Intersex Persons and the Church: Unknown, Unwelcomed, Unwanted Neighbors

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Abstract

Intersex persons – those born with some combination of male and female physical characteristics – require both sociology and Christianity to take human embodiment more seriously in order to understand better their human experience of self and society. Stories of the lives of intersex persons disclose their struggle with bodies that are physically healthy, yet socially and religiously pathologized, and subjected to medical intervention designed to enforce hetero-normativity. This imposed normalization re-constructs their bodies to be more exclusively male or female, regardless of the painful social-psychological costs to the individual.
Intersex is not uncommon, just largely unknown. Cultural, and originally Christian, insistence on a binary opposition of maleness and femaleness is at the root of Western antipathy toward intersexuality. Recent political activism on their behalf has brought some small social change, but in its concerns about the morality of sexuality, the Christian church is failing to affirm the integrous personhood of intersexuals, and to welcome and love them as neighbors like any others, just as Jesus affirmed eunuchs.

KEYWORDS: intersex, embodiment, medicalization, sex assignment, hermaphrodite, LGBTQI, Christianity

The human world is teeming not only with Durkheimian social facts and Meadian social consciousness, but with raw human bodies. Like all the physical facts of the universe, human bodies are material objects given by nature, but they are also given definition by the cultures created by humans. In short, bodies are enculturated. In this social construction of social reality (Searle, 1995), the facts of nature are given meaning based on how humans use and regulate them. So a river, for example, is defined, used, and ordered as a playground, a transportation route, a disposal dump, a political boundary, a source of hydro power, or a sacred space. The more

meaningful a particular social reality is, the more it is subjected to social control by the imposition of order (Allan, 2012).

Few aspects of human life are more meaningful, ordered, and controlled than sexuality. Western culture has traditionally insisted on the binary opposition of heterosexual maleness and femaleness, and marshalled its medical and religious social institutions, among others, to mandate hetero-normativity. When bodies and desires deviate from these cultural definitions of reality, they are not only defined as disordered, but pathologized and stigmatized. Yet nature has a way of confronting culture that renders even medical and religious definitions of reality precarious, and subject to change. When the raw, undeniable facts of some bodies do not fit the social order into which they are born, something has to give. Those bodies, and the persons who are defined in part by them, will yearn to be liberated from social control.

The academic discipline of sociology inherited classical and Enlightenment mind-body dualism, and has traditionally focused on the cognitive and the collective. Until recently, it has shown only passing, tangential interest in the individual's body, and then only as the object of social action, not the origin (Shilling, 2012; Turner, 2009). After all, it was the mind that was said to distinguish humans from other animals. From the classical sociological analyses of Marx and Weber through to the contemporary analyses of Goffman and Foucault, the predominant theme has been the social control of the body (Malacrida & Low, 2008).

As the sociology of the body gained more traction and sophistication by the end of the twentieth century, Synnott (1993) summarized it as follows: "The body social is many things: the prime symbol of the self, but also of the society; it is something we have, yet also what we are; it is both subject and object at the same time; it is individual and personal, as unique as a fingerprint, yet it is also common to all humanity…. The body is both an individual creation, physically and phenomenologically, and a cultural product; it is personal, and also state property" (p.4). Hence we come to understand that "the body is an enormous vessel of meaning of utmost significance to both personhood and society" (Waskul & Vannini, 2006, p.3).

Turner (2007) has identified four current theoretical perspectives in the sociology of the body. First, as already referenced, is the social construction of the body. Contrary to essentialism, the body is not only a natural phenomenon. Cultural definitions of the body deeply influence personal feelings of desire, pleasure, and pain, and personal assessments of well-being, relationships, and quality of life. Second, bodies are representations of the social relations of power. Legal, medical, and religious institutions compete to have their pronouncements on what constitutes a deviant body taken most authoritatively. In patriarchy, women's bodies are the battlegrounds upon which male power is played out. Third, the phenomenology of the "lived body" is the personal experience of embodiment in the everyday world. Our bodies mean we are always situated in a specific social space within a determinate social reality, "here" and "now." Try as we might with our minds, we cannot be just anybody, because our bodies impose limitations on our self-consciousness and actual lived experiences. Perception can never attain

disembodied consciousness (Merleau-Ponty, 1982). For example, obesity, disability, or terminal disease are physical realities that impose themselves on the self. Fourth, and finally, bodily performance of acquired practices examines how people learn to manage their bodies according to social norms. We learn how to "do gender" (West & Zimmerman, 1987), social class, and all forms of social distinction with our bodies (Bourdieu, 1984). All four of these theoretical perspectives can shed light on the sex, not just the sexuality, of human bodies.

