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INVITED ESSAY

Robert Stoller's *Sex and Gender*: 40 Years On

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Abstract By its title, *Sex and Gender* announced a conceptual breakthrough in distinguishing basic elements of human experience. In Robert Stoller's first book, patients illustrating this divergence were lucidly presented. Transvestites and the newly publicized transsexuals were two examples. Clinical and dynamic distinctions between the two formed a basis for Stoller's criteria for patient selection for "sex change." They remain current. The complex identity of the intersexed was described with sensitivity and insight. It, too, remains timely. An innovative description of the genesis of boyhood transsexualism was presented in considerable detail. This finding is less commonly reported today but is also not looked for. Stoller was sympathetic to the request for sex change. He credited a biological contribution to the development of masculinity and femininity. Both stances were remarkable for a psychoanalyst. Robert Stoller introduced the term "gender identity." It is now our vocabulary when we articulate this bedrock of personhood.

Keywords Gender identity · Transsexualism · Transvestism · Intersexuality · Psychoanalysis

Introduction

The significance of the title of Robert Stoller's first book was announced in the Preface:

> …we have split off "gender" as a distinguishable part of "sexuality." The word sex in this work will refer to the male and female sex and the component biological parts that determine whether one is male or female. [There remain] tremendous areas of behavior, feelings, thoughts, and fantasies that are related to the sexes and yet do not have primarily biological connotations. It is for some of these psychological phenomena that the term gender will be used…Thus, while sex and gender seem to common sense to be practically synonymous, and in everyday life to be inextricably bound together, one purpose of this study will be to confirm the fact that…sex and gender are not inevitably bound…each may go in its quite independent way. (Stoller, 1968, pp. vi–vii)

And, introduction of a seminal term: "While the work of our research team has been associated with the term *gender identity*, we are not militantly fixed either on copyrighting the term or defending the concept as one of the splendours of the scientific world" (Stoller, 1968, p. vi).

Gender Identity

I do not know exactly when Stoller began using the term. I am confident that it was the name of the program when I arrived at UCLA to begin my psychiatry training in 1962. The term was formally introduced to the psychiatric/psychoanalytic worlds in 1964 when he published "A Contribution to the Study of Gender Identity" (Stoller, 1964). What is this thing called "gender identity"?

> [It] starts with the knowledge and awareness, whether conscious or unconscious, that one belongs to one sex and not the other, though as one develops, gender identity becomes much more complicated so that…one may sense himself as not only a male but a masculine man… who fantasizes being a woman. (Stoller, 1968, p. 10)

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Stoller (1968) wrote of the

> …essentially unalterable core of gender identity (e.g., I am male) to be distinguished from the related but different belief, *I am manly* (or masculine)….The sense of core gender identity…is derived from three sources: the anatomy and physiology of the genitalia; the attitudes of parents, siblings and peers toward the child's gender role; and a biological force that may more or less modify the attitudinal (environmental) forces. (p. 40)

His rationale for clinical study: "It is not easy to study the relative importance of each of these factors in normals because one factor cannot be dissected from the others. However, certain rare patients provide such an opportunity…" (Stoller, 1968, p. 40).

Let the games begin.

Transvestism

Transvestism was more the perversion in 1968 than today. It was less the socially accepted behavior and in some jurisdictions was a crime. In consequence of the societal stigma, more transvestites were troubled then to bring their cross-dressing issues to a therapist. Today, in the UK, we have celebrity transvestites who are not stage performers but, for example, include an award winning sculptor and the recent male partner of a female TV celebrity and best-selling author. (The guy is also a cage fighter. This is a brutal sport fought by two men in close proximity. No sissy, this chap.)

In addition to more societal acceptance of cross-dressing, diminishing clinical contact resulted from the dismal rate of success of treatments. Aversion therapists had their day pairing electric shock or emesis with cross-dressing. That had only some short-term behavioral change. Aversion therapy has become a bete noir. Stoller commented on it in 1968: "…who defines what is anti-social and how much does this behavior endanger society or its individuals. How much pain should be inflicted on a patient to make him conform? For the homicidal, a great deal. How much for the transvestite?" (p. 243).

