



The International Journal of Psychoanalysis

(1964). *International Journal of Psycho-Analysis*, 45, 220-226

A Contribution to the Study of Gender Identity¹

Robert J. Stoller

Gender identity is the sense of knowing to which sex one belongs, that is, the awareness 'I am a male' or 'I am a female'. This term 'gender identity' will be used in this paper rather than various other terms which have been employed in this regard, such as the term 'sexual identity'. 'Sexual identity' is ambiguous, since it may refer to one's sexual activities or fantasies, etc. The advantage of the phrase 'gender identity' lies in the fact that it clearly refers to one's self-image as regards belonging to a specific sex. Thus, of a patient who says: 'I am not a very masculine man', it is possible to say that his gender identity is male although he recognizes his lack of so-called masculinity. The term 'gender identity' was arrived at in joint discussions of a research project on this and allied problems by Greenson and Stoller during which many of the formulations in this paper were worked out. Gender identity seems to be produced in normal human beings by the following elements: first, the anatomy and physiology of the external genital organs, by which is meant the appearance of and the sensations from the external, visible, and palpable genitalia; second, the attitudinal influences of parents, siblings, and peers. Whether these consider a child a boy or a girl will ordinarily play an extremely important part in establishing and confirming the gender identity. To these two determinants, those usually stressed when identity is discussed in terms of maleness or femaleness, is to be added a third. This third is a biological force, which, though hidden from conscious and preconscious awareness, nonetheless seems to provide some of the drive energy for gender identity.

Throughout his writings Freud (e.g. 1905), (1937) never abandoned the position that biological forces were an essential though unmeasurable part of personality development. He was not able, however, to investigate these forces further because the clinical material with which he worked was not appropriate. The present paper is an attempt to reopen this issue, for it is possible to gain insight into these forces by clinical examination of certain patients who seem to demonstrate their influence with unusual clarity. It would be of value, if any of the above three variables were removed or changed during normal development, to see in what way its absence distorted the process. This does occur. Intersexed persons—those who for genetic and/or constitutional reasons have defects in the appearance of their external genitalia or a strong shift in secondary sex characteristics towards those of the opposite sex—provide 'natural experiments' which permit us to study, in purer culture than is possible in the anatomically and endocrinologically normal, the variables responsible for this development. Most intersexed patients develop the gender identity appropriate to the sex that is ascribed to them at birth (Money et al., 1955), (1957). Thus, if the parents are not aware of the intersexuality and bring the child up as a boy, he will feel himself to be a boy, regardless of his biological status. There is no acceptable evidence in the reported cases that the latent genetic and biological forces exert any influence; the processes of psychological childhood development suffice to explain the resulting gender identity. However, among the intersexed patients I have seen are rare individuals in whom neither the external genitalia nor the gender role assignment and attitudes of the parents determined the individual's gender identity, but in whom some other factor seemed to be of decisive importance and overrode both these considerations. This other factor, assumed to be biological, will be demonstrated in the reports of two such 'experiments'. These patients were trying to maintain that they belonged to a certain gender despite the fact

¹ Presented at the 23rd International Psycho-Analytical Congress, Stockholm, July–August 1963.

² Associate Professor of Psychiatry, University of California School of Medicine, Los Angeles, California.

that society disputed this claim. The patients in question had arrived at a gender identity in a way opposed to that which is general in society. For example, although they had the external genitalia of one sex and the bringing up appropriate to that sex, they still felt certain that they belonged to the other sex. This certainty was not for the purpose of enjoying sexuality; they were not primarily interested in obtaining sexual gratification, nor did they come for treatment because of inability to obtain it. They wanted help because of their impelling desire to be granted the right to belong to the sex they felt was theirs. They were remarkable in that their speech, posture, gestures, walk, and other behavioural

evidences of gender identity were in accord with their own psychological conception of their identity, though in flagrant contradiction to their anatomical structure. These patients did not caricature male or female behaviour or attitudes as one so frequently sees homosexuals and transvestites do. It was clear to all who observed them that these patients had the capacity to behave as we ordinarily expect a masculine man or a feminine woman to behave.

Clinical Material

Case One

The first patient to be described is a child who was found at birth to be an apparently normal female and so was brought up as a girl for fourteen years. When the child was born, the external genitalia seemed to be in keeping with what is expected of a normal girl. There was not even the appearance of an enlarged clitoris, a common enough normal variation in females. The physician and parents had no hesitation in considering the child a girl, and she was so named and brought up. Within a few months of her birth, however, her mother was already having difficulty. The baby was active and forceful, while her mother, a graceful, feminine, neurotically masochistic, perfect 'lady' increasingly despaired because her daughter was so lacking in gentleness and so much in opposition to many of the feminine qualities the mother wanted to bring forth from her daughter.

