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Submitted by interACT: Advocates for Intersex Youth

**Non-consensual surgical and hormonal interventions on intersex children constitute a form of conversion therapy**

1. **Reporting Organization**

interACT: Advocates for Intersex Youth, formerly known as Advocates for Informed Choice, is an independent human rights NGO based in the United States. It is the first and only organization in the country exclusively dedicated to advocacy on behalf of children born with intersex traits.

1. **Issue Summary**

The term “intersex” refers to variations in a person’s sex traits, including chromosomes, genitals, hormone production, and internal organs, such that their body does not fit typical definitions of male or female. It is an umbrella term that includes many different medical diagnoses, as well as variations in sex characteristics without a diagnosable etiology. Conservative estimates of the frequency of intersex births are between one in 1,000 and one in 2,000,[[1]](#endnote-1) while higher estimates reach up to 1.7 percent.[[2]](#endnote-2)

Beginning in infancy and continuing throughout childhood, children with intersex traits in the U.S. have been, and continue to be, subjected to intersex genital mutilation (IGM) and other unnecessary medical interventions to change their sex traits without their consent. These children often experience unnecessary genital surgery, removal of the gonads, and hormonal interventions to make their bodies more closely conform to the sex assignment chosen for them by their parents or doctors. Intersex individuals suffer life-long physical and emotional injury as a result of such experiences. These human rights violations often involve tremendous physical and psychological pain and constitute torture as recognized by multiple international human rights bodies.

Despite this vociferous international condemnation, practices such as forced genital surgery, gonadectomy, and hormone treatment continue on intersex children in hospitals across the U.S. In interACT’s view, subjecting non-consenting children to these procedures constitutes conversion therapy because they are intended to erase a child’s intersex traits and conform them instead to binary, heteronormative notions of sex and gender.

1. **History and Current Practices in the United States**

In the U.S., the “treatment” paradigm of coercively altering intersex children’s sex traits originated in the 1960s with psychologist John Money. Dr. Money believed that individual gender identity was malleable in infancy and that a child could be reared either male or female if their genitals were modified to “match” that sex assignment – and if the child was never told the truth about their body.[[3]](#endnote-3) Money tested this theory on a young boy named David Reimer whose penis was badly damaged in a circumcision accident, advising the parents to raise the child as a girl instead with the help of “feminizing” genital surgery. Known as the “John/Joan case,” Money’s experiment was believed to be a success and became the basis for the surgical alteration of intersex infants’ bodies.[[4]](#endnote-4) Early surgery and secrecy were considered paramount if the child was to “accept” their assigned sex category. In the 1990s, Money’s experiment was exposed as a failure – David Reimer had rejected his surgically-enforced female assignment, transitioned to male,[[5]](#endnote-5) and would later commit suicide. The practices inspired by his theory, however, continued to be carried out on intersex children, and they remain common even today.

A child who is deemed in infancy to be intersex or to have atypical sex characteristics is usually assigned a sex based on some combination of their genital anatomy, gonads, chromosomes, and other test results such as hormonal response. Surgeries are often performed – most commonly under the age of two – to make the child’s body conform more closely to notions of what is typical for either male or female bodies. For children assigned female, these may include surgeries to enlarge or create a vaginal opening, to reduce the size of the clitoris, or to reduce or reshape the labia.[[6]](#endnote-6) For children assigned male, surgeries to relocate the urethral meatus and create a more “typical”-looking phallus are common. In either case, gonads and other internal organs may be removed if they are not typical of the sex assigned (e.g., testes in a female-assigned child with Androgen Insensitivity Syndrome). However, intersex children, like all children, may grow up to identify with a gender other than the one in which they were raised. When this occurs, gender dysphoria may compound the irreversible damage done by procedures that altered the appearance and function of their bodies without their consent. Depending on the intersex trait, the chance that the child will ultimately not identify with their initially assigned sex ranges from 5 to over 60 percent.[[7]](#endnote-7)

