

# Intersexuality: a clinical singularity

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## Abstract

The intersexuality is considered a medical problem. Genital malformation can impede the definition of gender at birth and requires special care on the part of those responsible for the child. How does sexual definition occur among humans? Is it important to define gender at birth, or can this be postponed? Depending on the theoretical framework, intervention, conduct and treatment can occur in diverse and contradictory ways. We briefly summarize the different interpretations of intersexuality in different fields of knowledge, and addresses the theme through psychoanalytic theory.

**Keywords:** Genital ambiguity. Sexual ambiguity. Intersexuality. Sexual identification. Psychoanalysis.

## Resumo

### Intersexualidade: uma clínica da singularidade

A intersexualidade é considerada um problema médico. A má-formação do genital pode impedir a definição do sexo ao nascer, o que exige cuidado por parte dos responsáveis pela criança. Como acontece no humano a definição do sexo? É importante a definição do sexo ao nascer ou pode-se deixá-la para mais tarde? Dependendo do referencial teórico, as intervenções, a condução e o tratamento podem acontecer de maneira diversa e contraditória. O presente trabalho faz um breve relato dos diversos modos de leitura realizados por diferentes campos do conhecimento sobre a intersexualidade e aborda o tema mediante a teoria psicanalítica.

**Palavras-chave:** Ambigüidade genital. Ambigüidade sexual. Intersexualidade. Identidade sexual. Psicanálise.

## Resumen

### Intersexualidad: una clínica de la singularidad

La intersexualidad es considerada un problema médico. La malformación de los genitales puede impedir la definición del sexo al nacer, lo que requiere el cuidado de aquellos que son responsables por el niño. ¿Como ocurre la definición del sexo en el humano? ¿Es importante la definición del sexo en el nacimiento o se puede dejar para más tarde? En función del marco teórico, las intervenciones, la conducta y el tratamiento puede acontecer de manera diversa y contradictoria. El presente artículo ofrece una breve reseña de los distintos modos de lectura realizados por los diferentes campos de conocimiento acerca de la intersexualidad y aborda el tema mediante la teoría psicoanalítica.

**Palabras-clave:** Ambigüedad genital. Ambigüedad sexual. Intersexualidad. Identidad sexual. Psicoanálisis.

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Declararam não haver conflito de interesse.

Intersexuality calls into question how the definition of human sexuality occurs. Its main cause is congenital adrenal hyperplasia, which is responsible for ca. 90% of the cases. At birth, a baby is designated a boy or a girl, based on observation of the genitalia. Simplicity in the sex designation disappears when, upon observing the genitals, its conformation is not evident. The genitals are ambiguous when their appearance determines the difficulty, or even impossibility, of designating the child as a boy or a girl.

This is the situation of children who are born with some deformity or disorder of sexual differentiation (DSD). The complexity of the problem requires that the child be accompanied by an interdisciplinary team consisting of a pediatrician, an endocrinologist, a surgeon and a psychologist, as well as a team specializing in diagnostic support. Research is undertaken to understand what caused the genital ambiguity (GA), and thus make it possible to define the sex.

Since Freudian investigation, the importance of the parents in the process of psychic constitution and sexual identification of the child is well known. When a diagnosis of DSD is made at the beginning of life, this fact provokes intense anguish on the part of the parents, which may extend to other family members. The choice of the name and the civil registration of the child is up to the parents. They will have to make a choice. At this moment, they need to decide whether to call for a medical investigation, with the aim of defining the biological sex of the child. This definition orients the choice of a name and the entrance of the baby into the culture, the life of society.

According to the naturalist way of thinking, according to which one's own nature will be able to decide the direction of sex definition, the alternative would be to wait for the child to grow up and define its own sex. Although possible, this option is considered imprudent, because biology has already indicated that something has happened, impeding the definition of sex at birth. That theory ignores the fact that among human beings, language breaks down natural limits and comes to command human behavior and one's sexual choices, making it a unique process, no longer universal.