Case Study

In 1966, a baby was born in New York that confused the attending doctors. They could not determine if the baby was a boy or a girl. The baby had a rudimentary phallus and fused labio-scrotal folds, in other words, a small penis and a fused vagina. Medical experts were called in, and they ran dozens of tests, did internal examinations of various orifices and conducted surgery in which the gonads were removed and sent away for further testing. The parents, having had three prior miscarriages and having struggled to conceive again, had prayed for a healthy baby, and told others that it did not matter if it was a boy or a girl. Their prayers were answered – the baby was healthy and robust. Still lacking concrete medical answers as to the baby's sex five weeks after birth, they decided to raise the baby as a girl and named the baby Jackie[1]. Later as an adult, Jackie commented that what her parents had implicitly meant when they prayed was that they wanted a 'normal' baby, not just a healthy one.

Jackie grew up as, in her own words, "a rough and tumble tomboy, a precocious, insecure, tree-climbing, dress-hating show-off." Yearly visits to endocrinologists and urologists, endless medical examinations of her genitals, and her mother's unspoken shame about her 'boyish' behavior generated increasing shame in Jackie about herself. She talked of feeling different, like a misfit, an alien, a freak. And though being a tomboy worked well socially when she was a child, it was less acceptable in adolescence. While her friends went through puberty exploring dating, fooling around and getting hickeys, Jackie's puberty was preoccupied with hormone therapy. She watched in horror from the sidelines, feeling no connection to her own body. All she knew was what the doctors and her parents told her – she was a girl who "wasn't quite finished." That finishing would supposedly come with hormone therapy and a vaginoplasty surgery during her adolescence. However, that left Jackie feeling even more freakish, ever more afraid to let anyone see her body, much less her genital scarring. And all this was enveloped in silence.

As a young adult, Jackie had a fleeting lesbian relationship and found temporary relief in the reassurance it provided. At least she had some evidence that she was not "nothing", "unfinished", or the freak she feared she was. But the relationship was brief and private. Jackie was too afraid to let anyone really 'see' her, because her genitals were just so unusual, so unlike

[1] All personal names in this article have been changed to protect the privacy of the individuals.

other women. So Jackie tried to kill herself. Her suicide attempt was not completed, and she was required to spend three months in a community mental health center.

A few years later, in the process of a routine check of immunization records for a job application, Jackie obtained her old medical records and learned what her parents and doctors had wanted her never to know. The large clitoris with which she had been born was actually a uniquely formed penis that had been removed as part of the vaginoplasty surgery. Jackie was now fully convinced that she really was a surgically deformed monster.

Shortly after, Jackie met Tracey, fell in love, and came out publicly as lesbian. For a while that felt right to her, but doubts crept in. How could she be lesbian if she was a man with a removed penis? Yet she was not totally a man either – she had been born with some female characteristics as well. Jackie felt like an imposter and a fraud no matter what identity she chose. She was hospitalized a second time for depression.

This was followed by a deeper "coming out," this time as an intersex person. She also decided to switch to testosterone instead of estrogen therapy, and took on a male identity, becoming Jack. Jack married Tracy, and they eventually had two children together through an anonymous sperm donor. The relationship with Tracey brought healing to Jackie/Jack's life, but he remained a deeply restless person who faced bouts of self-doubt, self-loathing, and confusion. He never fully settled into any particular sexual identity because there was no room in the social world for what s/he really was – a combination of male and female. Jack talks of looking in the mirror every morning and being reminded of how "outward" outward appearances really are. He sees a husband, father, and computer geek who is looking forward to becoming a grandfather, all the while haunted by the question of what the Y chromosome in only some of his cells really means about his sexuality and identity.

