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Hermaphrodites with *Attitude*

Historian dares to look at the present

I recently spoke with historian Alice Dreger about the process of writing and publishing her new book *Hermaphrodites and the Medical Invention of Sex*. The book uses case studies written by doctors and the few personal narratives she could find written by hermaphrodites themselves to trace the development of medicine's authority to interpret and assign sex. It focuses on encounters between intersexuals and medical men in nineteenth-century France and Britain.

As Sherri Groveman—the American representative of the AIS Support Group—put it, “The book exposes the cultural imperatives that for so long have been disguised as medical necessity. The history of the clinical management of intersex has previously been relegated to medical texts—texts which illuminate technologies to ‘treat’ intersex while ignoring the experience of the recipients of such protocols. Alice Dreger’s book unveils the identities of those who heretofore have appeared in textbook photographs and illustrations with their genitals in sharp focus but with their faces obscured. In the process, Dreger reveals how medicine has often tragically subordinated what is between the patient’s ears and in the patient’s heart to what is between the patient’s legs. While physicians would be well served to incorporate the information and perspectives Dreger offers, the book should appeal to a far larger audience because it challenges the reader’s assumption that

sex is like Carvel (two flavors only) when in reality it is Baskin & Robbins.”

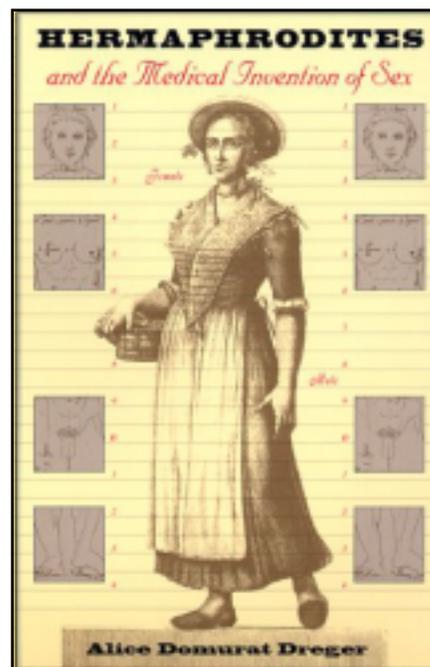
Most importantly, the book also contains an epilogue titled “Categorical Imperatives” which reveals the disquieting degree to which the nineteenth-century thinking described in the book has persisted, influencing even the current paradigms under which many intersexuals have suffered. As its title might suggest, the epilogue ultimately urges the reader to listen to the stories of living intersexuals and apply their perspectives to the creation of a new paradigm.

Although Dreger is much less radical than popular “queer theorists”—and

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Physician challenges the status quo

When I read Alice Dreger’s notes of Dr. Bruce Wilson’s May 1998 Grand Rounds Presentation at Michigan State University, I had trouble believing that it wasn’t merely a model for what we *wish* doctors would say. To hear of the Director of Pediatric Endocrinology at Michigan State University not only criticizing the old paradigm of intersex treatment along the exact same lines as ISNA, but also to have him recommend that his students listen to adult intersex patients and limit surgery to cases of medical necessity rather than external “normalization,” and to have him show the cover of *Chrysalis*



New from Harvard University Press.

magazine and sections of the video “Hermaphrodites Speak!” borders on unbelievable.

And Wilson’s message is not confined to his own campus; he has made this presentation at three of Michigan State University’s other campuses. What this means is that there is already a large group of medical students who will go out into the world with the idea that intersexuality is not a psychosocial emergency to be erased as soon as medi-

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Finding a voice, finding trust, finding care

David Vandertie recently took part in the intersex panel in Minneapolis [see *article below*], and had several of the attendees in tears at his reading of a letter he wrote

would've liked to have heard about himself as a child. "That was the essence of that essay, that being intersexed isn't a negative thing, it's a good thing. Not that

**"Being intersexed isn't a negative thing.
Not that we don't suffer,
but like other minorities,
we suffer because of prejudice."**

to himself last December. But as David will tell you, it has been a long road from first learning about his intersexual status to being able to speak about it in public.

David told me he found the conference "empowering; it was my first public outing, so to speak." It was the first time he had stood up in front of a group of non-intersexed people and spoken openly about his life. "It was remarkably easy, and it felt really good," he said. "I've been talking to Cheryl for five years, and I realized that I was really ready to take this step. I had had plenty of time to work up to it at my own pace: I took it really slowly and carefully."

