TRANSADVOCATE

#DiscoSexology Part II: The Timeline

By Cristan Williams

Published January 22, 2017 | Updated March 31, 2026
https://www.transadvocate.com/part-ii-the-history-the-rise-and-fall-of-discosexology-dr-zucker-camh-conversion-therapy_n_19630.htm

Abstract

By Cristan Williams Upon completion of this series, this work will be released, in its entirety, as both an audio and ebook. Installment Preface Welcome to the second installment in this series on the rise and fall of Disco Sexology. This article will provide a concise, yet comprehensive review of the way Disco Sexology rose in [...]

Article

By Cristan Williams

Listen to this article*

Upon completion of this series, this work will be released, in its entirety, as both an audio and ebook.

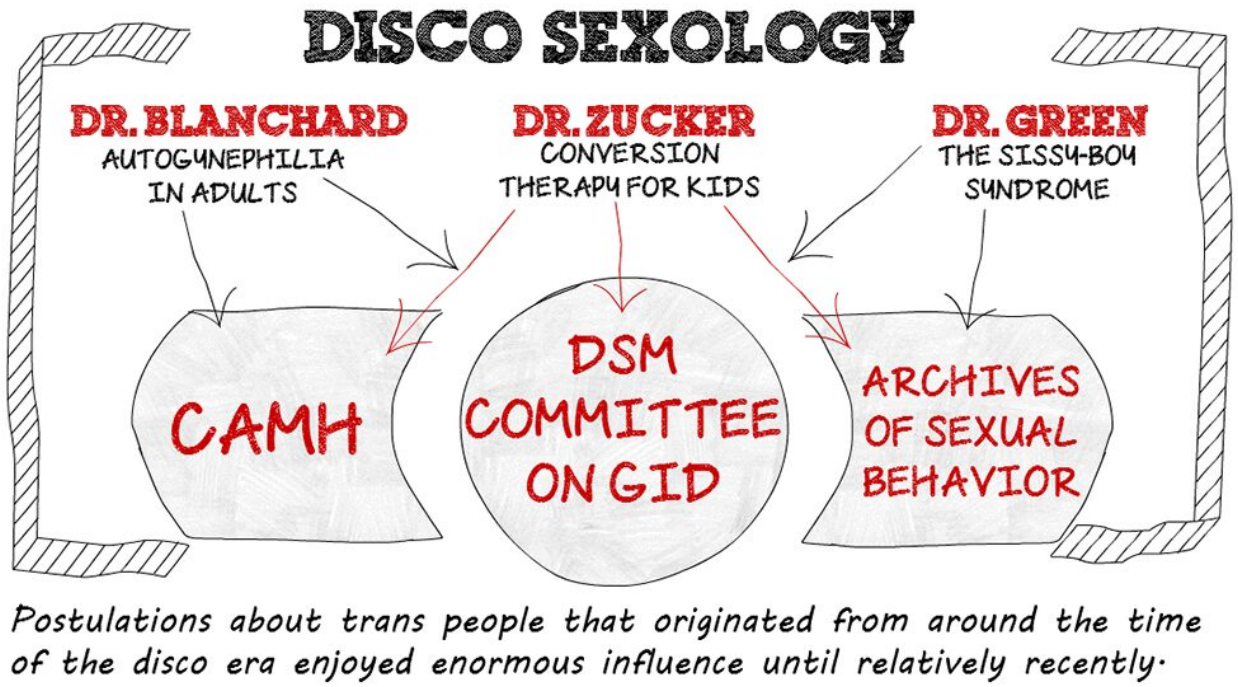


Figure 1. disco

Figure 2. div

Installment Preface

Welcome to the second installment in this series on the rise and fall of Disco Sexology. This article will provide a concise, yet comprehensive review of the way Disco Sexology rose in prominence, eventually defining the way trans and gender expansive people were pathologized as having the same mental illness: a “gender identity disorder.” Additionally, this historical account will track the rise of the critique of Disco Sexology’s metrics, beginning with feminist critiques of conflating gender role discomfort with gender dysphoria in the 1970s.

With the recent enthusiastic promotion of disco-era ideas about trans people and gender identity in general, the TransAdvocate felt that it would be important to release a comprehensive review of these ideas. In this series that will feature the tag #DiscoSexology, the TransAdvocate will review the fomentation of these gender postulations into an axiomatic body of circular logic, how this circular logic was and continues to be vigorously promoted and defended, regardless of the cost to it research subjects: children and even infants. Moreover, this series will trace the rise and fall of the Centre for Addiction and Mental Health (CAMH) gender program as envisioned by Disco Sexologists, featuring full length interviews with the clinical director of CAMH and a long term survivor of Dr. Zucker’s specialized treatment. Other interviews include:

- An interview with a Radical Feminist pioneer in affirmative care for trans people.

- An interview with the co-author of the SAMHSA's repudiation of reparative therapy and co-founder of Gender Infinity.
- An interview with the author of the groundbreaking book, The Last Time I Wore A Dress: A Memoir.
- An interview with a sexologist who dared question the gender postulations of Dr. Money and paid the price.

Along the way, this article will provide first-hand accounts of a presentation in which Drs. Zucker and Green presented back-to-back arguments against laws banning conversion therapy, as well as a comprehensive review of the uncritical media exposure disco-era gender ontology currently enjoys.

Five Pieces of Jargon

Throughout this article, I use certain jargon to conceptualize #DiscoSexology in a way that reveals rather than obscures some truths about its nature. Therefore, I've included this short review of the five concepts I use in this series:

- Opinion Leader: A group or individual that has the power to shape wider opinions.
- Ontology: Should one say, "think outside the box!" ontology is the box. In this article, "ontology" refers to institutionalized postulations concerning what it means to be trans.
- Power-Knowledge: Power created by and conferred through a knowledge-base/ontology.
- Governmentality: State-level power to modulate conduct using power-knowledge.
- Iatrogenic: Harm inadvertently caused by medical or psychological treatment.

Note: A review of terms used within trans discourse is located here.

The History

For me, the shocking truth revealed by the painful history of Disco Sexology is the corrosive hubris of an uncritical ontology. From its start in the 1970s, this ontological view of the trans experience informed practically every aspect of trans research and care, producing a self-referential power-knowledge that was cultivated into a form of governmentality through the state-run CAMH gender program. CAMH sexologist opinion leaders went on to inform the way the DSM-IV regarded the trans experience which, in turn, defined the way psychological professionals engaged the trans community around the globe.

Founded in 1968, CAMH established a gender program for youth led by psychiatrist, Dr. Susan Bradley in 1975. Until recently, the type of sexology CAMH both practiced and promoted was the product of 1970s-era gender theory. Dr. Zucker was introduced to Bradley while at graduate school and went on to collaborate with Bradley's gender identity program. Zucker became the program's clinical lead in 2001.

While Dr. Bradley was working to establish the CAMH gender identity program, Dr. Richard Green, founding editor of the Archives of Sexual Behavior, began working on a study that would inform the CAMH approach to working with gender diversity in children: The Sissy Boy Syndrome study. This study found that since almost all of a group of effeminate boys grew up to be cisgender, the authors presumed that most trans kids will therefore also grow up to be cisgender. Around this time, Dr. John Money was working on his own study concerning gender identity in youth. While Green's study continues to be cited

in mainstream news, both studies were later implicated in the deaths of their study subjects.

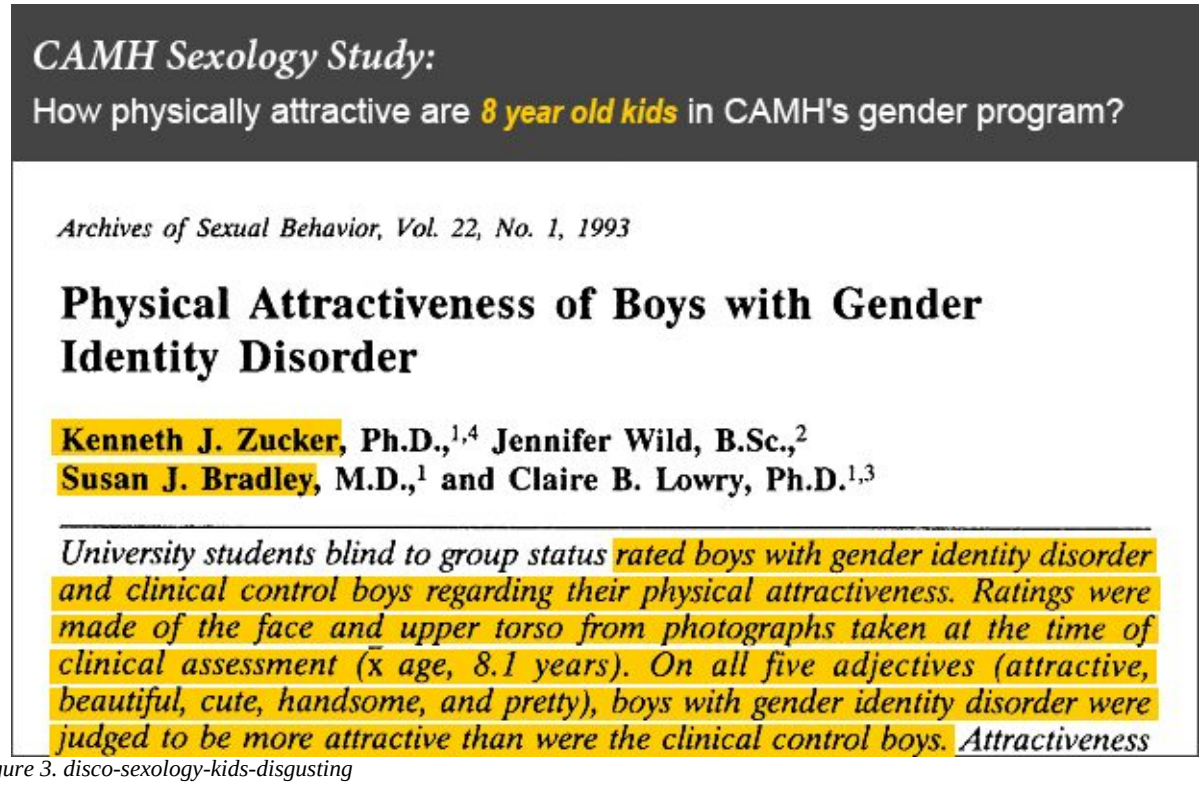


Figure 3. disco-sexology-kids-disgusting

What follows is an overview of how Green's research informed the clinical practice of CAMH's gender identity program for youth:

Comprehensive reviews of the literature by Zucker and Bradley (Zucker & Bradley, 1995, 1999; Bradley & Zucker, 1997) report that there are no definitive evaluations of interventions with children and adolescents diagnosed with GID. One study, often cited in discussions of the long-term implications of gender variance among youth is Green's (1987) report on "sissy boys." Very few discussions highlight the problematic findings of this study. Green conducted a follow-up on 66 feminine boys referred to his clinic and a control group of 56 masculine boys. He was able to contact only 44 of the feminine boys and 35 of the masculine boys for follow-up, representing a loss of approximately a third of both groups, growing concerns about biases among his remaining participants. Interestingly, of the feminine boys, only one was considering sex reassignment surgery at follow-up, but most reported same-sex or bisexual desires. Green concludes that most feminine boys eventually forgo the desire to change sex without therapy, suggesting that his sample largely consisted of "pre-homosexual" and not "pre-transsexual" boys. Green's study is a central cornerstone of early approaches to gender variant youth, yet the study has been overvalued given its biases. A better sense of what happened to Green's sissy boys was revealed in a recent report by one of the participants in Green's study. Bryant (2004), one of Green's "sissies," in a paper presented to the American Psychiatric Association, describes Green's treatments as a trauma. He reflected on Green's rejection of his femininity and said this:

I experienced this as a strong negative judgment about something I felt very deeply about myself, at

my core. As a result, I think that the main thing that I took away from my years at [Green's gender clinic at] UCLA was a kind of self-hatred and a loss of a sense of who I really was. I learned to hide myself, to make myself invisible, even to myself. I learned that who I was, was wrong.

Bryant suggests that treatment protocols for these children and adolescents, especially those based on converting the child back to a stereotypically-gendered youth, may make matters worse, causing them to internalize their distress. In other words, treatment for GID in children and adolescents may have negative consequences.

The idea that children perceive treatment for their gender variance as a threat to their self is reinforced by an emerging line of inquiry. Children receiving treatment for gender variance, they reason, will begin narrowing their interests, setting on options that they find less fulfilling and ultimately feel a "straight-jacketing of the self." Initially, Carver, Yunger, and Pony (2003) found that children who have atypical gender identifications and who are dissatisfied with their gender are distressed, especially if they feel pressure to conform to gender stereotypes.

[...]

Zucker and Bradley (1995) believe that reparative treatments (encouraging the child to accept their natal sex and associated gender) can be therapeutic for several reasons. They believe that treatment can help reduce social ostracism by helping gender non-conforming children mix more readily with same-sex peers and prevent long-term psychopathological development (i.e., it is easier to change a child than a society intolerant of gender diversity). Reparative therapy is believed to reduce the chances of adult GID (i.e., transsexualism) which Zucker and Bradley characterize as undesirable. Thus, "nipping" gender disorder "in the bud" holds the promise of an easier life for the child in adulthood, something that resonates with some parents (Bauer, 2002). Zucker and Bradley (1995) believe these goals are clinically valid and provide sufficient justification for therapy which will "help children feel more secure about their gender identity as boys or as girls" (p. 270). Indeed, Zucker (1990b) points out that reducing peer ostracism and prevention of transsexualism alone are reason enough for treatment given the distress that adult transsexuals experience.1

1966

The Clarke Institute opens

The Clarke Institute, named after eugenicist Charles Kirk Clarke, opens for business.

"Clarke's personal archive of correspondence, manuscripts and graphic materials supports a dark side profile of him that clouded his public life - seeming to extend beyond the norm even for his time and social context - as venomously anti-Semitic, bigoted against vulnerable immigrant and ethnic minorities, and a promoter of eugenics.

With a focus on Clarke's more positive attributes, however, and mindful of his dedication to institution building on behalf of Queen Street, the TGH in its move from Gerrard to College Street, the CNCMH, the TPH and the University's Medical Faculty and Department of Psychiatry, his memory was later resurrected through the naming of the TPH's successor institution, opening in 1966 as the Clarke Institute of Psychiatry. In 1998 the Province merged the Clarke Institute with three other

specialized mental health and addiction institutions, becoming the College Street Site of the Centre for Addiction and Mental Health (CAMH).

- Historical Synopsis, The Department of Psychiatry at the University of Toronto, 2008

1968

The Clarke Institute's trans program begins to take shape, led by Dr. Blanchard's colleague, Dr. Betty Steiner

[Figure] 1967: CAMH (née Clarke Institute) announcement of intent to establish gender project

The Clarke Institute begins studying the gender identity of trans people under the direction of Dr. Betty Steiner, who would later go on to co-edit Clinical management of Gender Identity Disorders in Children and Adults with the inventor of "autogynephilia," Dr. Ray Blanchard.

Dr. Steiner conceptualized heterosexual trans women as "homosexual males" and went on to co-author numerous papers with Dr. Blanchard, including the 1987 paper, Heterosexual and Homosexual Gender Dysphoria, which initiated CAMH metrics that would later come to define Blanchard's transsexual taxonomy: homosexual males and autogynephilic males. Steiner and her husband apparently committed suicide together in 1994.

Here's the official Clark Institute/CAMH 1967 announcement of the Institute's plan to formally study trans people:

TORONTO GROUP TO STUDY TRANS-SEXUALISM

Trans-sexualism, the belief by a biologically normal man that he is actually a woman or vice versa, is to be studied in the University of Toronto in collaboration with four university teaching hospitals.

The Toronto project is the first of its kind in Canada and the fourth in North America. Centers to investigate this problem have been established at Johns Hopkins Medical School, Baltimore, the University of California, Los Angeles and the University of Minnesota School of Medicine, Minneapolis.

Hospitals cooperating in the Toronto study are the Toronto General Hospital, the Wellesley Hospital, the Clarke Institute of Psychiatry and the Hospital for Sick Children.

Dr. Robin C. Hunter, professor and chairman of the university department of psychiatry and director of the Clarke Institute, said the gender identity project will study patients who present themselves with trans-sexualism as their main complaint. It is not known how many inquiries the researchers are likely to receive, but enough have been made over the past few years to indicate that such a study should be undertaken.

No decision about advocating sex-change operations could possibly be made at this stage. The reason the study is being planned is to learn more about the phenomenon.

The Baltimore centre has found that trans-sexualism occurs in eight men for every woman. Individuals who seek help from the Toronto fact-finding study will be interviewed and the study will be conducted in

depth by means of a staged multi-disciplinary evaluation, with particular reference to early family environment.

The project will be headed by Dr. Betty Steiner, assistant professor of psychiatry and a senior psychiatrist on the staff of the Clarke Institute.

1970

[TW: Death] Drs. Money, Green, & Stoller consider trans care & reparative therapy in the International Journal of Psychiatry

Dr. John Money, controversial sexologist to David Reimer and whose treatment was implicated in Reimer's suicide, used Dr. Stoller's 1964 term, "gender identity disorder" to describe the trans experience. Foreshadowing Dr. Green's terminology and Dr. Blanchard's trans taxonomy, Money conceptualized the ideal transsexual as an "effeminate-homosexual" whose childhood is "recall[ed] [as] a boyhood of having been a sissy", whom boys considered "a sissy and teased him".

Dr. Green responded to Money, writing:

The giant question marks which dot the constellation of phenomena collectively known as transsexualism motivate the student of gender identity to further research. Therefore, some questions to myself: What can be done concerning the present deficits regarding the developmental history, early symptomatology, and familial dynamics of transsexualism? Answer: One way is to study a group of young children who would appear to be of high risk with respect to the later manifestation of anomalous sexual or gender behavior, and to study their families. Most adults who request sex reassignment report difficulties in adopting appropriate gender-typic behavior during childhood.

Here, Dr. Green foreshadows what would become his Sissy Boy Syndrome study. Dr. Stoller responds to Dr. Money, suggesting a method of conversion therapy that would later come to be practiced at CAMH:

No form of psychotherapy including psychoanalysis can turn an adult transsexual into a masculine man. But reeducative therapy of very feminine boys can result in a moderately feminine but rather heterosexual man... For the last six years, my colleagues at UCLA (Baker, Green, Greenson, Newman, Rosen, Ruttenberg, and Zaitlin) have joined me in attempting to treat transsexual boys and their families. In contrast to adolescent and adult male transsexuals, whom we have so far found untreatable by psychotherapeutic means (if the goal is to make gender identity compatible with sex), the situation is more hopeful in children. We see these little boys when they start school, for it is only then that the condition becomes ego-dystonic to the family.

REEDUCATION OF THE PATIENT

The treatment of the boys is aimed much less at insight than at "reeducation." We believe the therapist should be male, to offer the boy masculinity with which to identify. This is necessary because in all the cases we have seen, the fathers are practically never physically present during the first few years of the boy's life. But more than simply being a male who is there, the therapist expresses his own pleasure in his masculinity. In addition, the therapist discourages feminine behavior and asks the boy's mother to discourage femininity and encourage masculinity.

