

Zucker: Manipulation of Young Feminine Boys

By Curtis E. Hinkle

Labels define and labels stick. But, what about statistics? Statistics lie so it is said. Or, is it that people lie?

When examining the work of Kenneth J. Zucker, we find labels, statistics, and lies. Although many homosexuals have been described as being masculine in behavior, an examination of their lives in childhood has found that many were “feminine” in behavior. (1) Reports of extreme boyhood “femininity” had also been thought to characterize male to female transsexualism. (2) In fact, there had been disagreement as to whether such extreme femininity dating back to age one or two was a representation of what would become “feminine” male homosexuality (3), or true transsexuality, known also as primary transsexualism or total psychosexual inversion (4).

Such extreme boyhood “femininity” had attracted the attention of clinicians and researchers for years. Richard Green of the UCLA Gender Identity Clinic saw them. Bernard Zuger saw them. Their descriptions were almost uniform. They were already stating they wanted to be girls or they were girls, often at the ages of 2 or 3. They were cross-dressing. They were playing with girls exclusively or almost exclusively and were playing with girl’s games exclusively or almost exclusively. Their behavior was overt. It was very observable and it was obvious. So obvious that many would be brought in to a clinician for evaluation and treatment.

However, others (5) rarely ever saw these same boys later as adult men presenting at sex change clinics as transsexuals and desiring sex reassignment surgery. Reports of this extreme “feminine” behavior were conspicuously lacking in those presenting for SRS. The lack of such stories in adult sex change applicants, led Chiland (5) to ask, “Is there such a thing as a transsexual child” (page 55). She had only seen two examples that would fit this description, although her group of adult transsexuals was over 200. Lothstein (see p.c. in ref. 5) had reported 3 in 1988 and 2 examples in 1992, and had worked with over 600 transsexuals. Fisk, who coined the term gender dysphoria, saw a wide representation of clinical histories amongst his group’s applicants for sex change. (6)

If these applicants who were adults seeking sex reassignment did not report extreme feminine behavior on any consistent basis (when such reports would have most likely impressed the “gatekeepers” and helped convince them of the “obviousness” of their “femininity”), then what label could adequately describe the majority of the children who did report extreme feminine behavior and if such reports were not substantiated by observations from others close to them as children, would such a label stick when they presented for sex reassignment?

We do get some ideas as to what these individuals were like as children. Chiland (5) described the situation as follows:

“The disorders that may lead to transsexualism in adults may thus be perfectly silent in childhood as far as an observer, parents, or teachers are concerned...the child has no clear idea why he feels bad, and will only give his trouble a name on reaching puberty.”

This is far from statements that the child wants to be a girl, or says he is a girl. Chiland (5) writes further:

“An outside observer may notice that something is wrong with the child, but they cannot imagine, any more than the subject himself, that the child is suffering from a disorder of gender identity.”

Again, this is far from what would be seen in the other boys described as already cross dressing at the age of 2 or 3, who were playing exclusively or almost exclusively girls' games and with girls. The following is more typical of the childhood of those who present at sex change clinics:

“we see an isolated boy who is ill at ease, does not make friends, and does quite badly at school. But the child has no clear idea why he feels bad, and will only give his trouble a name on reaching puberty.” (5)

Furthermore, these adult SRS candidates in adulthood, usually did not show “signs of trouble with their gender identity in childhood that might have attracted attention...very few were taken to clinics” and “still fewer were treated”. (5) Remarkably, “some were treated in childhood or early adolescence, with whom the question of gender identity never arose either in evaluation or in treatment; they were referred and treated for other reasons.” (5) When they thought their therapist would be more intuitive and the therapist wasn't, “they became more and more silent and eventually refused to continue the treatment”. (5)