Even when gender assignment rejection does not occur, there are many serious and documented risks associated with non-consensual medical interventions on intersex children, including scarring, chronic pain, urinary incontinence, loss of sexual sensation, loss of reproductive potential, PTSD, depression, and the need for lifelong hormone replacement therapy.[[8]](#endnote-8) It is no surprise that these practices have been condemned by multiple United Nations Special Rapporteurs and Committees on many occasions. For example, in 2013, the Special Rapporteur on Torture (SRT) “call[ed] upon all States to repeal any law allowing intrusive and irreversible treatments, including forced genital-normalizing surgery, involuntary sterilization, unethical experimentation, medical display, ‘reparative therapies’ or ‘conversion therapies’, when enforced or administered without the free and informed consent of the person concerned.[[9]](#endnote-9) The High Commissioner for Human Rights acknowledged that the rights infringed by the genital-“normalizing” surgeries carried out on intersex children include “their rights to physical integrity, to be free from torture and ill treatment, and to live free from harmful practices.”[[10]](#endnote-10) The Committee on the Rights of the Child reiterated the call to end forced surgeries or treatments on intersex adolescents.[[11]](#endnote-11) The Committee made further recommendations that protocols for intersex children should be established to ensure no one is subjected to unnecessary medical treatment and to “guarantee[] the rights of children to bodily integrity, autonomy, and self-determination.”[[12]](#endnote-12) Finally, various UN and regional bodies signed a call for the end of human rights violations against intersex children and adults, describing the practice of medically unnecessary surgeries as torture.[[13]](#endnote-13)

Following the actions of the SRT, in 2014 the Societies for Pediatric Urology published a paper concerning their “standpoint on the surgical management” of intersex traits. They recognized that non-consensual and unnecessary interventions on intersex children have been classified as torture but nevertheless failed to call for a ban on such surgeries, instead stating that more information must be gathered and that surgery could be justified “to restore more normal visible anatomy, and avoid ambiguity which is often the parents’ wish.”[[14]](#endnote-14) In 2016, a group of prominent physicians published a statement on the treatment of intersex children, and again failed to call for an end to these surgeries despite their recognition of “a number of agencies condemning or calling for a complete moratorium on elective genital surgery or gonadectomy without the individual’s informed consent”[[15]](#endnote-15) and that “many guidelines deem children’s participation and input indispensable to decisions, especially those that will have a life-long deeply personal impact on their lives, with heightened awareness that young children, in particular, may not be able to vocalize adverse reactions to many interventions.”[[16]](#endnote-16)

Many other published papers have recognized the potential for harm, yet intersex children continue to experience genital mutilation in the U.S.[[17]](#endnote-17) Physicians in support of the current paradigm argue there must be additional research prior to a change in practice, yet this excuse has been used for decades while unbiased medical research centering the input of the intersex community remains nonexistent. Conversely, intersex patient advocates point out that “there has never been sufficient research to show either that these surgeries benefit patients or that there is any harm from growing up with atypical genitals.”[[18]](#endnote-18) Proponents of performing unnecessary surgery in childhood often rely on the presumed stigma and psychological distress related to having a body that may be considered atypical as justifications for operating before the individual can give informed consent. The *Journal of Pediatric Urology* published an article asserting that while “surgery has been restrictively considered by some to be ‘cosmetic surgery,’ the cosmetic aspect of genitalia and the related stigma risk are also important issues for many patients.”[[19]](#endnote-19) One article cited “maintenance of ambiguous genital anatomy and its unknown psychological ramifications” as a disadvantage of not operating on intersex children’s genitalia.[[20]](#endnote-20) Yet, recent research shows intersex children who are growing up without medically unnecessary surgery are not showing signs of psychological distress or expressing concerns related to their unaltered genitals.[[21]](#endnote-21) This suggests that such “justifications” for surgery are more reflective of doctors’ and parents’ concerns than those of the intersex individual. As noted by a Swiss National Advisory Commission on Biomedical Ethics, “[a]n irreversible sex assignment intervention involving harmful physical and psychological consequences cannot be justified on the grounds that the family, school or social environment has difficulty in accepting the child’s natural physical characteristics ... If such interventions are performed solely with a view to integration of the child into its family and social environment, then they run counter to the child’s welfare.”[[22]](#endnote-22)

Doctors in the U.S. who object to advocacy efforts to limit the practice of non-consensual intervention on intersex children claim that such surgeries are performed infrequently, or only in cases of medical necessity. Findings from their own publications and presentations contradict this. Doctors at a major U.S. conference presented information from one registry in the U.S. regarding surgery on children with Congenital Adrenal Hyperplasia (CAH), one of the more common intersex conditions. They noted “544 patients underwent feminizing genitoplasty between 2004-2014,” with a median age at initial surgery of just 9.9 months.[[23]](#endnote-23) This conference included discussions of how to ensure these surgeries continue to be cost- effective/profitable for health care institutions. One study on intersex babies documented that 25 of 26 participants had undergone genital surgeries.[[24]](#endnote-24) Our organization receives continual inquiries from families who tell us that surgery is being or has been pressed upon them in respected hospitals in major cities across the U.S.

