PSYCHOANALYSIS WITH INTERSEX ADOLESCENTS: A PROPOSAL ON HOW TO LISTEN TO THEM IN THE CONTEXT OF CLINICAL SCHOOL

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ABSTRACT

The article starts from the problem of the anatomical difference of the sexes and aims to reflect on how psychoanalysis has allowed us to address the issues that arise in the body, and from the body, in the cases of intersex adolescents. It is a proposal to listen to them in the opposite direction of possible moralistic discursive crossings disguised as scientific, and, on the other hand, in the face of the frequent non-inclusion of the adolescent subject in decisions about their own bodies. We articulate the institutional specificities with those that concern this phase of life, seeking to give voice to a group of subjects that has been little studied. Finally, we reiterate the need to recognize the importance of qualified institutional and multiprofessional support provided in a context of comprehensive health care in university hospitals in which we engage as clinical psychologists.

Keywords: Intersex Adolescent. Sexuality. Body. Hospital Psychology. Psychoanalysis.

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INTRODUCTION

The bodies imprisoned by discourse[4].

Based on our work as hospital psychologists in the context of teaching hospitals, with intersex adolescents, we will open some aspects of our institutional clinic with these subjects, to think about some issues related to this moment of life. We will underline, on the one hand, the difficulties imposed by the crossings of the various discourses that are present in these consultations, as well as our observation that there is an important work to be done so that the adolescent subject is included in decisions that deal with their own bodies. We are aware that our work contains a series of challenges and is confronted with numerous complexities, which we will focus on below.

The institutional specificities were not indifferent to us, nor were the specific needs of the life phase of these subjects. It is important to emphasize that the problem of sexual anatomical difference in intersex bodies raises questions that arise in the body, and from the body, reiterating the importance of listening to the adolescent. Moreover, it is the clinical dimension that gives access to truths that would otherwise remain silenced.

At birth, a body that cannot be characterized as male or female, due to its genital anatomy, poses a series of questions and definitively puts in check the logic of the anatomical sexual binary (penis and vagina). In other words, the arrival of a baby with atypical genitals, when it is not possible to tell whether it is a vagina or a penis when looking and/or palpating (for example, when there is the presence of unseen or non-palpable testicles), puts the definition of biological sex on hold.

WHAT IS INTERSEX?

According to CFP Resolution No. 16 of August 30, 2024, intersex is considered a natural variation of biological sex, which encompasses singular corporeities with congenital sex characteristics, including genital, gonadal, hormonal differences, chromosomal and phenotypic patterns specific, which do not fit the medical and social norms for male or female biological sex, based on the perspective of endosex[5] (CFP 2024 Technical Note).

In the biomedical model, intersex bodies are given the taxonomy of biological sex variations (VBS) or differences of sex development (DSD) which are "congenital conditions in which chromosomal, gonadal, or anatomical sex development is atypical" (LEE; HOUK;

[4] MILLER, J. *Seminar 19: ... or worse*. Title of the last lesson of the *Seminar.*
[5] Endosex: a person who is not intersex.

AHMED; HUGHES, 2006). In addition to chromosomal markers, the development of anatomical sex originates in an undifferentiated gonadal stage, also called indeterminate (undifferentiated and bipotential gonads). A series of genetic, embryological, and physiological factors come into play for the development of typically female or male genitalia. However, a portion of the population has a genital development in which this does not occur, so that in it, the baby comes to birth at a stage that approaches the initial undifferentiated male-female, revealing an atypical sex development (DA SILVA, 2018).

According to Sax (2002), a DSD occurs in 1 for every 4,500 births. It is estimated that among the groups identified and described in protocol format by medicine, – the DDS 46 XY add up to the amount of 1 in 20,000 births, the DDS 46 XX 1: 14,000/15,000 births, with 1:10,365 cases of Congenital Adrenal Hyperplasia (CAH) in Brazil (Silveira; Saints; Bachega *et al*., 2008). The group designated Ovotesticular DSD occurs 1 in 100,000 (LEE; NORDENSTROM; HOUCK; AHMED; AUCHUS *et al*., 2016). UN estimates propose that 0.05 and 1.7% of the world's population (a proportion similar to redheads) are born with some difference in their development[6].

DSDs may exhibit one or more of the following features: atypical genitalia[7] incongruence between internal and external genitalia; virilization of the genitalia during puberty; numerical or structural variants of the sex chromosome; incomplete development of the genitalia; variations in gonadal determination.