Biological sex is not the only factor that determines or decides sex in the human species. This is because for verbal beings, sex definition does not depend solely on biological characteristics. Sex definition is related to the entry of the *infans* (a Latin term signifying *one who does not yet speak*) into language, into culture. Based on the concepts of psychoanalysis and casuistics, we shall see that the

psychic constitution depends on the entrance of the child into the world of language. Language is transmitted to the child by what Lacan called the Other.

This primordial Other is incarnated by one who can exercise the function of transmitting language, i.e., the mother. She plays the role of introducing language to the child, through her desire. It is for this reason that when we deal with the question of the sexual definition of the child at the start of life, we encounter not the child strictly speaking (because it is still being constituted), but rather a privileged individual: the mother. She is that fundamental Other who initiates the text of the Subject. The case presented clearly demonstrates the presence of the mother at this crucial moment for the appearance of the infantile Subject.

The discovery of the of the ambiguity of the genitals can occur at two moments: at birth, if the genitals clearly manifest a modification and the physician can make a diagnosis. The second possibility is tardy discovery, for example when the modifications of puberty do not occur. Temporality is important in these cases, because the medical interventions will be distinct and will depend on the moment when the discovery of the genital ambiguity is made. The time of discovery makes all the difference in conducting these cases.

Clinical experience shows that the definition of the sex of the child can occur based on the appearance that the genitals present. The parents seek out medical orientation, but the impression caused by the genitals becomes an important point of reference in the relationship with the child, who may even be named before the medical definition. This is the reason for the importance of diagnostic investigation right at the start of life.

Once a sexual identity has been chosen, the revelation of a pathology different from the sex assumed by the child must be discussed by the team, to evaluate how the case can benefit from the medical interventions. The decision is made case by case, with the determining participation of the patient, considering his or her history and the path taken up to that moment in the construction of identity. The team's evaluation is done *a posteriori*, along two axes of assessment: the biological and the psychological. The subject is examined by the endocrinologist and listened to by the psychoanalyst. The physical and laboratory exams will reveal the biological sex. Psychoanalytical listening will permit a comprehension of what has occurred in the course of construction of the psyche, which may or may not include the subjective choice of sex.

## Conceptual diversity

The diversity of theories for approaching intersexuality makes explicit the ethical and epistemological aspects of the question. Ethical, requiring as it does decision making on the part of those who deal with the problem. The decision is grounded in a determined understanding of the phenomenon. Thus the mode of comprehension of the theme of sexuality, and the explanation of how definition of sex occurs in human beings, are examined from an epistemological perspective. The steps to be taken depend on this understanding.

Investigation and clinical discussion have revealed a range of concepts about sex definition in human beings. The biological conception, based on research with rats and their response to hormones and grounded in the concept of imprinting - which might be translated as impression, modeling, learning. Originating in ethology, it argues for sex definition starting from the organs linked to reproduction and the effects of hormones on the brain.

The notion of imprinting arises out of research by students of the individual and social behavior of animals (ethologists), who sought to prove a relationship between animals' choice of an object and the influence of the environment (images) on the cognitive or cerebral functions. It is believed that the sexual behavior of these animals could be modeled or learned. This concept is related to biologically-based theories, according to which whatever is not innate can be acquired by imprinting.

In recent years, anthropological, sociological and psychological theory, influenced by the feminist movement (which for decades has been discussing and questioning the man-woman relationship and militancy for sexual equality), among others, has also acquired an interest in intersexuals. Crucial questions arise: in what manner do the different discourses approach and interfere in the intersex clinic? How do conduct and treatment unfold? The responses to these questions have been outlined through a brief historical survey of the different conceptions of the topic in psychoanalytic research on human sexuality.

## Historical survey

"Disorders of Sexual Differentiation" (DSD) is the term currently adopted to designate the problems encountered in the intersex clinic. *The term*

(...) refers to every congenital disease in which the chromosomal, gonadal, sexual or anatomical constitution is atypical<sup>1</sup>. "Intersex" was the terminology utilized for such cases.