Once he contacted Martha and let her know that he wanted to present at the conference, he was left to figure out what it was he should say. "I didn't know what to do; I had never told my story before." And as David told me, there's still a great deal of confusion about his medical history—his doctors didn't explain anything at all, he hasn't been able to obtain many medical records, and his family remains unhelpful. "So I don't have a complete story; I can't say, 'This is what happened to me.' I have to try to fill in the blanks, and say 'This might've been the case.'" So instead of a narrative presentation, he wanted to do something different. "I wanted to present something positive, to say 'This is what it's like to be a hermaphrodite. This is our life and it's not a terrible thing.'" He had written a letter of encouragement to himself, a letter that contained all the positive things he

we don't suffer a lot, but just like other minorities, we suffer because of the prejudice of others, not because there's anything wrong with us." He decided that that was the message he wanted to convey with his allotted time.

How much time he had to speak turned out to be problematic. The letter took at

least fifteen minutes when he timed it, so he gave it to his therapist for suggestions about what he should cut. "Don't cut a word," his therapist said. "When I was writing it, it all came out at once," David explained. "It was like a piece of my heart, a complete work that would've been impossible to pare down."

He wrote the letter thinking that he would never share it with anybody, which is most likely where its great force and honesty came from. Reading it in public was a whole different ballgame. "I'm forty-five years old," David told me, "and there's no way I could've written this even two or three years ago, let alone shared it with anyone. Only in the last few years have I begun to feel okay. I've had to get out from under a huge amount of shame."

As part of his coming to terms with his intersexuality, he has also won another personal battle: after decades of not trust-

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Intersex voices add to Trans Conference

When Martha Coventry ran into one of the organizers of the Midwest Trans Institute's first conference, she hadn't planned on organizing a panel on intersex issues, but soon she was contacting Max Beck, Angela Moreno, and David Vandertie, all of whom agreed to put it together with her. Then, the group was joined by a new member, 21-year-old Kristi Bruce. After several phone conversations and a final meeting at Martha's house, they had planned out their seventy-five-minute presentation.

On Saturday, 25 April, the video camera was set up and the group organized the room in Coffman Union at the University of Minnesota at Minneapolis. The moment the people attending the discussion walked in, they could see that this wasn't going to be the traditional "panel" arrangement. The panelists had taken the tables that the conference organizers had set up and stacked them in the corner. Then they moved the chairs into concentric circles and made it a point to leave space for people to sit between them. As

Martha told me, "It turned out to be a great arrangement." The room was full when they were ready to start, and Martha spoke first. "I introduced everyone, said where we were all from, and then I talked about what intersexuality meant, and what it didn't mean." The idea was to help correct prevailing misconceptions, to give the attendees "a sort of Intersexuality 101," so there would be a basic medical and social understanding to start off with.

The small, hot room was filled with all different types of people. Some of them were there because they're writers, some were in queer studies, and some were, as Martha put it, "people who were obviously not following strict gender roles, and the subject must have struck some sort of chord in them." When she was done with the groundwork, she suddenly decided to change the order of the speakers. The first she chose was David Vandertie. Once he was ready, he started

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(L to R) Max, Martha, David, Kristi, and Angela looking triumphant after the panel, on the steps of the University of Minnesota campus.

reading what Martha describes as “an incredibly moving letter” that he had written to himself six months before [*see article, previous page*]. Not too far into his reading, a man near him “just started sobbing,” Martha recalls. Soon, two other men were crying. “David was talking about loving his body just as it is, and it was a powerful experience for the other men,” she imagined, “because men so seldom talk out loud that way about their bodies and themselves.” After David read his letter, there was complete silence. “I think people were just surprised by the form David chose to express his feelings. The letter was so personal and so poignant.”

Angela was next. “She has told her story many times,” Martha said, but she ended up “speaking extemporaneously and emotionally about her life. She read a poem she had written earlier that some of us had heard before, but then she added to it. It was brutal and gut-wrenching. People were really blown away. They had never heard anything like it, I’m sure, and Angela delivered it in such a vulnerable way. The entire room was on edge.”