NPR piece on Money's patient:

1971

Dr. Green starts the Archives of Sexual Behavior

Dr. Richard Green starts the journal, Archives of Sexual Behavior. In the second issue he wrote:

My focus will be what we might consider the prevention of transsexualism. Other speakers have described the considerable difficulties encountered when attempting to meet the issues raised by this phenomenon in adulthood. I believe an effort should be made to make a psychiatric intervention during a life period in which gender misidentification may be reversible, thus saving the individual a considerable amount of subsequent distress. If we are to do this, we need to focus on a pediatric population. It should be possible to study young boys who are femininely identified and delineate those symptoms which are harbingers of an adult gender identity anomaly. We need to observe and understand the kinds of familial relationships which accompany the early emergence of such cross-gender behavior.

1973

It is agreed that the diagnosis "homosexuality" would be removed from the DSM

Dr. Green worked with gay activists like Ronald Gold to successfully help to remove "homosexuality" from the upcoming DSM-III. Drs. Green, Stoller, Spitzer, and community activist Ronald Gold, who later claimed that being trans was caused by a rejection of one's gender role, participated in a session of the annual meeting of the American Psychiatric Association (APA) in Honolulu, Hawaii, on May 9. 1973. The session was titled, Should Homosexuality Be in the APA Nomenclature?:

The Task Force on Homosexuality appointed by the New York County District Branch or the American Psychiatric Association, of which I was the chairman, unanimously agreed in April 1972 that homosexuality arises experientially from a faulty family constellation. (Some few homosexuals come from an institutional background, but in our opinion, they present special problems.) It was our finding that homosexuality represents a disorder of sexual development and does not fall within the range of normal sexual behavior. Further, between one-third and, one-half of male homosexuals who seek treatment, including those who had formerly been exclusively homosexual, become exclusively heterosexual as a result of psychoanalytically oriented psychotherapy.

Activists and contemporary best practice providers of trans mental health care will immediately recognize the particular stance, regard, and power-knowledge in the above passage as it has defined the very Disco-Sexology that has held sway over the lives of trans people until recently. Here are some quotes from that symposium:

In 1968, after 15 years of clinical research, I introduced the concept that in all homosexuals there has been an inability to make the progression from the mother-child unity of earliest infancy to individuation. This was called the preoedipal theory of causation. This failure in sexual identity, normally achieved by the age of three, is due to a pathological family constellation in which there is a domineering, psychologically crushing mother who will not allow the child to attain autonomy from her and

an absent, weak, or rejecting father who is unable to aid the son to overcome the block in maturation. As a result, there exists in (obligatory) homosexuals a partial fixation with the concomitant tendency to the earliest mother-child relationship.

It is my conviction that it is necessary for all human beings to complete the separation-individuation of early childhood in order to establish gender identity. Failure to do so results in a deficit in masculinity for boys, with a corresponding intensification and continuation of the primary feminine identification with the mother; thus begins the course toward homosexual development. It may well be clear now why homosexuality is prevalent, has existed since the beginning of recorded history, and spans all sociocultural levels.

- Charles W. Socarides

There is homosexual behavior; it is varied. There is no such thing as homosexuality... As regards to pathogenesis, probably no one these days, not even among those favoring the diagnosis, believes in a unitary cause for homosexual behavior, that would make it a thing... If homosexuals hate psychiatrists who would oppress them, let them also concede their debts to those who wish them free...

In the search for the multiple causes of homosexual behavior, I believe data can be found demonstrating that for many homosexuals the preferences in object choice and some essential, habitual nonerotic behavior (e.g., the effeminacy of some male homosexuals) were developed as the result of trauma and frustration during identity development.

- Robert Stoller

As I see it, society at large does not produce a homosexual condition nor can it mitigate the inherent psychological pain. If all discrimination against homosexuals ceased immediately, as indeed it should, I do not think their anxieties. conflicts, loneliness, and frequent depressions would be short-circuited... Does the inclusion of homosexuality in the diagnostic manual make homosexuals “sick,” as they claim? Discrimination against homosexuals existed long before modern psychiatric and diagnostic manuals.

There is no reason to believe that if homosexuality were removed from the diagnostic manual there would be a significant alteration in existing social attitudes. Even if it could be shown that improved social attitudes would eventuate, this would not be reason enough to exclude the term if we agree that homosexuality is not normal and is a treatable condition. Removal of the term from the manual would be tantamount to an official declaration by APA that homosexuality is normal. Undoubtedly it would be interpreted that way. More importantly, dropping the term would be a serious scientific error. Such an action would also interfere with effective prophylaxis. Prehomosexual boys are easily identifiable and should be treated. Further, young men in conflict about their sexual direction may be discouraged from seeking treatment by those who would reassure them that their homosexual proclivities are normal and that it is only “society” with its outmoded value system, that makes them reject a homosexual preference.

- Irving Bieber

Interestingly, many who would later take up very similar rhetorical stances against trans people (eg, Dr. Green and gay activists like Ronald Gold), as is seen in the above examples of toxic

power-knowledge, were, where “homosexuality” was concerned, able to see clearly that these “disorders” were constructed, that society created the pain and anxiety gay people experience as an oppressed minority, and that the APA’s understanding of the gay experience was rooted in circular logic.

For an excellent review of this history and the implications of the addition of GID, read The Disparate Classification of Gender and Sexual Orientation in American Psychiatry.

1974

[TW: Death] Dr. Green partners with (now) disgraced anti-LGBT activist for “Deviant Sex-Role Behavior” study

Anti-LGBT activist George “Rent Boy” Rekers, who was caught by the NY Times after having spent two weeks with a male sex worker from RentBoy.com, teamed up with Dr. Green, (current) anti-conversion therapy ban activist and author of the notorious so-called Sissy Boy Syndrome study, to produce a study titled, Behavioral Treatment of Deviant Sex-Role Behaviors in a Male Child. In fact, Green facilitated this study by sending “deviant” gender expressing kids to Rekers for him to study.

Dr. Rekers was a founding member of the Family Research Council and served on the board of the National Association for Research and Therapy of Homosexuality (NARTH).

Study Abstract:

This study demonstrated reinforcement control over pronounced feminine behaviors in a male child who had been psychologically evaluated as manifesting “childhood cross-gender identity”. The clinical history of the subject paralleled the retrospective reports of adult transsexuals, including (a) cross-gender clothing preferences, (b) actual or imaginal use of cosmetic articles, (c) feminine behavior mannerisms, (d) aversion to masculine activities, coupled with preference for girl playmates and feminine activities, (e) preference for female role, (f) feminine voice inflection and predominantly feminine content in speech, and (g) verbal statements about the desire or preference to be a girl. The subject was treated sequentially in the clinic and home environments by his mother, trained to be his therapist. The mother was taught to reinforce masculine behaviors and to extinguish feminine behaviors, by using social reinforcement in the clinic and a token reinforcement procedure in the home. During this treatment, his feminine behaviors sharply decreased and masculine behavior increased. The treatment effects were found to be largely response-specific and stimulus-specific; consequently, it was necessary to strengthen more than one masculine behavior and weaken several feminine behaviors, in both clinic and home settings. A multiple-baseline intrasubject design was used to ensure both replication and identification of relevant treatment variables. Follow-up data three years after the treatment began suggests that the boy’s sex-typed behaviors have become normalized. This study suggests a preliminary step toward correcting pathological sex-role development in boys, which may provide a basis for the primary prevention of adult transsexualism or similar adult sex-role deviation.

[Figure] Kirk Murphy during Reker & Green’s sexology treatments | Source: boxturtlebulletin.com

The Death of a Research Subject

According to the child's parents, Drs. Green and Rekers administered therapy to their child, Kirk Murphy. Rekers referred to Murphy as "Kraig" in his work and in Green's study the Sissy Boy Syndrome, Murphy was referred to as "Kyle." After receiving Rekers' treatment, Reker claimed that Murphy was "found to have normal gender identity and emotional, social, and academic adjustment." While Green reported that Murphy was bisexual, wanted to be a girl (prior to his treatment), and had attempted suicide at 17 (after his treatment), Green asserted that none of the "sissy boys" in his study were "obviously harmed."

Murphy committed suicide in 2003. Murphy's ordeal was recounted in a 2013 amicus brief:

At the age of 17, Kirk attempted suicide for the first time. The following year, Kirk explained to Dr. Richard Green, one of the leading advocates for removing homosexuality from the DSM in 1973, that he had a sexual encounter with a man weeks before his suicide attempt.

Kirk told Dr. Green that he felt guilty that the SOCE "treatment" he underwent at UCLA had failed to "fix" him, and admitted that he had tried to kill himself because he did not want to be gay.

Kirk was not able to recover from the severe harm that he suffered as the result of being exposed to SOCE at a young age, and ultimately took his own life at the age of 38. Through the painful process of losing her brother and then learning what was done to him under the auspices of government-sanctioned [conversion] "treatment," [Kirk' sister] Maris became committed to protecting other minors from being exposed to the dangerous junk science that cost Kirk his life.

1975

Clarke Institute's GID youth program begins, led by Drs. Zucker & Blanchard's colleague, Dr. Susan Bradley

The Clark Institute/CAMH youth GID program is started by Dr. Susan Bradley. Bradley would go on to help Dr. Zucker administer gender therapy to more than 400 children. Consider Bradley's own words:

We all found these children and their families quite fascinating and I was convinced there was something physical that we could research. When we were joined by Ken Zucker our capacity to examine the functioning of these children and their families really allowed us to develop a complicated formulation integrating temperamental and dynamic factors into our understanding of GID. This journey has been eventful and filled with lots of competing ideas and controversies.