Over the centuries, in different civilizations, the term "hermaphrodite" was employed generically to refer to intersexuals<sup>2</sup>. At the present time, this definition is being questioned, because it is considered pejorative and stigmatizing<sup>3</sup>. Some non-Western societies adopt the expression "androgynous" to refer to the phenomenon. From this perspective, a hermaphrodite is considered androgynous, or one who encompasses the unity of opposites. In the seventeenth and eighteenth centuries, there are records of use of the term "hermaphroditism" to designate homosexual deviations.

The term "intersexuality" arose in the mid nineteenth century, as a synonym of "hermaphrodite", still in relation to sexual orientation. In his approach to the domain of the anomalies, Foucault affirmed that the hermaphrodite is a type of monster, revealing the principle of intelligibility: from the Middle Ages to the early eighteenth century, the notion of a monster, related to the idea of mixed, persisted. The hermaphrodite is a mixture of two sexes: (...) *one who is at the same time a man and a woman is a monster*<sup>4</sup>. Foucault clarified that the term is not a medical notion, but rather juridical: (...) *when the disorder of nature undermines the legal order, the monster appears*<sup>5</sup>.

The treatment of hermaphrodites changed over time and among societies. In the West, from the Middle Ages to the sixteenth century, they were *considered monsters and were to be executed and burned and their ashes cast to the wind*<sup>6</sup>. Beginning in the seventeenth century, another type of jurisprudence appeared: the hermaphrodite was no longer condemned for having two sexes and, once recognized as such, was to choose the dominant sex and behave in accordance with that sex. The hermaphrodite would be condemned if he or she used the excluded sex, *being subject to the penal laws and deserving to be condemned for sodomy*<sup>7</sup>. In the West in the early twentieth century, under the gaze of Medicine, intersexuality came to be considered malformation, a pathology that was to receive attention, care and medical interventions.

To be sure, these conceptions may not be taken deterministically. Anthropological studies discovered autochthonous cultural conceptions of intersexuality among certain tribal peoples, for whom the characteristic is a natural one. Based on anthropological studies, Imperato McGinley and col-

laborators<sup>8</sup> have described cases of individuals with masculine pseudo-hermaphroditism who are reared as girls and assume a masculine identity in youth. Gilbert and Davidson's<sup>9</sup> studies in New Guinea likewise relate cases of masculine pseudo-hermaphroditism designated as a third sex. In that culture, the possibility is accepted of there being three genders: man, woman and "turning-men". From this we may conclude that the culture of each social group finds different ways to deal with the biological question of genital ambiguity<sup>10</sup>.

In Western medicine, the history of intersexuality is summarized in three major phases or "eras": those of the gonads, of surgery and of consensus. The first, the era of the gonads, extends from the late nineteenth century to the 1920's<sup>11</sup>. In that period were created the first medical classifications, used still today, such as "hermaphroditism". In the gonadal definition of sex, *the function of the tissues (ovarian or testicular), the aspect of the genital, the size of the penis, the presence of a vagina or breasts, the appearance or the sexual role were not important*<sup>12</sup>.

This way of thinking began to change with the advancement of science and technique. On the one hand, biopsy exams made it possible to discover the existence of true hermaphrodites; on the other, the designation, masculine or feminine, based solely on the criterion of the presence of their respective gonads, proved insufficient to resolve the issue of how the determination of sex occurs. This questioning initiated the re-evaluation of the gonadal definition of sex.

The surgical era got started with the scientific developments of the 1950's. During that period, the first surgeries for "correction" of the genitals were conducted; advances in operating techniques, such as anesthetics and asepsia, contributed to the initiation of these interventions<sup>11</sup>. In that phase, which lasted up to the early nineties, the determination of sex was made by the clinical physician, and it was up to the surgeon to "correct" the genitals.