Another group (7), when evaluating adult transsexuals, also found that those without extreme “femininity” in boyhood represented a group which had gender identity as the main motivation for seeking sex reassignment and re-labeled these individuals primary transsexuals. They were typically asexual and did not display homosexual behavior nor, as mentioned, were they extremely feminine acting in childhood. They write: “In our series of ten primary transsexuals, nine showed no evidence of effeminacy in childhood... As far as we can make out, they did not engage in girl's activities or play with girls any more than did normal boys... All ten of our primary transsexuals were socially withdrawn and spent most of their time after school by themselves at home... In effect, they were childhood loners...” (7) They further write: “to summarize, then, in childhood, the primary transsexual is not effeminate, but he feels either abhorrence or discomfort in boyish activities.” (7) If boys with extreme “feminine” behavior in childhood are not the primary transsexuals, then who are these boys studied by Green (8), Zuger (9), and others? If their behavior is so effeminate in childhood, yet they do not typically request sex change, what happens to them? It is in the follow-up studies, such as those by Green (8) and Zuger (9), which give us the answer. Green (8) studied 44 very

effeminate boys from childhood into adulthood and found that $\frac{3}{4}$ of them became homosexual (N=18) or bisexual men (N=14).

Around $\frac{1}{4}$ of them became heterosexual. Only one out of 44 was stated by Green to be transsexual, and Chiland (page 127) notes: "I felt that Green was pushing him further in transsexualism than the subject himself was going." (5) The subject was later reported to have said: "I don't feel like a woman. I want to feel like a woman." (5).

What have others found? Have they also found that these extremely "feminine" boys did not become transsexual, but instead became largely effeminate homosexual adult men? Indeed they have. Zuger (9) studied 55 boys, figures of which could only be accurately obtained for 45 of them in adulthood. 35/45 boys (77.77 %) had a homosexual or bisexual orientation (nearly identical to Greens' findings), 3 boys were heterosexual, and 7 boys (15.55%) were of uncertain outcome. Of the homosexually oriented boys (N=45), only one was deemed transsexual. Thus, Zuger concluded that effeminate behavior in childhood is the first stage of homosexuality. (page 63 in ref. 5).

When comparing Green (8) and Zuger's (9) findings, the probability that feminine acting boys will become transsexual is only between 2-3 %. Cohen-Kettenis (10) reported on follow-up of 74 children who were claimed to have gender identity problems and found that a higher percentage (23%) had applied for sex reassignment. However, her study did not state the sex of the child. Older reports by several other authors also indicate that "feminine" behaving boys do not turn out to be transsexual, but largely turn out to be adult homosexual men. (11-13).

What all of these findings point out is that feminine or effeminate type behavior in childhood represents behavior – gender role behavior and a higher incidence of homosexuality as the outcome. Indeed, feminine behavior in boyhood does not identify transsexualism or gender identity per se. Gender identity may be defined as "the merging of the concept of gender with the intrapsychic concept of identity" (page 120 in ref.14). Thus, what is observed in these "feminine" behaving boys, is their gender **ROLE**. Identity as a construct is a self-image, a sense of belonging to, an intrapsychic self-concept, which can't be labeled by just observing and categorizing behavior. It may only be inferred. It may be inferred from an interpretation of another's behavior, or from the evaluation of another's self-report. Each is fraught with its own difficulties. First, behavior need not be in accord with one's sense of self, emotions, or thoughts. Secondly, self-reports need to be believed by others, if one is to claim to be able to accurately gauge them.

In "feminine" behaving boys, the role behavior is clearly feminine to some, although it may be argued that typical young girls do not behave as such, and thus that these boys' behavior is a caricature (i.e., effeminate and not feminine). That they grow up not to think of themselves as women, and not desire sex reassignment, but instead identify as gay men, indicates that although their gender role behavior may be "feminine", and that although their sexual orientation may be pre-homosexual, that their gender identity, is in fact male. We may observe their role behavior, (whether it be cross-dressing, attempt at

penile removal, a gait, or aggression) and can only infer about its relationship to their identity. And, while we can listen to their self-reports that they are girls, or want to be girls; we do not know what they mean when they say that they are girls or want to be girls. We can only, in error claim that they have a gender identity disorder, when in fact, upon maturity, we see that it is not their gender identity which is affected. Conversely, for the other boys, those who do not behave in a “feminine” way in childhood, but are timid, withdrawn or shy, and who do not self-report that they think of themselves as girls, again, we can only errantly state that they do not have a gender identity disorder, since they struggle and hide silently, and that on maturity we realize their struggles when they appear at sex change clinics.

