THE SENSE OF MALENESS[1]

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For most psychoanalysts, it is axiomatic that the development of male sexuality is dependent on the way in which the little boy manages the fantasied dangers and pleasures of having a penis. His pride in the power of his penis and the growing realization of its value as a source of physical pleasure are threatened by his awareness of penis-less creatures and his fear that he might be made into the same. Recently there has been increasing discussion in the literature, especially by Greenacre (1958) of an earlier period of phallic awareness than the classic phallic stage. It is likely that from birth on, the infant boy is becoming more and more aware of his penis, first by feeling it is there and later also by endowing it with meaning.

From these beginnings of phallic awareness are derived the two theses to be presented in this paper. The first of these is that the sense of maleness - the knowledge and unquestioned acceptance that one belongs to one of a total of only two sexes, the male sex - is permanently fixed long before the classical phallic stage (around 3-5). The second thesis is that while the penis contributes to the sense of maleness, it is not essential. It should be noted that neither of these theses contradicts the importance of the contributions of the phallic stage, the Oedipal conflict, or the resolution of the Oedipal conflict to the boy's developing masculinity.

By the sense of maleness I mean the awareness, 'I am a male'. I wish to distinguish this from the related belief, 'I am manly (or masculine),'

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which will come later in life. The child's possession of these later acquired beliefs indicates that he has by this time much knowledge of the ways society expects that masculinity and sexual activities will be expressed, these customs being poured into the child especially by his parents. At this later time, possibly by about two years of age, the boy will already be creating identifications with females and fantasies of being like them, contrary to his sense of masculinity. These feminine fantasies may express such wishes as 'I would like to have a baby,' or 'I would like to have breasts,' and the many others which make up part of the 'latent homosexuality' so ubiquitous in many cultures. But this is not to be confused with the sense of maleness which starts developing much earlier and is to disappear behind these more familiar disturbances in gender identity.

The sense of gender identity* (that is, of being a male or being a female) in the normal is derived from three sources: the anatomy and physiology of the genitalia, the attitudes of parents, siblings and peers towards the child's gender role, and a biological force that depending on its strength, can more or less modify the attitudinal (environmental) forces. It is not easy to study the relative importance of each of these factors in normals because one factor cannot be dissected free from the others. However, certain rare patients have provided just this opportunity, and so I wish to present data on two boys who were born without penises and yet seem to have grown up with no question in their core sense of maleness.

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* It is not possible to take up here the very important contributions to an understanding of identity that have recently been made, especially by such people as Bissler (1958), Erikson (1956, 1959), Greenacre (1953, 1955, 1958), Lichtenstein (1961), Mahler (1958), and Spitz (1957).

Case Number One

This four-year-old genetically normal boy was born with no external penis but with bilateral testes in a bifid scrotum which had the appearance of labia majora, with labia minora, and with a perineal urethrostomy. Since he was recognized to be a boy, he was named as such and so reared. In the first three months of life, he developed a febrile illness which led to a diagnosis of severe right hydronephrosis with infection, eventually leading at 10 months to the removal of the diseased kidney. The perineal urethrostomy at this time was shifted so that the new urethral meatus was now in a position approximately where the penis would have been. The bifid scrotum was left unchanged, (as it has been to the present). He has a normal prostate. For four months following surgery, he did well. Then, in his second year, because of recurrent infections, an indwelling catheter was placed in the bladder to preserve the remaining kidney. This instrument has remained almost permanently to the present. It will be further commented on later. Before he was born, his mother left his father, who from then on dropped completely out of the child's life. However, some months later, his mother remarried, and so the patient and his three years older brother now had a stepfather and stepsister the patient's age.

The patient's stepfather very quickly took an active role in the family. A masculine man, he has served as an excellent object for the child's identification processes. Therefore, despite the early very dangerous illness with its serious surgical consequences and the subsequent chronic need for medical attention, several other surgical procedures, and the constant presence of the indwelling catheter, the patient is considered by both his parents to be a very

normal and healthy boy psychologically. They especially compare him to his seven-year-old brother, whom they feel to be more sensitive, more shy, and a little effeminate as compared to the patient. The latter is described as rough, active, and unequestioning in his status as a boy. He enjoys playing football and baseball with his father as well as wrestling with his older brother and sister, these vigorous activities being surprisingly little hampered by the catheter and bottle he carries with him. To quote the parents, "...He likes to wrestle and box. He likes all kinds of sports -- likes to watch sports on television, and he told me that he wants to be a wrestler -- big and fat -- when he is big. He plays with dolls, but when he does, he is the father and his sister the mother. He is different altogether than our daughter; she can't occupy her time by herself. You can give him a little stick and send him out to play and he can make everything out of that stick you can imagine. He doesn't need other people to play with, yet when there are other children he can play with them. They know he has a catheter on. They have seen it and they accept it and treat him like he was a boy.