Biological Realities

An intersex person is someone who has physical, gonadal, or chromosomal features that are a combination of male and female. Their sex chromosome is not XX or XY, but rather a different combination thereof (e.g. XXY, XYY, etc.) The gonads, which develop into testes or ovaries beginning at six weeks, are a unique combination of the two in an intersex fetus. Physically, intersex babies have a wide range of various combinations of external genitalia such as a penis and vaginal opening, or a scrotum and labia minora and majora (Creighton, 2001). If the combination of both male and female characteristics exists only in the baby's gonads or chromosomes, it will probably not be noticed at birth, perhaps only at puberty, or quite possibly not at all (Topp, 2013; Gurney, 2007; Blackless et al., 2000).

We do not know how many persons who live out of bi-sexual, gay, or lesbian orientations and identities do so without knowing that they were born intersex. There are approximately thirty types of intersex, and only one of them (Congenital Adrenal Hyperplasia) represents a

physical medical emergency in a newborn child, because it is related to the failure to produce cortisol, which is the hormone that manages stress. In almost all intersex cases, their genital tissues are healthy and without disease. They are generally robust, growing babies, just like most of us when we are born (Intersex Society of North America – www.isna.org).

The rate at which babies are born with both visibly male and female external genitalia, causing medical experts to be called in, is approximately 1 in every 1500-2000 births. However, in many cases, the mix of male and female characteristics is internal (gonadal or chromosomal), and thus unobserved at birth. Unless the child requires medical diagnostic tests for some other reason, numerous intersex babies are not recognized at birth, some are only discovered during adolescence, and others are discovered as intersex in adulthood in the process of non-related medical tests, or during autopsies. If all of these cases are combined, the rate of intersex people is approximately 1-2 of every 100 live births, according to a survey of medical literature from 1955 – 2000 (Zeiler & Wickstrom, 2009; Blackless et al., 2000). We must also consider the likelihood that some never discover that they were born intersex, and, therefore, are not included in these rates. Intersex isn't uncommon….it's just seldom heard of. As comparison, Down Syndrome is present in approximately 1 of every 800 live births in Canada (Canadian Down Syndrome Society), and 1 in every 700 live births in the United States (National Down Syndrome Society). Therefore parents are as likely to have a baby who is intersex as a baby with Down Syndrome, yet public awareness about the possibility of having a child with ambiguous genitalia is much less than it is about the possibility of having a child with Down Syndrome.

Medical Intervention

These infants – part male, part female – are born into a social world that has no room for their physical sexual ambiguity. Their birth is now deemed a psycho-social emergency. Yet despite the lack of threat to their physical health in most cases, the common treatment of intersex conditions recognized at birth in North America in the past sixty years has been to intervene surgically as soon as possible to make them either male or female as much as possible. Moreover, out of stated concern for the person's mental health, professional medical literature has unabashedly advocated misrepresentation, concealment of facts, and outright lying (Dewhurst & Grant, 1984; Mazur, 1983; Natarajan, 1996). This is a classic example of the medicalization of deviance, in which a person's physical condition, not behavior, is defined as problematic and unacceptable, and the person is stripped of control over their own body. Of course, infants routinely lose personal agency in the parenting process, but in this case even the parents lose agency at the hands of the more powerful medical establishment. The child's body becomes a representation of the social relations of power, the battleground upon which institutional power is played out.

Imagine, for a moment, how you as new parents might feel when you are eagerly waiting to hear "It's a boy!" or "It's a girl!" and instead you hear, "…..it's a…..baby." Virtually any time a child is born, if their health presents as anything other than "normal", parents are blind-sided by the experience. If you have never even heard of the possibility that a child might not be clearly either a boy or a girl, the degree of disorientation deepens significantly. The normal procedure in North America has been that medical experts provide the parents with test results and recommendations, and the parents are then asked to make the decision whether to surgically assign the child as male or female. However, recent research reports that many such parents felt a great deal of pressure from the medical experts to choose surgery, even though they wanted to 'wait and see'. Sex assignment is accomplished by repeated and progressive surgical and hormonal interventions that often last well into adolescence. Parents are strongly counseled by medical specialists not to announce the sex of the baby until a decision has been made, and never to reveal the ambiguous nature of their child's genitals. The rationale given for this is that once the sex of the child is selected, it is crucial to the personal and social success of the surgical sex assignment that no one know the baby was actually a combination of male and female. Parents are also strongly encouraged never to tell their child that they were born intersex (Zeiler & Wickstrom, 2009).