Intersex subjects have been seen throughout history from different perspectives, whether moral, religious or scientific, and have been given distinct signifiers that sought to name them according to the time. Telles-Silveira, in his classes on the psychological aspects of intersex people, illustrates this history (for didactic purposes) using the figure below, highlighting the works of Spinola-Castro (2005), Lee and his research group (2006), Cools et al. (2018), the Swiss bioethics letter of recommendation (Swiss National Advisory Commission on Biomedical Ethics NEK-CNE, 2012) and Mauro Cabral (2005) an intersex activist, describing the ways in which we refer to these people over time:

[6] Available at: https://www.unfe.org/wp-content/uploads/2017/05/Intersex-PT.pdf
[7] The presence of atypical genitalia coined the hermaphroditic syntagm to designate people who were born with what was considered an "ambiguous genitalia". It should be noted that the terms hermaphrodite and ambiguous genitalia are no longer used because they are considered stigmatizing.

História

ANTIGUIDADE	IDADE MÉDIA	RENASCENÇA	FINAL SÉC. XIX
MITO DIVINDADE	PUNIÇÃO DIVINA, ENVIADOS PELO DIABO	CURIOSIDADE CIENTÍFICA – ERROS DA NATUREZA	HERMAFRODITA

1896 - ERA DAS GÔNADAS	1917	2006 - 1ST CONFERENCE	2012 Comissão Suíça 2016 – Global Update
DEFINIÇÃO GONADAL DO SEXO	INTER-SEXUALIDADE	DDS – Distúrbios do Desenvolvimento do Sexo	Diferencas/Variações Diversidade no Desenvolvimento do Sexo (DDS) INTERSEXO/intersex

Spinola-Castro, 2005; Lee et al, 2006; Cools et al, 2018; Cabral, M, 2005.

The World Health Organization (WHO) understands adolescence between 10 and 19 years of age. Considered as a transition phase between childhood and adulthood, it is characterized by rapid physical, mental, emotional and social growth and development. In Brazil, the Ministry of Health adopts the term "young people" to refer to the group of adolescents and young people, that is, it comprises the age group between 10 and 24 years of age. Although this definition aims to encompass the specificities of this period of life, it differs from the subjective complexity pointed out by psychoanalysis, our line of theoretical-clinical approach. This difference has its reason for being for the approach we will present, so we now proceed to identify how it is conceptually anchored.

A CONCEPTION OF ADOLESCENCE

In adolescence, the effects of biological variations in sex are not the same as in childhood. For Sigmund Freud, founder of psychoanalysis, adolescence is based on puberty and in addition to the bodily transformations resulting from it, it implies a painful and arduous psychic work: that of disconnecting from parental authority. Alberti (2009) clarifies that from the moment the subject, coming out of childhood, is faced with the real of sex, puberty is the very encounter, unsuccessful, traumatic, with this real. "The real of sex is, by definition, something that can never be fully symbolized, leaving the subject – in the language of common sense – 'speechless'" (ALBERTI, 2009, p. 31). The issues of adolescence are marked by a long work of elaboration of choices and the lack in the Other (ALBERTI, 2004), aiming at "a possible separation of their designs [from the Other] to assert the difference that each subject represents" (ALBERTI, 2023). However, the adolescence of each subject is determined by the history of his life and the accidents of his

path. Mourning the child's body, disconnecting from parental authority and choosing a love object make up a tripod that runs through the entire adolescent journey.

The understanding that adolescence refers to a phase of development to be overcome is postulated based on normative knowledge from psychology and pedagogy and corroborates an imaginary reading of relationships, in which adolescents are seen as "fickle", "temperamental", "too hasty", "they want everything for yesterday", "they don't know what they want". However, the situation is much more complex than these stereotypes may suggest, and should not be generalized.

As clinical researchers, we were able to observe, in the process of decisions about interventions in adolescent bodies, the repercussion of biological sex variation (BVS) in their lives, sometimes highlighting an absence of words to say or a silence in the face of their experiences as intersex people.

