only as exclusionary criteria for the diagnosis of transsexualism. It stated, “In physical intersex the individual may have a disturbance in gender identity. However, the presence of abnormal sexual structures rules out the diagnosis of Transsexualism” (APA, 1980, p. 263). Thus, intersex was evidence of non-mental pathology in this edition. This changed with the *DSM-IV* (APA, 1994) placing intersex under the diagnosis of “gender identity disorders not otherwise specified.” This was the first move of intersex into a diagnosable psychiatric category in addition to a medical diagnosis. The final move, at the time of writing, is the incorporation of intersex (as the contentious term “disorders of sex development”) into the *DSM-5* criteria for “gender dysphoria” (APA, 2013). This latest edition has created two possible diagnoses herein: “gender dysphoria with a disorder of sex development” or “gender dysphoria without a disorder of sex development.” Consequently, intersex has increasingly come under the gaze of psychiatry and with it, become entangled in the psychiatric discourse of transgenderism and its pathologization.

Transgenderism: Psychiatric Etiologies

These diagnoses and their numerous changes have attracted condemnation from many groups, including gay, feminist, trans, and intersex activists in addition to academic and clinical criticism. This is particularly related to the narrow conception of gender and biological sex, as well as the use of pathologizing terminology (see Ansara & Hegarty, 2012; Bryant, 2006; Diamond, 2009; Ehrensaft, 2009; GID Reform Advocates, n.d.; Hegarty, 2009; Langer & Martin, 2004; Lev, 2005; Morgan, Wilson, & O’Brien, 2012; Tosh, 2011; Wilson, 2000; Wren, 2002). However, lacking in the critique is a comprehensive interrogation of the etiology described by psychiatrists in relation to gender-nonconforming diagnoses.

Despite childhood “gender identity disorder” being featured in the *DSM* for more than 30 years, the psychiatric profession lacks consensus regarding its causes, which has resulted in an accumulation of theories and correlation studies that assume causation. Hird (2002, p. 580) described some of the many possible causes of “gender identity disorder” listed by psychiatry and these include

‘effeminate’ fathers, domineering mothers, birth order, divorce (Pomeroy, 1969); IQ (Doorbar, 1969); temporal lobe disorder (Blumer, 1969); parental age (Wålinder, 1969); introversion, depression and non-adjustment to work (Johnson & Hunt, 1990); a precursor of transvestism and homosexuality (Limentani, 1979); and narcissism, profound dependency conflicts, immature, potentially explosive, demanding, manipulative, controlling, coercive and paranoid personalities (Lothstein, 1988).

However, a common theme is parental psychopathology, particularly *maternal* psychopathology (Di Ceglie, 2000; Zucker & Bradley, 2004). For example, Stoller’s theory on the causes of transsexualism has been summarized as, “too much mother

made possible by too little father” (Stoller, 1969, p. 166, cited in Hird, 2002, p. 579). In Green’s book, *The “Sissy-Boy Syndrome” and the Development of Homosexuality* (1987), mothers are described using words such as, “over-controlling,” “possessive,” “overbearing,” “emasculating,” and “hypercritical.” This is repeated in the *DSM-III* as “prolonged physical and emotional closeness between the infant and the mother,” which is framed as a contributing factor to the development of “gender identity disorder” in boys, and unavailable mothers are considered predisposing factors for the development of the disorder in girls (APA, 1980, p. 265). The framing of a secure attachment between mother and child as necessary for “normal” child development is one that has attracted much feminist attention (e.g. Burman, 2008), as “mother-centred,” often “mother-blaming” and decontextualized from social issues, such as poverty (Birns, 1999; Franzblau, 1999; Cleary, 1999). Therefore, not only are women pathologized within psychiatry, as described by many feminists (Chesler, 1972; Showalter, 1987; Ussher, 1991), but they are also constructed as almost “toxic.”

The focus on mothers includes another issue, their history of sexual violence and abuse. Zucker and Bradley (2004) found around 25% of mothers in their sample had been sexually abused and theorized that these experiences formed part of the “genesis and maintenance” of “gender identity disorder” (Zucker, Wood, Singh, & Bradley, 2012). For instance, Zucker (2008) framed a mother’s experience of sexual abuse as a potential causal factor in her child’s gender identity as follows:

Heidi’s mother reported a complex history of intrafamilial sexual abuse.... As the mother talked to Heidi about how dangerous the situation was, her behavior gradually transformed: she rejected wearing feminine clothing, insisted that her hair be cut short to look like a boy’s, began to call herself by a boy’s name and expressed a wish to have a sex change. During the assessment, her mother commented: “I wonder if I have scared her about being a girl. Maybe she looks at me and thinks ‘I don’t want to be like her’” (p. 362).

