When Girls Want to Be Boys and Boys Want to Be Girls

A play therapy room at CAMH

They assume a new identity at school, take hormones to suppress puberty and dream about the day they can have radical surgery. One CAMH psychologist says he can stop the urge if he treats them early enough. His critics say the kids don't need to be cured

BY WENDY DENNIS | PHOTOGRAPHY BY EAMON MacMAHON

MEGHAN* WAS FOUR YEARS OLD WHEN she took a pair of scissors to her long blonde ringlets and hacked off half her hair. When Diane asked her daughter why she would do such a thing, Meghan said she wanted to be a boy. Diane, who is a home care nurse, didn't think much of the incident at the time. Meghan was a tomboy, and most of her friends were male. "I just thought she wanted to look like her friends," she says.

On the first day of junior kindergarten, Meghan refused to go to school. Diane had dressed her in a flowery purple jumpsuit, and Meghan said everyone would laugh at her. Again, Diane shrugged it off. "I guess, looking back, those were warning signals," she says, "but I just let it go. I'm a feminist. I thought, More power to you. No dolls. No stereotypical roles."

Meghan loved sports, and until Grade 2, she played baseball with the boys. Then the teams were divided by sex. She went to her first practice, took one look around, and refused to play. "But you'll be the best kid on the team," said Diane. "I'm not playing," said Meghan. "Girls can't play baseball."

Despite these isolated incidents, Diane considered her first-born child happy and well adjusted. Meghan had friends in the east-end apartment building where they lived at the time. She had good grades, and her teachers reported that her peers looked up to her. Nothing worried Diane enough to seek professional help. The year Meghan turned seven, however, she became sullen and withdrawn. When Diane asked her what was wrong, she replied frustratedly that she didn't know. Diane attributed her daughter's moody silence to the fact that she and Meghan's father had split up that fall. He'd left town soon after, and had little contact with Meghan or

*Some names have been changed

Therapy sessions are observed through a one-way mirror and videotaped

her sister, Amy, who was four years younger. Diane's relationship with her husband had been verbally and emotionally abusive. Some nights, he had come home in a drunken rage, screaming and breaking dishes, and Meghan had awakened sobbing, begging her father to stop, desperate to help her mom. The turmoil at home, and her father's departure, seemed a plausible explanation for Meghan's behaviour.

Diane assumed Meghan's anger would subside; instead, it went nuclear. If Diane simply asked her to turn off the TV and go to bed, Meghan would erupt in rage. She began threatening Amy. The spring of her Grade 7 year, when she was 12 years old, Meghan locked herself in her basement bedroom and refused to go to school.

No amount of negotiating on Diane's part could defuse the situation. Distraught, she called the school principal, who referred her to Youthdale Treatment Centres, a social service agency that provides mental health services to troubled children and their families. A Youthdale social worker came to their home and spent a couple of hours talking to Diane, Meghan and Amy separately. Meghan agreed to enter Youthdale's residential program. For the next two and a half months, she lived on-site and attended a structured program of classes, meals, recreational activities and individual and group therapy sessions with 13 other kids.

Meghan's stay at Youthdale was a revelation. She'd always had a vague sense that she was different from the other kids but didn't know why; at Youthdale, she began to grasp what was fuelling her rage. One Sunday toward the end of her stay, when she was home for the weekend, she and Diane were standing in the living room having a casual conversation when, out of the blue, Meghan asked, "Mom, did you know that women can have real penises?" Diane said that she'd learned a little bit about that sort of thing in nursing school and inquired how Meghan knew about it. "I researched it," said Meghan. When Diane asked why, Meghan said, "Because that's what I want to do." Diane didn't know what to make of Meghan's comment; all she knew was that her daughter did not seem to be welcoming puberty like other girls. When Meghan had started taking swimming classes at school, Diane remembers her coming home and saying, "Man, those girls are retarded—putting on their makeup in the change room and showing off." Looking back, she thinks that swimming class was a turning point for Meghan.

It was in a meeting with Meghan's psychiatrist at Youthdale that Diane first heard the term "gender dysphoria." Her daughter, she was told, was deeply uncomfortable with her biological sex. She did not want to be a girl. She did not want to menstruate or grow breasts. Moreover, she was tired of explaining herself to doctors. She had told her psychiatrist that all the doctors at Youthdale were stupid. Couldn't they see that she just wanted to be a boy?