Again, imagine how you might experience this if you were the parent. You've never heard of this biological reality of intersex people, thus you have no tools with which to make sense out of a baby that is not clearly a boy or a girl. And rather than turning to your family or community to help you process this disorienting circumstance and decision, you are advised by experts to speak to absolutely no one about it…..for the sake of your child's future. There is nothing you care about more than your child's well-being, yet you are counseled not to confide in anyone that is a part of your, and more importantly, your child's life. The degree of pressure and disorientation is actually almost *un*imaginable.

Recent research interviewing parents of intersex children indicates that, given the highly gendered norms of parenting, they had no idea how to interact with their infant because they could not know if their child was a boy or a girl. In some cases, a medical specialist declared the sex of their baby, only to change their mind a few hours later. In other cases, medical specialists had differing opinions and the parents were left to decide between two conflicting recommendations. Further research exploring specialized medical procedures and interventions of intersex people reveals that when all the testing is done, genital appearance turns out to be the decisive factor in the final decision, because female genitalia are easier to construct surgically than male genitalia – "it's easier to dig a hole than build a pole" (Hendricks, 1993). Because multiple surgeries are necessary to assign maleness – twenty-two in one case (Stecker, 1981) – ninety percent of such infants are assigned as female (Zeiler & Wickstrom, 2009). Furthermore, medical specialists may conceal necessary information from parents, fearing that parents would feel guilt or shame about their child, or that worried parents would not be able to help their children enact

the chosen, surgery-assigned gender identity effectively (Topp, 2013). Intersex children are thus often left to "manage" their bodies unknowingly contrary to how they were born, and to perform bodily the imposed practice of heteronormativity, what West and Zimmerman (1987) termed "doing gender," and Butler (1990; 1993) termed "gender performativity." Said one intersexual who has lived the experience, "we as a culture have relinquished to medicine the authority to police the boundaries of male and female, leaving intersexuals to recover as best they can, alone and silent, from violent normalization" (Chase, 2008, p. 135).

Lived Experience

Intersex adults often report that, as children, they experienced the medical staff and treatment to be focused on righting the 'wrongness' of their genitals, in no small part due to the fact that they frequently underwent medical examinations every couple of months. Though unintended, the message the child hears is that their genitals are greatly in need of repair because they are somehow "broken," "unsightly," and "hideous" (terms used by intersex people). It is difficult to grow up in these circumstances without feeling a deepening sense of shame, further reinforced by the silence and secrecy in which they are asked to live (for example, trying to hide being absent from school in order to have surgery by offering a different reason for their absence). What complicates matters much more is that the vast majority of them have not been told that they were born intersex. Hence, they are left feeling that their genitals are the most important part of who they are, due simply to the sheer amount of attention, time, and energy given to their genitals. Yet they are strongly dissuaded from actually speaking of them. Jim Costich, an intersex person, interviewed in the Canadian Broadcasting Corporation documentary *Intersexion*, remarks with both humor and frustration that "people are NOT genitals. People HAVE genitals!" Many parents go to their graves never telling their children, and many intersex people never learn that they were born a combination of male and female.

Considerable evidence suggests that there has been a major shortfall in information about long-term outcomes in traditional treatments of intersex" (Zeiler and Wickstrom, 2009, p. 361S). Furthermore, many intersex people struggle with, and resist, the sex to which they have been assigned, particularly in puberty when hormones not in accord with their sex assignment begin to direct their sexual desires (Creighton, 2001; Zeiler & Wickstrom, 2009; Topp, 2013). Such was the case with Jackie/Jack, who, though surgically and hormonally assigned as female, felt more like a boy.

As the research of the past decade continues to unfold, there is mounting evidence of patient dissatisfaction with outcomes of medical intervention. A growing consensus maintains that it is impossible to define who needs a clitoral/penal reduction or a vaginoplasty in childhood, because it is not certain that the sex to which the child is assigned will be the one with which they identify as an adult. Rather than being allowed to grow into adulthood to discover the orientation of their gender identity and sexual desires, physical maleness or femaleness is quite literally

forced on them via surgeries and hormone therapies. It has become increasingly evident that surgical sex-assignment has been driven more by ideological commitments than by medical research, that is, by the social and ethical desire to impose a binary model on sex rather than allow for the spectrum of sex and gender that exists naturally in human form. The emotional and social lives of intersex people are complex and frequently deeply tormented because they live in social contexts that insist their sexual ambiguity or bisexuality is unnatural and morally wrong, rather than the natural state in which they were born. This perspective and judgment does not originate with the medical community, but rather is one which they have adopted, becoming a powerful current agent of its enforcement. This exclusively dichotomous perspective is in fact a broader social construction of reality and morality that is not present in all cultures.

