CHAPTER SEVEN

THE DISSIDENTS

Until the 2015 controversy that cost him his job, Kenneth Zucker was universally recognized as an international expert on child and adolescent gender dysphoria. As psychologist-in-chief of Toronto's Centre for Addiction and Mental Health (CAMH) and head of its Gender Identity Service, he spent decades conducting research and practicing what he had trained to do—help children and adolescents with gender dysphoria grow more comfortable in their bodies.

In 2007, Dr. Zucker oversaw the writing of the definition of "gender dysphoria" for the *DSM-5*.[1] He also helped write the "Standards of Care" guidelines for the World Professional Association for Transgender Health (WPATH).[2] Until transgender activists rallied against him, most health professionals practicing in this area regarded Dr. Zucker as an international authority on what "gender dysphoria" was.

His philosophy was simple, though his understanding of gender dysphoria was anything but: a child or adolescent in distress is not reducible to one problem. To reach an accurate diagnosis, Dr. Zucker believes mental health professionals need to look at the whole kid.

Some children latch onto gender dysphoria as a way of coping with trauma or other distress. A therapist needed to question the patient's understanding of gender in order to determine why the patient might have fixated on that as a source of their problems. What beliefs did the patient have about boys or girls? Why did the child or adolescent come to believe changing gender would lead to a happier life? The goal of the questioning was often to challenge the notion that biological sex was the source of the patient's problem and, wherever possible, to alleviate the dysphoria.

He was stunningly successful. Zucker's colleague Devita Singh examined the outcomes in the cases of more than one hundred boys who had been seen by Dr. Zucker at his clinic.[3] In cases in which a child had not been socially transitioned by parents, she found that 88 percent outgrew their dysphoria.[4]

For decades, Dr. Zucker practiced a therapy that has been called "watchful waiting," a term that Zucker once applied to his own method but has since come to dislike. He finds that it is overly simplistic and implies a passivity that only sometimes characterized his approach. Zucker administered more or less active therapy—and sometimes recommended no therapy at all—depending upon what he thought the child needed. But in all cases a diagnosis of "gender dysphoria" was only the beginning for Dr. Zucker. It neither exhausted his range of diagnoses nor determined the treatment he recommended.

"There are different pathways that can lead to gender dysphoria, but it's an intellectual and clinical mistake to think that there is one single 'cause' that explains gender dysphoria," he said in a BBC documentary about his life's work.[5] In the case of one child he treated, the boy's desire to be a girl stemmed from wanting to connect with his single mother, who had briefly abandoned him, to keep her from leaving again. The therapy addressed his feelings of abandonment and only secondarily the child's gender dysphoria.

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I spoke to Dr. Zucker several times, mostly over Skype. At sixty-nine, he has a close-cropped white beard, the gentle manner of someone who excels at working with kids, and a Talmudic habit of answering every question with a question. Although he has maintained a clinical practice for decades, when he talks about his work he is the consummate academic—apparently incapable of providing a straightforward answer to any question without considering every nuance, drawing all sorts of fine distinctions, and reaching for every caveat that will make his ultimate statement precise.

He is—in other words—a journalist's nightmare. But his even-handed, nonjudgmental approach and genuine open-mindedness seem to lend themselves to academic inquiry and therapeutic practice. It isn't hard to believe he's authored over 250 academic papers and book chapters or to imagine that his patients find him easy to talk to.

"I'll see a kid who will say, 'Well, I have a male brain in a female body' or a 'boys' brain in a girl's body.' 'I was born this way,'" he told me. Dr. Zucker doesn't dismiss this kind of talk out of hand. He acknowledges to me that interesting MRI studies have indicated that people suffering with gender dysphoria may have certain neural structures that more closely resemble those of the desired sex than the current sex.

But he also doesn't allow au courant gender theory to trump scientific research. "It's completely simplistic to say that there are 'male brains' or 'female brains,'" he told me. So he said to his young patient, "'Well, you know, [with] most traits, both physical and behavioral, there's a lot of overlap between boys and girls, or men and women.' I said, 'What if there is really no such thing as a male brain or a female brain?' The kid said, 'Well, then I would have to rethink whether I'm really trans, that maybe there's something else wrong with me.'"