Meghan left Youthdale with a referral to a psychologist named Kenneth Zucker, who heads up the gender identity program at the Centre for Addiction and Mental Health. Zucker is an international authority on gender identity disorder in children and adolescents. Diane was hopeful that he'd help Meghan work through her difficulties and cure her of the desire to be a boy.

After Youthdale, Meghan was a totally changed child. Now that the reason for her anger had been identified, she was so sunny and chatty, says Diane, "There were times you just wanted to tell her to shut up."

In June 2007, when she was 13 years old, Meghan embarked on an intensive assessment process. Zucker and his team have developed a protocol that includes family and individual interviews, medical and behavioural histories, cognitive and projective testing, general emotional well-being assessment and free-play observation, among other diagnostic tools.

Zucker told Meghan and her mom that in his and his staff's opinion, Meghan suffered from gender dysphoria and would, in all likelihood, continue to feel that she should be a boy. However, so as not to forestall the possibility that she might change her mind, he recommended a trial of counselling. Meghan was not keen on this suggestion. According to Zucker's notes from that meeting, she said therapy would be "a waste of time." Zucker referred her to an endocrinologist at Mount Sinai Hospital who would start her on hormone blockers—a series of injections to suppress puberty and put her into a kind of developmental limbo. (The effect is reversible should the regimen be stopped.) If, after a period of counselling, her desire to be a boy persisted, then the next step would be to help her transition to a cross-gender role. Typically, that process, which takes place in stages, involved instituting a name change, taking cross-sex hormones (testosterone, in Meghan's case) and, for some kids, eventually having surgery. Diane and Meghan would each meet weekly with separate counsellors. Zucker would supervise and review the case with his staff on a weekly basis.

Diane was stunned by the diagnosis. In her recollection, Zucker's recommendation was less a wait-and-see proposition than a done deal. It was her understanding that everything they did from that point forward would be in the service of helping Meghan become a boy. In spite of all the flares that Meghan had sent up, and the meeting with her psychiatrist at Youthdale, it had never crossed Diane's mind that her daughter might one day want surgery. She figured Meghan was just going through a phase. Now it appeared that her daughter was going to be heading down a tortuous road. Diane did not want her to go that route. She just wanted her to stay the way she was. The first thought that popped into her head was, Why can't she just stay female and be a lesbian?

One family landed in Zucker's office after their six-year-old son asked how to cut off his penis

Zucker described to Diane various factors that might have prompted Meghan's dysphoria to develop. One might have been Diane's abusive relationship with Meghan's dad, which, he said, might have resulted in Meghan taking on masculine characteristics to become Diane's protector. The comment infuriated Diane. She interpreted it to mean that Meghan's problems were all her fault. Moreover, when theorizing about what had caused the dysphoria, Zucker, as Diane recalls, focused exclusively on upbringing, whereas Diane believed that Meghan's nature had also played a role. After all, if Meghan's dysphoria had resulted strictly from the way she'd been raised, then why wasn't Amy sitting in his office, too? Why not blame all of society's problems on lousy parenting? Diane did not believe that Meghan's gender issues had arisen because of any scenes she'd witnessed. As she saw it, Meghan was who she was, at least in part, because she'd been born that way. "I was quite nice. I didn't storm out. I just told him that something was missing, that she could have grown up in a happy two-parent home with the white picket fence and this would have happened, and he acknowledged that biology could have possibly contributed."

Diane left that meeting reeling. The weight of an expert opinion had catapulted her into an alternate reality. Diane wanted her daughter to be happy, but were hormones and surgery the only way? Was a normal life even possible for Meghan?

KENNETH ZUCKER PRACTISES in a bright, book-lined office at CAMH's College Street location. His door is covered with Magic Marker drawings—one of which, an assured rendering of the Cat in the Hat, reads "Thanks for helping me." Zucker, who is a slightly built man with an exacting mind and a playfully engaging manner, was raised in Chicago, and came to the University of Toronto in the mid-'70s to do his doctorate in developmental psychology. Today he is the psychologist-in-chief at CAMH, teaches in the psychiatry and psychology departments at U of T, and has published more in the field of gender identity disorder in children than any of his colleagues. His gender identity clinic offers the most comprehensive program of its kind in North America and has gained an international reputation.