Alternative Practices

A cursory survey of the anthropological record further informs us as we consider how we might respond to all of this. Cross-culturally, we see that there have been, and are, other ways to handle sexual identities than our current North American binary model. The Sambia of Papua, New Guinea have a social gender category for a man who, for a time, becomes more like a woman. A *xanith* wears female clothing and has sex with other men, and while some *xaniths* return to standard male roles later on in life, others do not. Among some Native American groups, a *berdache* is a male who opts to wear female clothing, perform female tasks, and engage in sexual relations with either a man or woman (Miller, 2010). A more recent term popularized since the 1990s among indigenous populations is a *two-spirited* person, which refers to any LGBTQI person, and is intended to emphasize the spiritual nature of non-binary gender identities. In India one can find the *hijras* roaming the large cities, earning a living by begging, and offering street performance and dance. They dress and act like women, are born with either male or ambiguous genitalia, and are neither admired nor disrespected – they are simply accepted. Among the peoples of Southeast Asia, a common gender category is the *kathoey*. Usually originally male but dressing and acting as a female, they are a respected third gender that may be either hetero-, homo-, or bi-sexual (Miller, Van Esterik, & Van Esterik, 2010). The Bugis people of Indonesia have five gender categories: 1) men, 2) *calabia* = feminine men, 3) *calalai* = masculine women, 4) women, and finally 5) *bissu* = a perfect combination of male and female that are considered to have special spiritual powers (Paris, 2011). For the most part, there is no way of knowing how many of the individuals in these various gender categories may have been people who were intersex, either visibly, or internally.

Intersex people have also been present throughout human history, including our own Western society. Historically, they have been known as hermaphrodites, a term that comes to us from the Greeks. Various discussions of hermaphrodites can be found in the work of Greek and Roman physicians and philosophers, as well as in early Jewish commentaries on the creation of

Eve out of Adam, where the first human is posited to have been a hermaphrodite prior to being separated into male and female. No attempts were made to alter natural-born hermaphrodites in the Greco-Roman world, though much discussion was given to how to 'manage' them in familial, legal, and religious contexts. European legal history indicates that, prior to the nineteenth century, the individual hermaphrodite him/herself decided which sex they were, and was then required to remain so permanently. Nineteenth-century medical doctors began documenting ever larger numbers of hermaphrodite patients due to the greater willingness of individuals to submit to medical examination. With this intensified attention to sex, gender, and sexual politics of the Victorian era, there was also considerably more obsession with 'managing' hermaphrodite conditions socially, medically, and religiously than was present historically. The twentieth century brought a significant historical transition due to the advent of medical/surgical options which continued into the twenty-first century. Now we are generally no longer socially managing intersex persons, rather, we are attempting to physically eliminate the biological category of intersex people in society through early medical intervention (DeFranza, 2015).

Political Activism

In the past twenty years, intersex people have increasingly been finding each other, forming alliances, and 'coming out,' together resisting current social and medical norms that force them into dichotomous categories of hetero males or females. In 1993, the Intersex Society of North America was formed to "provide peer support to deal with shame, stigma, grief, and rage," and to lobby for respect for "the intersex person's agency regarding his or her own flesh" (Chase, 2008, p.137). Other support groups such as Ambiguous Genitalia Support Network, and advocacy groups such as Hermaphrodite Education and Listening Post (HELP), advance similar goals. They do not want more intersex people to be violated and harmed either physically or psychologically for the moral, social, or religious comfort of others. They want intersex people to have the choice to wait until the natural course of maturation signals to each person how they identify in terms of gender and sexual orientation. Tragically, their advocacy has been met with resistance from the medical establishment, including the American Academy of Pediatrics, which has remained insistent that medical intervention as early as possible is in the best interests of the person (Chase, 2008).