Elsewhere Zucker (2006) concluded that mothers who have been sexually abused communicate to daughters “that being female [is] unsafe” (p. 3). This is despite Beitchman et al.’s (1991) meta-analysis identifying a higher rate of childhood sexual abuse histories in mothers of children who had also been sexually abused. Arguably, being female/feminine in a patriarchal society is unsafe and to be aware of that threat is “normal.” However, there is a prioritized concern regarding the mother’s ability to “contaminate” her children due to her negative experiences of men, masculinity, or male violence, rather than consideration of how living in a rape culture (Buchwald, Fletcher, & Roth, 2005) could impact those with a feminine gender identity more generally.

These experiences of sexual violence are also framed as causing a “devaluation” of masculinity within the mother, which is passed on to her children. For example, Zucker (2008) emphasized the role of the mother’s prior sexual abuse in the following case study:

Exploration of the mother's life history revealed many reasons for her ambivalence about men and masculinity. She had grown up in a family in which her father was largely absent, she had been gang-raped at the age of 13 years ... For Harry's mother, fantasy aggression (e.g., sword play, squirt-gun play) was equated with real aggression and she worried that if such behavior was encouraged in Harry that he would develop into a rapist (p. 362).

He concluded that this fear resulted in mothers "who have experienced negative life events involving men, such as sexual abuse or assault ... [discouraging] any signs of rough play in their sons" (Zucker, 2008, p. 361). Consequently, mothers' experiences of sexual abuse are framed as contributing to the development of "gender identity disorder" in children through fears of expressing femininity and a rejection of (idealized) masculinity. Rather than viewing this as a consequence of masculine violence, the potential for feminine individuals to be targeted in sexually violent ways is disregarded in place of a pathologized and individualized causal factor: the damaged and toxic mother.

Childhood Sexual Abuse (CSA)

Another theory on the causes of gender nonconformity put forward by psychiatry is childhood sexual abuse (CSA). This perspective has developed from studies highlighting the more frequent child maltreatment, emotional, and sexual abuse of individuals with a diagnosis of "gender identity disorder" (Bandini et al., 2011; Kersting et al., 2003). Although it is acknowledged that CSA is a more frequent experience for young girls than young boys, the hypothesized resulting gender nonconformity is viewed as a more likely consequence in boys (Beitchman et al., 1991, 1992).

This theory purports that childhood "gender identity disorder" is reactive: a defense mechanism in response to CSA (e.g., Beitchman et al., 1991; Zucker & Kuksis, 1990; Zucker, 2006, 2008; some feminists, known for their strong views against transgenderism, also draw on this connection between childhood sexual abuse and transgenderism, e.g., Jeffreys, 2005). This perspective assumes that feminine children with a diagnosis of "gender identity disorder" were more masculine or gender conforming prior to abuse and that the trauma pushed them into a more feminine gender expression. For example, Zucker and Kuksis (1990) summarized their conclusions related to a case study of "M." "M. had a somewhat vulnerable sense of himself as a boy and that this was exacerbated by the sexually abusive experience, thus pushing him toward a more intensely gender dysphoric state" (p. 282). However, "M" was reported to be gender nonconforming from as young as two years old and the abuse did not begin until the child was around nine years old. Zucker and Kuksis also stated that "M's mother indicated that he had always been 'on the feminine side' compared to his older brothers... At times B. [the perpetrator] would call M. a 'fag'" (p. 281). From this description it would be possible to conclude that "M" was targeted for gender-nonconforming behaviour and victimized due to fear that such behaviour indicated a potential for homosexuality. This could signify the homophobia inherent in gender-conforming masculinity and

the resulting violence when it is threatened (Kimmel & Mahler, 2003). However, Zucker and Kuksis (1990) concluded that “M’s desire to be a girl and to have his penis removed ... followed the initiation of sexual contact by his brother” (p. 282).