After Angela’s and David’s very emotional readings, Martha thought it was best to go next to Max Beck, “who is calm and centered and intellectual, yet very in touch with his heart.” Max too read a letter, one he had written to John/

Joan fifteen years ago. In the letter, Max told John/Joan how, as a young woman, Max had found his case in the library in a medical journal, and how much it meant to Max at that time to find someone else like himself. Max told John/Joan how he’d given him strength, applauded him for his courage, and wished him the best of luck. “It was a beautiful letter,” Martha said.

Next was Kristi.

“She’s very young to this—she’s only been dealing with it for a matter of months,” Martha explained, “and the whole thing is a lot to take on. To have lived your life as female and then to find out you have XY chromosomes while you’re sitting alone in your car reading your medical records is difficult enough, but then to speak about it publicly is a huge, brave step. Kristi provided an excellent contrast to some of us who have been talking about our lives and this subject for a couple of years now. She was raw and undefended and her words

came straight out of her.” Kristi spoke about what finding out about her history means to her, what her life has been like, and what she feels called to do now. Martha described Kristi’s talk as “a real stunner for all of us, panel members and audience both, to hear that level of truth and conviction.”

Martha made sure to leave some silent space after each person’s story, though she wishes she had left even more time,

she admits, to give the full force of each speaker’s words a chance to sink in.

The question and answer period that finished the session that was “great: there were a lot of really good questions asked. There was also another woman from Minneapolis who spoke up for the first time,” revealing that she too was intersexed. Martha told me that it was a fascinating sharing of thought and feelings, particularly when the man who had started crying at David’s letter and another woman in attendance spoke about the alliance of movements like muscular dystrophy with the intersex movement. They also spoke of the dominance of the medical world over people’s bodies, all in a way that was respectful toward the audience. “I was amazed: you know how usually in a crowd like that, there’s someone who just speaks to hear him/herself talk,” but Martha found nothing of the sort. Instead, “everyone said what they wanted to say, and it was met by everyone in the room with interest and respect.” People were “blown away,” Martha said; they called it “the best presentation of the whole conference.” Loathe to take credit herself, Martha ascribes the emotional force of the panel “not so much to us, but to the subject. People were hearing about it for the first time, and in such an intimate way.”

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The panelists capped off the evening by going back to Martha’s house and relaxing. They were joined by the intersexed woman who spoke up during the panel, and “spent the evening wandering around my neighborhood in a pack: to the liquor store, to the food co-op, then home to cook dinner.” Besides feeling like they’d really accomplished something with the panel, as I heard from both Martha and David, “it was just a wonderful reunion.” ■

Physician challenges

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cally possible. There is a group of doctors out there (and the number will grow) who have instead been taught that “it is more important to get gender assignment right in a process that involves the patient than to get it fast,” that the patient should be fully informed and involved in decisions about surgery and hormones, that there is a wide range of genital anatomy (“not statistically normal does not mean pathological”) and that there is a great need for early and consistent counseling in order to “get away from the veil of shame” so often associated with intersex issues. According to Wilson, what is truly shameful is that the sort of shaming and traumatizing treatment which Angela Moreno describes in “Hermaphrodites Speak!” remains the national standard.

Wilson has been researching intersexuality for a long time; however, his first exposure to ISNA was last fall, when one of the adult endocrinologists at Michigan

encountered one or two people who were firmly attached to the current paradigm, but that “most of the pediatric community has been very open to the message”—in fact, the moderator of the Kalamazoo presentation called it the best Grand Rounds they’d had all year. Primary care pediatricians and pediatric endocrinologists have shown the most positive reception, Wilson said, both because they are used to a lot of changes and advancements in patient care and because they are the ones who have the most direct contact with patients and parents. There has been a movement lately to involve parents more closely in all of the decisions for their child, so a lot of these caregivers are more receptive to opening up communication. The resistance, Wilson says, is found more within surgical and urological communities. That’s a big part of the problem in creating change. “Intersex treatment involves so many different types of specialists that you get a lot of disagreements,” he explained. And the disagreements aren’t limited to general policy: it’s not uncommon to have a debate over which sex to assign a

“If we don’t have proof that the risky surgeries being performed are better than no surgery, why do them?”

State’s Center for Ethics got a group together to talk about intersex issues. Afterward, he and Alice Dreger were asked to do a presentation for the Women’s Studies Department, and in preparation, she showed him the profoundly moving film “Hermaphrodites Speak!” As Wilson says, “Things went from there.”