Gender identity dysphoria first appeared as a formal psychiatric diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* in 1980. To warrant a diagnosis, a person must, among other criteria, have a strong and persistent cross-gender identification that's expressed as the desire to be, or belief that one already is, the opposite sex. The person can't simply perceive a cultural advantage in being the other sex. A tomboy doesn't qualify; nor does a girl who wants a sex change to play on the boys' hockey team. Patients must also demonstrate an intense feeling of discomfort with their biological sex, so much so that it causes significant distress or impairment in their life. No one knows for certain how many people suffer from GID, but in recent years diagnoses have skyrocketed internationally—particularly in adolescents.

Over the past five years, Zucker's waiting list has tripled, to about 65 kids. He speculates that the increase is due to heightened media interest and an on-line universe where kids have boundless opportunities to identify themselves and find others like them. By the end of last year, Zucker had assessed over 550 preadolescent children (12 years old and younger) and 375 adolescents (between 13 and 20). He's currently treating about 25 kids or adolescents and their families and typically handles one new GID case or more a week. Most of his referrals originate in southern Ontario; some come from across Canada and the U.S.

The causes, diagnosis and treatment methods for GID are rabidly contested. Zucker's prominence and point of view on an already fraught subject have made him a lightning rod for controversy. Within the profession, some practitioners call his methods coercive and unethical. And last fall, when Zucker was invited to speak at a Royal Society of Medicine conference in London, England, protesters decrying his presence stood outside the conference hall handing out leaflets and carrying signs that read "No Reparative Therapy Here."

Zucker is a leading proponent of the view that GID is a psychiatric disorder. Helping children adjust to their birth sex, he believes, is not only possible but also a more desirable alternative for them than switching genders. At the same time, he says that kids with GID eventually reach a stage, usually in early-to-mid-adolescence, when they become unshakable in the belief that living in the opposite gender role will make them happiest. If he thinks that a child has embraced that conviction and views a sex change as the best chance for a well-adjusted life, he supports the child's decision to transition and helps his patient to consider all the implications. However, he does not think a child can be definitively declared trans-gender until the age of at least 10 or 11—"even 10 feels too early to make a decision about this, especially without a trial of therapy," he says.

Zucker's critics, on the other hand, argue that kids who cross-gender identify are born trans-gender. Trans-gender advocates do not believe they are suffering from a disorder. They believe that they were born in the wrong body, and that who they are is who they're always going to be. What they need isn't therapeutic intervention—it's encouragement and support to live in accordance with how they feel inside. These advocates equate trans-genderism with homosexuality, and they see Zucker as a kind of therapeutic Dr. Evil reminiscent of psychiatrists who sought to cure homosexuals of their aberrance using such methods as aversion therapy, electroshock treatment and primal screaming. (Homosexuality, once considered a mental illness, was removed from the *DSM* in 1973.) They view their cause as a civil rights issue and are lobbying hard to have GID struck from the books in 2012, when the current edition of the *DSM* is slated to be revised. Accordingly, they are not pleased that Zucker has been appointed to chair the committee that will make the recommendations.

Zucker's cross-gender detox involves weaning children off toys and clothing suited to the opposite sex

In recent years, a small but growing group of activist parents whose goal is to normalize cross-gender behaviour has surfaced on the Internet. They view kids who exhibit it as one might view a child with a learning disability or peanut allergy. Some parents of children kindergarten age or younger are pronouncing them trans-gender, cross-dressing them, changing their names, and sending them to school as the opposite gender. They argue that they are nurturing their children's true selves—in defiance of the vast majority of psychiatric opinion and critics who accuse them of unconscionably permissive parenting.

Research about gender identity is still relatively young, but investigators know that gender development takes off during preschool years, when children are seeking information about the world. Around age two or earlier, kids begin to realize that the world is divided by gender, and using perceptual markers like voice and clothing, they start to distinguish males from females. Bright two-year-olds will begin to label themselves and say "I'm a boy" or "I'm a girl"; once that happens, they want to know how

Kenneth Zucker (above) handles at least one new gender identity case a week

boys and girls behave. In some kids, that process goes awry. Boys are five times more likely to be referred to the clinic than girls, until adolescence, when the ratio drops to 2:1—partly because girlish behavior is less likely to be tolerated in boys, and less extreme actions on their part prompt a referral. Zucker is also seeing more kids whose gender dysphoria is intertwined with a host of other mental health issues that have to be parsed to determine what's driving the GID—in particular kids with Asperger's syndrome, who are fastening on gender as another of their obsessions.