We have no way to state that they have a gender identity disorder of childhood. It is because of these factors, that we can state that the diagnosis of gender identity of childhood in the Diagnostic and Statistical Manual of Mental Disorders (DSM) is fallacious. It is the misrepresentation by so-called professionals of some very basic tenets of human understanding. When GID of childhood was placed in the DSM in 1980 (15) and in the DSM-R in 1987 (16), the outcome of extreme boyhood “femininity” was not well known. (Green’s work (8) and Zuger’s (9) work were in progress). Thus, these professionals’ misrepresentation of these boys may be justified. However, with subsequent revisions of GID in childhood diagnoses, as found in the 1994 updated DSM IV (17) and the 2000 updated DSM IV TR (18), we still find that boys who are largely pre-homosexual and who have gender ROLE behavior which is highly unusual are mislabeled as having a gender identity disorder, despite no evidence to support that gender identity per se is involved and despite evidence to the contrary.

We also see that maintaining this erroneous classification has a unifying thread and that those who are the most vocal representatives defending this erroneous classification work for the Canadian government, specifically the Province of Ontario – in particular, Kenneth J. Zucker who was on the 1994 subcommittee (with his colleague from Canada, Susan J. Bradley) and was one of only four on the 2002 subcommittee, and who is currently slated as being head of the current subcommittee for DSM V. (19)

When we examine the work of Zucker (20), we find, that he knows well that gender identity disorder of childhood represents largely a pre-homosexual clinical picture, that it does not fit in with what he and his colleagues refer to as gender identity, that it instead relates to what his colleagues know to be sexual orientation and gender role behavior, and that it thus pathologizes sexual orientation and gender role behavior. But we also find that it also serves more primary goals. It only pathologizes children who fit this category until they become adults and then they do not have a disorder anymore, due to homosexuality being removed from the DSM in 1973. But to have a category of pre-homosexual boys remain in the DSM, under the mis-label of GID, Zucker and his colleagues can make it look like GID of adulthood is highly inflated due to the logical expectation that a GID of childhood will become a GID of adulthood.

In fact, Zucker’s colleague Bailey (21) states: “Zucker thinks that an important goal of treatment is to help the children accept their birth sex and to avoid becoming transsexual.

His experience has convinced him that if a boy with GID becomes an adolescent with GID, the chances that he will become an adult with GID and seek a sex change are much higher. And he thinks the kind of therapy he practices helps reduce this risk.” (page 30). (It was under Zucker’s colleague Susan J. Bradley, that in 1994, transsexualism was omitted from the DSM IV and replaced by GID of adulthood) (17).

Since as we have discussed, transsexualism cannot be identified in childhood, it’s abusive that this change of transsexualism in adulthood to GID of adulthood uses homosexual boys to pathologize adult transsexuals. Since it uses GID of childhood which is not about gender identity, one could be led to believe that transsexuality or even intersex (under gender identity disorder not otherwise specified) is also not about gender identity. In fact, that is what Zucker’s colleagues Ray Blanchard (22) and J Michael Bailey (21) are proposing. In all of their research, as well as the contention by Zucker (20) that gender identity is malleable, there have been NO studies which have sought to correlate the effects of hormones on gender identity with the known times of differentiation of sexually dimorphic human brain nuclei or regions, or the exploration that transsexuality is the result of neural growth factors which render the brain even “more female or more male” than is found in typical males and females. These are major limitations of the interpretation of the findings of Zucker’s (20, 23) as well as other research involving atypical sexual development (24).

In regards to GID of childhood not being about gender identity, for Zucker, this classification creates additional problems. Although the “inexperienced clinician” may easily be lead to believe that GID of childhood is about gender identity, and that it does progress to a GID of adulthood, every time Zucker gives a diagnosis of GID of childhood on a claim form to the Ontario government, we should be suspicious.

We know that he knows that it is largely (pre-)homosexuality which he is diagnosing, despite that homosexuality is not considered a mental disease. We know that he knows that adolescent transsexuals which he diagnoses as having GID are likely the same – pre-homosexuals. That would be an incredible amount of billing for diagnoses which he knows fits on paper (to him and his colleagues’ DSM efforts), but does not fit in with actual results because they are homosexuals. Thus, we have misdiagnosis in theory, but he is able to bilk the taxpayers, because most won’t think that GID is not ABOUT GID. But, that is only the beginning of the problem for Zucker. As his colleagues are quick to say, the DSM diagnosis, does not in and of itself suggest particular types of treatments. This is a red herring because Zucker has his own treatment and can suggest the same treatment to others.