WORDS FAIL

Ferreira da Silva (2021), in his doctoral thesis[8], returns to the issue that the subject is constituted in the social bond and its effectiveness takes place through discourses. The articulation of the social bond starts from the observation of the effects of the Other on subjectivity. In other words, the question about his body is evidently in the subject, but not unrelated to the current discourse, that is, what is said about the subject and his condition. If, on the one hand, language is binary and heteronormative, it is also what introduces the dimension of a hole in what is established, that is, one cannot say everything, there is something impossible to say, but it is still said.

It is important to emphasize that the more adolescents have access to information related to their condition, the more they find symbolic resources to construct their own statements. However, in the face of so much information, silence and questioning, it is up to the health team to take care of the **HOW to** say, being attentive to the subtleties and movements of the adolescent himself, understanding whether or not he is able to follow what is said about him. One should not fall into the ledo deception that "the more information the better!". A prudent and ethical clinic should guide its steps by providing the necessary information in the rhythm of what the adolescent can bear and understand according to his interest, understanding that the issue of intersexuality is still covered with a series of taboos, unheard of and invisibilities.

[8] "From the mysteries of the body to the speaker: the psychoanalytic listening of intersex subjects in the hospital context". Thesis defended in the Graduate Program in Psychoanalysis at UERJ in 2021.

A clinical vignette can be illustrative: Vic was grappling with understanding his XY karyotype, when he arrives at the session announcing: "You won't believe it, I read everything about the XX karyotype on Google and I understood everything... but when I got to XY I messed up, you know when you read and you can't know what you read? As if the words didn't make any sense? It was like this..." To which the analyst asks: "And what would you like to do with it?" To which she replies: "Nothing! At some point the words will fall into place!" Another time passes and Vic brings a dream: "I'm in a theater, the actors on stage are of certain genders, but in their bodies I see parts that are not of the corresponding sex, as if men had parts of women, and women, of men..." Later on, he goes on to say: "I found it, I found it, I found the winning sticker, the one that every doctor wants to have!" And what is it?, she is questioned. "My karyotype!" "And what was it like to find him?" asks the analyst. "Nothing much, this is part of a little piece of who I am, today I can understand what it means".

The subject only perceives his own body and the body of the other through a certain symbolization of his desire. It is the regime of encounters that allows me to recognize myself and my fellow man. In this crossing, misunderstandings... For the doctor, the body is a material reality, while for the psychoanalyst the body also contains psychic reality. The analyst addresses himself not only to the organismal body, but also to the body as a drive; to the one who has been invested with symbolic marks, and by the body as a surface on which the self is inscribed (FREUD, 1923/2011).

THE BODY AND THE SUBJECT

Genital anatomy, the affirmation of gender identity and sexual orientation condense the issues related to sexuality in adolescence. And, although they are not dependent on each other, they are confused with each other. When listening to the adolescent statements, it is important to differentiate what is being dealt with in each question presented. With some intersex adolescents, at the time of the awakening of puberty, due to genetic, hormonal or phenotypic variants, secondary sexual characteristics do not develop or develop in opposition to the sex assigned at birth, which seems to make it even more difficult to have a sexual naming of one's own body. In cases of congenital adrenal hyperplasia[9], with irregular drug control, for example, some girls can "virilize", causing the growth of hair, beard, muscles, and deepening of the voice. This sometimes generates an estrangement that remains silent, gains paths of dissatisfaction or dysphoria. Houk and

[9] Congenital Adrenal Hyperplasia is a group of autosomal recessive disorders characterized by impaired cortisol synthesis. Most of these disorders produce some hormones in excess or deficiency, such as glucocorticoids, mineralocorticoids, and sex steroids.

Lee, American physicians, (2012) point out that "dissatisfaction [regarding gender] occurs more frequently in individuals with DSD than in the general population. It is not predictable by karyotype, androgen exposure (AE), degree of genital virilization, or sex assigned, and has not been well studied in relation to social, personal, or biological factors" (p. 29).

In many cases of intersex adolescents, we often observe that the body, more specifically, the genital anatomy, assumes the role of preventing access to the enjoyment of the sexual act. An adolescent, after waiting a long time for the neocolpovulvoplasty surgery[10], upon receiving the explanation of the surgical technique and the immediate post-surgery, in which it was emphasized that she would come out of the surgery with a compressive dressing and with a "tampon" that would be introduced in her neovagina, requiring the use of dilators after removal, immediately asks: "Hey, doesn't it stay open? Are you the ones who take my virginity, then? Because this tampon will take my virginity, right?" Her speech is a witness to this adolescent's unique issues that must be heard and welcomed.