Under Ken [Zucker]'s leadership we made a significant contribution to the field. Our book Gender Identity Disorder and Psychosexual Problems in Children and Adolescents, published in 1995, continues to be the main reference in this area. In an era where much of psychiatric formulation is reduced to the five axes of the DSM, the patients we have the privilege to see through the Child and Adolescent GID clinic, continue to intrigue me with the constant challenge to make sense of complicated family/child dynamics and biological factors.

As part of my interest in developmental psychopathology I became convinced from the beginning of my career that a focus on prevention was worth pursuing even though the specifics of how to do this were not clear. One of my first jobs was as consultant to a therapeutic nursery program (Thistletown

Preschool). In this setting, I learned how to do behavior management, something not taught in our residency program at that time. - Susan Bradley

A 2009 right-wing paper that draws from “Catholic Bioethics,” anti-GLBT and anti-abortion activist Paul McHugh, and Trans Exclusionary Radical Feminists (TERFs), focused on Drs. Zucker and Bradley’s sexology to justify conversion therapy for trans people:

Kenneth Zucker and Susan Bradley’s book Gender Identity Disorder and Psychosexual Problems in Children and Adolescents represents years of work with patients with GID. According to their clinical model for boys with GID, the disorder begins in early childhood with an insecure mother-child relationship and tends to affect boys who are emotionally vulnerable:

The boy, who is highly sensitive to maternal signals, perceives the mother’s feelings of depression and anger. Because of his own insecurity, he is all the more threatened by his mother’s anger or hostility, which he perceives as directed at him. His worry about the loss of his mother intensifies his conflict over his own anger, resulting in high levels of arousal or anxiety.

When anxiety occurs at such a sensitive developmental period, the child may choose behaviors common to the other sex, because in his mind these will make him more secure or more valued.

In her book Affect Regulation and the Development of Psychopathology, Susan Bradley classifies GID with internalizing anxiety disorders:

What makes GID different from anxiety disorders is that there are factors in the family making gender more salient. Specifically, boys with GID appear to believe that they will be more valued by their families or that they will get in less trouble as girls than as boys. These beliefs are related to parents’ experience within their [own] families of origin, especially tendencies on the part of mothers to be frightened by male aggression or to be in need of nurturing, which they perceive as a female characteristics.

The child’s first experiments of identifying with the other sex may be subtly or openly rewarded with smiles, particularly by the mother. She or other females in the family may exclaim, “Look how cute he is dressed up in his mother’s shoes. He would be a pretty girl,” or something similar.

Zucker and Bradley explain a mother’s positive reaction to cross-sex behavior in her baby: “The mother’s need for nurturance and fear of aggression allow her to tolerate these behaviors, which may also be reinforced by her perception of her son as attractive; her tolerance may actually lead to a positive response to the initial crossgender behaviors. The mother may be unwilling to make the child “unhappy” by discouraging cross-dressing, while the father may be convinced that his son is going to become homosexual. It is only later, when identifying with the other sex leads to teasing and rejection, that the mother becomes concerned. Zucker and Bradley have found that many parents of these boys when confronted with obvious symptoms of GID “profess a rather marked ambivalence,” ignoring the problem until it is impossible to do so. Presumably, those with even more ambivalence never seek help.

Because of their own problems, parents are sometimes unable to meet their child’s needs for security, acceptance, love, and a positive image of his or her own sex. In contemporary culture, fathers often bond with their sons through sporting activities and may not know how to help boys to incorporate their

special creative, artistic, or other non-athletic talents into their masculinity. Fathers with creative or artistic sons need to learn how to support and affirm these interests as authentically masculine. Parents may also fail to appreciate the importance of helping these boys in early childhood to develop strong male friendships with boys who share their interests.

In some cases, a parent may have wanted a child of the opposite sex, and dresses and treats the child as being of the opposite sex. Some parents pressure the school to allow the child to cross-dress school, and may even take the child to a transgender support group. Family dysfunction leaves the child vulnerable:

The parents' ongoing difficulties in dealing with the child's cross-gender behaviors may intensify the child's anxiety and insecurity, but also permit the child to develop a fantasized but valued opposite-sex self. With development and the repeated need to use this fantasized other self, the child may be very resistant to relinquishing this defensive solution. (Zucker)

What's important to note about the above rhetoric is that there exists remarkably little difference between the ontology of a right-wing group advocating reparative therapy and Disco Sexology. Below are more quotes from this op-ed, published in the anti-abortion group, The National Catholic Bioethics Center:

- "Ray Blanchard, of Clarke Institute of Psychiatry in Toronto (now part of the Centre for Addiction and Mental Health), has spent years studying and treating transsexuals. He identified two distinct syndromes: homosexual transsexuals (HT) and autogynephilic transsexuals (AT). J. Michael Bailey's book The Man Who Would Be Queen explores the difference between the two."
- "Resistance to SRS is not limited to religious conservatives. Some lesbian and radical feminists, such as Janice Raymond, feel that men who have undergone SRS, who were not born female and so have never experienced growing up as women, have no right to claim to be women or, as they do in some cases, claim to be lesbian women."
- "Those who believe that it is impossible to change a person's sex do not want to be insensitive to others, but neither should they be forced to lie by calling a man a woman or by calling a woman a man."

1978

Modeled after Dr. Green's "Sexual Identity Conflict", GID is added to the DSM-III draft

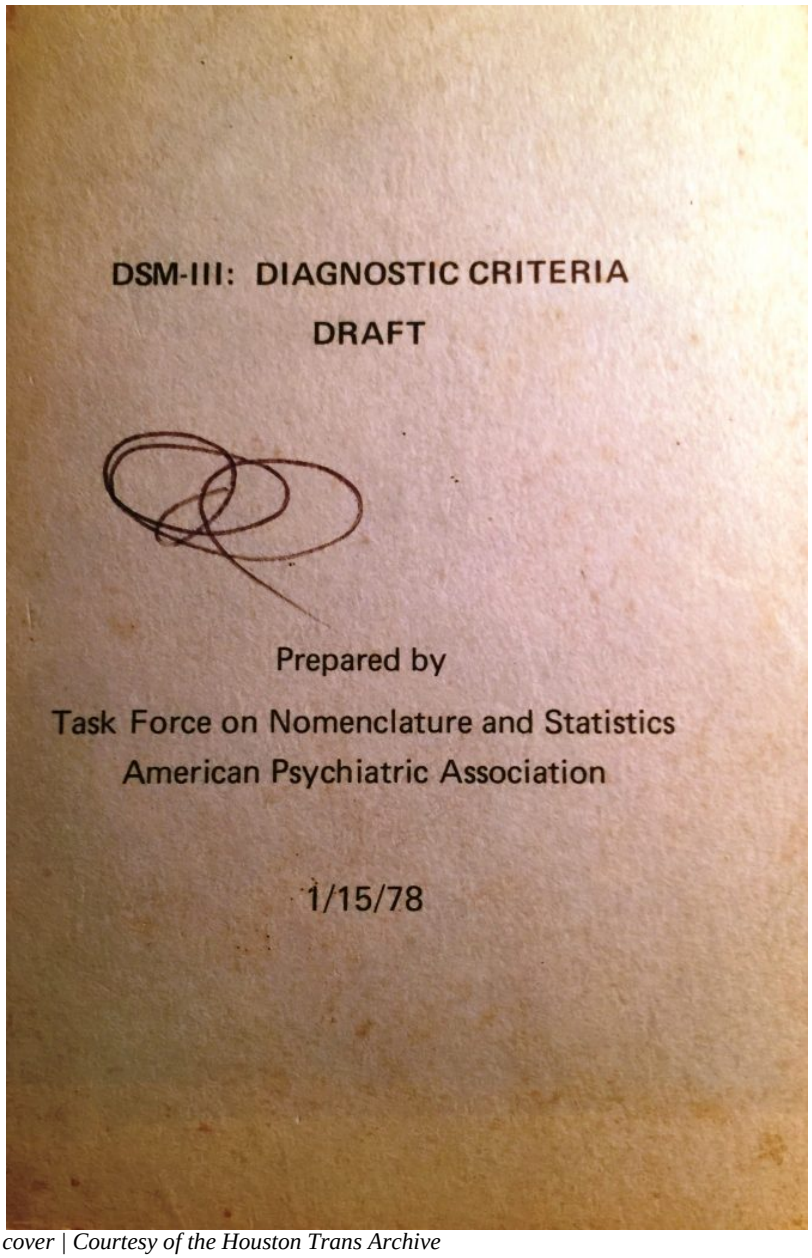


Figure 4. DSM-III draft cover | Courtesy of the Houston Trans Archive

Draft DSM-IIIs, including a handheld version called the “Mini-D”, is published. Noted sexologist, Dr. Spitzer, who initially supported the removal of homosexuality from the DSM, but who, in 2003, published a (now retracted, but originally published by Dr. Zucker) paper claiming that homosexuality could be cured, was the chair of the DSM editing board. Spitzer initially criticized his detractors as being politically correct saying that the study, “questions the politically correct view that once you’re gay, that’s it and suggests that there is more flexibility than many people have assumed.” In 2006, Spitzer asserted:

Granted that hormone therapy or surgery may now be the only treatment that we can now offer the adult with GID... But surely something remains profoundly wrong psychologically with individuals who are uncomfortable with their biological sex and insist that their biological sex is of the opposite sex. The

only diagnosis that is appropriate for such cases is GID.

The DSM-III draft replaced the diagnosis of “homosexuality” with “ego-dystonic homosexuality;” “transsexualism” and “gender identity disorder of childhood” were added as subclasses of “gender identity disorders,” which itself was a subclass of “psychosexual disorders.” Early versions of this GID entry were modeled after the transsexual ontology presented by Dr. Green in his 1974 book, Sexual Identity Conflict in Children and Adults in which he asserts that transsexuals are primarily concerned with achieving “sex roles” of the “opposite sex.” Consider the following takeaway from a review of Green’s book:

The second major section of Green’s book deals with young children who show extreme cross-sex identity and behavior... In this section, Green also reveals his own point of view, or theory, which is largely experientially, learning-oriented. He lists 10 variables relevant to the development of typical femininity in boys, and he observes that the most necessary variable is that, as any feminine behavior begins to emerge, there is no discouragement of that behavior by the child’s significant caretakers.