"At first I was real shook up about all this because I had never heard of anything like this. At the time he was born my first husband and I were on the verge of divorce, and at one time I even thought about giving the baby up for adoption before he was born, but I changed my mind after he was born, the minute I saw him.

"He dislikes anything that looks girlish to him - any kind of shirt that even looks like it might belong to a girl -- he wants everything boy's. He will play in the den by himself. Sometimes he is Superman. He will mimic quite a bit; in other words, when it comes time to comb his hair, he will comb

way back like his father. Father: He likes to go down to where I work. I think he likes to be like me. Mother: Someone may hit him hard and really hurt him and then he will come to me and cry, and I will say, 'Go fight your own battle.' One day he was mad at his brother for something -- let him have it in the stomach and took his breath away. When he gets mad he has a temper, but he treats his sister pretty well; he doesn't fight with her."

The patient's relationship to his catheter and its collecting bag is worthy of note. His mother says, "...For a while, I had to talk to him about showing it to everybody. He'd lift down his pants and show it to everybody and I had to tell him that you just don't do that. He was proud because to me and to everybody else he gave the impression that he was something special because he had this and they didn't. He thinks the tube is part of him. When they took the tube out for four months, he missed it." (Because he was uncomfortable?) "I think he missed it because it was part of him. He wasn't uncomfortable. After they took it off, they also took his bottle off. Every night he would go to bed and would want to take that bottle to bed with him even though the tube was not actually in."

The patient loves to imitate his stepfather. For example, the latter has a gun collection, and the little boy with his own toy guns imitates his father's interests in handling guns. His father manages a gas station; the child has a favorite game of playing "gas station". This is a recurring game which he may play by digging in the dirt, by building a station with blocks, or by using the cat's tail as a gasoline pump. Obviously, his interest in gas stations is overdetermined, being influenced not only by his father's profession of managing a gas station but also by the tremendous interest and concern with

his own "gas pump".

The parents are convinced that he would not wish to be changed to a girl. In a previous hospitalization for evaluation, some months before being seen in psychiatric evaluation, the possibility of his being raised from that point on as a girl was brought up by his urologist. His sister was present during the discussion. The patient's mother later heard his sister telling him that he was now going to be a girl, and he said very vehemently, "No!" Since that time, he has never again talked about it except once the day following the first discussion, when his mother told him to pay no attention to his sister for telling him he was going to be a girl.

In summary, the parents very clearly described a little boy with a masculine identity, a little boy whose relationship with his mother is good the way masculine little boys will relate to their mothers and whose relationship with his father is also good in that he uses his father successfully not only as an object of his love but also as a person from whom to learn how to be masculine. Neither his father nor his mother appear to have any significant problems in their own gender roles.

The appearance of the child himself corroborates all the information the parents give. He is an alert, friendly, intelligent, warm, and unafraid child. He is so openly likeable that one cannot adequately account for his obvious ego strengths in the face of the continually traumatic medical experiences he has suffered, except by grossly attributing his excellent mental health to his good luck in having the parents he has. He talks easily of the games he likes to play -- baseball, hunting; of his toys -- trucks and gas stations; his

relationships with his sister and brother -- the games of house in which he says he always plays the part of a father, his sister the mother, and his older brother the policeman. He talks a great deal and with great pleasure about his dog, his puppies, his cat and his chicken. In his appearance, mannerisms, and expression of interests, he leaves no doubt that his gender identity is well formed and that he is unquestionably masculine.

When asked why he was in the hospital, he picked up his tube and held it out to be seen. When asked why he had the catheter, he replied, "Because I was born ...in October." Thus he revealed not only that he knows, but also his method of dealing with the knowledge and of trying to get it out of his mind.

It is impressive that this child who has been severely handicapped anatomically, who has been subjected to many medical and surgical experiences, who knows he is abnormal and ill, whose mother was divorced early in his life -- has nonetheless progressed in a remarkably normal manner both in his general psychological development and more specifically in his development as a boy with masculine identifications. It is a tribute to his mother and his step-father that all this has been accomplished in the face of such great obstacles.

Some of the experts in the Medical Center recommended that the child be converted to a girl and that the parents' efforts now be devoted to assisting him to transform himself into a woman as the years passed. This recommendation was made because of the large amount of surgery to which the child would have to be subjected to construct an adequate penis and because this reconstructed penis would never have a sexual function. However, because he was so clearly masculine, because it was felt his gender role could not by shifted by means of

psychotherapy or other learning experiences, and because of limited life span due to kidney disease in the remaining kidney, psychiatric recommendation was that he continue to be a boy. The parents were very relieved with this recommendation, which has been followed by the attending physicians.