Another teenager, a guy raised as a girl, at the age of thirteen is the victim of an attempted rape perpetrated by three teenagers who locked him in an abandoned shed. An atypical genitalia is revealed and the girl is beaten because "there was no hole". Arriving at the Outpatient Clinic where we worked, having done the karyotype exam (46, XY) and listening to the medical explanations, he reveals that he has always felt like a boy and chooses to change his name and have a *male puberty* mimesis[11]. If the family, in a situation of social vulnerability, at first feels strange, after the words of the doctors, to whom it supposes knowledge, it begins to reframe all the moments in which Claudia[12], who has now chosen the name of Jeferson, "did not look like a girl". The mother recalls how much her daughter always seemed "a street kid" and, in her words, if doctors say that "her sex is a boy's", she believes it. The word of medical knowledge predicts. We must pay attention to the fact that not every XY woman identifies with the male gender, this was the interpretation of this particular adolescent. However, the biological appointments available in culture initiate identifications that often do not go through a choice of the subject.

On the other hand, a teenager sentences: "what is worse about this disease are the people! I walk on the street and people point at me, *curse*, keep teasing... They talk a lot, a

[10] Surgical technique that builds a neovagina from the use of the intestine.
[11] Hormoneization in which you will receive doses of testosterone that your body does not produce.
[12] The case reports presented briefly and with fictitious names mentioned throughout the study were submitted to and approved by a Research Ethics Committee in their ethical and methodological aspects (Plataforma Brasil CAAE 67851017.8.0000.5282), according to the CEP-CONEP system, a process based on a series of resolutions and regulations deliberated by the National Health Council (CNS). agency linked to the Ministry of Health.

lot of nonsense to me. They say I'm not a woman. That I'm a man dressed as a woman... How can a woman with a beard? They ask me all the time. The other day they said I'm that horrible thing... I forgot the name... Remembered! Hermaphrodite. Crosses! Why do they say that about me? I want to disappear from the world", Letícia tells us in her first appointment.

We received Leticia's referral from the medical clinic with the following words: "for God's sake! You have to fix this aberration. A girl with a vagina like that can't do it!" Leticia, who had congenital adrenal hyperplasia[13], at the age of seventeen, presented a picture of intense virilization that included hair, beard, muscles and an "immense clitoris" (*sic*). Leticia had been accompanied during her childhood in the hospital by the pediatric team. However, as a teenager, he interrupted the treatment and returned for the consultation years later. At this point in the consultation, the doctors described Letícia as "psychically blunted" and "very suffering" by "a traumatic perception of herself" caused by her genitalia, considered, in this biomedical context, as the maximum expression of the differentiation between men and women, and whose virilization pointed to a suffering that could only be extirpated by surgery.

When she arrives at the Outpatient Clinic, we find Leticia with well-outlined eyebrows made of henna, false eyelashes, red lipstick, and a low-cut outfit. She only answered the questions asked. He could not explain why he had abandoned the treatment for so many years, nor why he had gone back to it now. However, when alone with the analyst, Letícia was able to talk about her difficulties and tell a little of her story, which at that time boiled down to having a body that did not behave as expected: instead of secondary female sexual characteristics, virilization! This did not cause her suffering, nor did her "gigantic clitoris", she was even married and had an active sex life with "some difficulties in penetration", which "depended on the position". In his words, the suffering came from others, including doctors who took his body variation as "unacceptable". "The world is my trauma," [14]says Leticia.

Gherovici (2019) points out that "the face has the most important role as a marker of the body for gender attribution [...] In most social interactions we see each other's faces, not each other's genitalia" (GHEROVICI, 2019, p. 109-10). Did being a "woman with a beard" make Leticia not feel her body as completely her own? Besides, how could she, so feminine, not be seen as a woman? The question then opens: "doctor, will I be able to have

[13] As previously stated, congenital adrenal hyperplasia is associated with the overproduction of adrenal androgens. At puberty, with irregular drug control, these androgens can virilize the girl.
[14] MOMBASA, J. 2017. Available at: https://piseagrama.org/o-mundo-e-meu-trauma/

a child? Because being a woman is being able to have a child. Take care of this child. To see his son grow and love". We question how much this case shows that we live under the auspices of a gender ideal based on the genitals. In other words, in the antipodes of biomedical conceptions of biological sex, Letícia seems to better distinguish between gender and sex from her own vision of femininity. Leticia's demand for a surgical change seems to be a demand for something that guarantees her possibility of motherhood and not for a genital change.