The influence of the work of John Money, in the sixties, determined the nature of practice. His assumptions were taken as a reference in treating patients with GA. The surgical era demonstrated something fundamental in the intersex clinic: the comprehension of human sexuality, and more specifically, the direct influence of the way differentiation between the sexes was characterized in the approach to, intervention in and treatment of GA. Interventions are made in accordance with the chosen theoretical explanation. The change in the way of understanding sex determination in human

beings modified the criteria for prescribing and conducting trans-genital surgery, i.e., correction of the genitalia. Subsequently, around the eighties, the new way of conceiving of sexuality provoked a decline of the surgical period.

The emergence of the paradigm of gender identity, of sexologist John Money, was decisive for the prescribing of surgery for intersex babies. According to Money and Ehrhardt<sup>13</sup>, gender identity refers to the mental processes in which the individual's capacity for self-recognition as belonging to the male or female sex is implied. Besides erotic activities, gender role includes non-genital activities defined by social convention and distinctly attributed to men and women. The concept of gender includes not only the biological state as a man or woman, but also the question of intimate recognition and social or legal attribution. It does not, therefore, rest solely on genital distinctions, but rather covers both the body and behavioral criteria.

Psycho-sexual neutrality was another concept introduced by Money, and which helped him to ground his ideas. According to Pino, the sexologist argued that the sexual constitution of human beings could be treated in terms of (sexual) behavior as something that could be learned, taught and modeled. Such sexuality was considered a pedagogical topic: *It was understood that the condition of being a man or a woman was not innate but learned, and subject to cultural and environmental influences*.<sup>11</sup> Pino stresses that for Money, *sexual behavior would not arise totally out of natural instinct, but also from education and socialization processes*.<sup>11</sup> Also according to Money, as Pino puts it, *intersex children should not be informed about the surgery, or even about their condition*.<sup>11</sup> He guaranteed that such information could interfere in their gender identity, or in the gender identity into which it was intended to model them. Therefore, the surgeries performed were grounded in the theory of psycho-sexual neutrality, a conception that refused to acknowledge both subjectivity in the constitution of the children and the importance of the parents in the process.

According to psychoanalytic theory, Money took into account only those aspects of consciousness tied to behavior, what can be observed in the individual's acts and posture, that is, in those processes of the imagination related to the ego; furthermore, he kept his concepts tied to biological processes. The elements of the imaginary record do not encompass other things, also fundamental, treated by Lacanian psychoanalytic theory, such as those referring to the records of the real and the

symbolic. For psychoanalysis, the real is what cannot be apprehended by language. The symbolic is tied to the domain of language and the imaginary refers to the image; it is the record that is linked to the constitution of the ego. According to Lacan<sup>14</sup>, in the *mirror stage*, the ego is formed through the process of identification, which includes the prematurity of the human baby; the *Gestalt* of the mirror image is the recognition coming from the Other.

The biological school seems to have concluded from Money's experience that human sexuality can only be determined by biological (cerebral, genetic, hormonal, etc.) and/or social factors. Diamond<sup>15</sup> criticizes Money's theories, defending a biological conception of sex. For him, sexuality is determined by the brain. His theory presents the discussion as circumscribed by a dualistic logic which, without responding to the doubts, maintains the impasse. According to this duality, what isn't biological is learned, or alternatively, sex is either innate or acquired.

Freud surpasses the question of the dual discourse. He affirms that human sexuality is neither innate nor acquired. The human being is not submitted to instinct, but to impulse. Language is what subverts the biological condition. Being male or female does not coincide with being a man or a woman, because while we may be born biologically determined, male or female, this condition will be translated into what it is to be a man or a woman. This is a unique, private construction, which, for that very reason, cannot be learned, but only constructed. This construction is initiated by the transmission from the Other to the little baby, by means of language.

In studies of sexuality, psychoanalysis presents other factors that form a part of infantile sexual determination, and which are unknown to the work of Money. Subjectivity, the subjective participation of the parents and infantile sexuality, are just a few of the topics developed by psychoanalytic theory to explain human sexual constitution. Medical procedures supported by Money's theories were questioned and modified. Such changes contributed to the decline of the era of surgery.