Case Number Two

Like the first child, this boy, now 15, also was born a genetically and anatomically normal male except for an absent penis and a perineal urethrostomy. Both testes were placed within a normal scrotum. He is the youngest of four children, the oldest a mongoloid, the next two a normal girl and a boy. Before the patient was born, his mother was no longer interested in having more children. Given the proper assignment of sex at birth, he was raised as a boy without question by a relatively uninterested mother and a natty, bejeweled father who was a perfume salesman.

At the age of 1½, he received the first of six hospitalizations that were to follow in the next five years, the last being an unbroken three year stay during which he never went home even to visit. He had many operations, a laparotomy followed by repeated plastic procedures which resulted in a phallus which a urologist has recently described as "a monstrosity", and of "unearthly appearance". It is not surprising then that in his adolescence he developed into a behavior problem at school and in the neighborhood. He has also created a fantasy life which in times of stress spills over into his real life in a paranoid manner (e.g. 'I am the grandson of God and maybe I am the Messiah." -- said in a white-faced and fear-ridden rage during a critical moment in treatment).

Out of a mass of clinical data related to the development of this boy's gender identity only two observations directly pertinent to a sense of maleness

will be discussed. The first of these is concerned with the patient's "homosexuality". Since age seven he has played sexual games with neighborhood boys. These games have evolved into ceremonies with rules that must be maintained. For example, in one called "The Pull", each of the two partners pulls forward on the other's penis in order to produce pain. The first to cry out in pain loses and must do to the other whatever the latter asks. Although the patient, with his skin pedicle, feels no pain, he will at times cry out. Both children know this is fake, but neither ever admits it. In the mutual masturbation that then follows, the patient usually permits a partner only a few minutes - timed by the watch - for he does not want his partner to have an orgasm. After this, the partner has to do exactly the same for the patient (except with anal intercourse which the patient cannot perform because the skin pedicle has no erectile ability). It is clear from his descriptions that a main purpose of these activities is to force the partner to treat him as if his "penis" were as good as one that works (a mechanism of "proving" the penis that seems related to the dynamics of exhibitionism). In addition to using homosexuality in this successful defense against loss of the sense of maleness, these activities, plus a peculiar form of masturbation to be described below, are also the patient's sexual life. He scarcely dares to contemplate heterosexuality consciously, though he is friendly with girls. He does get some instinctual gratification from these games; however, it is scarcely direct, for he has never been able to have an orgasm. He has no genital, perineal, oral or anal sexual sensations analagous to the genital sexual excitement of normals but simply feels an increased body tenseness that gradually exhausts itself. Almost every night he has a "fight",

a hypnagogic masturbatory writhing with a blanket between his legs during which he has exclusively homosexual fantasies of being ruler over a man, such as a movie star, and commanding this man to play the "games". The patient has never fantasied having an erection or an orgasm. Following the "fight" he wets the bed while asleep, this accompanied by dreams of the same activities he has thought of in his fantasies or has performed in actuality. The elements of these dreams make little recognizable use of such dream mechanisms as condensation and displacement.

There is a second factor in his life which he uses to augment his gender identity: knives. This is not simply the interest in knives seen in so many boys; though it has the same psychodynamic meaning, it is more intense and concretized. In this child, much of his personality is expressed through knives. Each has a name; each has a different function; and each has a different hiding place in his room. All of course are used for a language of aggression. For example, the knife "Uncle Eddie" is always placed in a special pocket of a special knapsack. When the patient is angry at home, he takes the knapsack off a shelf and rides off on his bicycle. He rides once around the block; if he then throws knapsack and knife on the lawn, he is only moderately angry; if he rides off with knapsack and knife, he is very angry and will be gone for an indefinite number of hours in an unknown place; if he throws the bare knife on the lawn serious trouble lies ahead.

Obviously this is a very disturbed child. Nonetheless, for all the disturbances he has in ego functions and for all the problems with identity formation, his core gender identity is intact. He has no question that he is a

male. For him, the critical issue is that, although a male, he is a very defective male. Both his normal development and his psychopathology are aimed at repairing the psychological damage or learning to live with it, not in becoming a female. He does not offer himself as a female to his sexual partners, nor is he a feminine appearing or acting person. Instead his 'homosexual' activities are a pathetic and grandiose attempt to insist to other males that his 'penis' is as good as theirs. He of course does not really believe this, but in the real-life fantasy of these sexual games there is the momentary belief that he is intact.

Discussion

We have now looked briefly at two boys who have maintained a sense of maleness although they have no penis. Let us see how the clinical material helps us with the two theses noted earlier, the first that the sense of maleness (of core gender identity) is present and permanent from earliest life, and the other that the penis is not essential to this sense of maleness. The line of argument for understanding the first thesis is as follows: A male, because of a variety of psychological and biological forces, begins from birth on to develop an increasing awareness that he is himself. That "himself" includes an awareness that he belongs to a gender, and early in life he recognizes that not everyone belongs to this gender. Later he will learn that not everyone possesses the prime insignia of this gender -- the male external genitalia, and this will be very disturbing. But by this time, he will know he is a male (whether a masculine one or not). While in the normal the male external genitalia are thus used as a sign to the individual and to society that this is a male, the external genitalia are not essential to producing the sense of maleness.