SOME IMPASSES IN TEAMWORK

The fabric of the listening work within the multidisciplinary team with intersex adolescent subjects is forged in the articulation with social, psychic, sexual issues and technical-scientific-surgical mediation that provides new possibilities of existence. However, it cannot be done without the history of the body taken as abnormal, medicalized, and whose discursive crossings are not without effects on the clinic itself. Such crossings, often violent, appear as a source of intense psychic suffering. In these cases, it is necessary to read suffering without incurring in a modern pathologization, in which adolescent subjects are extremely medicalized, disregarding the sources of suffering, since Freud (1930/2010), pointed out as a triad: coming from one's own body, from external sources and from relationships with others.

A psychoanalytic clinic in the hospital offers a space where these young people can explore their subjectivities without the theoretical and pathologizing exclusion often found in medical and social discourse. Intersex adolescent subjects find a space for elaboration for questions whose answers are not always so simple. Intersex adolescents often arrive at the service with the dead-end answer: "I don't understand what they say about me". Faced with the impasse, in an analytical path, it is verified that it can build better solutions than those offered by the medical-scientific discourse.

The construction of a medical-scientific discourse that legitimizes urgent diagnoses and early clinical and surgical interventions in the bodies of intersex subjects arises *pari passu* with the attempt to eliminate "terms that could cause doubts and/or give the connotation of the individual being or being raised in a sex *incompatible with his diagnosis*" (DAMIANI; GUERRA-JÚNIOR, 2007, p. 1014, emphasis added). The existence of specialized medical-scientific production continuously produces new models of conduct and management of intersex cases, and what we have is a nomenclature "based on increasingly 'technical' terms and with very complex and specific codes" (MACHADO, 2008, p. 112) which often excludes parents, intersex subjects from their own treatment, as well as

prevents the medical team from finding other solutions for the subject in front of them. We start from the conception that, when genital aesthetic surgery occupies the centrality of treatment, it is not possible to meet the health care demands of intersex people, nor to carry out analytical work.

Telles-Silveira (2009), in a study carried out with patients with congenital adrenal hyperplasia[15], states that "when sex needs to be diagnosed", the challenge of putting the doctor's knowledge face to face with that of the patient and/or his family members is present. These different discourses must be welcomed and differentiated, in such a way that knowledge can be heard in its particularities, so that all those involved in this care scenario can feel included and contemplated.

When we take into account that there is no subjectivity that is constituted outside the social bond and that its effectiveness occurs through discourses, many problems become evident: on the side of the physician, who often renounces his subjectivity in the name of the scientific medical discourse (CLAVREUL, 1983), on the side of the families, who do not understand the medical taxonomies, and of intersex people, who are deprived of their histories. Thus, a clinic with intersex subjects is absolutely necessary, because without it one cannot achieve what is at stake for the subject, for his family, for the physicians and for society in general. A clinic that makes us much more collectors of something, than enunciators of an *a priori discourse*, of knowledge.

This article arises from the fact that, given the observations we have just made, given the international movement that opposes actions guided exclusively by the medical-scientific discourse, and given our own anguish aroused in the daily life of this clinic, we are questioned by the fact that clinical protocols for hormonal interventions and early genital surgeries in children born with atypical genitalia are in full swing in the country, despite humanized health care. To the idea that operating would solve all questions, including subjective ones, we superimpose listening to what these questions would be and who these questions would be. In this context, it is necessary to shed light on practices considered established.

THE INTERSEX ADOLESCENT AND THE SCHOOL CLINIC

Every intersex adolescent should be understood as a protagonist in the process of knowing their conditions and/or treatments for health issues, when necessary. This way of approaching the issue of health care has been highlighted in studies on the human rights of

[15] Congenital adrenal hyperplasia (CAH): a condition that, due to alteration in the adrenal gland, virilizes the genital while still in utero.

this population, as shown by the following studies: http://www.yogyakartaprinciples.org, 2007, 2017; Pasterski *et al*., 2014; Leone de Souza, Canguçu-Campinho, Aguiar da Silva, 2021; Schiavon, Favero, Machado, 2020; Leivas PGC, et al., 2023. Much is known about the clinic of endocrinological diseases in the biological variations of sex with regard to pediatrics and adult life, but little is said about the needs of adolescents within the institutional context assigned to their care in hospitals or specialized outpatient clinics. Understanding the institutional context in which all subjects and health providers will be involved is essential for the spheres of care to be effective, understanding the specificities of a clinic inserted in the reference centers of public university hospitals.