The end of that period, in the 1990's, was characterized by manifestations of intersex patients who began to testify and to introduce the dimension of subjectivity with the publication of their biographies. Thus were raised questions concerning the incidence of medical interventions and the intersexual condition itself, including them as elements of their psychological and sexual constitution. The community of intersex individuals rose up at that moment, pressing for the personal history,

or the uniqueness of each one's experience, to be considered an important factor in the determination of sex.

Thus began the era of consensus, characterized by revision of conduct in the intersex clinic. That moment was considered the period of consensus, *because it proposes an individualized conduct, based on the characteristics of each case (...) besides a comprehensive discussion of future conducts to be established for these patients*<sup>16</sup>. At that time, human sex determination ceased being a matter restricted to organic or biological factors, along with environmental stimuli and influences. Nevertheless, such factors, biological and social, now participate as elements included in the process of subjectivity, the path that the little baby takes toward assuming his or her sexuality.

This way of understanding sexuality approximates that developed by psychoanalytic theory, according to which the constitution of the psyche is essentially determined by the entry of the baby into the world of language, which is derived from the relationship with the Other. According to Lacanian psychoanalytic theory, the Other refers to language, the Other of culture. The parents are privileged beings in the transmission of language. Psychic structuring includes, therefore, elements tied to sexual identity, which takes shape in human beings through the language transmitted by the parents.

### The constitution of sexuality in psychoanalytic theory

Psychological accompaniment in cases of DSD has revealed the importance of identifying, in each case, the dilemmas faced by the person responsible for the child, and the questions that the child is capable of formulating. It was seen that it is of fundamental importance to theoretically define the factors that form a part of the process of subjective constituting.

The investigations of human sexual constitution anticipated by psychoanalytic theory were taken up again, in order to input the discussions permeating the issue of differentiation between the sexes in children with genital ambiguity. Such research can be demonstrated via casuistics. The case reported below was accompanied by the Outpatient Unit of the Division of Pediatrics of the Clinical Hospital of the Federal University of Minas Gerais (UFMG), during two periods in the life of the patient (from birth to 4 and from 8 to 16 years of age).

Right after the birth of her third offspring, a mother receives the news that it will not be possible, based on the genitals, to identify the sex of the baby. Very surprised, she feels herself unprepared to understand the situation and strives to seek a solution as quickly as possible. The gynecologist orients the mother to seek out the service specialized in the treatment of DSD. The mother also receives the orientation to await the results of the examinations before choosing a name and registering the child. The diagnosis was female pseudo-hermaphroditism, now DSD 46, XX induced by excessive androgens. Upon observing the baby's genitals, the mother believes that for sure the doctors had concluded that it was a boy. Furthermore, she could not believe that the child, with genitals so similar to those of boys, could turn into a girl.

Divided between the desire for the child to be a boy and the obligation to continue to investigate what was happening with the baby, she starts the exams. At the specialized service, she once again receives the orientation to await the diagnosis before registering the child. She is alerted to the possibility of the baby being a girl.

Several months pass, prolonging the delay. The mother observes that the child's development is healthy, like that of her other children. Deep inside, she has no more doubts: with those genitals, it could only be a boy. She gives a provisional name to the baby, even without registering it.

The child was 8 months old when the mother received the news that in fact, it was a girl. She had been referred for registration and counseled to have surgery to correct the genitals. The child was to take medicine to not virilize again. Far from bringing a solution, the diagnosis provoked a reaction: the mother felt she could not care for the child, with that sex declared by the doctors.

Nevertheless, even in the face of the impossibility of taking her baby as a girl, the child was registered with a female name, in conformity with the medical orientation. The question of the loss of her child becomes unavoidable in various ways. The first, with the announcement of female sex. Afterwards, with the withdrawal of maternal care, the child falls ill and comes to be cared for in the hospital institution. Later, the mother receives notice that she may lose the right to care for her child. Finally, she perceives that the very life of the child would be threatened if it remained apart.