Psychoanalysis has not fared much better, although it is often difficult to fathom the results of therapy. For example, in 1997, the psychoanalytic panel on transvestism and transsexualism in Barcelona reported on three cases. All contained fascinating insights. But no data one way or the other on behavioral change (Chiland, 1988).

How does transvestism come about? Why do some males experience sexual arousal to dressing in womens' clothes? For Stoller, the essence was early trauma and its threat to masculinity:

> Transvestism is…a defensive structure raised to protect a threatened but desired sense of masculinity and maleness, and…to preserve a badly threatened potency. One should not be fooled by the apparent paradox that he does this via the detour of dressing like a woman. (Stoller, 1968, p. 180)

So, sexual arousal (erection), accompanying cross-dressing, bolsters damaged masculinity. For Stoller, the prototypic instance of the scarring humiliation early in life for the young boy is being dressed as a girl by a female.

How often is this the origin? For the researcher, there are obvious, perhaps insurmountable, obstacles in asking an adult to describe accurately the events of early childhood. How much of ancient history is re-inscribed by the pen of contemporary experience and attempts to come to grips with personal oddities? So, unless we are fortunate enough to welcome a parade of old mothers or adult sisters of the transvestite confessing to their earlier sins, we are often crippled in our race to the truth.

Stoller helped clarify some distinctions between transvestism and the recently emerged topic of interest—transsexualism. His insights on their relevance to patient selection for sex-change surgery remain timely. Study of the transvestite helped elucidate the distinction between sex and gender:

> A man with a sense of being feminine while cross-dressed is excitedly aware of being a male. Essential to his perversion are two aspects of gender identity, the latter one, *I am feminine*, and the earlier core identity, *I am (nonetheless) a male.* (Stoller, 1968, p. 40)

Stoller collaborated with Virginia Prince for three decades. Virginia was the most significant transvestite activist. She edited the magazine *Transvestia* for 100 editions (nearly as many as I edited *Archives of Sexual Behavior*), and, like me, founded an international organization (but, probably, with more cross-dressers). She died only recently, age 96.

Stoller recorded 2000 sessions of their dialogue. When he would be on holiday, the task of seeing Virginia would befall me. I would sometimes cringe. I would be subjected to her constant hectoring. But she had good points, as well. She delighted in informing us that there is no such thing as male or female clothing. A 3-piece suit does not have a penis.

The psychodynamics of the women in the lives of transvestites were also explored. As a clinician, his small sample may not have been representative. Two subgroups were described: the male-hater and the succoror. In writing of the male-hater, he was incubating his thoughts on the later exposition of hostility in erotic excitement (Stoller, 1979). The succorer (as a wife) encouraged the cross-dressing "with an air of innocent enthusiasm…" (Stoller, 1968, p. 207). "She does not know yet that as he becomes a more successful transvestite, her enthusiasm will wane…they will divorce" (Stoller, 1968, p. 212).

Other published reports are all over the place. One looked at 20 wives seen in a clinical setting and found all to be "moral masochists" (Wise, 1985). Relevant to Stoller's description of the male-hater was a subgroup termed "eye-for-an-eye." This wife would "extract punishment" by forcing the husband to do

housework while cross-dressed (symbiotic salvation?). Another interviewed wives obtained from the cross-dressing organizations of their husbands (Brown & Collier, 1989). Any former wives who might fit Stoller's subgroup would be long gone. Another characterized the primary reaction of wives as "stigma management" (Cairns, 1997). What will the neighbours say? What about the kids? Indeed, what about the children of transvestite fathers? Do they cross-dress more than most children? When they do, is it sexually arousing? Are the kids like the kids of homosexual parents, perhaps visiting, but not emigrating? Finally, a study with hundreds of subjects. Here, wives were "an unremarkable group…[who] unexpectedly found themselves in a marriage with a transvestite husband" (Docter, 1988).

I characterize the psychoanalytic, psychiatric, and psychologic descriptions of the wives of transvestites as an example of the blind men groping the elephant to provide its description. (Consider the description given by the one who grabbed the male's prehensile penis.)