After the Women’s Studies presentation, he decided that he had enough information on the topic, and that he “now wanted to start carrying the message to the pediatric community.” That message was the call for change that made up most of his Grand Rounds presentation, which he gave in four cities in Michigan. I asked him if he found any resistance to what he was saying. He told me that he

child. He told me about one recent case where the geneticist wanted to assign the baby female, and the urologist wanted a male sex assignment.

So how do we bring about change? Wilson explained that the greatest resistance comes from “bigtime medical centers” who can get stuck in their ways. The best way to change their minds, he suggested, is to show them why they need to change and what’s happening. “The double-blind study is the classic justification for a change in policy,” he said, “but in this case, that’s neither ethical nor feasible.” He said that Dr. David Sandberg and Dr. Heino Meyer-Bahlberg both suggest that, until we have better data, the treatment protocol ought not to be altered.

But Wilson disagrees: “As more people sit down and look at the issue, it makes a lot of sense to go back to the primary rule in medicine: *Do no harm*. If we don’t have data proving that the risky surgeries being performed are better than no surgery, why are we doing them? Sure, Money has written articles saying that people who weren’t given surgery developed psychological problems, and right now I’m reading two urological articles that talk about the degree of psychological distress in individuals who aren’t given surgery, but there’s no data to back up these claims.” He went on to tell me about a major article in the professional literature written by a pediatric endocrinologist. The article is sixty pages long, and in all it contains just one sentence about talking to the patient or the parents about what’s to be done. “They never talk about who we’re really taking care of,” he said.

I asked him why surgeons would still do the surgeries based on a paradigm that’s not only unsupported by data, but has in fact taken a great beating lately with the exposure of the failures of the John/Joan case, frequently cited as proof that the traditional model for treating intersex births works. This case of identical male twins, one of whom was reassigned and (supposedly successfully) raised female after a circumcision accident burned off his penis, is seen as the main evidence supporting Money’s theory that sex can be arbitrarily assigned up until the patient is eighteen months of age. That theory provided the basis for the current paradigm of intersex treatment. Wilson explained to me that a single case is not likely to cause the immediate revision of an entire paradigm, even if (as in the case of John/Joan) it was so instrumental in its creation. It can certainly shed light on certain flaws in the paradigm which heretofore went undetected, but a single case can really do no more than raise a debate: “It can start something kind of like a snowball going down a hill; as it gathers new material and momentum, it gets big enough to actually cause change. The change will flow from a single case, but you can’t expect an imme-

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diate response; you have to get people to examine the paradigm and think about what they're doing and where it's going to go." Change takes time.

Minds *are* changing, particularly in certain circles of the pediatrics community, but "we still have a long way to go," observes Wilson. For instance, he told me about an eight-year-old patient who went in for a urological repair, but the surgeon did a clitoroplasty while she was anesthetized. Wilson and her primary care pediatrician had agreed that she shouldn't have those surgeries, but they had no opportunity to voice their objections. "We need to start with pediatricians and pediatric literature and eventually get to urologists. Then, finally, we need to get to the pediatric surgeons who are doing this and don't read the literature."

To change policies, he also mentioned the great need for more behavioral studies. We were discussing the usual response that we hear from surgeons and other medical professionals when confronted with adults who are not just angry at the lies they've been told, but also at the results of the surgeries forced on them by doctors following the old paradigm. These surgeons will be quick to retort: "Oh, but the procedures are much better today; they're constantly improving, so what these people have to say is not relevant." As Wilson puts it, "If surgeries are improving, that's an even better argument for waiting ten years, when the surgery will be even better and the patient will have a chance to withhold consent if s/he chooses. The point is, there's no reason to leap into doing something just to get it done fast." Wilson also agreed that the basic issue is that changes are being made to people's bodies without their consent. "Absolutely," he said. "These are parts of people that they have a right to keep."

Hopefully, as he told me, in ten years, not only will surgical options be better (for those who want them), but "we'll be more open as people grow and change. Birth gender can be different from adult gender, and that change is okay. We (the medical community especially, but really

all of society) need to be more open and accepting of that gender fluidity in individuals." Wilson commented on how, fifty years ago, there were basically only two races in terms of social categorization: white and black, a division which completely ignored the spectrum of difference not just within those two categories, but also outside of them. Hopefully, just as that line in the sand is beginning to blur and get a little less deep, so will the divide between male and female. "Hopefully, in terms of social stigma, that divisive categorization will change," he said.