According to Dr. Zucker, the mere fact that patients may have fixated on gender as a source of their problems does not mean that they are right or that transitioning will alleviate their distress. "I said to this kid, 'I

don't care if you have a male brain or a female brain. This is how you're feeling currently and we need to figure out why you're feeling this way and what is the best way to help you lose this dysphoria.'"

His method certainly isn't "affirmative therapy," but it isn't quite the opposite, either. In cases in which gender dysphoria had persisted without change into adolescence, Dr. Zucker sometimes recommended medical transition. But transition was never his goal—if he could help a child or adolescent become more comfortable in their skin, he would. And he doesn't believe in taking a patient's self-diagnosis at face value, either. After a lifetime of study, he was the professional, after all.

By 2015, however, "affirmative therapy" fever had swept Canada, where it became the prevailing standard for therapists and doctors who work with transgender patients. That year, Ontario became the first province to ban "conversion therapy" even with regard to gender identity. Activists took the Ontario ban as a bill of attainder and headed straight for Dr. Zucker's door. On the basis of their claims that he had engaged in "conversion therapy," as well as specious accusations that he had denigrated and humiliated transgender patients (later proved false), Dr. Zucker was fired and his gender identity clinic shut down.[6]

Nearly five hundred mental health professionals from around the world signed an open letter to CAMH protesting Dr. Zucker's firing. It seemed obvious that the hospital had sacrificed an international expert on gender dysphoria and the families he served "for some real or imagined local political gain."[7]

But to any mental health professional paying attention, the message was clear: Not even the most prominent members of their profession were safe from the activist mob. Get on board with "affirmative therapy"—or lose your job and maybe your license.

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There are, however, a few professionals who refuse to play ball and are nervy enough to say so. Many of them treated transgender patients

long before such work was fashionable. They have earned international reputations as giants of psychiatry, sexology, or psychology. Some have authored major academic research on psychiatric disorders, sexuality, or gender dysphoria. Others are Jungian analysts and published authors. All have suffered professional setbacks and reputational smears for their stubborn insistence that "affirmative therapy" isn't really therapy at all.

They disagree with each other on plenty: they believe medical transition is appropriate only for some children, or only for adults, or never appropriate at all. They characterize gender dysphoria according to age of onset, or sexual orientation of the sufferers, or the idea on which the sufferer fixates. Each approaches the question of how best to treat it from a different angle, bringing different conceptual tools to the question, and often disagreeing on best treatment.

But they all believe gender dysphoria is, first and foremost, a psychopathology—a mental disorder to treat, not primarily an identity to celebrate. They all agree that the current epidemic of gender dysphoria among adolescent girls is atypical (some deny it meets the requirements for "gender dysphoria" at all). And they believe that "affirmative therapy" is either a terrible dereliction of duty or a political agenda disguised as help.

All of them read Lisa Littman's paper with great interest, believing she was onto something. All suspect that this epidemic may be the result of peer contagion. They also have all suffered ostracism, deplatforming, and public censure for having insisted that gender dysphoria ought to be treated—and not merely facilitated. They believe that it is wrongheaded to regard helping a patient overcome gender dysphoria as "conversion therapy." They are dissidents from the current order, by dint of therapeutic duty and the Hippocratic oath.

THE SEXOLOGISTS: RAY BLANCHARD AND J. MICHAEL BAILEY

In the world of research into sexual orientation and paraphilia, Dr. Ray Blanchard is a giant. If you've ever encountered the theory that older

brothers increase the odds of homosexuality in later-born males—you're familiar with Dr. Blanchard's work. And he advanced the still-prevailing explanation of the phenomenon: giving birth to successive boys, some mothers produce antibodies that attack male-specific antigens, hampering sexual differentiation in the brain of succeeding male fetuses.