Green’s interest in studying boys, of course, stems rather naturally from his earlier work with adult TSs. It is indeed true that many of these children present a picture that is completely consistent with the one that adult TSs paint of their own childhood. The data are consistent with the hypothesis that many extremely feminine boys will grow up to become, in the absence of favorable environmental actions, adult transsexuals, effeminate homosexuals, or transvestites... Green acts on these data and provides treatment for feminine boys. A chapter discusses the treatment rationale and methods.

It was stated above that the TS wants to act in accordance with the traditional sex role.2

While Dr. Green was involved with early work on the DSM-III, he was fighting bitterly with Dr. Spitzer. Green was later removed from the DSM-III workgroup and a more feminist understanding of the difference between gender role and gender dysphoria became evident in the post-Green draft. This draft version largely equates “gender identity disorder” with a transsexual experience of dysphoria with one’s physical sexed attributes, whether in children or adults. For children, merely rejecting cultural gender roles and stereotypes was not enough to diagnose a child with GID: “Differential diagnosis. Children whose behavior does not fit the cultural stereotype of childhood masculinity or femininity but do not have the full syndrome.”

While this distinction between being transsexual and being gender nonconforming was later very deliberately removed when CAMH sexologists became more involved in the GID Workgroup, feminists worked hard to ensure that Dr. Spitzer would make this distinction more clear in the DSM-III. Consider the following excerpt from The Making of DSM-III: A Diagnostic Manual’s Conquest of American Psychiatry:

[T]he largest group of documents in the Archives are letters to and from Ann Laycock Chappell, M.D., a member of the APA Committee on Women. Chappell had apparently been sent a copy of the DSM-III draft, and she, in turn, had duplicated sections about which she was troubled and sent them to various professional women for comment... The Archives also contains an exchange of letters between Chappell and Spitzer that chronicle a winning exchange in the making of DSM-III. Much attention in the opening letters was focused on the diagnosis of “Gender Identity or Role Disorder of Childhood”...

Chappell sent all the replies she had received to Spitzer, who appeared both bemused and taken aback by the large volume of material and chose to deal with the situation humorously. “I have decided to become famous by editing a book on the correspondence regarding Gender Disorders of Childhood. Since you are largely responsible for engineering this literature, would you like to be co-editor? On a more serious note, I am, to say the least, a little overwhelmed by all of the input from your female network. Can I expect to get from you a summary of what you think we should do with specific rewriting of the offending section?” This being the early days of the feminist movement, Spitzer was obviously unfamiliar with the seriousness with which some women viewed the unequal status of women... We should also note that with the women’s objection to the Gender Identity descriptions we see another favorite tactic of Spitzer when he faced complaints about material in DSM-III. He turned to the objector and asked her or him to provide specific changes and rewritten text for himself and the Task Force to consider, thus placing the burden on the critic, who many times withdrew.

But that did not happen this time. Chappell replied in a week with a three-page letter, which unfortunately is missing page 2 in the Archives. But on the first page there is a long discussion of the “Gender identity Disorder of Childhood” repeating twice the “potential for harm” that was contained in the category as written. Moreover, Chappell declared:

A major concern is that the category tries, but fails, to differentiate true identity confusion with failure to follow sex stereotyped roles... Such a failure is unforgivable and unacceptable. There is a real philosophic argument on how to impart gender identity without imparting sexual stereotypes [but] it does become imperative ... that in these criteria we must remove all sex-stereotyped material.

[...]

Soon after his letter to Chappell, Spitzer made serious efforts to carry out the women’s proposals and objectives. He informed the “Advisory Committee on Gender Identity” of Chappell’s positions, enclosed the correspondence that Chappell had earlier forwarded to him, and asked the Committee how the category could be “defined without reliance on stereotyped sex behavior, which most of Dr. Chappell’s respondents found objectionable.” Within two months, Spitzer and Jon Meyer of the Psychosexual Disorders Committee rewrote the Gender Identity Disorder of Childhood section and sent it out for comments from the people who had originally written the section and from Chappell.

If one compares the Gender Identity Disorder of Childhood section in the April 15, 1977 draft of DSM-III with the section in the revised draft of January 15, 1978, it is readily apparent that almost the entire category had been reworked with an attempt to meet the concerns of Chappell and the other critics. In the later draft, under “Essential Features” and “Diagnostic Criteria:’ the discussions of boys and girls were done separately. The new descriptions were written so as to stress the significant pathology of the disorder, and they explicitly declared, “There is not merely the rejection of stereotypical sex role behavior as, for example, in ‘tomboyishness’ in girls or ‘sissyish’ behavior in boys.”

Again, it should be noted that after CAMH sexologists became part of the Gender Identity Disorder Workgroup, the distinction between the transsexual and gender non-conforming experience was purposefully removed. Studies that later claimed that most children grow out of being trans were based upon later criteria wherein a child could be diagnosed with GID without having ever experienced gender

dysphoria.

While the incorporation of the feminist perspective of not pathologizing gender nonconforming children was a positive step, the DSM-III, nonetheless, conceptualized heterosexual trans women as homosexual gay men. This (mis)understanding of the sexuality of trans people would be carried forward, forming the ontological basis of Dr. Blanchard's trans typology of so-called "autogynephilia" in 1989.

For an account of the way GID was used to lock up and institutionalize trans youth, giving rise to anti-trans reparative therapy, read The Last Time I Wore A Dress. See also first-hand accounts of the way the psychiatric community failed to grasp the way their pathologization of the trans experience would stigmatize trans people.

1979

Dr. Paul McHugh manages to shut down the Johns Hopkins gender program because he thought it was the "grimmest in the practice known"

When Dr. McHugh began working at Johns Hopkins, his goal was to force the closure of the hospital's gender program saying, "It was part of my intention, when I arrived in Baltimore in 1975, to help end it." McHugh went on to describe his professional assessment of how and why transgender medical care was made available at Johns Hopkins:

The zeal for this sex-change surgery-perhaps, with the exception of frontal lobotomy, the most radical therapy ever encouraged by twentieth-century psychiatrists-did not derive from critical reasoning or thoughtful assessments. These were so faulty that no one holds them up anymore as standards for launching any therapeutic exercise, let alone one so irretrievable as a sex-change operation. The energy came from the fashions of the seventies that invaded the clinic-if you can do it and he wants it, why not do it? It was all tied up with the spirit of doing your thing, following your bliss, an aesthetic that sees diversity as everything and can accept any idea, including that of permanent sex change, as interesting and that views resistance to such ideas as uptight if not oppressive. Moral matters should have some salience here.

Compare Dr. McHugh's fact assertions about the genesis of the Johns Hopkins' program with the way the program's creator, Dr. John E. Hoopes, described the program in 1966:

After exhaustively reviewing the available literature and discussing the problem with people knowledgeable in the area. I arrived at the unavoidable conclusion that these people need and deserve help... Over the years, psychiatrists have tried repeatedly to treat these people without surgery, and the conclusion is inescapable that psychotherapy has not so far solved the problem.

1980

The DSM-III is published

While feminists were able to help ensure that differences between (social) gender role and (anatomical) gender dysphoria were recognized, the DSM committee nonetheless conflated form with function, and defined "gender identity" as, "the private experience of gender role." The DSM asserted

that transsexuals exhibit “considerable anxiety and depression, which the individual may attribute to inability to live in the role of the desired sex.” Transsexuals were considered homosexuals if they engaged in penis-in-vagina sex. This sexual ontology would form the basis of Dr. Blanchard’s trans typology of so-called “autogynephilia” in 1989.

The diagnosis code for “transsexualism” was 302.5x and the code for “gender identity disorder of childhood” was 302.60.

1981

Dr. Zucker starts working at the Clarke Institute GID youth program

CAMH sexologist, Dr. Ray Blanchard invents “autogynephilia”

Using the trans ontology of early 19th and 20th century German sexologists -gender expression and sexual arousal are linked, so that gay effeminate men and trans women must exist along the same sexual orientation continuum- Dr. Blanchard borrowed from a postulation presented in a 1970 paper published by H.T. Buckner, asserting that crossdressing behavior in humans begins as a masturbatory preoccupation (Buckner’s paper also asserts that electroshock therapy cured crossdressers). Taken with the understanding of “gender identity” asserted by the DSM-III, Blanchard added to Buckner’s German/American-gender/sexuality postulation mashup, constructing an amalgam of 1970s-era and early German sexology thought to then postulate that trans women are, in actuality, extreme forms of homosexual men and/or are sexually aroused by transition.