Beitchman et al., (1991) noted that “These studies need to be interpreted cautiously, however, since most people with a homosexual erotic orientation have not been sexually abused as children; moreover, it is not clear whether a nascent homosexual orientation itself predisposes to homosexual contact which may be abusive” (p. 545). However, there is much evidence to show that LGBT youth are more likely to be sexually victimized than other groups (Human Rights Watch, 2001; Grossman & D’Augelli, 2006). Therefore, it is possible that gender-nonconforming youth are likely to experience sexual victimization *as a result of their nonconformity*, rather than their victimization initiating a change in gender expression. The overt sexualization and objectification of femininity, as well as the association of femininity with sexual passivity and masculinity with sexual vigor (and aggression; see Gavey, 2005) could explain the targeted victimization of children with a feminine gender expression.

This form of “corrective” rape is not uncommon. Di Silvio (2005) defined corrective rape as being “meant to ‘cure,’ or simply to punish, nonconforming sexual orientations” (p. 1470). When describing corrective rape attacks in South Africa she stated, “Attackers, often family members, friends, or neighbors of the victims, say they are teaching lesbian women ‘a lesson’ by raping them and showing them how to be ‘real women’” (Di Silvio, 2005, p. 1470). Lawrence (2008) acknowledged that gender-nonconforming individuals are “at increased risk for assault, sexual assault and rape” (p. 438). However, the life-long perspective of the victimization of transgender individuals is lacking from the psychiatric account that focuses on childhood and frames CSA as causing “gender identity disorder.” Gehring and Knudson (2005) found that 55% of their sample had experienced sexual assault prior to their eighteenth birthday. They also identified a specific form of sexual assault not applicable to other groups, the sexual assault of transgender persons due to a curiosity about that person’s gender or genitalia. This is consistent with Wyss’ (2004) interviews with transgender youth. She quoted from “Kyle”:

I was grabbed a lot. Usually while it was happening they would say something along the lines of “see you have tits ... not a dick.” [A] ... lot of the guys had a thing with trying to poke me with pens and such in between my legs (p. 717).

She went on to describe the second rape of “Crystal”: “The second time was by a guy who said that I was a monster, and that I had better enjoy what he was doing to me, because it was the only way anyone would ever touch me” (Wyss, 2004, p. 718). Wyss (2004) concluded that transgender youth are being terrorized because of their gender nonconformity, or as Spade (2008) identified, transgender individuals can experience “sexual harassment and assault motivated *by a reaction to gender nonconformity* [emphasis added]” (p. 758).

Intersex: Medical Interventions

Edmunds was the first to argue that surgical intervention on intersex children was necessary in *The Lancet* in 1926 (Reis, 2009). From the 1950s onward the work of Money (e.g. Money, Hampson, & Hampson, 1957; Money & Ehrhardt, 1972) was the most influential in this area. Money emphasized the role of psychology over surgery and argued that children's gender identities could be as malleable as their bodies with the intervention of medicine and psychology (Kessler, 1990). This was the theory underpinning intersex medical intervention for the following 50 years within the U.S. (Reis, 2009). However, the limitations and potential consequences of this approach were aptly revealed with the case of David Reimer, or the John/Joan case as it was known within academic publications. This case described a botched circumcision and Money's advice to the parents for the child to undergo genital surgery and subsequently be raised as a girl (Money & Ehrhardt, 1972). David struggled with his gender identity and was distressed by the revelation at fourteen years old that his parents had chosen to raise him as a girl. He outlined his difficulties with the imposed gender identity and treatments in the book *As Nature Made Him: The Boy Who Was Raised as a Girl* (Colapinto, 2000).

Further challenges were also made regarding Money's model (e.g. Diamond & Sigmundson, 1997; Fausto-Sterling, 2000; Kessler, 2000), and new guidelines were produced as a result of increasing debate within the profession. In 2006 the "Consensus Statement on Management of Intersex Disorders" (Lee, Houk, Ahmed, & Hughes, 2006) asserted that any surgical intervention should be done to preserve functionality rather than for purely cosmetic reasons. This coincided with guidelines published by the Consortium on the Management of Disorders of Sex Development (2008), which stated, "Genital cosmetic surgeries are sometimes offered to relieve parental distress, but parental distress should instead be addressed directly through peer support and competent mental health care" (p. 28). This cautioning against surgical intervention in infancy and advocating for delayed treatment was due to the increasing acknowledgement that such surgeries risked negative consequences, such as infection, scarring, infertility, and high rates of reported dissatisfaction and reduced sexual sensitivity in adulthood (Ehrenreich & Barr, 2005; Köhler et al., 2012).