Stoller saw society as the primary source of conflict for the transvestite (Stoller, 1968, p. 241). The International Classification of Diseases (ICD), the endless catalogue of illnesses published by the World Health Organization, includes transvestism. However, three countries in Europe (Denmark, Norway, and Sweden) have recently deleted transvestism from the version operant in their country. This because of the associated stigmatization (www.revisef65.org; www.pinknews.co.uk/). Both the ICD and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association (APA) are undergoing revision. Is transvestism to remain a perversion, a paraphilia, or some less pejorative euphemism to designate sexual mental disorder?

Transsexualism

In 1968, sex-change surgery in the U.S. was in its infancy. The Johns Hopkins Hospital announced its program, inspired by my other mentor, John Money, in 1966. The first multidisciplinary text on the subject was co-edited by John and me in 1969 (Green & Money, 1969).

Research conducted in the mid-1960s by myself with Stoller and MacAndrew revealed that most physicians, including psychiatrists, were opposed to the surgery, even after a patient had had years of psychotherapy and was probably suicidal if surgery were to be denied (Green, Stoller, & MacAndrew, 1966). So, for a psychoanalyst in 1968 to endorse sex-change, albeit begrudgingly, was brave. Stoller (1968) wrote: "…if one does not assist transsexual patients, they are deeply unhappy" (p. 248); "…most transsexuals are less depressed and anxious, more sociable and affectionate…after 'the change'" (p. 249).

He knew the objections:

> It has been suggested that "no psychotherapeutic procedure less than intensive, prolonged, classic psychoanalysis would have any effect. If properly done, it could probably reduce the patient's agitation and the level of unhappiness. It is not impossible that his major symptoms may decrease in frequency and urgency." (Ostow, personal communication, Stoller, 1968, p. 249)

Stoller (1968) responded: "This statement has the vigorous ring of sober caution; it also must have been written by someone who has never tried to get such a patient into psychoanalysis" (p. 249).

I interviewed a patient who did undergo psychoanalysis. One of the first transsexuals I saw was when I was seeing some of Harry Benjamin's patients in New York in the mid-1960s. Harry was the "father of transsexualism," published the first text in 1966, and had more patients than anyone (Benjamin, 1966). This patient had just completed ophthalmology residency training. For years, he had wanted to be a woman. His family, which contained psychoanalysts, dispatched him into analytic therapy for 8 years. There he was, in Benjamin's office, requesting sex change. (He, now she, has been the subject of a film starring Vanessa Redgrave, titled *Second Serve*. The patient was also a tennis star.)

Stoller argued in *Sex and Gender* that sex-change should be utilized as a research technique. Patient selection was crucial. It should be limited to those males who had been very feminine in childhood, had never lived acceptably in a masculine role, and who had not derived pleasure from their penis. He termed these "true transsexuals" (Stoller, 1968, p. 251).

I found such a patient at about the time *Sex and Gender* was published. Barbara had lived for 10 years as a woman. She was employed as a woman receptionist at a prominent restaurant. She was living with a man as husband and wife. The man reportedly considered her penis to be a congenital anomaly that would be corrected surgically. She reported that their sex life did not include her penis. She denied ever being sexually aroused by cross-dressing.

Will Goodwin was a urological surgeon at UCLA who had also emigrated from Johns Hopkins. He was willing to perform the surgery. I proposed the procedure to the psychiatry department chair, Henry Work. Stoller stood aside, providing me with enough rope.

A concern was raised about legal action, prosecution for mayhem. This common law crime derives from medieval England to punish anyone who would cut off the limb of one of the King's fighting men. For clarification regarding possible prosecution, I contacted the University of California legal counsel in Berkeley. This was a couple of years after the Free Speech Movement protest against the Vietnam War. Then, the university president was Clark Kerr and placards were all over Berkeley lettered FUCK. That stood for Freedom Under Clark Kerr.

I suspect that my query was a welcome change from that tumultuous period. I have never received such a swift reply from an attorney. He conceded that I would be vulnerable to prosecution for mayhem. The penalty if convicted was up to 10 years

in prison. Furthermore, since this proposed act involved two of us, a psychiatrist and a surgeon, it constituted conspiracy. The penalty was now up to 14 years. But, the university counsel reassured me, the University would pay our legal bill. Barbara had her surgery. We were not prosecuted.