Dr. Blanchard’s autogynephilia (AGP) postulation now appears in the DSM-5 as a subtype of a “Transvestic Disorder” and is not diagnostically linked to the transsexual experience:

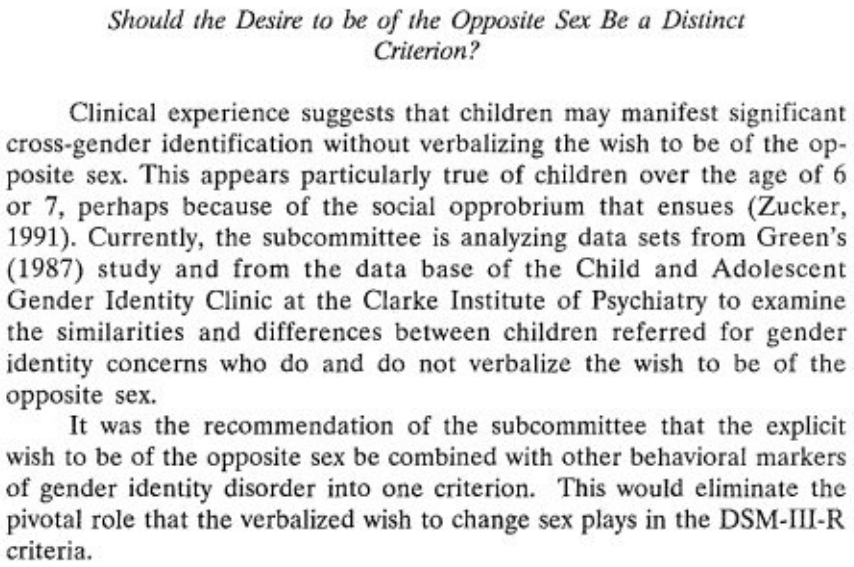
“Transvestic disorder in men is often accompanied by autogynephilia (i.e., a male’s paraphilic tendency to be sexually aroused by the thought or image of himself as a woman). Autogynephilic fantasies and behaviors may focus on the idea of exhibiting female physiological functions (e.g., lactation, menstruation), engaging in stereotypically feminine behavior (e.g., knitting), or possessing female anatomy (e.g., breasts).” - DSM-5, p 703

This is not waving a magic wand and a man becomes a woman and vice versa,” he says. “It’s something that has to be taken very seriously. A man without a penis has certain disadvantages in this world, and this is in reality what you’re creating.” - Dr. Blanchard

Dr. Kelley Winters said, “It’s important to note that Blanchard has offered two definitions to his AGP term. The first is the plain language meaning that describes the phenomenon of eroticized self-image in non-birth assigned gender roles. The second is his theory of AGP that all, not some but all, transsexual women whose sexual orientation does not meet his definition of strict attraction to men (which includes political and intellectual dissent) are motivated to transition by erotic self-obsession. When he’s cornered on the latter, he pivots to the former as a red herring argument.”

1991

Dr. Bradley chairs the GID DSM-IV Workgroup, Dr. Zucker becomes an opinion leader



Should the Desire to be of the Opposite Sex Be a Distinct Criterion?

Clinical experience suggests that children may manifest significant cross-gender identification without verbalizing the wish to be of the opposite sex. This appears particularly true of children over the age of 6 or 7, perhaps because of the social opprobrium that ensues (Zucker, 1991). Currently, the subcommittee is analyzing data sets from Green's (1987) study and from the data base of the Child and Adolescent Gender Identity Clinic at the Clarke Institute of Psychiatry to examine the similarities and differences between children referred for gender identity concerns who do and do not verbalize the wish to be of the opposite sex.

It was the recommendation of the subcommittee that the explicit wish to be of the opposite sex be combined with other behavioral markers of gender identity disorder into one criterion. This would eliminate the pivotal role that the verbalized wish to change sex plays in the DSM-III-R criteria.

Figure 5. Citing Green & Zucker to target non-transsexuals for a GID diagnosis

Dr. Bradley becomes Chair of the DSM-IV GID workgroup. Of the eight Workgroup members, a third were sexologists from CAMH. These sexologists included Drs. Bradley, Zucker, and Blanchard. Moreover, Dr. Green joined the workgroup and his Sissy Boy Syndrome study was used by the group to justify diagnostic criteria that targeted both transsexual and non-transsexual children for the clinical diagnosis of GID.

This departure from the DSM-III standard was justified in the 1991 DSM-IV GID Workgroup interim report. Under the section, Should the Desire to be of the Opposite Sex Be a Distinct Criterion?, the Workgroup asserted:

Currently, the subcommittee is analyzing data sets from Green's (1987) study and from the data base of the Child and Adolescent Gender Identity Clinic at the Clarke Institute of Psychiatry to examine the similarities and differences between children referred for gender identity concerns who do and do not verbalize the wish to be of the opposite sex. It was the recommendation of the subcommittee that the explicit wish to be of the opposite sex be combined with other behavioral markers of gender identity disorder into one criterion. This would eliminate the pivotal role that the verbalized wish to change sex plays in the DSM-III-R criteria.3

This passage explicitly states that the type of sexology promoted by Dr. Green informed the GID standards that facilitated diagnosing children with GID without the child actually wanting to physically transition. More problematically, this standard -a standard which very purposefully created a mixed diagnostic pool of gender dysphoric and non-gender dysphoric children- was used to support the claim that most children grow out of their gender dysphoria. In fact, Dr. Zucker would later state that a full "70% of the children we see [at CAMH for treatment] are sub-threshold for GD." 4

Additionally, in 1991 Dr. Zucker became a Senior Psychologist for the CAMH GID youth program.

1998

In a peer-reviewed follow-up on the positive outcome of using puberty blockers on a trans kid, the misinformation of Drs. Green, Bradley, & Zucker is credited as being the reason medical help was not available to trans kids

A 1998 peer-reviewed case report follow-up notes the positive outcome of the use of puberty blockers on a transsexual youth:

European Child & Adolescent Psychiatry
7:246–248 (1998) © Steinkopff Verlag 1998

CASE REPORT

P.T. Cohen-Kettenis
S.H.M. van Goozen

Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent

Accepted: 8 June 1998

P.T. Cohen-Kettenis (✉)
S.H.M. van Goozen
Department of Child and Adolescent Psychiatry of the Utrecht University Hospital, P.O. Box 85500
NL-3508 GA Utrecht
The Netherlands
e-mail: P.T. CohenKettenis@psych.azu.nl

Abstract Early cross-sex hormonal interventions (that is, between 16 and 18) as a treatment for young transsexuals are often considered to be risky. However, the delay of such treatment until after the development of secondary sex characteristics has obvious drawbacks for transsexual individuals. This paper reports a postoperative follow-up case-study of a female-to-male transsexual who was treated with a combination of an LHRH agonist (which delayed her secondary sex characteristics development) and psychotherapy at age 13, and subsequently underwent sex reassignment at 18.

Key words Gender identity disorder – transsexualism – adolescence – sex reassignment – hormone treatment

However, this report cites Drs. Zucker, Bradley, Green (specifically, Dr. Green's Sissy Boy Syndrome study), and Zuger5 in the second sentence of the paper: "Prospective studies have shown that most GID children under 12 will not grow up to become transsexuals."6 Specifically, this 1998 report credits the misinformation disseminated through Zucker, Bradley, Green and Zuger's flawed trans ontology as being the reason medical help wasn't accessible to trans youth at that time:

Prospective studies have shown that most GID children under 12 will not grow up to become transsexuals (5[Dr. Green citation], 13[Drs. Zucker & Bradley citation], 14[Dr. Zuger citation]). Because of this, hormonal or any other medical intervention is never considered in prepubertal children.

However, for some adolescents applying for sex reassignment, medical interventions may be a treatment option. Until recently, clinicians have been reluctant to start hormone treatment before the age of 18 or 21. It was felt that only in adulthood gender identity could be consolidated enough to allow for decisions regarding invasive interventions such as hormone and surgical therapy. Such a relatively late treatment start, however, has it drawbacks. Some individuals who have shown a pattern of extreme cross-sex identification from toddlerhood onwards may develop psychiatric disorders, e.g., depression, anorexia or social phobias, as a consequence of their hopelessness. Social and intellectual development may be adversely influenced. Also, the physical treatment outcome following interventions in adulthood is far less satisfactory than when treatment is started at an age at which secondary sex characteristics have not yet been fully developed. This is obviously an enormous and life-long disadvantage...

In some gender identity clinics a selected group of transsexual adolescents are now being treated hormonally before they are legal adults (age 18), but still after the age of 16. A careful diagnostic procedure includes more rigorous eligibility criteria than used for adults and a prolonged diagnostic procedure. The first follow-up study of adolescent transsexuals showed that 1--5 years after surgery the now young adults functioned socially and psychologically satisfactory and that none had regrets in their decision. They functioned psychologically better than a group of transsexuals, who was treated in adulthood and evaluated with partly the same instruments (2). Despite these initial positive results, even younger adolescents (between 12 and 16 years) who wish to apply for sex reassignment have no other option than to wait for several years.

While this 1998 Dutch study was part of Dutch research that was going on (since the 1980s) which informed what became collectively known as the “Dutch Protocols” in 2006, by as early as 1997, Dutch research into the positive outcomes of puberty blockers in trans youth was being published in the peer-reviewed literature. From 1997:

In Holland adolescents are referred for hormonal treatment (and surgery) to members of the Free University Hospital Gender Team, which is responsible for the treatment of 95% of the Dutch adult patients. Partial hormone treatment blocks the action of sex steroids in a reversible way: the male-to-female bodies do not masculinize any further, and the female-to-male patients Stop menstruating and sometimes experience a weakening of breast tissue (Gooren and Delemarre-van de Waal, 1996). Full hormone treatment is not reversible and masculinizes the female body or feminizes the male body. It is given before the age of 18 only when the patient has responded favorably to the partial hormone treatment.

2001

Dr. Zucker begins running the CAMH GID youth program & Dr. Green’s Archives of Sexual Behavior

2002

Dr. Blanchard accepts an award for CAMH’s work with trans people from Division 44

[Figure] Blanchard receiving an award for CAMH, August 2003 | Source: CAMH Newsletter

The CAMH gender identity program receives an award from the American Psychological Association's Division 44. Dr. Blanchard accepted the award on CAMH's behalf.