However, disagreement and inconsistency remain within the profession and infant genital surgeries continue. For instance, Hutson (n.d.) stated in relation to his work in Australia, "Despite the debate in many centres about avoiding irreversible surgery in infancy ... we continue to offer early intervention with full informed consent, if that is the *parents'* [emphasis added] wish" (para. 28); and the official APA Report on the treatment of "gender identity disorder" stated, "Genitoplasty is often employed to bring the appearance of the external genitalia in line with the gender assigned" (Byne et al., 2012, p. 7). Similarly, authors from London Great Ormond Street Hospital have listed "an acceptable cosmetic outcome" as one of the justifications for surgical intervention (Brain et al., 2010, para. 32). Therefore, the role of surgeons and the importance of the appearance of genitals remain significant. While Brain et al. (2010) acknowledged that this "paradigm shift" (para. 32) of delaying surgical interventions has increased in popularity, they attributed this

method to “the future,” illustrating that this is yet to occur on a practice level or has yet to become the “norm.”

The Invisibility of Intersex Abuse

While there is debate and inconsistency regarding when genital surgery occurs, or how often and for what purpose, intersex children are often examined, manipulated, and operated on. These interventions are framed as preventing children from social ostracism and victimization, as well as enabling adult sexual relationships (e.g. Meyer-Bahlburg, 2008). However, they can be painful and distressing. For example, daily vaginal dilation is used to ensure that the surgically constructed vagina does not close or become too small for heterosexual intercourse when the individual is older. Ehrenreich and Barr (2005) described the following scenario involving vaginal dilation of an intersex child:

Not surprisingly, children object to such manipulations, and their parents sometimes find it difficult to perform them over the child's objections. In an educational video released by ISNA [Intersex Society of North America], a speaker describes a scene involving a family that had come to the hospital seeking help with vaginal dilation. In the scene (as described in the video), a doctor tried to dilate a nine-year-old girl who was being held down, spread-eagled on the examination table by medical students, while eight to ten professionals looked on (p. 14).

As Kessler (2000, pp. 59–60) queried, “What meaning does the intervention have for inserter and insertee? Does the body part lose all its sexualized connotations or is it experienced by the [child] as a violation by [their] parents—indeed, as sexual abuse?” (pp. 59–60). Regular vaginal dilation can be painful even in consensual adult procedures (Boyle, Smith, & Liao, 2005). Subsequently, parents have stated that they feel as if they are raping their child (Reis, 2011), and children have later compared the experience to rape and sexual abuse (Alexander, 1997; David, 1994; Ehrenreich & Barr, 2005; Triea, 1994). This parallels other experiences framed as “nosocomial sexual abuse” (Money, 1992), meaning sexual abuse that occurs within a hospital or clinical setting. Kitzinger (2006) described women’s accounts of traumatic births as “birth rape” due to feelings of powerlessness over their body, physical examinations, and pain. These women use this emotive term because they “feel that their bodies have been violated, and that they have been coerced into consenting to procedures without being informed of their details and accompanying risks” (Elmir, Schmied, Wilkes, & Jackson, 2010, p. 2151).

While the distress experienced by individuals through vaginal dilation is increasingly recognized, the medical literature is inconsistent. For instance, despite the 2006 Consensus Statement (Lee et al., 2006) arguing against vaginal dilatation before puberty, the opposite recommendation can be found in a paper published by members of the Great Ormond Street Children’s Hospital DSD team in 2010. It stated, “If the vagina is short, vaginal dilation treatment is the treatment of choice” (Brain et al., 2010, para. 37). However, this is the choice of the medical professional rather than the parents or the child. As Crissman et al. (2011) have highlighted, parents of intersex children often follow the recommendations of doctors without

realizing that there is a choice available. Parents from this U.S. study stated, “We really never had to make a decision ... the doctors told us what was gonna need to be done”; and another explained, “I wanted them to do the best that they can for my son. So umm, anything they asked for or wanted to do, I was ok with it” (Crissman et al., 2011, para. 21). Emke (1992) identified several assumptions within medicine, such as “doctor knows best” and that the “patient” has a duty to comply as part of their role as “sick.” This issue of choice is also impacted upon by the “medical monopoly” that makes it appear that there is only one way to formulate the issue and subsequent treatment (Conrad, 1992). Thus, these situations appear less like choosing medical treatment and more like complying with medical authority. As Trostle (1988) stated, “Compliance is an ideology that transforms physicians’ theories about the proper behavior of patients into a series of research strategies, research results, and potentially coercive interventions that *appear* appropriate” (p. 1300).