Zucker further knows himself that extreme feminine boys usually turn out to be adult gay men and not transsexual. Zucker (20) writes: “Follow-up studies of boys who have GID that largely is untreated, indicated that homosexuality is the most common long term psychosexual outcome” (pg. 562). The key word in Zucker’s statement here is the word UNTREATED. Zucker acknowledges that GID boys most commonly turn out to be homosexual adult men, not adult transsexuals. This is in striking contrast to his recent documentary statement that “when one engages in psychotherapy” with children and

adolescents with gender dysphoria that one may find that many give up the wish for a sex change and come to an alternative to the “only way I can feel good about myself” is with a sex change. (25). It also contradicts his colleague’s description of Zucker’s view that, “Zucker thinks that an important goal of treatment is to help the children accept their birth sex and to avoid becoming transsexual”. (21) With this statement, Zucker’s colleague, J Michael Bailey, exposes Zucker’s “treatment” as fraudulent, since we have already seen that Zucker knows that most of these boys DON’T become transsexual, but instead become non-transsexual adult homosexual men. Thus without Zucker’s treatment, they mainly become gay men anyway; and thus, Zucker has no proof of his own fraudulent claims. We are not surprised then, that Bailey again exposes Zucker’s “transsexual prevention” treatment of GID boys as fraudulent and baseless, by this following comment, “Zucker believes that most boys who play with girls’ things often enough to earn a diagnosis of GID would become girls if they could. Failure to intervene increases the chances of transsexualism in adulthood, which Zucker considers a bad outcome. ...Zucker ...is the first to acknowledge that no scientific studies currently support the effectiveness of what he does.” (21)

We strongly recommend, in the interest of the protection of Canadian taxpayers and the health of Canadian citizens, that investigation into Zucker’s and his colleagues’ grant applications be carefully evaluated for fraud, that is, to see if Zucker has indeed suggested in grant applications, that any type of treatment he is employing, or requested grant money for, is in fact having an effect on the gender identity outcome of GID boys. This is from the research side of things. From direct clinical services, we also suggest, that the Canadian government, carefully review ALL claim forms for monetary coverage of children with GID and related issues whom Zucker has treated, along with those who have co-treated them, in order to see if their GID diagnosis co-exists with services billed to the government for treatment which Zucker has already indicated is non-scientific and which is not substantiated. Such would be a violation and abuse of such childhood victims as well as fraudulent use of health care dollars, since it is reasonable to expect amongst healthcare systems that a treatment for a condition is indeed meritorious and not fraudulent.

The diagnostic manual (DSM) does not suggest treatment. It is only for diagnostic purposes. Zucker’s colleagues are well aware of this. BUT, any treatment thus taken, must have demonstrated its efficacy, and further must indicate whether it is experimental, along with risks to the patient (in this case the patient’s parents). Moreover, even if it were found that Zucker has declared the treatments to be experimental, and even if all risks were carefully “spelled out” to the parents of the children, it would also follow that evidence which is contrary, such as presented here, would need to be told to the parents as well. To not do this, would be to violate certification/licensure regulations and to engage in practice which is unethical and detrimental.

Now that we have shown that Zucker’s treatment in fact does not largely prevent adult transsexuality and that Zucker knows that there is no scientific proof for what he does, and that he knows that the vast majority of boys with GID will develop into homosexual men, we will take 4 further examinations.

(A) Does Zucker's treatment or therapy have an effect on the sexual orientation outcome of boys with GID (does it help prevent or cure homosexuality)?

(B) Does the replacement of adult transsexuality with adult GID and addition of GIDNOS into the DSM IV in 1994 (17), under the direction of CAMH clinician (and Zucker colleague) Susan J. Bradley, use this replacement term of GID and its association with pre-homosexual boys, to pathologize adults with transsexuality and intersexed persons? (Note: pre-homosexual boys are removed from pathology categorization when they become 18, due to homosexuality being removed from the DSM in 1973. (Adult transsexuals and intersexed persons with GID/GIDNOS, are pathologized well into adulthood).