And though we definitely need more data from the medical side of things, we also need to look at this as a family problem. "Why is something like cleft palate so different?" he points out. After all, it's a

condition that calls upon the whole family to deal with the issue of a child's body being different from the "norm." "Medicine can lead the way, but we need changes in family attitudes regarding intersexuality," he said; "we need more discussion about the issue to reduce the stigma." Wilson is also quick to include the necessity of qualified psychotherapy for the whole family, as well as the need for support group referrals.

Though he would agree that we still have a long way to go before things change, it cannot be denied that with such trailblazers as Wilson not only listening to former patients who were until now "lost to follow-up," but also going out there and spreading the word, the future we've all hoped for is at the very least beginning. ■

Historian looks at the present

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much more comprehensible—she is actually rather *avant garde* when positioned in relation to her peers. Indeed, she told me, "a lot of people in academia think there's a risk to doing this kind of work, that your peers will look down on you, but I haven't found anybody yet who thought that way." Maybe some think she's odd, she told me, but really "a lot of people tell me they are envious that I'm able to do so much good, and for people who are so appreciative." Dreger has already gotten feedback, all of it very positive. She especially treasures Sherri Groveman's note saying that the book helped her get in touch with her intersexual history, and that she cherished all the stories it gave her about her hermaphroditic ancestors.

Her publisher was not as convinced initially that many people would find the book meaningful. The epilogue, too, was a problem at first. Her editors warned her that, as a historian who was talking about current events, she might not be taken seriously if she bit off more than she could chew. But precisely because it deals with extremely important current,

real-life implications of all of the historical material, she considered the epilogue essential. "When it was still in the early stages, they asked me to cut it out," she said. To be fair, Dreger continues, "it really did need to be more comprehensive and better documented. Cheryl Chase helped me a lot with that." And she confesses to being glad that she had to rewrite it. So, it seemed, was Harvard. "I showed it to them, and they were very impressed." They didn't expect her to be able to document the medical model's failings so thoroughly.



Dr. Alice Dreger

There were other challenges too: it would have been impossible to cover everything. Dreger regrets that she couldn't include every story and every concept, finding that part of the process frustrating. She also added, "It's extremely difficult to write someone else's story, to represent a person who's dead and didn't leave that many records behind; it's difficult to be sure that I did them justice."

She does appreciate feedback, though at present she's getting so much of it that she's having trouble keeping up. It would seem that the book has touched many more people than she or her editors could have ever imagined. ■

Finding a voice

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ing doctors because of the way he was treated, David has finally pushed himself to seek medical care again. However, he

“It’s so narrow to use the development of secondary sex characteristics as the measure of success in hormone therapy.”

is quick to clarify: “I trust my doctors as individuals; I still don’t trust the system.” We discussed that system and its drawbacks. “It’s tough,” he pointed out, “because unless you’re really lucky, you will need good medical care at some time in your life. I’m a very well informed consumer, but it’s still a challenge to not fall through the cracks.” Actually, David is especially well informed; as it turns out, he is a pharmacist. In fact, he is currently writing an article for *Transgender Tapestry* on intersex health issues. The problem is that they want something only two thousand words long, a seemingly impossible task, considering the amount of material he might cover. “Almost everything I’m writing has to do with trust,” he explained. “How do we reestablish that so that we can take care of ourselves?”

David found himself in need of medical care because, like many intersexuals, he has osteoporosis. I asked him what was new in terms of research and medications for the condition. “It’s a very hot topic for research right now; a lot of resources are being put into understanding it and developing drugs as treatments for it.” The old treatment for osteoporosis was to prescribe hormones. “But hormones aren’t really a satisfactory substitute for a functional endocrine system,” he explained. “There’s some stuff they don’t do very well.” David took testosterone for fifteen years, but ultimately, he didn’t like it. “It changed me. I was a different person in terms of my emotional life and personality.” So he stopped taking them, and he likes himself off hormones a lot better. He told me how frustrated he was with the medical

establishment’s narrow viewpoint on hormone use: “I was just reading this Canadian study about a case similar to John/Joan that was labeled a success [see back page for a full bibliography of all the articles discussed in this issue]. There was a circumcision accident, so

they castrated the child and prescribed hormones and they say she’s a ‘tomboy,’

Minister works toward love of difference

Brad Bunnin has followed many paths to get to the one he’s currently traveling. He was the executive VP of a public utility company, then a publishing lawyer for twenty years, working with artists and writers in their legal affairs. Though he still works as a publishing consultant, he recently completed both his Master of Art in Ethics and his Master of Divinity at Pacific School of Religion and looks forward to starting a post as a parish minister. He wrote his thesis on intersexuality, and I recently spoke with him about that project, as well as what inspired him to change his life’s work.