1. **Non-consensual Interventions on Children with Intersex Traits Constitutes “Conversion Therapy”**

*What different practices fall under the scope of so-called “conversion therapy” and what is the common denominators that allow their grouping under this denomination?*

Because non-consensual surgeries and other interventions on the sex characteristics of intersex children aim to conform their appearance, function, behavior, and even identity to match the sex assigned to them, these interventions should be understood as a physical form of “conversion therapy.” As discussed above, the entire basis of the “treatment” paradigm initiated by John Money was to ensure intersex children accepted their sex assignment without question, and genital surgery was intended to cement that assignment into identity.

Even though Money’s theory was discredited, these rationales persist in intersex care today. Procedures like clitoral reductions, vaginoplasties, and hypospadias surgeries on children are often performed for the express purpose of making the child’s body match societal notions of what is considered “normal” for a male or female body, and to (attempt to) ensure the child will grow up identifying with the “corresponding” gender. One group of physicians wrote that the goal of “feminizing surgery in girls and women with CAH [Congenital Adrenal Hyperplasia] is that the postoperative genital appearance is compatible with female rearing” – implying that such a child cannot be raised as a girl unless surgically shaped into one first.[[25]](#endnote-25) However, studies show that up to 1 in 8 children with CAH and XX chromosomes will not grow to identify as female.[[26]](#endnote-26) Proponents of feminizing surgery for CAH patients continue to claim that surgeries like clitoral reductions and vaginoplasties are necessary to ensure the child grows up with a body that matches their identity while blatantly ignoring the fact that they cannot know which of their patients will experience precisely the opposite outcome. In these latter cases, the surgery will not make them grow up as girls – it will only function, like non-physical forms of conversion therapy, to scar and shame them on account of their difference.

Another group of doctors found that approximately 45 percent of patients with one intersex diagnosis self-reassigned from female to male and, *rather than recommending delay of surgery to accommodate the risk of incorrect gender assignment,* recommended that development of male gender identity could be *prevented* with the early removal of gonads. They wrote: “Although existing data are limited, early orchiectomy is likely to result in retention of female gender identity, avoiding the complications related to virilization in adolescence.”[[27]](#endnote-27) When the emergence of a child’s true gender identity is seen as a “complication” to be “avoided,” and not an outcome to be facilitated, interventions on intersex children too young to consent are clearly not done with the patient’s best interests in mind. An attempt to change the patient’s gender identity or force conformity with a category contrary to the patient’s identity constitutes conversion therapy and should be recognized as such.

In addition to identity, these forms of conversion therapy on intersex children also include enforcing gender-typical behavior and heteronormativity. For children raised as boys, an acknowledged goal of hypospadias surgeries is “to achieve an unobstructed, sex-typical manner for urination (i.e. standing for males).”[[28]](#endnote-28) Hypospadias surgeries and other masculinizing procedures, as well as feminizing procedures such as vaginoplasties, are also performed with the goal of facilitating penetrative intercourse. “Providing anatomy suitable for penile-vaginal intercourse” is a stated reason for invasive surgical intervention on infants[[29]](#endnote-29) – many long years before it can be known whether the individual undergoing these surgeries will want to engage in those activities, or how their sexual orientation will develop. Intersex individuals interviewed for a Human Rights Watch and interACT report also were told by doctors that certain surgical procedures would be necessary in order for them to have sex with a future husband, while their own sexual pleasure was compromised by those operations.[[30]](#endnote-30)

Individual patients’ gender identity and their sexual health and satisfaction are often of lower priority in this treatment paradigm than conformity with the social expectation that they should grow up to be cisgender and heterosexual. This paradigm does symbolic harm to the entire LGBT+ community, and very real physical and psychological harm to the intersex individuals who are subjected to it.