(C) No matter what clinical entity boys with childhood GID represent, is Zucker fudging his data, manipulating statistics, to include more boys in the GID of childhood category, thus fraudulently inflating its numbers?

(D) If Zucker and colleague Blanchard are studying homosexuality, what happens should they try to remove gender identity as a disorder, and do they even believe in gender identity?

Now that we have seen that there really is no solid scientific evidence that Zucker is preventing transsexualism by treating GID boys, the next question is, does Zucker's therapy prevent or change homosexual orientation in these boys?

By Zucker's own admission, as we have seen, the majority of untreated GID boys become adult homosexual men. In Green's (8) study the majority of boys treated became homosexual or bisexual irrespective of whether they were treated or not. Surprisingly, Zucker states that clinical experience (sic) "suggests that psychosocial treatments can be effective in reducing gender dysphoria". (20) Zucker further states, "in considering these various therapeutic approaches, one important sobering fact should be contemplated. With the exception of a series of intrasubject behavior therapy case reports from the 1970's, no randomized controlled treatment can be found in the literature". (20) His only reference to these studies of the 1970's is a publication by him and his colleague, Susan J. Bradley. (26)

However, when we look at behavioral treatments from the 1970's for very feminine type boys, we find reports by Rekers. (27, 28) Perhaps, Zucker did not wish to cite these directly, as Rekers' treatments seemed to be harmful and to be largely ineffectual. Zucker doesn't define gender dysphoria, although others indicate that gender dysphoria is related more to gender identity/role than it is to sexual orientation. But, it does not necessarily mean transsexualism. Thus we can't know what Zucker means precisely when he speaks here of gender dysphoria. Certainly gender role BEHAVIOR may also be interpreted as part of gender dysphoria. Zucker mentions only one follow-up study of one boy at a one year follow-up (which did not make random assignment to different treatment protocols), in which a child was claimed to have had BEHAVIORAL change. (20) But behavior is

not synonymous with sexual orientation, and again, Zucker made no direct references to the shortcoming of the treatment by Rekers.

For a discussion of one of Rekers failed attempts at turning a GID boy into a heterosexual, see Zucker's colleague, J Michael Bailey's account, on pages 24-26 in his book. (21) But, more importantly, Zucker's colleague Bailey, again exposes Zucker's belief, that in fact Zucker believes that adult homosexuality in men cannot be prevented or treated by therapy or treatment of GID boys. Bailey demonstrates this as follows about his colleague: "Zucker thinks that kids with GID need to be treated with psychotherapy, and that their families do as well...but Zucker also disagrees with the right's emphasis on preventing homosexuality. Zucker does not consider this an important clinical goal, because he thinks that homosexual people can be as happy as heterosexual people, and regardless, he doubts that therapy to prevent homosexuality works." (page 29 in ref. 21)

Thus, here we have it (A) Zucker's therapy is not preventing child transsexuality. (B) Zucker's treatment is not curing child transsexuality. (C) It is said by his colleague, that Zucker does not believe that his own treatment prevents homosexuality either, and that it is not even an important goal to do so. (21)

In regards to treating "homosexual" or "pre-homosexual" GID boys, Zucker nonetheless states the following: "Others have asserted—without direct empiric documentation—that treatment of GID results in harm to children who are "homosexual" or "pre-homosexual". (pages 562-563 in ref. 20) Again, we have another attempt at conniving by Zucker. In order to accumulate empiric documentation of the efficacy of such treatments for homosexual or pre-homosexual conditions in GID boys, one needs to secure grants or acquire funding for treating homosexuality or sexual orientation. But, one cannot do this readily, since homosexuality is not considered a disorder, and has been removed from such in 1973 by the very Association (American Psychiatric Association) which Zucker is now slated to lead as gender identity disorder subcommittee chair. One can only reasonably expect to study the effect of treatment of pre-homosexuality or homosexuality in boys, by calling it another name; in other words by changing the label and claim that GID in childhood is not about sexual orientation/pre-homosexuality (although we have seen that it is), but falsely claim, as does Zucker, that it is about gender identity. Only when Zucker can pretend to be treating gender identity, by using terminology such as gender IDENTITY disorder (GID) of childhood, can he secure funding for research and more - to treat children for SEXUAL ORIENTATION (pre-homosexuality). If he called it what it usually is in fact (but not on paper), that is, gender ROLE and pre-homosexual disorder of childhood, it is likely, that he wouldn't be able to connive the public so easily.