The stringent criteria Stoller set for patient selection for sex-change was too influential. Subsequently, nearly every patient presented to psychiatrists with precisely the winning psycho-sexual history. When it dawned on our profession that perhaps we were being presented with a song and dance, the criteria for patient selection changed. It was no longer where you had been, but where you were going.

Money coined the term "Real Life Test." Patients needed to live full-time successfully in their aspired for gender role for at least a year to be eligible for surgery. Now patients acknowledged some masculinity in their life, fetishistic cross-dressing, pleasurable penile activity, and even heterosexuality. Stoller's diagnostic selection criteria have remained valid. Current research demonstrates that males from non-true transsexual backgrounds do not fare as well post sex-change (Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005).

Notwithstanding his "passive" endorsement of sex change, Stoller remained sceptical of the extent to which the procedures accomplished all the patients hoped for:

> Their anguish before the procedures is intense and genuine…nonetheless, they are left more or less dissatisfied, feeling that although the necessary procedures have feminized some of their appearance and functions, the results are far from complete. (Stoller, 1968, p. 247)

In the unique use of words that was a precious jewel in Stoller's writing, he later characterized the post-operative male as a "Near Miss" (Stoller, 1982).

Stoller's acknowledgement of the difficulty in engaging a pre-operative transsexual in psychoanalysis or even psychotherapy was echoed in 1997 by psychoanalyst Colette Chiland of Paris.

> We see a certain number of transsexuals before they undergo hormone treatment, but as soon as they start the process of so-called sex change, they are as good as lost to psychotherapy. It is very rare to get a transsexual in real analysis because they have very strong narcissistic defences and resistance to transference; when they begin to experience transference dependence, they run away. [However], we see more and more transsexuals coming for psychotherapy or even analysis after surgical sex reassignment. They do not regret the surgery, they feel they could not have done without it, but they still feel unhappy, too isolated, nether completely a man or a woman. (Chiland, 1988)

In Bob's words, a "near miss."

Chiland is indebted to Stoller: "All the work I have been doing with transsexuals for thirty years has its roots in the contributions of Stoller" (C. Chiland, personal e-mail communication, 29 October 2009).

But have all psychoanalysts given up the ghost of curing the preoperative transsexual? The Portman Clinic in London is one of the last psychoanalytic strongholds in the UK and carries a long history of treatment of sexual disorders. Here is their Letter to the Editor with 8 signatories published in the *Telegraph* newspaper in 2002:

> The recent judgment in the European Court of Human Rights in which a post-operative transsexual person was granted permission to marry in his [sic] adopted gender role, is a victory of fantasy over reality…Through years of psychoanalytic psychotherapy, some patients begin to understand the origins of their painful conflicted feelings and can find new ways of dealing with them, other than by trying to alter their bodies. The recent legal victory risks reinforcing a false belief that it is possible to actually change a person's gender [confusion here, perhaps, between sex and gender]. It might also strengthen the view that the only solution to psychic pain is a legal or surgical one. (Telegraph, 15 July 2002)

Those who forget the past…

Cross Sex and Gender Children

There is excited debate today on the significance of cross-gender identity and behavior in prepubertal boys and girls. Television shows feature families in which grade school age kids are attending school and living as a child of the other sex. There is vitriol from activists against treatment programs where the goal is enabling the child to live comfortably in his or her birth sex. There is demand that the diagnosis of Gender Identity Disorder be removed from the list of mental disorders. In 1968, Stoller wrote:

> The condition is pathological….If these boys are the adult transsexuals of future years, with their demands for sex-transformation procedures and the reportedly hopeless prognosis for psychiatric treatment, then the time to help them is in childhood, when their gender identity is still forming….The goal of treatment should be to make the child feel that he is a male and wants to be a masculine boy….The first step in treatment is to establish that one is in fact dealing with a childhood transsexual. Next one must start treatment immediately. If one waits until five or six or seven, the undoing is more difficult. (p. 252)

In the mid-1960s, I saw a very feminine 5-year-old boy and his mother was seen by Stoller. She entered analysis and was the source for a seminal theory of cross-gender development in a

male child, described below. I was seeing the boy twice weekly when I was a psychiatry resident, but, as described in a paper by Ralph Greenson, "When the resident was called into military service [sic] some six months later I decided to undertake the treatment" (Greenson, 1966). This resident took the boy to Greenson's home where they enthusiastically formed a treatment alliance.