In addition to vaginal dilation, intersex children are often examined multiple times. Genital examinations can involve stimulating the child’s genitals to assess sexual function (i.e., erection; Fausto-Sterling, 2000) and can occur in front of numerous medical professionals or students (Ehrenreich & Barr, 2005). These experiences have been acknowledged as intrusive and distressing to individuals, to the point of some perceiving the process as abusive (Money & Lamacz, 1987; Meyer-Bahlburg, 1999, 2008; Speiser et al., 2010). Kessler (2000) quoted from a psychoendocrinologist, “I personally feel that excess genital exams... is a form of abuse” (p. 59), which concurs with an individual who described their experience as “horrible, tense visits to the pediatric endocrinologists to have my genitals gawked, fondled and stared at by hordes of what I perceived to be nasty, despicable men” (Ehrenreich & Barr, 2005, p. 108). While there is acknowledgment that these procedures can be distressing, painful, and humiliating for those involved, as well as accounts from parents and children later describing these events as “abusive,” these procedures remain framed in a medical discourse of legitimate “treatment.”

This disregarding of abusive genital touching based on the premise that it occurs within a medical context is problematic. It assumes that abuse cannot occur if there is an underlying medical justification for the action. Such an argument highlights a key difference between psychiatric and feminist definitions of abuse: Psychiatry defines the actions as non-abusive on the basis of the motivations of the individual doing the touching, whereas feminism defines the experience based on the perspective of the individual being touched (Tosh, 2013). Thus, the potentially painful, unwanted, or non-consensual genital examinations and surgery experienced by intersex children are not framed as sexual abuse because the individual’s motivation is seen as medically warranted and therefore non-sexualized. Even though the experience of the child could be very different, it is silenced by the authoritative medical discourse that frames the accusation overtly as “false” (e.g. Money & Lamacz, 1987).

Rather than ask, “Do physicians suppose that a young child understands that a painful, humiliating procedure done for ‘appropriate medical procedure’ is not sexual abuse?” (Kessler, 2000, p. 63), we should be asking, “Who defines sexual abuse and

for what reason?” In the context of transgender children’s experiences of sexual abuse, such acts are deemed abusive and have the potential to redirect children from “normal” gender development. For intersex children, those who define their experiences as abusive are dismissed as misinterpreting medical procedures: procedures that are designed to “correct” a “disorder of sex development.” In other words, when sexual abuse contributes to gender nonconformity, it is framed as “abusive”; when it forms part of the gender normalizing process, it is not. To paraphrase Garner (in press), “some [touches] are considered to do harm while others are thought to correct it.”

Conclusions

As Alderson (1993) argued, surgery or bodily contact within a medical setting without consent is abusive. However, as children are positioned as inexperienced and unknowing, their perspective is often dismissed in place of more authoritative views, such as those of adults and medical professionals. This social disadvantage of age intersects with gender and psychiatrization, as transgender and intersex children experience potentially abusive situations that would not be considered appropriate or necessary with a gender-conforming child (e.g., see Williams, 2013).

There are differences in how these individuals are described, particularly in relation to sexual abuse. For transgender individuals, sexual abuse is framed as “perverting” their “normal” gender development; whereas for intersex individuals, such accounts are dismissed as a misunderstanding of medical practice. Both focus on the pathologized individual rather than the sexual abuse. I argue that these narratives could be evidence of individuals being targeted in response to gender nonconformity and that there is therefore a need for social intervention. As many have stated in relation to such approaches, the subject of the intervention shouldn’t be the victimized, but rather those who victimize. Moreover, while I highlight the potential to frame the experiences of intersex children as abusive, this does not mean that such procedures are abusive, or that they are always experienced as such. Experiences of abuse cannot be generalized, as they are part of a larger network of identities, oppressions, and privileges that can be experienced at multiple levels (Collins, 1990; Yuval-Davis, 2006). This is further compounded by the complexity regarding consent, abuse, and sexuality. As Burgess-Proctor (2006) stated, we need to consider how these numerous intersecting subjectivities produce a “distinct *social location* for each individual” (p. 36). Therefore, I am arguing that transgender and intersex individuals should have the ability to define their own experiences, and these accounts should be valued and heard rather than interpreted and dismissed.

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