On this score, it is interesting, that adult transsexuality as a diagnosis was omitted from the DSM IV when Zucker's colleague - also at CAMH, Susan J Bradley, was in charge of this committee. (17) Removing adult transsexuality is a clever way to connive people and bilk them for their money, when it is re-LABELLED as GID of adulthood, since the less experienced clinician may think that a childhood GID has a lot in common with an adult GID. Childhood transsexuals largely are not seen (see above) clinically and usually keep their secret hidden and they suffer in silence. They typically didn't get a diagnosis of

transsexuality per se, until well after childhood. So, when CAHM member Susan J. Bradley as chair of the DSM IV gender identity subcommittee succeeded in removing adult transsexuality as a diagnosis in 1994 (17), the replacement with GID (adulthood) terminology consistently served to pathologize children, adolescents, and adults, all under the same LABEL, DESPITE their being separate clinical entities. As a result, pre-homosexual children/adolescents could be pathologized until adulthood, by falsely suggesting their condition was one of gender IDENTITY, only to be automatically disorder free at 18 (adult), when it was usually found (as was expected) that it was about the child's SEXUAL ORIENTATION. Since there was no way to identify child transsexuality (and no label of childhood transsexuality per se), which would be a true childhood gender identity "disorder", they would only be LABELLED transsexual per se, in adulthood, when it also found (as expected), that they did not have what is generally REGARDED as a childhood GID. Yet their numbers to the less experienced clinician would falsely inflate the GID of childhood diagnosis, since it would seem unlikely that a transsexual diagnosis would present or manifest only after childhood.

Thus, the pathologization of sexual orientation and behavior by Zucker, under the guise of gender identity (GID disorder of childhood), uses and abuses pre-homosexual boys for a more devious purpose-to pathologize adult transsexuals, and also adults with intersexed conditions who reject their assignment who are also said to have a gender identity disorder not otherwise specified (GIDNOS) in the presence of a physical intersex condition.

But even as GID of childhood is usually not about gender identity per se, and even if Zucker has no scientific evidence that he is preventing adult transsexualism, is there any evidence that even more people who should not be diagnosed as having childhood GID, indeed are being diagnosed as such? Indeed, when we and others (29) examine Zucker's writings, we see him including further, without evidence, people who don't meet the diagnostic criteria for inclusion. (30) This suggests that Zucker is manipulating data, fabricating data, and engaging in fraudulent misrepresentation of data in the very publications with which he is receiving grant money to do.

When we examine further some of Zucker's research, we find that in fact, he manipulates data to inflate the numbers of boys who receive a diagnosis of GID of childhood. Again, we have heard that statistics lie. But we think it is not statistics per se which lie, but people who lie. What about Zucker? We suggest that the Canadian government review the following data manipulations by Zucker and decide for themselves. We will just present the data here, as observed by another group of Zucker's peers from Canada. (29) (We do need to say, that one of the authors (29), Paul Vasey, is being investigated by OII as to whether he was asked by Zucker's colleague, J Michael Bailey, to request Bailey's colleague, Alice Dreger, to write a "tabloid style journalism" article for the publication *Archives of Sexual Behavior*, which is edited by Zucker to defend a controversial book written by Zucker's colleague, J Michael Bailey.)