A couple of years later, in *Sex and Gender*, Stoller (1968) wrote: "The first successfully treated case of a childhood transsexual is that of Greenson. A report written after the treatment was ended gives a vivid and warm account of this boy's rescue" (p. 254).

(I will digress to an autobiographical coincidence. The one other psychoanalytic paper on treating a "boy transvestite" published before Greenson's was two years earlier. It was by Melitta Sperling (Sperling, 1964). Melitta's daughter, Susan, and I were grade school classmates at PS 241 in Brooklyn. What was in the Brooklyn drinking water to inspire that psychoanalyst and this classmate of her young daughter to pursue an interest in cross-gender behavior in boys? When I published my first paper on the subject in 1960, did she know that I had been a friend of her daughter decades earlier?)

Four years after *Sex and Gender*, Larry Newman, Stoller, and I published "Treatment of Boyhood 'Transsexualism'" (Green, Newman, & Stoller, 1972). Transsexualism was in quotes as we could not be certain that these boys were pre-transsexual. We wrote: "We have previously described the behavior of very feminine young boys. Based on retrospective reports of childhood behavior given by adult males who want sex-change surgery, there is reason to believe these boys are pre-transsexual" (Green et al., p. 213). Why treat?

> As long-term follow-up data are not yet available, we cannot state with certainty that these boys, if untreated, would mature into adult transsexuals. However, because 1) there are no reports of adolescent or adult transsexuals who have successfully reoriented their profound cross-gender identity…(and) 2) because males with an extremely feminine identity in our culture undergo considerable social hardship, at all ages, we have attempted… intervention during boyhood. (Green et al., 1972, p. 213)

But, should we change society or change the child? "While privately, one might prefer to modify society's attitudes toward cross-gender behavior, in the consultation room with an unhappy youngster, one feels far more optimistic about modifying the behavior of that one child than the entire of society" (Green et al., p. 217).

Our caution about the adult outcome of such boys was wise. I had begun a long-term study of dozens of very feminine boys at about the time *Sex and Gender* was published. I had received a grant from the NIMH and Stoller was my supervisor. The study continued for about 15 years. Some boys entered therapy with myself or others; others were only periodically assessed.

In 1974, I considered the boys to be probably pre-transsexual. Their histories were juxtaposed with those of adult transsexuals in *Sexual Identity Conflict in Children and Adults* (Green, 1974). In 1987, it was clear that most were homosexual. Perhaps one was transsexual. The book title of the sequel was *The "Sissy Boy Syndrome" and the Development of Homosexuality* (Green, 1987).

In addition to the analytic treatment reports of Greenson and Sperling, Haber (1991) published a detailed report of five years' analysis of a boy from age 3. At last follow-up, when he was in his early 20 s, his mother reported that he was not dating and was interested in a career in acting. Regarding Haber's other similar patients, he has informed me, "I saw many boys and one girl in long-term intensive therapy and all seem(ed) to be gay" (C. Haber, personal e-mail communication, 26 October 2009).

How did these boys catch GID?

It was on a hot summer day in a public square in Madrid in 1966 at a psychiatric congress, with his wife Sybil standing by. Stoller proudly told me that he had unravelled the first psychodynamic explanation for the etiology of a psychiatric disorder. This was the ontogeny of extreme cross-gender behavior in a young boy. Deriving primarily from his analysis of the mother of the 5-year-old boy I had referred to Greenson, he had an extraordinary insight into the forces and influences yielding boyhood transsexualism:

> There had been excessive sharing of each other's anatomy by identification, made possible by continuous skin contact all through the day….he was never separated from the sight of her for more than a few minutes. Since he never slept more than an hour and a half at a time during the first year, her nights were spent in exhaustedly patting him, feeding him, or singing him back to sleep. (Stoller, 1968, p. 111)

"Another prime factor is a disturbance in (mother's) gender identity, her bisexuality…a heavy proportion of sensed and observable thoughts, feelings, and behavior reflecting both masculine and feminine identifications" (Stoller, 1968, p. 112).