Studies suggest that biology may be part of the puzzle, but Zucker considers GID far too complex in nature to be tracked to one source—although he's compassionate toward those who, in his opinion, attribute the problem to one external cause in order to assuage their guilt. He believes that many of the children he sees have crossed the gender divide as a "fantasy solution" to an array of psychosocial problems, and what he likes to call "family noise." That din often sounds in the form of emotionally unavailable mothers and distant or violent fathers.

A quarter of Zucker's patients are five years of age or younger. His research shows that among his preadolescent patients, 80 to 85 per cent no longer want to switch their gender at adolescence—findings that have been corroborated by follow-up studies at a clinic in the Netherlands and elsewhere. (Other studies show an even lower persistence rate.) In 30 years, not one of the kids Zucker has treated from age six or younger has persisted in the desire to switch genders. Those results have persuaded Zucker that gender is malleable—at least until it reaches the point when kids get "locked in" to their cross-gender persona. Consequently, the earlier he sees a child, the better his chances of resolving the child's confusion. Still, whether the dysphoria resolves or persists, says Zucker, so many other factors must be weighed in determining how well kids do over the long haul that "there's no easy way to talk about long-term outcomes."

As well as treating kids with gender issues, Zucker has also seen kids who want to be a different race, nationality or religion. He likens treating a child with gender identity disorder to one who wants to change the colour of his or her skin, and says that no clinician would simply let it go if a preschool-aged black kid walked into their office expressing the desire to be white; the thera-

pist would look for the underlying reasons why the child had embraced such a disturbing fantasy.

Some of the parents who consult Zucker are worried that their child might turn out to be gay. For religious or other reasons, the parents are so uncomfortable with that prospect, they've told Zucker that it would be easier for them to deal with their child having a sex change than finding out they were gay, because then they could view his or her sexual attraction as normal. (Researchers generally agree that the majority of boys who have GID as young kids will turn out to be homosexual or bisexual; with girls, about half become lesbian or bisexual.) Zucker explains to these parents that therapy is designed to help kids feel better about their identity as it relates to their birth sex, not to change their sexual orientation. "Some parents are fine with that; others don't necessarily like to hear it."

Zucker usually recommends that parents of GID children implement a kind of cross-gender detox program that they devise in collaboration with him, during which they gently but relentlessly wean their children off toys, hairstyles and clothing more suited to kids of the opposite sex. Because family psychodynamics, or the parents' own gender issues, may be driving the child's confusion, parents receive ongoing therapy as well.

One couple landed in Zucker's office when their six-year-old son tucked his penis behind him in the bath and asked his mother how to cut it off. Zucker advised the mother to get rid of her son's dolls (he was obsessed with the Ariel character from *The Little Mermaid*), discourage his female friendships, encourage his male ones, step back from him, and involve her husband more in his parenting. Her husband thought this regime made perfect sense, but she found it wrenching. She feared the therapy was cruel and felt they were over-manipulating his character, "changing who he is." For a year and a half, she ricocheted between hiding her son's dolls and giving them back when he cried and begged. When she removed the dolls, his behavior became more boyish; when she returned them, he would become more girlish. She cried all the time, until one night she called another mother in the program for support. The woman said to her, "Look, if your son wanted to be a cat, would you allow him to be a cat? Would you give him cat food and a bowl and let him behave like a cat? Then why do you allow him to behave like a girl? He's a boy." And that's when she thought, That's it. We're doing this.

Her son was in therapy for six years. She and her husband nurtured his interest in art, swimming and cycling in place of his previous obsessions with dolls, dressing like a girl and playing house. Her husband also spent far more one-on-one time with his son. Gradually, his cross-gender behaviour dissipated. He is 14 now, and his mother says he is happy and no longer has any memory of his desire to be a girl. She doesn't know if he's gay, but that's irrelevant to her. All she knows is that he's not going to have to worry about being ostracized or having body parts removed.