Bartlett et al. (29) brilliantly point out flagrant errors in data compilation and interpretation in Zucker's research. The fact that there are in fact 5 confluences of the data

lead us to suggest that in fact, Zucker may be fudging his data to inflate the numbers of boys who are diagnosed as having a GID of childhood diagnosis. Consider the following-

“As outlined in the DSM- IV, for a diagnosis of GID in children, there must be a ‘strong and persistent cross-gender identification.’ In children, one manifestation of this ‘disturbance’ is the individual’s ‘repeatedly stated desire to be, or insistence that he or she is, the other sex.’ To arrive at the conclusion that the majority (76.1%) of gender-referred children, including those with a diagnosis of GID, expressed cross-sex wishes, Zucker aggregated the categories ‘once-in-a-while’ and ‘very rarely’ together with ‘frequently/every day’. A more... diagnostically relevant interpretation of Zucker’s (2000) Table 36.2 leads to the conclusion that the minority (23.4%) of the boys and girls in his sample expressed what could be considered ‘repeated’ (i.e., ‘frequently/every day’) cross-sex wishes indicative of ‘strong and persistent’ cross-gender identification.” Cross-sex wishes that are expressed ‘once-in-a-while’ or ‘very rarely’ are, arguably, not indicative of ‘strong and persistent’ cross-gender identification.” (29)

“Zucker cited Green (1987) “to support his position/conclusion that expressing verbally a wish to be the other sex is consistent with Zucker’s own data. BUT, AGAIN, Zucker did this, “by combining disparate categories, in this case, ‘occasionally’ and frequently’.” The authors noted that it is doubtful, that “occasional” wishes and “frequent” wishes are “diagnostically equivalent”. (29)

The authors further state that they are “intended to be “conceptually distinct”. (29)

Zucker inflated his (2000) data (30) as well as that of Green (8) to compare cross-sex wishes by combining boys who were only gender REFERRED with those who were gender DIAGNOSED, and by comparing these two clinical groups, with non-feminine boys or control children. (29). Furthermore,

“...such a comparison has limited relevance to a diagnosis of GID per se. That either clinical group expressed cross-sex wishes more than control children does not mean that they expressed such wishes to an extent that is of clinical or diagnostic significance.” (29)

Zucker (30) also did not define what he meant by his categories “once-in-a-while” and “very rarely” in his data. Thus, there is no objectivity here. This is also confusing for the informant who provided him information “who may have subjective notions regarding the meaning of the categories ‘frequently’, ‘once in a while’, and ‘very rarely’, based on their own experience and tolerance of cross gender/sex behaviours”. (30)

In Zucker’s work (30) he further COMBINED the categories “frequently” and “every day”, but when these categories were presented on the maternal rating scale that he used to gather his data, they were two SEPERATE categories. (30)

Finally, Zucker (30), alternately referred to children as “Gender Identity Disorder” group, in his TABLE, but as gender REFERRED in the TEXT. Zucker (30) responded that not all of the children met COMPLETE DSM-IV criteria for GID. This of course, limits the value of making specific statements about those children who specifically have GID per se. Although Zucker stated “that if only the children who met the DSM-IV diagnostic criteria for GID were included in the analysis, the percentage expressing cross-sex wishes would have been higher. Unfortunately, he presented no data to support this statement.” (see page 192 in ref. 29)

We have seen that Zucker has very sloppy usage of statistics and labels in this particular report of his. (30) We encourage others to find comparable examples which may exist in his work and suggest that Zucker has manipulated data. Even if not intentional, this does a great injustice to the samples with which he is studying and to the conclusions which he is drawing, as well as its influence on the clinical and research subjects with whom he is dealing, and also with the professionals who would be adversely affected in their understanding of his data, and in their attempt at dealing professionally with comparable issues. We do suggest that the government inquire in to how so many errors/manipulations of Zucker’s data could occur by Zucker, and if, in fact, it represents intentional “fudging” of data, and if so, what Zucker stands to benefit from this, and at whose expense.

By conflating gender identity with pre-homosexuality, Zucker is able to victimize many populations. Transsexuals should be outraged that they should be misrepresented in clinical history and in treatment proposals. “Feminine” homosexuals should also be outraged in the use of one type (“feminine” homosexuality) of homosexuality to pathologize non-“feminine” homosexuals as well as themselves. Transsexual and intersexed groups should also be outraged, that pre-homosexuality further pathologizes them by extending a childhood diagnosis (GID of childhood) to include adults (GID of adulthood) or intersexed persons (GIDNOS). All others should be outraged at the role of Zucker in oppressing these groups, with its psycho-emotional toll and with doing this at the expense of the Ontario taxpayers and the Provincial Government.

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