We know that the clinic-school outpatient clinics are organized around a turnover of professionals (annual changes of groups of residents, trainees and graduate students), under the compartmentalization of medicine into subspecialties and the division of specialized centers that do not communicate with each other (TELLES-SILVEIRA; KNOBLOCH; KATER, 2015 AND TELLES-SILVEIRA; KNOBLOCH; KATER, 2016). It is noted that the management and organization of specialized health services focus on the way families and adolescents will be communicated, welcomed and listened to within a health facility. Institutional challenges are part of and inherent to the model of public policies adopted and to the health management of specialized outpatient clinics linked to university hospitals in Brazil (TELLES-SILVEIRA, 2016).

It is up to the hospital psychologist to understand the dynamism of the institutional functioning in which he or she will be inserted, as well as to understand issues related to the formation of identity and cognitive, emotional and sexuality development. It is expected that this professional takes into account the contours and limits outlined by this institutional framework so that he can do an authentic and differentiated work from private practices. Being in a University Hospital will require the professional psychologist to be based on an ethics of listening combined with institutional specificities. In other words, the hospital psychologist will circulate around the hospital, offering his listening wherever there is psychic suffering (here, we mean wards, ICU, Emergency Room, outpatient clinics and wherever else he is requested).

Protecting the physical and psychological integrity of children and adolescents requires care in reviewing the modes of communication within the health device, seeking to adapt language to the stages of affective and cognitive development typical of childhood and adolescence. The professional psychologist working in the hospital has the role of understanding how the information was received by the children, adolescents and their families, keeping in mind: 1) What was or was not absorbed in each stage of the follow-up?;

2) What is the stage of the subject's development?; 3) Is the adolescent able to discuss consent to corrective surgery?; 4) Does the adolescent want surgery? (when necessary), and realizes that there is any risk to your health? (when applicable); 5) Is there consonance or dissonance about the assigned sex and gender? 6) Is there the presence of psychological symptoms in which psychic suffering is detected? If so, what are they?; 7) Do the family and the adolescent understand the functioning of the outpatient clinics in which they are inserted? If not, it is up to the hospital psychologist to explain the functioning as a whole, favoring the gain of autonomy of the subjects within the health equipment.

It is expected that the hospital psychologist will pay attention to the fact that there will be a juxtaposition of different knowledge about these bodies, given the multiplicity of medical clinics involved in care. The beliefs, thoughts and hypotheses created by parents, children and adolescents themselves can lead to a confusion of languages between the receiver and the sender of the messages. The place of subjects with desires, conflicts, sufferings and anxieties is lost in the imbrication and convergence of so many discourses and must be cared for by someone within the health team (TELLES-SILVEIRA, 2015).

Producing work **WITH** the teams and not "for" the teams is one of the precautions attributed to the hospital psychologist involved with the intersexuality clinic. It is, therefore, up to the hospital psychologist to make room to listen to the unspeakable, to sustain the anguish of moments of uncertainty, whether of the subject (baby, child or adolescent), of the family, or of the team of which he is a part. An active listening attitude is expected for health promotion.

It is essential to develop a listening work that contributes to reducing the fragmentation resulting from this operating model, taking into account the way the subject is inserted in the institution, the particular forms of institutional organization and the emotional difficulties experienced by families and adolescent subjects (TELLES-SILVEIRA; KNOBLOCH; KATER, 2015). Let's look at one more case: "I was always the most feminine of all the cousins, although I knew I was different from the other girls. [...] When I was little, I had a body that didn't tell me if I was a girl or a boy... It was just weird. When the doctor told me, as a teenager, that I was XY, I felt so bad that I don't even like to remember. [...] I wanted a perfect neovagina."