1. **Risks of “Conversion Therapy” on Intersex Children**

*Has there been an identification of risks associated with practices of so-called “conversion therapy”?*

As discussed above, there are numerous risks associated with non-consensual medical interventions on intersex children. Removal of hormone-producing gonads often requires that the individual be placed onto lifelong hormone replacement therapy. It can also constitute sterilization. Genital surgeries risk the irreversible loss of sexual sensation and function, urinary incontinence, and chronic pain.[[31]](#endnote-31) Intersex individuals who experience these non-consensual interventions go on to harbor levels of trauma and suicidality comparable to survivors of sexual abuse.[[32]](#endnote-32) Of course, there is the aforementioned risk that surgery will enforce a sex assignment that does not match the individual’s gender identity. However, even when this is not the case, the harms that result from invasive surgeries that violate bodily autonomy and affect sexual and reproductive function are severe and irreversible. Finally, these surgeries expose young children to unnecessary anesthesia, which has proven risks to the developing brain.[[33]](#endnote-33) There are no known risks, on the other hand, associated with delaying medically unnecessary procedures on intersex children’s sex traits until they can participate in the decision about whether any interventions are desired. Intersex children who have been allowed to grow up without unnecessary surgery are reported to be healthy, happy, and well-adjusted.[[34]](#endnote-34)

1. **State Action**

*Are there any State institutions, organizations or entities involved in the execution of practices of so-called conversion therapy? If so, what criteria have been followed to consider these as a form of valid State action?*

Non-consensual interventions on intersex children, which we have argued constitute so-called conversion therapy, are performed in state hospitals in the U.S. and occasionally reimbursed with state (Medicaid) funds. interACT has received data through Freedom of Information Law and Public Records Act requests on state-funded procedures in New York and California, respectively, and found evidence of state Medicaid reimbursement of thousands of surgical interventions on intersex children within the last few years.

In terms of state responsibility for private activities, much of the “treatment” performed on intersex individuals by physicians in the U.S. has already been recognized as torture or CIDT.[[35]](#endnote-35) According to the UN Committee Against Torture, states’ obligations to protect persons from such treatment extends into the private sphere, including where such practices are committed by private individuals.[[36]](#endnote-36) In the case of female genital mutilation (FGM), which encompasses the clitoral reduction and labiaplasty surgeries carried out on many female-assigned intersex children,[[37]](#endnote-37) the United Nations Special Rapporteur on Torture (SRT) has specifically pointed out that where this is performed in private clinics and physicians carrying out the procedure are not being prosecuted, the State de facto consents to the practice and is therefore accountable.[[38]](#endnote-38) We are unaware of any jurisdiction in the U.S. that enforces FGM laws in cases where the child undergoing clitoral or labial cutting has an intersex trait.

1. **State Positions and Safeguards**

*Have any State institutions taken a position in relation to practices of so-called “conversion therapy”?*

*Is there a State position on what safeguards are needed, and what safeguards are in place to protect the human rights of individuals in relation to practices of so-called “conversion therapy”?*

In 2018, California’s legislature passed a resolution expressing the state’s support for the autonomy of intersex people and their right to choose whether to have surgery or other interventions on their sex characteristics.[[39]](#endnote-39) It also called upon the medical community to develop policies and practices to safeguard intersex children from these harmful, non-consensual procedures. This resolution, while a victory for the intersex community in terms of affirmation and awareness, is non-binding and contains no enforcement mechanisms to curtail the practice of non-consensual surgery. In 2019, five U.S. states had legislation introduced that would have prohibited non-consensual and medically unnecessary interventions on intersex children’s sex traits, but none of these bills became law.

**VIII. Conclusion and Recommendations**

Despite international condemnation from bodies including the World Health Organization, Amnesty International, and multiple committees of the United Nations, and the explicit classification of intersex surgery as torture under several frameworks of human rights abuse, the non-consensual interventions inflicted on intersex individuals in the U.S. continue. Because of the similar cultural beliefs underlying these interventions and practices more traditionally understood as “conversion therapy,” as evidenced by the stated aims of interventions on intersex children conveying a preference for gender conformity and heterosexuality, non-consensual interventions on the sex traits of intersex minors should be understood as a sub-category of “conversion therapy” and treated accordingly under any applicable state’s laws. Efforts to protect the LGBTQ+ community from coercive efforts to change sexual orientation and gender identity should be inclusive of intersex children, who suffer both physically and psychologically from medicalized attempts to reinforce their assigned sex.

We accordingly recommend that states take the following measures:

1. Include non-consensual interventions on intersex children’s sex characteristics in enforcement efforts of laws and regulations banning or restricting the practice of “conversion therapy.”

2. Include non-consensual interventions on intersex children’s sex characteristics in prohibitions on state funding of “conversion therapy.”

3. Include non-consensual interventions on intersex children’s sex characteristics in state-led educational campaigns warning families about the dangers of “conversion therapy” and promoting affirming psychosocial care as an alternative.

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