The mother talked of her daughter's infancy and childhood: 'The child ate so fast. It wasn't like a little girl, but at least it wasn't a big fuss over every meal. There was no colic. As a tiny baby she moved too fast. She did everything crash! bang! nothing gentle, yet because she ate well and slept well she was a good baby. But there was still the feeling in me—no one else. They all thought I was just very young, and I was worried for nothing. She didn't rebel about eating, but that seemed rather gluttonous to me, like a little animal just eating—and playing wildly. I don't recall her ever sitting down with a book, except to take a magazine and fling it over the floor and look in the pages and page through and tear it—violently. Not to hold the book as if it was something beautiful to see, but as if it was something to destroy or throw away. The bicycle seemed not a thing of pleasure but something to get as far and as fast as possible.' (When you use the word 'violent', how far back in her life do you feel that it applies?) 'About one. When she was put out to play on the sidewalk with the other children, she played with a neighbour boy and they played very much alike. So I thought, well, here is a fellow human being. It dissatisfied me. I wanted a girl—but here she was a—. I never figured out if I was hostile to her or she was hostile to me. There was just nothing.'

(What didn't she give you?) 'She seemed to take the food and go to bed. I couldn't play with her. That's what I was crying about the day I was looking at her, as a tiny baby. I was trying to play games and sing songs. There was nothing I could do for her. It was just as if I wasn't even necessary to her.'

Thus it can be seen that from the very first something was going wrong between mother and child. The rest of the child's development proceeded as if according to plan, but not the mother's plan. In all games with other children the child seemed to take male roles. Her bicycle was her pride and joy and was constantly kept polished. She could scarcely be forced into girl's clothes. The family finally compromised and permitted her to dress as a cowboy or in jeans and T-shirt, except on rare occasions such as Christmas or Easter, when she grudgingly consented to wear dresses. Her companions were boys, with whom she played boys' games—hiking, jumping, exploring, football. In the course of these she was bruised and cut, continually tearing her clothes but never complaining, enjoying the roughness and anxiety of these games. She did average work throughout school but well below what psychological tests had measured as her potential.

As the years passed, her mother bribed, threatened, and when allowed by her, loved her in continuing attempts to get the child to dress, walk, sit, talk, think, feel, and otherwise act as

- 221 -

a feminine girl. The great effort failed. The hopelessness produced was only partly eased by three subsequent babies, two boys and a girl, all of whom had intact gender identities.

When adolescence approached and her girl schoolmates began to sprout, she became quiet. At this time she developed a cold with a hoarseness that persisted. Because of this change in voice she withdrew in great embarrassment from all social contacts and wanted to drop out of school. A physical examination made at this time raised doubts shortly to be confirmed at the medical centre. When the enquiry was completed, it was revealed that although the external genitalia looked the same as those of a normal girl of her age, she was in fact a chromosomally normal male with a fully erectile tiny penis of clitoral size, hypospadias, bilateral cryptorchidism, bifid scrotum and normal prostate. Just before the final confirmation by the urologist and by the chromatin staining techniques, the child was first seen in

psychiatric consultation. In her bandana and dress she looked grotesque, and yet this was her usual appearance, for she had been told for fourteen years that she was a girl. Since she was so obviously miserable when dressed as a girl, since she had such a tremendous desire to be considered a boy, and since the anatomical and laboratory tests indicated that she was unequivocally a male, it was decided to tell her she was a boy. While this was done with some trepidation, it seemed there was more danger in not telling her. So she was informed of her proper sex in a straightforward manner. It had been expected that she would react to this information with intense affect, and so the lack of impact the information seemed to have on her was striking. It must be stressed on the other hand that neither was there any pathological absence of affect. She acted as if she were being told something of which she was dimly aware and had no doubt. She did not have the sense of relief of someone who had struggled to prove a point, or the sense of triumph of one who has fought against great opposition, or the sense of shock of one given some astonishing information. Rather, her attitude was as if to say, 'Yes. Very good. Thank you. I am not surprised.' This poised and well integrated reaction was confirmed by the patient's behaviour. She went home, took off her girl's clothing and became a boy, immediately beginning to behave like other boys in the community. This was confirmed when the child was seen a few days later, and in the two years that have followed there has been no reason to change this opinion. The family, understanding some of the complications this might make in the community, moved to another neighbourhood where they were unknown. He was accepted fully at a new school, where his past history was not known. He takes part in sports as an equal with other boys, has close friends among boys who have no doubt that he is a boy and about whose own masculinity no doubts have been raised. He goes on dates with girls; he is attractive to girls; he is attracted to girls; he has no difficulty in getting dates; he is capable of intense sexual feelings towards girls; he has orgasms with ejaculation either from wet dreams or genital masturbation, in both of which his sexual objects are females (as they were before he was told he was a boy). He has the typical concerns, pleasures, and interests that are found in boys who have been brought up without any ambiguity about their gender identity. He is tall, well built, good looking, with no effeminate mannerisms or vocal expressions, and with no hypertrophied masculinity either. Significantly, he has passed from being a mediocre to an excellent student. For example, he is among the first in his class in mathematics, a subject in which he did very poorly when he thought he was a girl. He has developed for the first time an affectionate and understanding relationship with his mother and now treats his father openly as a rival. Parenthetically, it may be remarked that this has had some interesting repercussions on the family, but that is not the province of this paper.