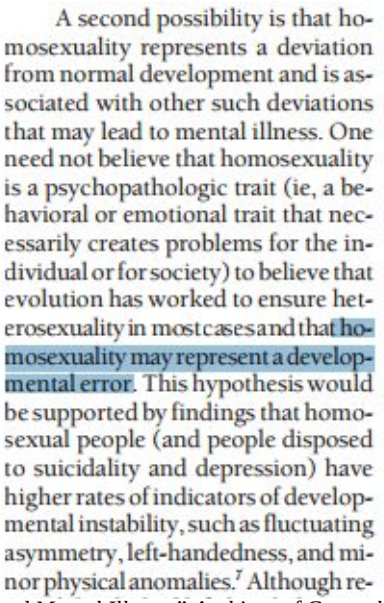
The award reads:

"The Gender Identity Clinic has established itself as the premier research center on gender dysphoria, has remained on the frontiers of gender dysphoria and clinical care since 1968, and is celebrating its 35th year."

The award presenter, Dr. James S. Fitzgerald, was a gay man who supported the notion that transsexual women were actually homosexual men, a view which is the foundation of Blanchard's autogynephilia postulation.

2003

Sexologist Dr. Bailey, publishes The Man Who Would Be Queen, introducing "autogynephilia" to pop culture.



A second possibility is that homosexuality represents a deviation from normal development and is associated with other such deviations that may lead to mental illness. One need not believe that homosexuality is a psychopathologic trait (ie, a behavioral or emotional trait that necessarily creates problems for the individual or for society) to believe that evolution has worked to ensure heterosexuality in most cases and that homosexuality may represent a developmental error. This hypothesis would be supported by findings that homosexual people (and people disposed to suicidality and depression) have higher rates of indicators of developmental instability, such as fluctuating asymmetry, left-handedness, and minor physical anomalies.[7] Although re-

Figure 6. Bailey, J. Michael. "Homosexuality and Mental Illness." Archives of General Psychiatry 56, no. 10 (1999): 883. doi:10.1001/archpsyc.56.10.883.

TMWWBQ

The Man Who Would Be Queen (TMWWBQ) by sexologist Dr. J. Michael Bailey is published, supporting Drs. Green, Zucker, Blanchard and Bradley's trans ontology while also introducing the idea of autogynephilia to popular culture. TMWWBQ was nominated by a TERF for the LAMBDA Literary award; the award was then withdrawn after the trans community protested the nomination.

"To focus on this question, we have to assume that whatever means parents will use to do this are, in themselves, morally acceptable. So, if you have any problem at all with abortion, assume that pregnant

women can guarantee a heterosexual child by, say, taking a pill, or avoiding certain foods, or even by reading their children certain bedtime stories. What would make avoiding gay children wrong?" - TMWWBQ, p 114

The CAMH sexologist Dr. J. Michael Bailey, criticized as a neo-eugenicist neo-eugenicist7 8, was repudiated by the central figure in his trans research, Anjelica Kieltyka. Kieltyka, duped into being a primary source for supplying Bailey, with other likewise uninformed trans research subjects, lodged an official complaint with Bailey's research employer, Northwestern University for significantly misrepresenting her history. Moreover, it was alleged that Bailey practiced psychotherapy without a license. In the end, the university sealed its investigation and Bailey was allowed to step down as the university's Chairman of the Psychology Department.

The anti-LGBT hate group NARTH endorsed TMWWBQ while the hate watchdog group, Southern Poverty Law Center, issued a bulletin about the "science" found in TMWWBQ:

But Bailey does have company. Many of those who praised his recent book, The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism, belong to a private cyber-discussion group of a neo-eugenics outfit, the Human Biodiversity Institute (HBI).

This exclusive group of academics, race scientists and right-wing journalists -- along with a reported handful of liberals -- exchanges thoughts about "differences in race, sex and sexual orientation" for a chilling purpose: promoting and studying "artificial [genetic] selection."

The Man Who Would Be Queen is only the latest in a series of controversial studies and articles by HBI members, many of whom are bent on overturning the most widely held psychological and scientific views of gender, sexual identity and race.

But Bailey's book has brought negative publicity to this "anti-PC" movement, both because of Bailey's controversial conclusions and because most of the transgendered women profiled in his book say they never knew they were going to be written about.9

An in-a-nutshell review of the controversy surrounding TMWWBQ was published in 2004:

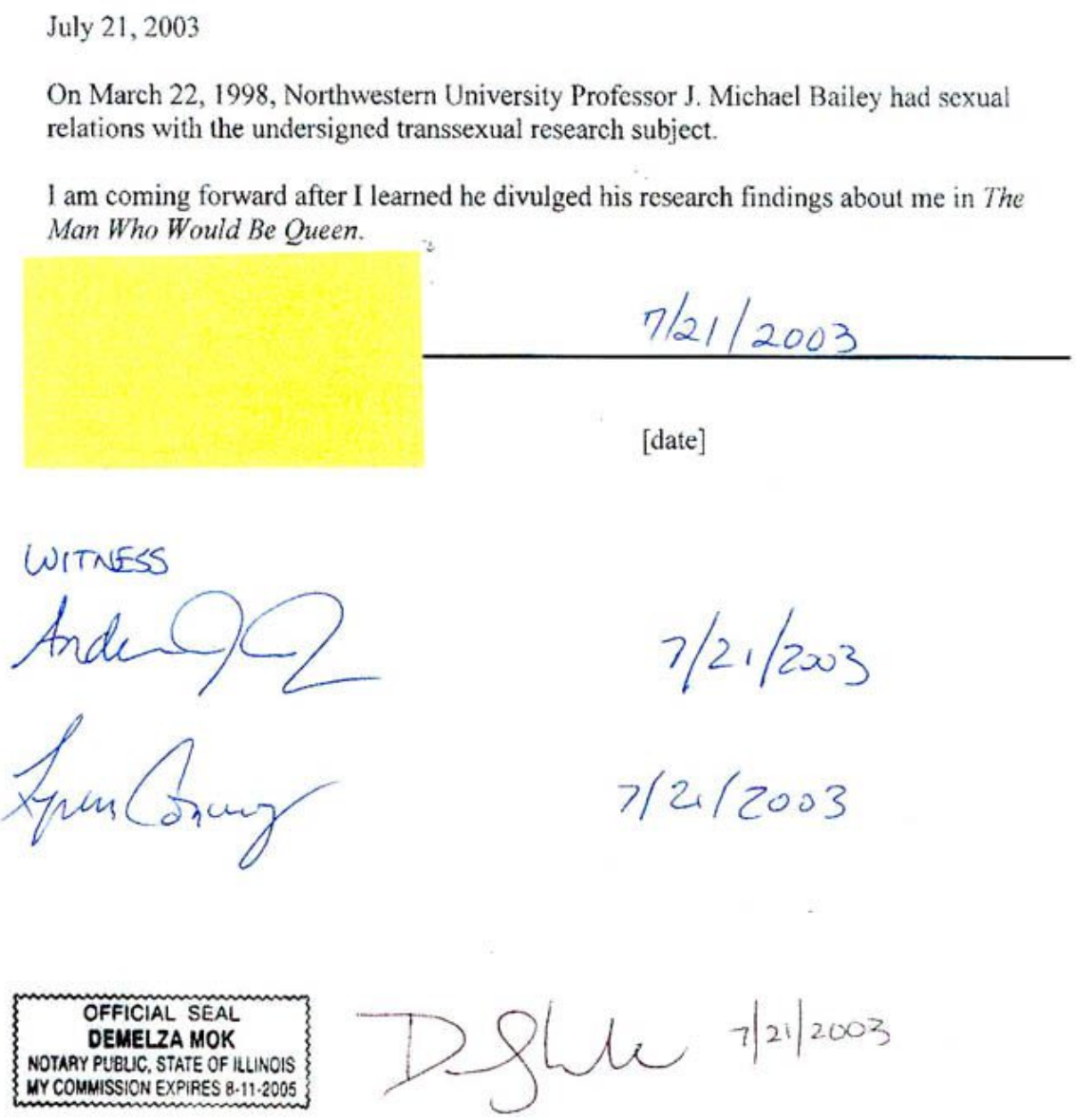
"J. Michael Bailey was visiting the popular Chicago nightclub Crobar to recruit subjects for a study on transsexuals and drag queens, and found himself especially entranced by a transsexual he called Kim. She is spectacular, exotic and sexy, he wrote in The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism. Her body is incredibly curvaceous, which is a clue that it may not be natural. It is difficult to avoid viewing Kim from two perspectives: as a researcher but also as a single, heterosexual man.

It's this sort of rumination that has gotten Bailey, now chairman of Northwestern University's psychology department, and an expert on the biological origins of human sexuality, into trouble. His book, published last year, has sparked both a bitter ideological dispute and an ongoing university investigation that will likely have ramifications far beyond the Bailey case.

In the minefield of sexual research on human subjects, preconceptions can easily taint observations, and the intimacy between researcher and subject can overtake objectivity. The Man Who Would Be Queen is presented as science, but at times it seems more like a voyeuristic memoir by a man admittedly

fascinated by the links between sexuality and gender.

Some transsexuals have charged that the book is lurid and unscientific, with a half-dozen (some of whom have never met Bailey) complaining to Northwestern that he failed to obtain written “informed consent” from his human subjects a federal and university requirement for scientific research. One transsexual further claimed that Bailey had sex with her two years after writing a letter backing her sex-reassignment surgery, an allegation Northwestern subsequently dismissed.



July 21, 2003

On March 22, 1998, Northwestern University Professor J. Michael Bailey had sexual relations with the undersigned transsexual research subject.