Prior to our meeting, she had seen a Barbara Walters *20/20* special about kids whose parents had accepted their child's cross-gender behaviour. The show had enraged her. The parents of a six-year-old boy, as she recalled, had said, "Well, he knows what he wants." "How can a kid know at six what he wants?" she asked. "To allow a six-year-old to decide to make those choices and not guide him? Why don't you let him cross the street without watching where he's going and hope a car doesn't run him over?"

DIANE TRIED TO KEEP AN OPEN MIND after the shock of Zucker's diagnosis had faded. She was the kind of person who liked to work toward a goal. Her job, as she saw it, was to ease her daughter's way. "She's my child," she said. "What can I say?"

Meghan began to take hormone blockers. The blockers, which must ideally be started around the onset of puberty, have become an increasingly common treatment option worldwide. Her next step would be cross-sex hormone therapy, which is usually started around age 16 and—unlike the blockers—is a largely irreversible process that stimulates the growth of secondary sex characteristics. For those who are born female but identify as male, testosterone—usually injected intramuscularly twice monthly for life—results in a deeper voice, greater muscle mass and facial and body hair; in the opposite case, estrogen, usually taken orally, engenders breast growth, redistribution of body fat and thinner skin.

Meghan soon announced that she wanted to enter Grade 9 as a boy. The family had moved to a new house in a different neighbourhood in the east end, and Meghan would be less likely to run into kids from her middle school, which was in another part of the city. Zucker approved and suggested ways to implement the plan. Diane met with the principal of their local high school to explain Meghan's situation. After that, they had to deal with some logistical matters, and Meghan needed a male name. The name she chose for her new identity was Jake. She'd always been partial to the name. It was her signature handle when she played video games.

At this point, Diane and Meghan had confided in only a few family members and friends. Diane's step-grandmother thought Diane should throw a coming-out party as a way to tell the rest of the family. At first, Diane thought it was a stupid suggestion. "I said, 'Why the hell are we having a coming-out party? This situation is not a party.'" But Meghan liked the idea, and her mom came around.

Diane cast it as a housewarming and invited her parents, her sister and brother, her grandfather and step-grandmother, and Deborah, a close friend who always joined them on important family occasions. Meghan's only guest was a friend she'd known since childhood, and whom both she and Diane felt should be told about the situation. Meghan's dad wasn't invited. They hadn't told him or his side of the family what was going on; Diane feared he'd blame her and make fun of Meghan. Meghan was going to tell him when she was ready.

Some parents view gender dysphoria as normal. To them, it's no different from a peanut allergy or a learning disability

Diane prepared a speech and was planning to deliver it before dinner, but she kept putting it off, screwing up her courage with one more glass of wine. At one point, she broke down crying but managed to pull it together. She thanked everyone for coming to their housewarming party (Amy was offering tours) and explained that Meghan had been seeing a lot of specialists in the last while. It turned out that she had gender dysphoria, and her doctors felt that Meghan should start taking hormone blockers. Then she explained a little about what they were, and after that she said that Meghan had been accepted into a high school program that she really wanted to attend, and had decided to go there as a boy.

Now that she'd come out, Meghan had decided that she didn't want anyone to call her Meghan anymore. She wanted them to call her Jake. She didn't think of herself as a girl, even though that's how everyone else thought of her. She thought of herself as a boy. From then on, Diane referred to her as Jake: he was her son now, and she wanted the best for *him*.

When Diane finished speaking, her mother, shocked at what she'd just taken in, nearly dropped her wine. Her dad stood up and congratulated Jake for having the courage to make such a difficult disclosure. Jake, knowing that Deborah was Jewish, joked, "Hey, this is my bar mitzvah. Can I have the money now?" and went around trying to collect money from everybody, and everybody started laughing, and then Diane's step-grandmother said, "OK, let's eat."

The family took the news surprisingly well. Diane figures they must have known on some level what was coming. In any event, they've been a tremendous support. Jake's grandfather was one of the first to make the name switch and often clips articles about trans-gender matters for Jake and Diane to read. Jake's great-grandfather and his wife offered to help in any way they could. Amy's biggest worry was how to introduce Jake to her friends. Diane's mother is having a tougher time. "She thinks we're playing around with Mother Nature," Diane says.