The mother's parents had accepted her earlier cross-dressing. She was described as having experienced intense penis envy of her brothers and father. The boy was physically beautiful. He had been fascinated by women's clothes from 8 months and began cross-dressing as soon as he could walk. The behavior was admired by both parents.

> While she was able to permit him some chance of separation, she greatly slowed the process down, a fixation produced especially by the primordial joys of the continuous skin-to-skin contact…. (Stoller, 1968, p. 125)

> The boy was (the phallus) of her flesh…*He was his mother's feminized phallus*. (Stoller, 1968, p. 120)

Another case in which Stoller had been hoodwinked was consistent with these findings. This involved a patient who con-

vinced him, a sociologist, endocrinologists, and surgeons that, although a normal appearing male until puberty, the feminization that then occurred was the result of a biological variant. UCLA was not yet performing sex change surgery on transsexuals. But this patient was "intersex." So genital reconstruction was performed to conform to her very ample breast development resulting from her "intersex" condition. Five years later, she confessed that the whole story was a scam. She was transsexual. She had been swallowing her mother's estrogen tablets, secretly, from age 12.

Converting major embarrassment, and some anger, into victory, Stoller interviewed the patient's mother. The child had been beautiful. He was dressed in girls' clothes. Significantly, mother recalled that

> …from 2 to 8 years she and her son played a nighttime game. It was "mother hen and baby chick." Every night they both went to bed together at the same time, and the mother would curl herself up in such a way that she completely surrounded the little boy within the curve produced by her bent head, her torso, her arms, and her curled-up thighs and legs. (Stoller, 1968, p. 137)

As for the mother's gender identity, as a child, she thought of herself as a boy. "All of her interests were those of a boy….She dressed in boys' clothes" (Stoller, 1968, p. 138).

Here, Stoller obtained the retrospective history of an adult transsexual and mother that matched that obtained contemporaneously for a boy transsexual and his mother. He acknowledged that these "findings and speculations" did not completely exclude some biological force. "For instance, these mothers might not have wished to 'over-love' infants who struggled away from their excessive body contact" (Stoller, 1968, p. 139).

Chiland, for all her praise for Stoller, reports being unable to confirm some of his findings with children. "What he described was only a case among others, though he thought it was the typical constellation." She did, however, have a family that was just as he had written (C. Chiland, personal e-mail communication, 29 October 2009).

Psychoanalysts have not queued to propose theories of gender identity since 1968. An exception is Person and Ovesey (1983). They critiqued those of Freud, Horney, Jones, and Stoller and flogged their own. They faulted Stoller for his emphasis on a non-conflictual origin of male femininity and his analogy to the ethological concept of imprinting. Their proposal was a defence against separation anxiety. However, as their critique of Stoller was in response to a subsequent volume (Stoller, 1975), I will avoid this fray over how many angels dance on the head of the gender identity pin.

Non-analytic psychiatric critics snipe that Stoller's insights have not been confirmed. Yet, how many clinicians have replicated his methodology? And, for current researchers, this is not where the grant money is. Follow the money. The search for the "smoking gene."

Intersex

Treatment of the intersexed person has undergone radical change from 1968. How these persons are referred to has changed. How they should be treated in infancy and early childhood has changed. Whether their gender identity derives primarily from nature or nurture is in fresh dispute.

Stoller used the term intersex and hermaphrodite. At the time, patients were often referred to as pseudohermaphrodites if they, as was usually the case, did not have both ovarian and testicular tissue. Some thought that term made them seem like imposters.

Both the terms intersex and hermaphrodite were adopted by a patient activist group successful in bringing problems with their medical care to professional and public attention. This was the Intersex Society of North America. They were also known as "Hermaphrodites with Attitude." A major thrust of the early intersex activism was the genital conforming surgery carried out on infants and young children with ambiguous genitalia. Often these were females with congenital virilizing adrenal hyperplasia (CAH) where excessive prenatal androgen virilizes the female genitalia (New, 2001).