A major consequence of this line of argument is that the clinical states with which we are familiar in which there are fantasies and behavior of a feminine sort -- both in normals and those who will develop perversions -- are not evidence that the core gender identity, the sense of maleness, has been made uncertain but rather that these fantasies and their behavior overlie and hide the core gender identity. For example, behind Schreber's delusion that he can give birth as a woman to God's children is that unalterable knowledge against which in part he raises the delusion as a defense, his awareness he is a male.

The clinical data on the four-year-old boy presented above, (case 1) is offered as evidence for the thesis that the sense of maleness is established before the full-developed phallic stage. His parents report that his behavior well before the age of four already was showing a decidedly masculine flavor. It is apparent that the child is not simply normally masculine but has had to exaggerate his masculinity because of his parents' fears that he might not be sufficiently so and also because of his own independent discoveries of his defectiveness. Nonetheless, although the expressions of his masculinity are intensified, his sense of maleness is unquestioned. Establishing a sense of maleness seems to be more difficult to do without the proper genitalia. But obviously it can be done. However, it is not necessary to turn to this boy to demonstrate the thesis, for observation of any normal child of either sex from 1½ to 2 years on will already show clear distinctions between the gender roles of the two sexes.

The second thesis, that the penis is not necessary for a sense of maleness is demonstrated in each of the boys described, for each has no question he is a male.

It was stated earlier that the core gender identity is produced in the normal by the anatomy and physiology of the genitalia, by attitudes of parents, siblings and peers, and by a biological force. These three reinforce each other; to speak teleologically, their redundancy may serve the purpose of more securely guaranteeing the masculinity that will be required for procreation. Be that as it may, the cases presented here show that these three factors are not all essential. In these two cases, inadequate external genitalia in themselves did not destroy the capacity for a clear-cut core gender identity to develop so long as the parents felt unquestioningly that their child was male.

One question must be raised now, even if it cannot be answered. Though the penis played no part in these boys' gender identities, may not the testes and scrotum have done so? ~~at any rate in the two who possessed these structures?~~ Bell (1961), in a paper which is not concerned with the issues of identity being considered here, stresses the need to consider all the external genitalia, not just the penis, in order to understand castration anxiety. The same holds here. May not the sense of maleness still be created by the presence of testes and scrotum when there is no penis? I do not think so, though they undoubtedly contribute, at least by confirming to the parents that the ascription of maleness was proper. However, my not thinking so is only an assertion for which clinical evidence will have to be collected (for example, a male with no penis, testes or scrotum, who was nonetheless raised from birth as a male). In the absence of complete evidence on either side of the question, I would generally agree with Money and the Hampsons (1955, 1957), who can show in their large series of intersexed patients that

gender role is determined by post-natal psychological forces, regardless of the anatomy and physiology of the external genitalia.*

Because it leaves out consideration of the testes and scrotum I feel that the second thesis as stated in the beginning of this paper -- that the penis is not essential to the development of the sense of maleness -- is inadequate. However, it was first put in this form because almost invariably -- and incompletely as Bell indicates -- theorizing on male sexuality is done by analysts in terms of the penis instead of the totality of the external genitalia. To be more accurate, the second thesis should read that while the external genitalia -- penis, scrotum and testes -- contribute to the sense of maleness, no one of these structures is essential, nor even all together.

There is an interesting element, which you have probably noted, in both the little boy with kidney disease (case 1) and the older boy with the long period of hospitalization in childhood (case 2). Both have psychologically created a penis which carries the same symbolic, aggressive, and intrusive meaning as in normal males. For the first child, it is his catheter and collecting bottle, and for the second it is his knives. Whether there was a primitive biological ("instinctive") need for a penis which tends to compel these children to invent the organ if they cannot grow one or whether such invention is due to psychological pressures, or whether it is the result of a combination of the biological and environmental cannot be answered by the data. However, these two cases at least suggest that when a little boy knows he is a male, he will create a penis which will have similar functions symbolically as does a normal penis.

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* I would make the exception that the biological may at times play a significant role, even overpowering the kind of rearing the child is given (1963).

Summary

In order to substantiate the two theses of this paper - first that a sense of maleness (the knowledge and unquestioned acceptance that one is a male) is permanently fixed long before the classic phallic stage, and second that while the penis contributes to the sense of maleness, it is not essential, case material on two boys born without penises was presented. In each case, the boys are masculine and with a clear-cut awareness they are males, evidence for this having been present since the first signs of awakening sense of self developed.

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