An international joint statement compiled by intersex community organizations now calls for "recognition that medicalization and stigmatization of intersex people result in significant trauma and mental health concerns" (Organization Intersex International). Furthermore, "in view of ensuring the bodily integrity and well-being of intersex people, autonomous non-pathologizing psycho-social and peer support [should] be available to intersex people throughout their life (as self-required), as well as to parents and/or care providers." Like Down Syndrome, intersex is not a disease, disorder, or defect. It is inappropriate and offensive to refer to people with Down Syndrome as "afflicted with," "suffering from," or "disabled by" it. Down Syndrome itself does not

require either treatment or prevention (Canadian Down Syndrome Society). So too with most intersex conditions. Increasing numbers of medical and psychological researchers now suggest that to label intersex bodies as problems to be fixed can, in and of itself, bring forth pathology and create psychological illness in a person who would otherwise have none (Topp, 2013). The largest intersex advocacy group in the world, Organization Intersex International, sees intersexuality as a human rights issue of self-determination, *not* as a medical problem to be repaired.

There is by now some substantial governmental action on these issues as well. Already in 1999, the Constitutional Court of Columbia passed a law restricting the use of surgery to treat intersex infants. In 2011, Australia instituted a passport in which there are three gender choices available – male, female, and indeterminate. The German Parliament passed a law in 2013 that gives parents the option of leaving the gender designation blank on a child's birth certificate, which frees parents to choose against an immediate surgery in infancy that forces an intersex baby toward full maleness or femaleness.

Religious Roots

According to Berger and Luckmann (1966), religion is the most powerful legitimator of the social construction of reality, because it so effectively grounds meaning in a cognitive and moral ethos that explains and justifies notions of reality. In acting as an agent of social control, the medical establishment takes its orders from culture, which historically has been largely formed by religion. Religion thus functions as the ultimate agent of social control, as demonstrated on multiple fronts of society. On the question of intersex, Western culture has taken its cue from the Christian teaching that God created males and females (Genesis 1:27), interpreting it to mean sexual dimorphism, not the two poles of a sexual continuum. This reading appears to be the primary source of Western culture's antipathy toward intersex persons.

For example, Alfred was born in South Africa with ambiguous genitals and raised as male, though no surgical sex assignment was performed. In 1987, he was ordained as a Catholic priest in England, after which he went on to teach theology in various university colleges. He only discovered the full nature of his intersex condition at the age of forty, when he had medical tests, and it was revealed that his hormone levels were predominantly female. He was then counseled to take on a female identity and have his penis removed. He took the name Sara and tried to live as a female. Sara did feel that this fit better than trying to live as a male, but she still did not feel entirely comfortable; living as a female was simply less uncomfortable. However, because Sara refused surgery to remove her penis, she was excommunicated, and told by an academic Christian colleague that "an intersexed person does not satisfy the biblical criterion of humanity, and indeed even that it follows that [you are] congenitally unbaptizable" (DeFranza, 2015). In an interview, Sara, with eloquent dignity, simply said, "I'm not a male; I'm not a female. I'm a person".

In Matthew 19, Jesus teaches about marriage and divorce, and the disciples conclude, with some surprise, that Jesus is suggesting it is better not to marry (v.10). Jesus affirms this understanding as correct while recognizing that not everyone can accept this teaching. Jesus then goes on to list three types of eunuchs. First are those who have been so from birth – this is a term of inbetweenness roughly equivalent to intersex. The second type are those made into eunuchs by others – individuals who had been castrated by someone else, which was a common practice in Ancient Near Eastern culture. These eunuchs who could not threaten or disrupt generational hereditary patterns of inheritance by impregnating a man's wife or daughter, were ideally suited to serve as household managers for the wealthy as a result. The third type are those who had made themselves eunuchs for the sake of the Kingdom. These were men who were not literally castrated, but were celibate in order to focus on the work of the Kingdom – functional eunuchs. Jesus includes himself in this final category. The first two categories of eunuchs were highly stigmatized in Ancient Near Eastern culture, yet Jesus aligns himself with despised eunuchs, *and* he aligns service to the Kingdom of God with eunuchs, adding "let anyone accept this who can" (v.12).

These verses invite consideration of the possibility that Jesus did not exclusively assume a binary model of human sexuality. Jesus aligned himself with a sexual identity other than that of clearly male or clearly female in Ancient Near Eastern culture, presumably because all eunuchs remain whole persons. Irrespective of our own degree of (dis)comfort with this, Jesus frequently made counter-cultural choices, and this situation is no exception. Megan DeFranza (2015) suggests that "we must learn to read the scriptures afresh in order to recover the full humanity of intersex persons and their place in the community of faith, and attend to the lessons they can teach us about the complexity of sex difference so that we can advance our exploration of the theological significance of sex, gender, and sexuality."