Brad was taking a course from noted Christian ethicist Karen Lebacqz called “Ethics and Difference,” and while his classmates wrote about skin color, disabilities, and gender (in the more binary sense), he decided to do his final paper on the topic of intersexuality. His interest in the topic began years ago, on a long trip to a religious celebration in a car shared with an adult who had grown up intersexed and had escaped surgery. She identified as female and lesbian, and told him freely of her experiences: she had encountered some teasing and even physical violence in the boys’ locker room in junior high, but it didn’t do any lasting harm; she grew up well grounded, self-aware, and confident in who she

she says she’s bisexual, she works a blue collar job in a male-dominated industry, and she’s in a long-term relationship with a woman. It’s so narrow of them to use the development of gross physical secondary sex characteristics as the main measure of the success of hormone therapy.”

A naturally functioning endocrine system is much better than synthetic hormones. Although the risk of cancer, in persistent undescended testes, is higher than usual, the risk is different for differ-

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“I find the variety of expression of what it is to be human exciting. We should be encouraged to show love and support for difference.”

dominant medical model for intersex treatment, and his professor deemed it of publishable quality. She encouraged him to expand it and make it the thesis for the Masters in Ethics he had considered pursuing.

Brad took her advice and expanded his thesis, arguing that intersexuality in an infant is not a psychosocial emergency,

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ent conditions. For some conditions, if the testes are capable of producing testosterone, the person might reasonably choose to keep them and to monitor them carefully for cancerous changes. For most conditions, the risk of testicular cancer before early adulthood is quite small—so undescended testes can reasonably be left in and the person allowed to make their own choice by weighing the risk of cancer versus giving up the natural hormones produced by testes. [see “Frequently Asked Questions” on ISNA’s webpage at www.isna.org for more information.] David criticized the dominant medical thinking on this issue and the lack of information provided.

but is a condition that (except in cases where the child’s physical health is threatened) does not demand surgery, and certainly does not warrant medical erasure. He read John Money and was troubled by the reporting of the John/Joan twin case and upset that its disastrous outcome had tremendous real-life implications for thousands of intersexed infants. It really touched Brad’s sense of justice. He decided that he wanted to write a paper that would work to discount such misinformation. He also particularly wanted to write a paper for clergy. “A lot of times, clergy are the people parents will come to when their baby is born intersexed,” and he wanted to educate them about the topic so they’d have a clue about what to say, something more than “it’s God’s will” or “this is your cross to bear.” He wanted them to know that “they should encourage parents to just let the

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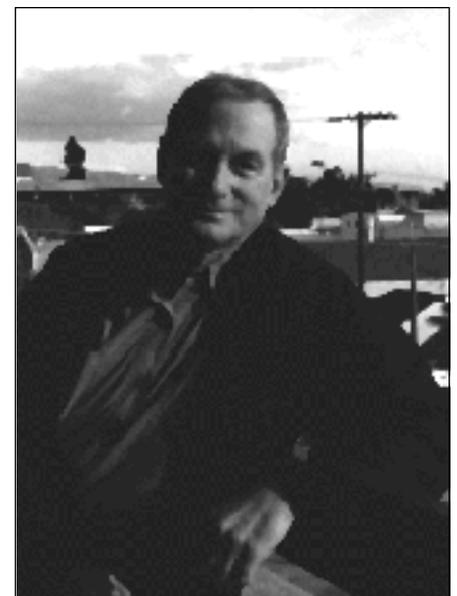
“It’s an easy thing to do, in medical thinking; just cut off the offending organs and replace them with synthetic hormones. But I wonder how successful hormone-based therapies are.” According to David, “a lot of people stop using hormones, and I don’t know if anyone has looked at why.”