When these young children were correctly identified as 46,XX female, there was concern over the masculinized genitalia, notably the clitoris, which can appear as a small penis. To avoid social embarrassment with peers, and to avoid an androgynous sex signal to the child, the clitoris was cut down to size. This was decried by many now adult intersex activists as it often resulted in major loss of erotic sensation. The Intersex Society in 1994 stated that any genital surgery not required for strictly medical reasons should be postponed until the intersex person is old enough to provide informed consent (ISNA Recommendations for Treatment, www.isna.org).

To which sex should the infant be designated? In 1968, the prevailing theory was derived from the seminal work of John Money. Thirteen and 11 years before *Sex and Gender*, Money, working with the Hampsons, published three classic papers (Money, Hampson, & Hampson, 1955a, b, 1957). They showed that gender identity (not yet so named) followed the sex to which the infant was designated. This ascription would trump any biological variables, including gonads, genital appearance, internal reproductive structures, chromosomal configuration, etc. This dictum was engraved on tablets handed down from Mt. Hopkins.

Importantly, if it became apparent that a diagnostic error had been made in assigning sex to the infant, reassignment to the correct sex was feasible up until only about 18 months of age. Thereafter, identity as male or female was fixed.

Stoller did not challenge these tenets. But from his clinical experience, he enriched understanding, especially with his exposition on a possible hermaphroditic identity. Here, there was inconsistency, confusion, ambivalence over the "correct" sex designation for a child. Consequently, neither clear cut male nor female core gender identity was set in place. Years later, that person, well beyond the 18 month cut-off point could want

to, and be able to, change (Stoller, 1968, p. 36). "If from the start, the child's elders are not sure enough, because the child is anatomically ambiguous, then a defect in character structure can develop in which the patient knows only the gender identity of a hermaphrodite" (Stoller, 1968, p. 23).

Examples of late sex change in the intersex are more recently reported. Meyer-Bahlburg et al. (1996) described four patients who had CAH with gender change from female to male. The process was gradual and extended into adulthood. Factors appeared to be gender-atypical behavioral self-image, a gender atypical body image, and the development of erotic attraction to women.

I asked the lead author about Stoller's concept of a hermaphroditic identity in these patients. He replied "I did not discuss it with them, so I don't know. However, I later added a 'third gender' question to my follow-up protocol for XY (a different group of intersex patients) and the result was 15% (of 59 patients) agreed" (H. F. L. Meyer-Bahlburg, personal e-mail communication, 13 October 2009). Those persons with ambiguous genitalia reported more uncertainty about gender and more endorsed themselves with a third gender.

Stoller was sensitive to the issue of when, if at all, to do genital surgery. He reported a case where the penis was removed, leaving only a stump 3/4 inch at erection. This was in a chromosomal male, living as a woman, whose undescended testes had been previously removed. "At the time, she was relieved to have the operation; it shut others up about her abnormal genitalia….the patient now profoundly regrets the operation" (Stoller, 1968, p. 32).

He understood the conflicts of the intersexed and their suffering from secrecy and poor clinical management. He respected the work of Money but recognized the variance attributable to the parent–child experience of sex and gender that could yield a whole new ball game. There was a complexity of sex and gender requiring a different attention and a more nuanced understanding.

Biological Force

Proposing a biological force behind gender identity was heroic in 1968. As noted, between 1955 and 1957, the stone tablets handed down from Mt. Hopkins decreed the ultimate triumph of nurture over nature. As radical as it would be for any clinician to question that mandate, it was ever more so for a psychoanalyst. But, Stoller was confronted with an extraordinary case:

> This person had been born appearing as a normal female. During childhood, she was very much the tomboy. "In all games with other children the child seemed to take male roles.…She could scarcely be forced into female clothes. …Her companions were boys, with whom she played boys' games." (Stoller, 1968, p. 68)

At the onset of puberty, she developed a hoarse voice, presumably from laryngitis. The hoarseness continued. Her body began to virilize, not feminize. Endocrinological and surgical exploration revealed an intersex condition, namely 17 B-hydroxysteroid dehydrogenase-3 deficiency, and intra-abdominal testes (Liakopoulov, Keramydas, Dracopoulov, & Dacou-Voutetakis, 2009). The enzyme defect interferes with production of testosterone from androstenedione. Consequently, external anatomy does not differentiate prenatally as male. But, then, at puberty, androgen production and its effects can be sufficient to virilize.