Jake entered Grade 9 last fall. Only the school principal and guidance counsellor knew the truth. Zucker gave Jake a note to be excused from physical education, and the school gave him a key to the handicap washroom. If somebody recognized him as Meghan, he planned to say that they were twins, and Meghan was living up north with their dad. If that didn't work and he was outed, the plan was for him to transfer to the TDSB's Triangle Program—an alternative high school for lesbian, gay, bisexual and trans-gender kids.

Meanwhile, Diane did her best to adjust to Jake's new identity. When she looked at him, she no longer saw her daughter. He was a huskily built kid who galumphed around in baggy clothes like a typical teenage boy (and was so much more agreeable as Jake than he'd been as Meghan). Still, Diane has trouble calling him Jake to his face. When I asked her why, of all the adjustments she'd had to make, that one was so difficult, her voice flickered with irritation. "Because I gave birth to a girl named Meghan," she said.

Each day is a high-wire act. Jake befriended a kid at school who knew him in elementary school, although they were never friends. The boy has no idea that the girl he knew as Meghan is the buddy he now calls Jake. They had a close call one afternoon when Jake's friend was at the house and Jake's dad, who still hasn't been told about Jake's gender dysphoria, dropped over to see his daughters. Diane managed to send Jake's friend home before his dad called him by his old name and ruined everything.

Sometimes Diane wonders if she could have done anything to avert the path her child is on. Zucker had told her that he might have reversed the dysphoria had he been able to intervene at an earlier age, but Diane is skeptical. She doubts that Jake's life would have turned out differently if she'd sought therapy for him as a child. She's not even sure she'd have wanted him to undergo therapy then; she wonders whether it would have been like forcing him to be someone he's not. On the other hand, if it could have eased Jake's hardship, maybe she would have agreed.

How Diane is doing depends largely on the day. Her heart broke when Jake came home from school and asked if he could join the football team. She had to remind him what he already knows—that for now, given the risks of locker room exposure, sports are not an option. Or she'll learn that one of Jake's old friends now has his first girlfriend, and she'll capsize with sorrow.

Sexuality doesn't seem to concern Jake yet. A girl in his English class likes him, but he's not ready to reciprocate. "I'm too young for that stuff," he told Diane. Nor is it clear whether he'll be gay or straight—although Diane's sense (and Zucker's) is that he'll be attracted to girls. As for the future, Jake doesn't talk about that much, either, but sometimes he mentions what he's going to do when he gets married and has kids, and it's clear that he imagines his life as any other kid might.

Mostly, he just wants to get on with it, to say "Hi, I'm Jake," and not have any hurdles standing in his way. Since he first confessed his secret at Youthdale, he has repeatedly told doctors and counsellors that he wants to be a boy—to the point where he's frustrated with how long everything's taking. Life will be simpler when he has proper ID. Diane has applied to the province for a new birth certificate; once it arrives, she can organize new identification in Jake's name.

Despite the blockers, Jake's breasts have partially developed, and he has put on almost 30 pounds in an effort to mask them. If anyone notices, he can just say that he's fat. He's anxious to have his top surgery, as patients often call it. (The procedure involves removing both breasts and reconfiguring the chest as a male's.) Since his initial comment about wanting a penis, he hasn't said much about bottom surgery. (It involves hysterectomy, ovarectomy and possibly genital reassignment, such as phalloplasty, although many candidates choose not to have the procedure, as it is risky and mostly cosmetic.) Ten people a year have the surgery in Ontario, and the $20,000 to $30,000 cost is currently covered by the province.

Sometimes Diane is amazed at how far her family has come since the first day she sat in Zucker's office. She tells herself that things could be worse; her child could have a terminal illness. Drug and alcohol abuse are rampant in the trans-gender community, and its members are at high risk for suicide. Many of those who opt for sexual reassignment surgery report a high level of satisfaction afterward, and that knowledge is what keeps her going. Since all this began, she has read a lot about kids like Jake who manage to lead successful lives, and she thinks as long as he has the support of his friends and family, he'll be fine. Because there is really only one thing she wants for her child. "I just want Jake to be happy," she says, "and lead a normal life." **END**