These phrases were said by Danila[16], one of the first intersex teenagers we treated at the hospital. Danila was born with atypical genitalia and did not undergo any early surgical intervention. She was raised as a girl in the most complete family silence about the

[16] Fictitious name. However, it retains the patient's unusual feminine name in relation to the names considered typically Brazilian feminine.

issues related to her genital anatomical variation. As a teenager, when she encountered the sexual issues that usually mark this moment, she found that, because of the vagina she had, "not even a cotton swab passed", as she told us. She began to see death as the only solution to her "problem", which she always faced "absolutely alone". That is why she had been operated on in another hospital, in fact, twice, to build a neovagina that, in her words as a teenager, had become "horrible-looking". On the occasion of these two surgeries, the cytogenetic test was performed to define the chromosomal sex, leading the doctor to conclude that his karyotype was 46, XY7, which he would have translated using the following words in the conversation with Danila: "that means you have a boy in you"!

When she arrived at our hospital, she was already eighteen years old and came to medical care with three very clear demands: she wanted a perfect vagina, no longer having to use the mold she wore 24 hours a day as a way to avoid surgically opening the vaginal canal and, her greatest desire, she wanted to get rid of a "giant clitoris" to be able to "wear a bikini without that volume showing". She emphatically said that she wanted a "perfect neovagina". After a year of follow-up in a multidisciplinary team, she was reoperated and, in her words, she had obtained what she considered a "better neovagina than the one I dreamed of". However, "this perfect future was not ensured by the scalpel" (MAFFIA; CABRAL, 2003, p. 88).

In the postoperative period, Danila began to be monitored in the office, however, we noticed some important issues that made us understand the need to reinsert Danila into a multidisciplinary care team, such as: the need for follow-up due to post-surgical complications, the hormones she was taking irregularly, a sadness in the face of the biological diagnosis that she had never understood and that, she even confused it with the issue of transsexuality, in addition to physical health care that Danila had neglected with the justification that she never wanted to go back to the hospital.

During the period in which the patient was away from the hospital, she had begun to limp, stopped eating and complained of enormous sadness. In fact, the "perfect vagina" could never solve all the impasses of a subject. However, it became evident during the consultations that the patient knew very little about what was going on in her condition of biological sex variation (VBS). Danila's case points out that, when we do not choose, we are not in the position of subjects. There is only a subject when there is a choice. However, in order to choose, the subject himself must have the necessary information, and not only that, but understand what he is told. When he does not understand, he is not the one who chooses.

From her return to the pediatric and adolescent outpatient clinic, and not adults, as she had been referred, Danila was able to talk again with several specialties, which was of enormous importance to the patient. Access to medical explanations about her own body proved to have been a fundamental condition for the patient's treatment, including from a psychic point of view. However, these conversations were not so simple, because there was a gap between what the patient wanted to know and what the doctors were able to tell her.

At this moment, we acted in order to help the patient to formulate her questions and, upon receiving the medical answers, to interpret with her what was a limit of medical knowledge and, also, to recognize what they said as something that helped her to situate herself in her own history. In order for this communication on the part of the team to take place, it was also necessary to work with the doctors. It is not evident to include the lack and absence of answers in a scientific discourse traditionally averse to the impossible to know.

The transition of intersex adolescents to adult outpatient clinics should be a priority in care, and should be planned, discussed and cared for among health teams. This care should be planned in stages so that the intersex adolescent subject can take ownership of his or her health history. We even found that there is often a leap between pediatrics/hebiatrics and adult care, leaving adolescents without their own space to deal with their specificities. We emphasize that this moment can contribute to the teams understanding what the adolescent understands or does not understand about what is happening to his body and what he needs as care. However, our clinical experience witnesses the occurrence of young people who arrive at adult care services totally dependent on their parents, carrying with them copies of their medical records (which they often do not understand), or with referral letters written in encrypted form by their pediatricians.

One day, Cássia, another teenager, sent an audio message, in tears, to the psychologist, after picking up a copy of her medical record at the pediatric hospital. She said: "There are so many acronyms, so many exams, I don't even know where to start, they handed me a Pandora's box! I'm alone and confused..." We told her that we would see each of the written sheets together and that most of what was there, she had heard at some point in her life, and that she would be surprised to know much more than she thought.

The literature points to the fact that transitions made without careful referral can lead to an increase in emotional symptoms, bringing difficulties in various areas of relationships in life, whether in love partnerships, or in the search for autonomy and employment.

Improper transition directly interferes with treatment adherence (TELLES-SILVEIRA *et al*., 2022).

