DISCUSSION OF THE ARTICLE BY DR. HARRY GERSHMAN "THE EVOLUTION OF GENDER IDENTITY"*

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IN "The Evolution of Gender Identity," Harry Gershman has presented a clear, logical paper on the understanding of the concept "masculine-feminine essence."

The familiar and important cry, "It's a boy" or "It's a girl" is well known to us. Before pregnancy and during pregnancy the parents are often asked, "What do you want—a boy or girl?"

The motivation for Dr. Gershman's paper can lead to a total concept of sexual identity as part of the core-gender-identity process. It also will lead to a fresh approach to the problems of emotional illness and of specific sexual difficulties. Further, as clinicians we can utilize and work with this core-gender-identity concept, which leads to healthy or unhealthy expression of sexuality in our patients.

Unfortunately, whenever we hear about the imprinting development, a feeling of permanency and hopelessness results in the apparent unchangeability of this indelibility. If imprinting is another expression of conditioning and even if it is self-reinforcing, it can be reversible, unconditionable, self-deenforcing, and unlearnable.

Gender cannot be neutral or indifferent in spite of an apparently unconscious wish fulfillment expressed in the neutrality of gender in some languages. The individual is faced with a decision of how much maleness or femaleness "have I, do I feel, and does society expect of me?" This decision cannot be avoided, and a choice, conscious or unconscious, must be made eventually.

Since the gender role is the essence of what is considered masculine

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or feminine behavior, it is related to biological sex, but is shaped by cultural influences. First, there is the biological sex assigned to the infant. This is then influenced by culturally defined cues, which ultimately shape the gender identity to its assigned sex.[1]

Acculturation does occur with the passage of time, as in certain female gender role patterns that were previously traditional in Western civilization and have now changed. For example, the aggressive sexual, dominant female of the present may be contrasted with the passive female of the past. Thus changes occur in the pattern of relations between the male and the female.

We must also take into consideration the biological differences between the sexes and the variations in cultural reaction to these differences. Therefore we can understand the basic differences and similarities between men and women only in relation to the time-space continuum. Interaction between the body image of the anatomical-physiological being and his environment is the key to this problem. In our time it is possible that the male can now be passive and submissive and still be able to penetrate sexually; the female can be an aggressive and dominant recipient in coitus with very active female genitalia.

Although values placed on the birth of boys are greater in our society and greater freedom is given to them, there is a shifting equilibrium in our male-female relationships. Penis envy is not universal or organic. Envy of woman by men is now emerging as a cultural response. The clitoris has as good nerve endings as the penis, and the culturally underprivileged position that women previously held is now gone. As a result woman can respond as well or better orgastically, and evidence certainly indicates that penis envy or clitoris inferiority is culturally and neurotically induced.

The evolution of gender identity develops from standards of gender role and gender typing that exist. In other words, behavior is matched to internal and external standards and there is a drive to conform to it.

The standards of the child are made up of a cluster of attitudes, wishes, feelings, and values identified with models (such as parents), who possess this cluster. A child desires acceptance and yearns to possess these same traits. By adopting the parental standards he hopes to prevent social rejection.[2]

The standards of gender role thus dictate the adoption of a different response by boys and girls. The response becomes a learned associa-

tion between selected attributes, behavior, and attitudes on the one hand, and the concepts male and female on the other that are culturally approved characteristics of males and females.

The standards of gender role are publicly shared beliefs of male and female characteristics. The individual's concept of his own degree of masculinity or femininity is idealized and may differ from the cultural view.

Thus, the degree to which an individual regards and feels himself masculine or feminine, consciously or unconsciously, is his gender role identification that is part of his total identity. The gender type is the characteristic of male and female in physical, behavioral, and emotional attitudes that are present consciously or unconsciously.

By the age of three years, the child first realizes that boys and girls are different. The healthy central identity of gender role is established in the child by perception of similarities to parental models of the same sex with whom he identifies consciously or unconsciously as well as by his acquisition of attributes and skills of his sex, reinforced by his peer relations.[2]

Sometimes a child resents the behavior that is assigned to him because of his biological sex and feels anxiety over it, with the result that inner neurotic conflicts lead to sexual disorders. Often I have seen maternal dominance over a passive father with maternal rejection of the child that leads to schizophrenia in a male child and also to sexual difficulties. I suspect that this may be present in many transsexual males. I saw this problem in a man referred to our clinic who had had an operation for change of sex. He had been married previously and had two children. He related his unhappiness to his feeling that he belonged to the female sex. He wished to live as a female and he considered his sex organs as disturbing deformities, which he succeeded in having removed.