Re-assumption by the mother interrupts the series of internments. Clearly, the sex of the child

was in question. The mother relates that faced with the threat of death, she vowed to care for the child, regardless of the sex. However, she was unable to keep her promise. She couldn't believe that the boy no longer existed.

In the eyes of the mother, the child continued the same, a boy; this despite the name having been changed, the surgery for correction of the genitalia having been performed and medication having begun. Beginning at 8 months, the mother dressed the child as a girl and called her by the registered name, the female name.

But these actions were no more than pragmatic compliance with medical prescriptions and procedures. Prevailing in the maternal thinking was that the child continued to be a "boy-man", as she liked to say. Now, together with the genital ambiguity, another ambiguity arose: the sexual. The mother states: *"Before the diagnosis, it was a boy. Afterwards it became a girl for the doctors and a boy for me (...) I have never been able to believe that it was a girl"*.

This was the mother's declaration when she returned to treatment, when the child was 8 years old. At that time, the mother couldn't say what was the sex of her child, and neither could the child. Thus the child alternated between the two sexes: formally, at school and at the doctor's office, it was a girl; intimately, at home and among friends outdoors, the child declared that it was a boy. Psychoanalytic listening made it possible to identify and clarify a contradiction between the demands of the mother and the child at the moment of return to treatment: *"I don't know what I am"*, and, later, the declaration that the child makes a subjective definition of its sex at 4 years of age, declaring that it is a boy - the moment that the mother and child decide to abandon treatment, considering that the sex designated by the biologist is contrary to his decision.

At 4, the child began to affirm that it was not a girl, but rather a boy. The mother was happy about that, because the child's attitude was a confirmation of her suspicions since maternity. After all, she had never really understood how the doctors affirmed the contrary. Thus the mother, together with the 8 years old child, decide to return to treatment, so that the ambiguous situation could be resolved. The child decided to drop out of school to avoid the embarrassment when faced with the teachers and classmates. There were continual questions about the ambiguity. *"I don't want to be called gay"*, was the declaration at the first interview.

The genital ambiguity had been treated by medicine, but it returned because of the sexual ambiguity. It is not true that all subjects born with genital ambiguity will become sexually ambiguous in the future, as we have observed in the clinic in various cases of DSD. It is precisely this aspect that the case of Rodrigo reveals; he made his sexual identification at the expected time. Actually, the uniqueness of the subject's experience of subjective constitution is what explains the fact that being born with the biological sex defined does not guarantee a lack of sexual ambiguity, as demonstrated by famous cases of transsexualism. In Rodrigo's case, a sexual choice was made and he put into practice the sexual identity he had declared, already at 4 years of age, as male. The contradiction at the moment of the baby entered the scene was undone in the course of treatment, and that was to be the demand at exit: to receive from the physician a declaration that could make it possible for him to legally change his name and sex.

Why, however, did the sexual ambiguity persist, if the mother, and principally the child, affirmed, in their intimacy, that they knew the sex was masculine? Furthermore, he had chosen another name, an unequivocally masculine name, which permitted him to circulate among his classmates. As for his bodily image, his appearance was masculine, because he had abandoned the treatment. Beginning at 4 years of age, he wore masculine clothes. His demand for treatment is clarified right away: *"I don't want to be taken for a gay, I don't want to be intersexual"*.

Even though he had made changes and taken on masculine sexuality, he couldn't ignore the existence of the medical diagnosis, which said he was a girl. His name and registered sex were also female. Thus he was subject to situations of constraint and embarrassment that impeded his social participation, especially at school. He asked himself what would define his sex, whether biology or his identity, his history, which led him to make a subjective choice and come to affirm that he was a boy?

In "The three essays on the theory of sexuality"<sup>17</sup>, Freud defines sexuality as initially perverse and polymorphic, because in that sexuality, the sex impulse has its mode of satisfaction defined within the body itself, divided up into erogenous zones. The sex impulse appears as a modification of the natural functions, a deviation from the original objective tied to self preservation.