Adolescents inserted in medical contexts show what is disruptive in adolescence, as the transition from childhood to adult life raises new questions. We know very well that we are in a shaky, rather complex territory, and that we must not immediately give in to the appeal of the technological and scientific imperative that seeks to capture and model bodies (ARÁN, 2009). Psychoanalysis recognizes the place of inscription in the singular history of each subject, however "to leave to the individual the inevitable confrontation with society and its prejudices, its ideological and political limitations is to evade a social responsibility" (PORCHAT, 2014, p. 78). In the face of the Other who vociferates standardized responses, asserting the subject is the policy of psychoanalysis. However, the insertion of psychoanalysis in the field of public health engenders challenges, to the extent that interventions are thought of on a case-by-case basis, in singularity, in order to make the discourses rotate. In addition, the unique inventions of each intersex adolescent subject cannot be standardized, nor standardized. They point to subjective criteria that are often not quantifiable.

Access to health, in the case of intersex subjects, has problems that are sometimes dramatic due to the intensity of the moral values at stake, in addition to the prejudice expressed, both socially and institutionally. According to Butler (2018), sexual norms "undo" the subjects. This implies, on the one hand, that some people, in order to have social recognition, need to get rid of what they are; On the other hand, some are undone because they do not have this recognition, they lose dignity as human beings. Intersex is the paradigm of this identity paradox, to which is added invisibility (SANTOS, 2012). The clues found in this clinic, at the same time that they invite us to think about the *socius*, do not cease to show us that the subject only asserts itself in the one by one, in the radical affirmation of its singularity.

FINAL CONSIDERATIONS

"Intersex bodies help us realize that there is always something that escapes what is symbolized and naturalized in culture" (PERELSON, 2018). The issue is evidently in the subject, but not unrelated to the current discourse. In this way, a clinic with intersex subjects is absolutely necessary, because without it what is at stake for the subject, for his family, for doctors, and for society in general cannot be achieved (FERREIRA DA SILVA, 2021).

Adolescence clearly demonstrates the weight of the effect of discourse established beyond the size of the body. An example that "the social is the subject of the individual"

(FREUD, 1921/2011). It is not everyone's problem. The question that each one asks about his own sex and what discourse he will say about it is inseparable, even if the subject puts himself in a position to contest it. Anatomy is not destiny, nor does the construction of a genital anatomy considered "normal" point to the guarantee of a "perfect future was not assured by the scalpel" (MAFFIA; CABRAL, 2003, p. 88).

Our clinic, based on an ethics of sexual difference, "of desire beyond the normative ideologies of sexuality" (GHEROVICI, 2019, p. 101), seeks to send the decision back to adolescents, so that they can take responsibility for their stories. Understanding, however, the weight of the social fabric and how much prejudices delegitimize existences. We support a psychoanalytic clinic in the institution with an ethical-political orientation. Within the various vicissitudes that may arise, we know that it is in adolescence that the question imposes itself on the subject: what to do with what they have done to my body?

In addition, we think that the institutional and, above all, social approach should be considered in an intertwined way in interventions, promoting holes in blunt knowledge, provoking reflection in the medical profession that repeats social patterns and has deep-rooted moral prejudices. We must not overlook the fact that there is a social gulf between those who provide assistance and those who receive it. This type of hiatus can cause what Letícia experienced on her skin, when she was seen with monstrosity, when she had all her female insignia, seen by the analyst, made invisible to the medical team. Let the adolescents speak and, if possible, that we can help the health workers to listen.

The case reports presented briefly, with fictitious names and with all ethical care for the anonymity of these adolescents, point to the need to recognize the importance and even the need for institutional and multiprofessional support in a context of comprehensive health care. As clinical psychologists with psychoanalytic training, we verified the importance of a discursive operation that includes the transmission and support of the speech of each subject – both users and their families, as well as team members – in order to make the possibility of creating another discourse where decisions are made. It is in the discursive dialectic that a new discourse can emerge. A discursive operation that includes the transmission and support of psychoanalysis, making another discourse exist where decisions are made. The impossible to bear for the subject, proper to psychoanalysis, and the impossible to bear for the social body, are mixed in this clinic. There is a need for openness to diversity, otherness and commitment to human rights. As psychoanalysts, we were led to dialogue at the political and clinical level, to position ourselves in the democratic debate, to enunciate where we are talking about and to sustain a discursive intervention in the real of social ties.

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