An area of great concern has been his embarrassment in undressing in the presence of other boys because of the absence of a penis. He has undergone several surgical procedures to bring the testes into the scrotum and especially to attempt to construct a penis. These operations, which he has accepted stoically because of his high motivation, have not yet succeeded in producing a very successful penis. Despite the very severe disturbance in mutuality from birth onward, not only is this child not psychotic but he is remarkably free from neurotic signs and symptoms. However, during his first fourteen years he gave the distinct appearance of being severely maladjusted in certain important areas of his life but within no clear-cut diagnostic category. This disappeared instantly with the change from being a girl to being a boy, and it must be considered to have been a reaction against a reality situation, not

- 222 -

inner conflict. This child, who dealt with the world as if he were a boy, though apparently in a female body and treated by everyone as a girl, reacted 'neurotically' to this external pressure. Before the change, the child was shy, had few friends, and was chronically moody, irritable, and somewhat depressed. However, when told that she was a boy, the symptoms of the supposed neurosis completely disappeared. It might be expected that such a momentous change in the life of a child would have led to psychological reverberations; it has not been possible, despite the many hours spent with the child, his father or his mother, to discover any neurotic symptoms beyond the range of the normal emotional variations of healthy people in our society. It appears that what was momentous for the investigators was not so for the child. Somehow, preconsciously, the child must always have known his true gender identity and has had no doubt about it. Being told he was a male only confirmed to him that now the world was no longer opposing something in him. Thus there were no reaction formations, denials, ruminations, or the excessive doubting that one would expect in a person in conflict about his identity. He only reacted as though the world had come to its senses. Although he would seem to fit into the category of those rare people who have no difficulty in shifting their gender identity from one sex to the other, this of course is not so. He never did shift his identity. He always felt (though not

consciously) that he was a male. He did not shift from female to male, but only had the rights of maleness confirmed by society.

Discussion

In order to understand better the development of this child and his remarkable ability to maintain a fundamental sense of maleness in the face of overwhelming pressures from his anatomical structure and from the meaningful environment, it would be well to put aside the clinical data for the moment and consider further the elements which go to form gender identity. Most discussions of this problem concern themselves with the consequences of castration anxiety and penis envy. Relevant as these are for understanding some of those patients who later in life develop internal conflicts about their gender identity, such problems as castration fear and penis envy are not in my opinion relevant to the discussion of what contributes to the formation of the earliest aspects of gender identity. By the time of the phallic stage, an unalterable sense of gender identity—a core gender identity ('I am male', 'I am female')—has already been established in the normal person. While later, as a result of conflict, the boy may have doubts about his maleness or even may say 'I wish I were female', this still implies that he knows he is male but would rather it were otherwise. Thus we can say that the core gender identity remains unchanged throughout life; this is not to say that gender identity is not constantly developing and being modified, but only that at the core the awareness of being either a male or female remains constant. This core gender identity is produced, starting at birth, by three components. The first of these is the contribution made by the anatomy of the external genitalia. By their 'natural' appearance, the external genitalia serve as a sign to parents that the ascription of one sex rather than the other at birth was correct. Then too, by the production of sensation, the genitalia, primarily from external structures but in females additionally and dimly from the vagina, contribute to a part of the primitive body ego, the sense of self, and the awareness of gender. The second component, the infant-parent relationships, is made up of the parents' expectations of the child's gender identity, their own gender identities, the child's identifications with both sexes, libidinal gratifications and frustrations between child and parents, and the many other psychological aspects of pre-oedipal and oedipal development. The third component is the postulated biological force.