In that text, which deals with fundamental issues of human sexuality, Freud communicates the findings of psychoanalytic research related to the

topic of sexuality - which leads him to rectify the everyday viewpoint that sexuality is absent in childhood and only manifests itself at puberty, linked to the reproductive function. For him there is a biphasic starting point: human sexuality starts at a tender age, and after a period of latency, starts up again in puberty.

This contribution of Freud's is contrary to the arguments proposed nowadays by a school of researchers who suggest suspending corrective surgery in cases of GA, or any other intervention to determine the baby's sex at the beginning of life. They find support in the idea that there is no need to define the sex of babies, considering that sexual questions only arise with the advent of puberty. Thus it would be better to wait for the child to make its own choice, guided or determined by the cerebral sex<sup>18</sup>.

From our viewpoint, the question is not whether or not to do the surgery or any other intervention; rather, the argumentation is evidence of erroneous thinking. It is easy to prove that sexuality is present in infancy. It is also true that the absence of medical procedures or another intervention, such as giving a name, is no guarantee that the child will not have problems in realizing his or her sexual identity. Quite the contrary, the child will probably encounter even greater difficulties.

Let us examine what the analysis of Rodrigo's case has revealed. Right at the beginning, we have the diverse interpretations that the mother was forced to make in order to meet the needs of the baby. The condition of helplessness obliges the mother to transform the shout, which in and of itself is meaningless, into a call, into demands. She saw herself forced to answer the question, *"What does he want?"* Already in the maternity ward, she looks at the baby and seeks signs that might help her in her care. What does the baby want? Why does it cry? What does it like? How will it be when it grows up? These are questions that the mother in question did not hesitate to ask.

It is for that reason that she couldn't take the baby home without forming an impression regarding the sex of the child. She argued that the doctors could wait to know whether the baby would be a boy or a girl, but for her, waiting was an impossible task. That's because of the fact that to take responsibility for caring for the baby, she needed to know who she was caring for. For that mother, caring for a boy was very different from caring for a girl. Now we can understand why the child was abandoned at the moment she received the news that her child was

not a boy. She complained that she no longer knows how to care for the baby.

When she thought it was a boy, she had no difficulty, because she had already made a series of interpretations of what he wanted and what he liked. When they told her that it was a girl, she lost all notion with regard to that child, who appeared to be someone impossible to care for. At that moment, the mother vacillated and thought that maybe her husband was right: who knows, maybe another person, more qualified and wealthy, could take better care of the child than she could.

Then the mother asked herself an interesting question: *“Won’t what has occurred between myself and the baby bring consequences for it in the future?”* After all, up to 8 months, the baby was being treated as a boy. He had an identity, a name. In the face of all that, she asked whether it would be possible to treat him as a girl. She pondered over what she considered to be the response: *“If I start calling him by another name, the name of a boy, he can get confused”*.

If, on the one hand, these thoughts tormented her, on the other, she thought that the doctors ought to know what they were doing. She decided, then, to ignore her fears and follow the medical orientation. At that moment, confused by *“not knowing what would be best for the child”*, she transferred the responsibility to scientific knowledge, represented by medicine. That was the moment of her withdrawal and delivery of the child for medical care. The situation becomes unsustainable. According to her: *“That doesn’t mean I didn’t want, or didn’t know how, to take care of girls, because I already had one child of each sex”*. The fact is that there was a history between that mother and that child that couldn’t be erased. She had already made a libidinal investment in that child as a boy. The vision of the masculine genitals was decisive for the mother to come to believe that her baby was a boy. The impression was so persuasive that it led the mother to conclude that she would certainly have held to that same conviction, even if it had been possible for the doctors, immediately after birth, to declare that it was a girl. It should be stressed that mother’s experience had been transmitted verbally to the child, but the main thing is that the place the child occupied in the mother’s desire contributed as a fundamental element in the formation of the identity of the child, becoming a part of its own history.