Western culture is now becoming increasingly informed about the presence of intersex people as they actively seek social and medical reform, as well as the reality that biologically, human sex is not a binary opposition. If the Christian church, as each of us experiences it, continues to ignore these biological realities, and persists in being the ultimate agent of the social control of bodies, it will continue to be an oppressor of intersex people, rather than the messengers of grace God has called Christians to be, even as the medical community and popular culture at large may come to liberate them. The Christian community must come to accept that intersex bodies are temples of the Holy Spirit within them too (1 Cor 6:19).

Loving Neighbors

The biological reality of intersex people significantly muddies traditional Christian moral, ethical, and theological categories and conclusions, not least because the LGBTQI person in front of you or me may indeed have been "born that way." But complexity, and "seeing through a glass darkly" does not absolve us from authentic, edifying engagement. The second of the greatest

commandments, "like unto the first", remains unmuddied, and intersex persons remain our neighbors regardless of our (in)ability to satisfactorily categorize them theologically. And it is a harmful oversimplification of a complex biological and social reality to pathologize the body of a person who is intersex as a simple solution to our ethical and theological conundrum, by suggesting that they are a de- or malformed person, and not what God intended. We inflict greater wounding when we do so. In talking about eunuchs, Jesus does not dismiss biological sexual inbetweenness as a product of the Fall to be overcome. Rather, he teaches his disciples that they can learn from eunuchs, and instructs them that they should in some way model their lives after eunuchs who do not fit neatly into a male-female dichotomy.

Socially, we have gained increased sensitivity regarding the negative psycho-social impacts of pathological labeling in understanding and interacting with persons with Down Syndrome, the partially abled, and those with various other types of cognitive and behavioral challenges. We would be wise to learn from this regarding the way that we think and talk about intersex people. There are some theologians who suggest that bodily differences, now perceived as impairments, may persist even after our bodily resurrection, just as Jesus continued to bear scars on his hands and feet after his (Eiesland, 1994; Cornwall, 2008). In this light, it is how communities perceive bodies that will be healed, not the actual bodies of persons, to the point that identities of difference that now divide and diminish communal life will no longer do so. Again, we would be wise to learn from this in the way we theologize about intersex people.

What does the Christian community have to say *to*, and *for*, the intersex person? The current, usually dominant discourse surrounding issues of LGBTQI Christians in the evangelical church primarily functions to alienate *all* LGBTQI people (some of whom are intersex), Christian and otherwise. The inadequately informed nature of the public Christian discourse on these issues, and the too often quick and easy applications of the biblical text results in the practice of socially distancing ourselves from all LGBTQI people. And it seems the most intense judgment is reserved for those LGBTQI who dare to claim they are Christians. Whether Christian or otherwise, they are our neighbors whom we are called to love and live within community, yet the message we are sending often sounds otherwise. Families who have intersex members are frequently isolated, silenced, and alienated – alone within the Church. We usually do not even know they are there – but there they are. Let us not presume to pronounce, categorically, what God thinks about their own intersex state, or their intersex child, or their or their child's non-hetero orientation, before we have at the very least heard their stories and become aware of at least the most basic facts about the biological and psycho-social realities they face.

When the search for biblical and theological truth is divorced from basic kindness (not to be confused with politeness) and love (the great overarching commandment), we have lost our way in the most painful way possible. When 'truth' serves to create boundaries around community rather than creating practices of welcome and hospitality, we wield truth as a weapon. History is our witness to the tragically misguided nature and consequences of such

practices. But to even have the opportunity to hear their stories, both the tone and content of the still predominant Christian discourse surrounding homosexuality, and all LGBTQI persons, Christian or otherwise, must change. Or they will continue to remain our unknown, unwelcomed, unwanted neighbor, whom we have shamed into silence, whom we have left standing at the doorstep, alone. The Christian command to love our neighbors as ourselves calls us to a more careful attention to persons as they are found in the real world rather than in the ideal world of philosophical and theological systems (DeFranza, 2015). Let us instead practice the profound hospitality and generous, life-giving love of neighbor that both the Old and the New Testaments require of us.

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