On turning attention back to the patient described above, we find that much of the previous discussion of the sources of the sense of gender identity does not apply. First, the child's anatomy did not give the visual confirmation of maleness nor was there a penis or a scrotum with testes to produce genital sensation. Second, the child's development defied the parental attitudes. Yet there was an overpowering drive unalterably and continuously thrusting this child towards maleness. While it is true that problems may arise in certain people postponing the development of core gender identity or leading to grave problems or doubts about their gender identity, this child practically from birth on gave unmistakable indications of a force at work which was powerful enough to contradict his anatomy and environment. It was of such magnitude that even the absence of male genitalia did not raise significant doubt in his

- 223 -

unconscious mind as to his maleness. This force was also strong enough for him successfully to withstand the 'temptation' to submit to the entreaties and seductions of his parents to adopt a feminine attitude. There appears then to be evidence of a third component producing gender identity which, variably powerful in most humans, is usually hidden silently behind the effects of postnatal psychological influences. This force has as yet not been demonstrated by endocrinological or neurophysiological studies, though musculo-skeletal development, height-weight ratios, etc. in children are suggestive of such gender differences (Bayer and Bayley, 1959). It may in part be made up of interrelated hormonal thrusts such as occur in the foetus to differentiate the Wolffian (male) from the original Mullerian (female) structures found indistinguishably at first in both sexes (Jose, 1958). Some day, such a force may be found to be the algebraic sum of the activities of a number of neuroanatomical centres and hierarchies of neurophysiological functions. At present we cannot be so specific.

Is it really necessary to invoke a biological force to explain the data? There may instead be errors in the data themselves. How can we tell that this is not a child, like many others, who, in a pathological relationship with its mother, has developed a very masculinized gender identity? The world abounds in 'butch' homosexual women. Then this child would be one of these, with the additional non-contributory coincidence of being biologically male. Unfortunately, a critical part of the argument is not available to the reader, and there is no easy solution to this defect. The missing part is the appearance and behaviour of the child. It is here, in the clinical data, which must be seen at first hand, that the calm,

sure masculinity of this child shows itself in glaring contrast to the 'butch'. It is important to emphasize that no one who has seen the child—either in the research team, or his family, friends, teachers, or strangers in society—questions his masculinity or his certainty of being a male.

A second possible source of error lies in the lack of detailed, psycho-analytic data which would reveal the parents' true attitudes during the early years of rearing the child. May they not have unconsciously influenced his gender choice from birth on by their own hidden needs and attitudes? Mothers in psycho-analysis reveal that what they really felt and did to their infants is quite different from their conscious memories of those events. Since we have no analytic data from the child's mother or father, we cannot say in what ways they may in fact have in a hidden manner influenced his gender choices. Nonetheless, while these parental attitudes are known to be important in producing homosexuality and other perversions, they do not produce an intact core identity that contradicts the evidence of genital anatomy, so that in the face of all apparent evidence to the contrary, a child would know (rather than only wish) that she is a he. One or both parents may wish consciously or unconsciously for a child to be of the opposite sex. When this attitude is expressed pathologically, the parents may permanently damage the gender identity of their child. The child that results, however, does not have the unequivocal, solid, unimpaired gender identity that this child has. Transvestites who claim to be females trapped in male bodies are common enough, but their core identities have so many openly bisexual components that these people clinically look very different from the patients here discussed. In addition, such parental attitudes contribute not only to equivocal gender identity but to subsequent neurotic or psychotic symptomatology. This is not present in this child. While he was neurotically disturbed as a girl, this immediately disappeared the day he changed to a boy. None of the symptoms have recurred in the two years following. If neurosis is per se evidence of deficiency in the functioning of ego structures, how were these deficiencies so instantly remedied? One wonders what part core gender identity plays in the aetiology of neuroses and psychoses. Can a very strong biologically reinforced sense of gender identity help protect one from neurosis or psychosis? In this child, an examination of his mental status at any time during his 14 years as a girl would have revealed a neurotic character structure. Yet all along, although latent, very strong ego functions existed. One also wonders how these strong ego functions could have developed and persisted in the face of a continuing bad relationship with mother, severe 'homosexual' temptations, traumatic relationships in society, etc. Why was he always unconsciously sure of his masculinity when everything in the outside world contradicted it? How did he for years prepare for a masculine life—silently, unremittingly, and successfully—so that he was able immediately to be a masculine boy when given permission?