I am coming forward after I learned he divulged his research findings about me in *The Man Who Would Be Queen.*

[redacted] 7/21/2003

[date]

WITNESS

7/21/2003

7/21/2003

OFFICIAL SEAL
DEMELZA MOK
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8-11-2005

7/21/2003

The crux of the issue is whether or not Bailey’s book is science, or a work of journalism. If it isn’t science, Bailey would have had no obligation to follow regulations on scientific research requiring that he submit his project proposal to a Northwestern University Institutional Review Board; nor would he have needed his pseudonymous subjects formal written consent.”10

Bailey's sexual relationship with his "research subject"

Dr. Walter Bockting repudiated TMWWBQ in The Journal of Sex Research writing, "the book will appeal to those who share Bailey's essentialist point of view while alienating those who favor a biopsychosocial perspective."11

2008

Dr. Zucker chairs the DSM-5 GID Workgroup, Dr. Dreger defends CAHM sexology in Zucker's (previously Dr. Green's) journal

Sexual and Gender Identity Disorders

KENNETH J. ZUCKER, PH.D.
Chair

Lori Brotto, Ph.D., *Text Coordinator*
Irving M. Binik, Ph.D.
Ray M. Blanchard, Ph.D.
Peggy T. Cohen-Kettenis, Ph.D.
Jack Drescher, M.D.
Cynthia A. Graham, Ph.D.
Martin P. Kafka, M.D.
Richard B. Krueger, M.D.
Niklas Långström, M.D., Ph.D.
Heino F.L. Meyer-Bahlburg, Dr. rer. nat.
Friedemann Pfäfflin, M.D.
Robert Taylor Segraves, M.D., Ph.D.

Figure 7. Members of the DSM-5 GID Workgroup

Dr. Zucker is appointed the chairperson of the DSM-5 "Sexual and GID workgroup." Two years after being appointed the chair of the Workgroup, Zucker announced that Workgroup transparency will take place through his journal, the Archives of Sexual Behavior. Moreover, he announced that community feedback would be considered by the Workgroup if submitted to the Archives of Sexual Behavior, and be no more than 1500 words in length:

Publishing these reviews in the *Archives* is part of the transparency process that is of critical importance to the DSM-V Task Force. It allows interested members of the scientific community and other stakeholders to scrutinize the thinking of our Work Group and to provide feedback. In our post-modern era, where a micro-thought is just a twitter away, the scientific periodical is, I hope, still a useful forum for reflection, critique, and dialogue.

Commentaries that are no more than 1500 words in length will be considered for subsequent publication in the *Archives*. Commentaries should be submitted to Kenneth J. Zucker, Ph.D., Editor, *Archives of Sexual Behavior* at Ken_Zucker@camh.net. The commentary should be submitted as an e-mail attachment using WORD, should contain a brief title, the author's complete mailing address, and the use of the reference style of the American Psychological Association.

Figure 8. Arch Sex Behav (2010) 39:217-220

The same year that Dr. Zucker was made chair of the GID Workgroup, the Archives of Sexual Behavior published a defense of The Man Who Would Be Queen -and CAMH sexology- by the sexologist Dr. Alice Dreger.

2015

CAMH sexology practices come under heavy scrutiny, Dr. Zucker is fired from CAMH

CAMH's practices come under scrutiny after media confronts its clinical director with a statement Dr. Zucker made to the media in which he admits that his therapy is designed to "lower the odds" of children becoming trans adults. After an independent review finds that the CAMH gender program is insular and out of step with current ethical practices, Zucker is fired, and the program begins the process of restructuring. The following media timeline tracks the problematic representation of CAMH by Zucker in the media:

February 2015

"That is welcome news for a number of therapists and activists who say the clinic Dr. Zucker heads tries to prevent kids from growing up to identify as trans, and could even put his clients at greater risk of depression and other mental illness later in life.

"He really instills a sense of shame," says Hershell Russell, a Toronto psychotherapist who has worked with adults who saw Dr. Zucker as children. Some of those clients "have never been able to shake that sense that there's some awful, embarrassing, shameful thing that's wrong about me."

While Dr. Zucker can't comment on individual patients, he describes his approach quite differently than Zane's parents. "We are trying to help a child feel more comfortable with the gender identity that matches their birth sex," he said in an interview. "That way, you are lowering the odds that as such a kid gets older, he or she will move into adolescence feeling so uncomfortable about their gender identity that they think that it would be better to live as the other gender and require treatment with hormones and sex-reassignment surgery."

- National Post, Canada

March 2015

In an interview with the National Post published this year, Zucker indicated his therapy would prevent children from growing up to be transgender.

"You are lowering the odds that as such a kid gets older, he or she will move into adolescence feeling so uncomfortable about their gender identity that they think that it would be better to live as the other gender and require treatment with hormones and sex-reassignment surgery," he said.

Upon learning that Zucker had said that, [CAMH Clinical Director] McKenzie told Metro: "That's not what we're supposed to be doing."

- Metro News, Canada

June 2015

"This week, Ontario became the first province to legally ban so-called conversion therapy for LGBT children when it passed the Affirming Sexual Orientation and Gender Identity Act.

Conversion therapy, also known as reparative therapy, is designed to “cure” children and adults from being gay, an effort often associated with religious practices. The same term is used to describe attempts to reverse the gender identity of a child to prevent them from growing up trans.

- CBC News, Canada

2016

A defense of CAMH sexology is nominated for Lambda Literary Award, Drs. Zucker & Green condemn conversion therapy bans for trans kids

LAMBDA Literary Award Nomination

A book that defended The Man Who Would Be Queen and CAMH sexology, including autogynephilia, by the sexologist Dr. Alice Dreger is nominated for a LAMBDA Literary award; the award was withdrawn after the trans community protests its promotion of Disco Sexology.

“The Lambda Literary foundation this week withdrew an award nomination from the author Alice Dreger, for her book Galileo’s Middle Finger. While Dreger and her allies are already playing the victim card, the truth is that Dreger, her ideas, and the people she defends are deeply transphobic and inextricably linked with hate groups working to legislate transgender people out of public life.

In Dreger’s book, she defends The Man Who Would Be Queen by J. Michael Bailey. Bailey’s 2003 book promotes the pseudo-scientific theory that there is no such thing as transgender people, just self-hating homosexual men who believe they could have guilt-free sex if they were female and heterosexual men with an out-of-control fetish (autogynephilia). This theory has helped paint transgender people as hypersexualized perverts -- a smear that has devastating consequences that affect more than just trans people.

- The Advocate

Green & Zucker: Anti-Reparative Therapy Laws Denounced

Figure 9. Green (top) and Zucker (bottom) at WPATH, 2016

Green (top) and Zucker (bottom) at WPATH, 2016

Drs. Zucker and Green gave separate back-to-back presentations at the 2016 WPATH Symposium, both taking a stand against laws banning reparative therapy. Dr. Green falsely claimed that bans on reparative therapy was a violation of free speech while Zucker falsely claimed that reparative therapy bans make trained therapists too afraid to work with trans and gender expansive kids.

Figure 10. div

1. Karasic, Dan, and Jack Drescher. Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation. New York: Haworth Press, 2005.

2. Bentler, PM. Sex Roles; Jun 1978, Vol. 4 Issue 3, p 461, 4p

3. Bradley, Susan J., Ray Blanchard, Susan Coates, Richard Green, Stephen B. Levine, Heino F. L. Meyer-Bahlburg, Ira B. Pauly, and Kenneth J. Zucker. Interim Report of the DSM-IV Subcommittee

on Gender Identity Disorders. Archives of Sexual Behavior 20, no. 4 (1991): 333-43. doi:10.1007/bf01542614.

4. Zinck, Suzanne, and Antonio Pignatiello. External Review of the Gender Identity Clinic of the Child, Youth and Family Services in the Underserved Populations Program at the Centre for Addiction and Mental Health. Report. CAMH. 11.

5. Dr. Zuger was a New York-based doctor who went on to publish work with Drs. Blanchard, Zucker, Money, Green, and Bradley. The Zuger study that is cited in this 1998 report itself cites the work of Zucker, Bradley, Green, Money, and Dr. “rentboy” Rekers to support his gender identity claims.

6. About this Dr. Kelley Winters wrote: “Dr. Zucker is technically correct in this sentence, only because he and the Clarkeites influenced the DSM-IIIR and DSM-IV GIDC criteria to be met by mere gender nonconformity. The pants-on-fire falsehoods happen when he and others substitute ‘gender dysphoric children’ for ‘GID children’ and get away with it”.

7. “Well, the evolutionary hypotheses about homosexuality, and I have reviewed these very carefully...I’m writing a paper on them...they have all been, in my opinion, quite lame, um, and this is another place where sensitivity has impeded careful thought. I mean, one thing to realize is that evolutionarily, homosexuality is a big mistake. ” - Bailey, J. Michael in 91.7 FM Interview. KOOP. May 2003.

8. “...homosexuality may represent a developmental error. This hypothesis would be supported by findings that homosexual people (and people disposed to suicidality and depression have higher rates of indicators of developmental instability...” - Bailey, J. Michael. “Homosexuality and Mental Illness.” Archives of General Psychiatry 56, no. 10 (1999): 883. doi:10.1001/archpsyc.56.10.883.

9. Beirich, Heidi, and Bob Moser. A Group of Scientists and Journalists Tries to Turn Back the Clock on Sex, Gender and Race Using Eugenics and Controversial Genetic Theories. Intelligence Report, December 2003.

10. Ethical Minefields: The Sex That Would Be Science. Seed Magazine. June 14, 2004. Accessed November 30, 2015. https://web.archive.org/web/20040614034224/http://www.seedmagazine.com/?p=article&n=above&id=130.

11. Bockting, Walter O. Biological Reductionism Meets Gender Diversity in Human Sexuality. The Journal of Sex Research 42, no. 3 (August 2005): 267-70.

Suggested citation

Cristan Williams. "#DiscoSexology Part II: The Timeline." TransAdvocate, January 22, 2017. https://www.transadvocate.com/part-ii-the-history-the-rise-and-fall-of-discosexology-dr-zucker-camh-conversion-therapy_n_19630.htm