> When the patient was informed of the discovery, the switch to living as a male was immediate. "She acted as though she were being told something of which she had always been dimly aware, of which she had no doubt. Her attitude was as if to say, 'Yes. Very good. Thank you. I am not surprised.'"! (Stoller, 1968, p. 70)

(As I write this, here in England we are in the midst of another 3 day postal strike. I see this intersex case as a further example of delayed male.)

Consider this note by Stoller, on this case, to stoke the debate on nature versus nurture in academic performance. This debate was fuelled in recent years by Larry Summers, then President of Harvard. He was forced to fall on his sword for suggesting perhaps the wrong explanation, an innate one, for why males excel in science and maths. (He has since been resuscitated as Director of the White House National Economic Council by the new President of his entire country). Stoller (1968) wrote: "After the sex reassignment, this patient came to be among the first in his class in mathematics; a subject in which he had done very poorly when he thought he was a girl" (p. 70).

Today, debate continues over whether a person with 44,XY karyotype and normal prenatal androgen, but born with defective genitalia, should be socialized as male or female. The "John/Joan" case challenged the intersex model of nurture trumping nature. Essentially, a monozygotic male twin lost his penis traumatically in infancy, was reassigned as a girl, raised as a girl, but in adolescence insisted on continuing life as a male. An explanation is normal prenatal androgen (Diamond & Sigmundson, 1997).

Cloacal exstrophy was not mentioned in *Sex and Gender*. Here, there is a horrific pelvic birth defect obscuring the genitalia. In consequence of the genital defect where phallus construction for an XY male child would be extremely difficult, many male infants were socialized as girls. However, many later requested to live as male. The explanation is that their prenatal androgen levels, presumed normal for a male, organized their brain as male (Reiner & Gearhart 2004). Stoller's biological force is alive and well.

Conclusion

Stoller's sensitivities and insights to the clinical issues in sex and gender cannot be fairly assessed by current practice or research. There is no comparable corpus of psychoanalytically derived data on the class of patients reported in *Sex and Gender*. There is no one clinician or researcher amassing and publishing such a corpus.

Sex research published in science journals typically reports extensive samples, assessed by questionnaire, and analyzed statistically. To this, Stoller complained, "Sex research is camouflaged by large samples, hidden in tabulated columns, and dissected beyond significance by statistical packages. Although statistical techniques may enable us to corroborate or deny a hypothesis, they do not produce one" (Stoller, 1973).

Even that strategy of impersonal personal research has latterly become even less personal. Sex research may be via the Internet. Large samples of almost every sexual oddity can be generated online. Human contact is limited to clicking "Send" or "Inbox."

As for the term "gender identity," Stoller demurred that it was not to be defended as one of the splendours of the scientific world. What has been its impact?

It has become the diagnostic term for extensive cross-sex identification and cross-gender behavior. For children, the term Gender Identity Disorder of Childhood entered the DSM, in 1980, promoted by an advisory committee on which I served. Then, in 1994, the diagnostic term "Transsexualism" was replaced by Gender Identity Disorder in the DSM, recommended by a subcommittee on which I served.

From 1994 to 2006, in London, I was research director and consultant psychiatrist at the world's largest treatment program for persons who want to "change sex." The surgeons perform three sex-change operations a week. The program is named the Gender Identity Clinic.

Google the term "gender identity" and you will retrieve 4 million responses. If you narrow the search terrain to Google Scholar, you will get 1.5 million responses. You need not scroll through all 1.5 million to find *Sex and Gender*. It is number 11.

Sex and Gender, with its wide clinical scope buttressed by extensive verbatim interviews, was a landmark contribution to the study and understanding of the bedrock of our personhood. Four decades have not dimmed its luminescence.

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