Although he still insisted that he was satisfied with his new-found sex, he attempted suicide. His self-hatred, compartmentalization, and concreteness still existed. His attempted solution—externalization of the problem to his genitalia—did not suffice. In these cases schizophrenia is probable. The ability to split off gender identity from total identity is part of the schizophrenic process, I believe. In his recent book, *The Transsexual Phenomenon*, Benjamin expresses the belief that true transsexuals cannot be changed by psychotherapy; he recommends surgical and hormonal treatment.[3] This may be a further sign of resignation on the part of the patient and doctor as well.

It would be important if we could predict the behavior of a child with respect to his gender role. This would require the degree of identification with the model of the same sex, as well as the gender role behavior displayed by the model, and the patterns of reward issued by that model. Additional influences such as the rate of physical maturation, the sexual attractiveness of the developing being, and the social class and its sexual attitudes are also important.

The significance of a child's gender role identity relates to psychological problems of stability of behavior in time, differential mastery of academic skills, sexuality, and behavior with love objects.

As a result of unhealthy relations between parent and child and a fragile gender role identity, fear of interaction with the opposite sex may arise. Anxiety over failure to attain behavior appropriate to the gender type can lead to homosexuality.

The homosexual does suffer from a lesion in basic gender identity. One male patient felt himself less of a man rather than more of a woman. Therefore he attempted to live vicariously through a male partner; he magically sought a mirror image in order to attempt to restore his failing masculine identity.

A homosexual patient who has a similar conflict had a dream wherein he was having fellatio with someone he had not seen since childhood. Pus came out of his partner's penis; he found it "distasteful" and he awoke. His association with his childhood friend was one of idealized masculinity. His distaste was associated with his inability to accept masculinity.

He spent his first two years in an orphan asylum. Then he was brought up in a female household, which consisted of his mother and sister. When the patient was six months old his father was killed while robbing a store with a gun. While a child, the patient consciously desired to be a girl. Later he wished to be a male but felt compelled to seek out men with large penises in order to live vicariously through them. He was trying to reestablish his maleness in order to relate to females again.

The child at three divides the world into male and female. At six it molds its behavior in concordance with cultural standards appropriate to his biological sex and will feel anxiety if it cannot accomplish this. Conflicts are generated because of anxiety over deviation from standards of gender role. Once learned, these standards are not easily altered,

but modification is possible during early school years and by society and psychoanalytic help later in life.

As clinical psychoanalysts we want to know the critical periods of this development. The critical early period of sensitivity to experiences will determine the direction of social, intellectual, and emotional development.[4]

In 1935 Lorenz emphasized the importance of critical periods of the formation of primary social bonds in birds; the process is called imprinting.[5] McGraw later demonstrated critical periods in the infant.[6] Critical periods in the child are for learning, infantile stimulation, and formation of primary social bonds by human contact.

Anxiety increases the strength of imprinting by emotional arousal. The importance of basic anxiety in neurosis and healthy growth is well established.[7]

The critical period for primary socialization in the infant is shown by its visual investigation and smiling response, in interaction with the supporting and nurturing mother. This contact and emotional arousal results in social attachment. Prolonged basic anxiety prevents healthy attachment. By lessening the anxiety, the critical period can be lengthened and hope for increased development is possible.

This primary socialization or imprinting is also modified by later development. Formation of social attachments through contact and emotional arousal is a life-long process. There are also critical periods for stimulation. Animals handled early show earlier maturation of adrenocortical responses to stress, with reduction of fear through familiarity of the handler. However, too much stimulation can lead to traumatic emotional experiences.

Some crucial points can now be made. The total character structure develops first and ultimately determines the primary core gender identity and the secondary identity with expressions of its sexuality.

A healthy climate in the home leads to greater acceptance of the gender role by the child.

The type and quality of response of the mother and other important caretakers of the infant to its requests and to stimuli of crying or smiling help in forming healthier identities in that infant.

The extension of basic anixety interferes with this development.

Sexual disturbance is produced in the individual by the early attitude of parents who lack respect for him as an insecure and helpless infant.

As a result, he will feel alienated from himself, from his true core gender identity, and from the rest of the human race.

On the other hand, the maturing gender identification will lead to the maturer relationship of sexual love, which leads to the healthier way of life in family and society, as Dr. Gershman has shown.

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