We know that when a child is born, its sex is designated by anatomy. The case of Rodrigo teaches us that anatomy remained the decisive element

in the definition of sex, based on the mother’s gaze. However, it is not always that way. Clinical observation, case by case, reveals that determination of sex does not occur in the same manner for all individuals. There are clinical situations in which the anatomy of the genitalia does not offer any possibility for affirming that it is a boy or a girl. In these cases, the mother or the parents really are obliged to await medical investigation. Nevertheless, in cases in which there is an anatomical preponderance of one sex or the other, the parents wind up forming an impression, based on the observation of the genitals, that finally defines the sex of the child. That impression may often not coincide with the biological sex.

### Final considerations

Distinguishing genital ambiguity from sexual ambiguity is essential for those who work at a clinic for disturbances of sexual differentiation. Genital ambiguity goes back to a problem of a biological nature: the difficulty encountered in distinguishing the anatomical difference between the sexes based on the genitals. Sexual ambiguity refers to the vicissitudes in the choice of sex, which encompasses a broader process, involving a set of elements that go beyond the discussion of genitality. Sexual ambiguity is consistent with the process described by Freud, referring to the organization of sexuality.

Genital ambiguity can be diagnosed right at the start of life. When it occurs and is identified, it constitutes a problem that is presented to the mother right at the start of the baby’s life. Even before the child, she is the first person who has to deal with the situation. This is not without consequences for the child, because it is the mother who will present the first worldly significances to the baby. Thus it is the mother who initiates the “text of the child”, who will edit it later, when it has been submitted to language.

The clinic of intersexuality is unique, because it raises the questions of chance and temporality. The baby may or may not be diagnosed at the start of life. Thus the baby is subject to chance, because it depends on the one from whom it first receives care. This is a decisive fact and brings consequences, considering that the baby is bereft of resources capable of satisfying its vital necessities.

Such a condition of incapacity to satisfy itself, with which the human organism is born, is what Freud calls “initial helplessness” (*anfängliche Hilflosigkeit*). The experience of satisfaction can only manifest itself if by chance there is an interven-



tion from outside, from the external world, that promotes a specific action. This action is work performed by an experienced person who responds to the baby's shout. This process constitutes the principle of mental functioning. It originates the communication between the mother and the baby.

Thus it is precisely this initial helplessness that winds up introducing the baby into the world of relationships. Its vital necessities are initially signaled by the baby through a discharge. The mother or the person who responds to this discharge - which appears as a shout - interprets it to mean that the baby is experiencing something: pain, thirst, cold, discomfort, sleepiness, etc. The mother will have to be able to translate what the baby needs.

Here we have something essential: in the beginning, the relationship between the child and the mother rests on the satisfaction of biological needs such as hunger and pain. With the intromission of the mother, this "primordial being" engenders something more than purely and simply nutrition. In responding to the shout, the mother introduces something of subjectification, something related

with desire, marked by the alternation of the mother's presence and absence. Such facts, described by psychoanalytic theory, also acquire relevance when dealing with the child with ambiguous genitalia. For this reason, it is indispensable to clarify how the family handles the question of genital ambiguity and how it transmits this to the child.

The questions related to temporality and contingency raised at the clinic for disturbances of sexual development bring to the field of medicine an important discussion, designed to question and investigate what would be the most appropriate moment to deal with genital ambiguity. It is an ethical and epistemological question. Ethical, because it requires taking a stance, making a choice, a judgment, a deliberation. It refers to an ever-present concern, as evidenced by the question, "What would be best for the child?" Epistemic, because if we believe that in infancy there exists subjectivity, psychic elaboration and sexuality, the intervention will be oriented in such a way as to consider the subjective positioning of the child, or will take as its starting point the questions the child itself is capable of asking.

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**Participation of the authors**

Ana Amélia Oliveira Reis de Paula participated in the conception of the research project and in the writing of the text, and Márcia Maria Rosa Vieira participated as master's degree supervisor.