People whose gonads do not produce sex steroids (estrogen or testosterone), or who were born without gonads, or whose gonads have been removed by surgeons, are at risk for developing osteoporosis—particularly if they do not use hormone replacement therapy. And osteoporosis can be a very serious and debilitating

child grow up without surgery,” or at the very least “talk to intersex adults and see what their take on the issue was.” He took the “wait-and-see” position in the paper, and attempted to construct a guide for clergy in how to help the parents cope with the decision not to alter their child surgically. “They need to know about the many sources of information and support, about how the church itself is a resource.”

In fact, he sees love and support of difference—any difference—as the real test of how well a community (in his case, the Christian community) lives up to its responsibilities. However, he underscores, “that doesn’t mean I minimized the problem.” He made sure that those who are placed in the position of advising parents understood the possible parental distress at raising a child outside of the range considered “normal,” though as Brad points out, “I’ve never met a single person, professionally or personally, who didn’t have his or her own intellectual, physical, or emotional quirks.” He adds, “I find the variety of expression of what it is to be human exciting, and we should be encouraged to show love and support for difference.” The problem begins, he says, when children are taught to be ashamed of their difference. “When we’re children, we’re taught very early the difference between good and bad.” If a child’s body can’t even be discussed, the child assumes that his/her body must be really horrible. “I don’t think that any

condition. “There’s a twenty percent mortality rate when people with advanced osteoporosis break a bone,” David told me. “Your bones can break from sneezing or just turning over in bed.” As David said, though, there’s good news. “There are more choices in medications and treatments, some that don’t involve taking sex hormones, to preserve and increase bone density, and there are a lot more on the horizon. I would encourage others to find a doctor you can trust, someone who respects you, and find out if you are at risk for this condition. Or if anyone wants to talk with me more about this, they can contact me through ISNA.” ■



Brad Bunnin

kind of ridicule an unaltered child might face even comes close to being as harmful as the shame that results from what is not discussed. Shame has to do with who you are,” and that can be the hardest thing in the world to come to terms with.

Brad says that his decision—to follow a true calling he received in church one day, and to completely change professions—has proven “wonderful, liberating, and energizing; I would recommend it to anybody. I think people ought to change jobs every five or seven years unless they’re totally satisfied with where they are. Finally, I feel a sense of connection, of being in the right place.” ■

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**See the ISNA website at <http://www.isna.org> for ordering details.

that we get about 1200 emails per month, sometimes many more when ISNA is particularly hot in the press (which, thanks to Cheryl, happens pretty consistently). Cheryl handles all of the publicity and media affairs, keeps up on where intersex is in the news and coordinates sending out press releases, does almost all of the networking, and organizes and speaks at conferences. She is also constantly developing sometimes several books and articles on intersex issues at once, in addition to editing many intersex publications.

We are also lucky enough to have had Cade McCall on board since 1997. Cade provides us the wonderful service of maintaining our website.

Finally, I am the newest addition, here as an intern (full time, thanks to a grant from Wellesley College, where I will be returning in the fall to finish up my B.A. in Women's Studies). I got interested in intersex issues while researching a final project for a women's studies course. The more I learned about it, the more the treatment of intersex people angered me, and I thought something really needed to be done. So here I am! The main things I've been up to are doing the bookkeeping and data entry, writing handouts for conferences, and updating our library and some of our pamphlets. The most fun has been putting together this newsletter, which gave me the opportunity to speak with all of the kind, brave, and dedicated people you just read about. I must say, I'll be sad to leave when the fall comes, though I hope to keep up my relationship with ISNA and pitch in from Boston. ■

Who's who at ISNA

Olivia Kienzel

It occurred to us the other day that some of you might wonder what happens here at ISNA. To that end, I thought I'd write a little article about who we are and what we've been up to.

Many of you know David Cameron, who comes in regularly to sort through and answer the great deal of correspondence ISNA receives. He also lends his invaluable assistance with taking care of orders for anything from videotapes to magazines to bibliographies to back copies of the newsletter. Furthermore, David coordinates ISNA peer support meetings for the Bay Area and most recently used his connection with the San Francisco chapter of PFLAG (where he also volunteers)

to set up an intersex panel to speak at one of their meetings.

I'm sure that just about everyone who reads this newsletter knows Cheryl Chase. She is the fearless leader of the whole operation, which she began in 1993. At present, she answers the email queries—an enormous job, considering

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