- 224 -

This concept of a biological force would seem to be controversial. Although many analysts accept a constitutional biological factor in all sexuality, libidinal development, and personality development it is not likely that they would have accepted a thesis that in certain patients this biological force is the decisive factor and that in fact it can even override anatomy and the parental influences. However, if this thesis is correct, then the normal development of gender identity may be as follows:

A sex-linked genetic biological tendency towards masculinity in males and femininity in females works silently but effectively from foetal existence on, being overlaid after birth by the effects of environment, the biological and environmental working more or less in harmony to produce a preponderance of masculinity in men and of femininity in women. In some the biological is stronger and in others weaker. The case that has been discussed would fall in the former category. Had he been born with normal-appearing external genitalia, he would have grown up unnoticed as a masculine boy. This line of reasoning tends to confirm what many have suggested, that extremely effeminate men and masculine women (e.g. transvestites) are the result of an unhappy combination of a weaker biological push toward proper gender plus noxious effects of environment (e.g. a special type of pathological mother-infant relationship).

This is a heavy burden of speculation to hang on a single case. So it may be well to indicate with a brief summary of another patient that, although rare, other people do exist in whom a need to belong to the gender opposite to the only acceptable one was substantiated by biological criteria.

Case Two

Until the age of 17, this child was a boy. However, at puberty, he developed all the secondary sex characteristics of a girl, including full breasts, feminine-appearing waist and buttocks, female hair distribution with absence of facial hair, peaches and cream complexion, etc., all in the presence of a normal-sized penis and testes. From the beginnings of memory at age 3 conscious fantasy life consisted completely of playing at being a female. In adolescence, because of the very feminine appearance

which had to be disguised, the patient became more and more withdrawn, finally at the age of 17 giving up the battle by changing to a female. She has since that time lived completely as a female undetected by either females or males.

At the age of 20, the penis and testes were removed and an artificial vagina created. Pathological examination of the testes revealed them to be the source of large amounts of oestrogen produced since puberty when the feminine appearance developed. However, what is inexplicable is the prior history of a feminine identity. So we again fall back on the biological 'force' to explain the fact that the core gender identity was female, despite the fact that the child was an apparently normal-appearing boy and was also genetically male.³

SUMMARY

In addition to the anatomy of the external genitalia and the infant-parent relationships—the more easily observable components in the production of gender identity—there is a third, usually silent component: a congenital, perhaps inherited biological force. In the normal, the three work together in the same direction to produce an intact core gender identity, a fundamental awareness of being male in males and of being female in females. In anatomically intersexed patients where one or both of the observable components is absent, the effects of the silent biological force are occasionally uncovered and then can be seen. Cases are presented in which this occurred.

REFERENCES

- BAYER, L. M., and BAYLEY, M. 1959 *Growth Diagnosis* (Chicago: Univ. of Chicago Press.)
FREUD, S. 1905 *Three Essays on the Theory of Sexuality*. S.E. 7
FREUD, S. 1937 'Analysis Terminable and Interminable.' *Contemp. Psychoanal.* 5
JOST, A. 1958 'Embryonic Sexual Differentiation.' In: *Hermaphroditism, Genital Anomalies, and Related Endocrine Disorders* ed. H. W. Jones, Jr., and W. W. Scott. (Baltimore: Williams & Wilkins.)

³ This case is reported in more detail elsewhere (Stoller et al., 1960), (Schwabe et al., 1962).

- 225 -

- MONEY, J., HAMPSON, J. G., and HAMPSON, J. L. 1955 'An Examination of some Basic Concepts: The Evidence of Human Hermaphroditism.' *Bull. John Hopkins Hosp.* 97
MONEY, J., HAMPSON, J. G., and HAMPSON, J. L. 1957 'Imprinting and the Establishment of Gender Role.' *Arch. Neurol. Psychiat.* 77
SCHWABE, A. D., et al. 1962 'Pubertal Feminization in a Genetic Male with Testicular Atrophy and Normal Urinary Gonadotrophin.' *J. Clin. Endocrin. Metab.* 22
STOLLER, R. J., GARFINKEL, H., and ROSEN, A. C. 1960 'Passing and the Maintenance of Sexual Identification in an Intersexed Patient.' *Arch. Gen. Psychiat.* 2

- 226 -

Stoller, R.J. (1964). A Contribution to the Study of Gender Identity¹. *Int. J. Psycho-Anal.*, 45:220-226