Blanchard has also conducted groundbreaking research into pedophilia. Using phallometric testing, he was able to demonstrate that men who say they are most attracted to pubescent children differ from men who say they are most attracted to prepubescent children and from those who say they are most attracted to physically mature persons. In other words, a man who pursues fourteen-year-old-girls may be a criminal, but he isn't a pedophile.

In the 1980s and 1990s, Blanchard developed a typology for understanding transsexualism (the term in use at the time) that is still actively employed and debated among academics today. In Blanchard's view, the "early onset" and "late onset" distinction for gender dysphoria is fine, but it doesn't, borrowing a phrase from Plato, "carve nature at its joints." Blanchard proposed dividing gender dysphoria into two categories: "homosexual transsexualism" (child-onset, effeminate boys or masculine girls who would grow into gay men and women; think drag queens) and "autogynephilic transsexualism" (adolescent-onset, heterosexual men who are aroused by the idea or image of themselves dressed as women; think men who transition to female in their fifties and are married to women). It was his discovery of "autogynephiles," a term he coined, that brought the outrage mob to his door.

In 2003, another academic psychologist and expert in gender identity disorders, J. Michael Bailey, publicized Blanchard's understanding of "autogynephiles" in a popular book, *The Man Who Would Be Queen*. Bailey offered a highly sympathetic portrayal of transsexualism—so sympathetic, in fact, that the book was a finalist for the Lambda Literary Foundation's transgender award in 2003. But then the mood swung.

Trans activists decided the book was unfavorable to them. "They calculated, and maybe correctly, that the general public could be sold a

woman trapped in a man's body, but a more nuanced and realistic version of events would be harder to sell to the general public," Dr. Blanchard said, recalling the uproar. A man trapped might be sympathetic. A man aroused might seem shameful—possibly even dangerous.

Transgender activists collected thousands of signatures protesting the Lambda Literary Foundation's nomination. The foundation's judges quickly changed their minds, decided the book was indeed transphobic, and removed it from their list of finalists. Deirdre McCloskey, a prominent transgender woman and distinguished professor of economics, history, English, and communication at the University of Illinois at Chicago, said that including Bailey's book among the list of nominees was "like nominating *Mein Kampf* for a literary prize in Jewish studies." Within a year, the executive director of the Lambda Literary Foundation who had approved the nomination had resigned.

Stripping Bailey of the nomination for the literary prize was not nearly enough. Activist academics launched an aggressive campaign to persuade Northwestern University to revoke Dr. Bailey's tenure, accusing him of violating the university ethics rules—based on the pettifoggery that he had lacked informed consent from research subjects and that he failed to obtain permission from the Institutional Review Board (neither was needed for a non-academic book) and the much more serious charge that he had had sexual relations with a transsexual research subject.[8] The last grievous charge was never proven, but the public allegation was more than sufficient to tarnish his reputation.

One reason that the existence of autogynephilia matters has to do with women's safe spaces. If transgender-identified biological men are completely uninterested in women sexually, one might argue that however uncomfortable it may be, there is little danger in admitting them to women's private spaces. But if some transgender men are heterosexual, aroused by the idea of themselves dressed as women and generally by the female form, the nature of the debate shifts and the possibility of admitting trans-identified men into women's safe spaces begins to seem untenable.

Nonetheless, it is hard to deny that autogynephiles exist. Many transsexuals conduct romantic relationships exclusively with women. Suppressing or denying the fact of autogynephila, according to Dr. Bailey, doesn't help anyone, least of all autogynephiles themselves. "[I]t prevents us from learning things that would help them perhaps in planning their lives. I mean, we don't really have good follow up studies" on various surgical choices a transgender patient might make.

Blanchard has stuck by his typology. According to him, a simple overlap in some symptoms does not necessarily collapse two different conditions into a single disorder. The boy who wants to be a girl and find a boyfriend and the man who is sexually aroused by the image of himself as a woman both experience gender dysphoria, but that does not mean that their psychopathologies are the same.

By way of comparison, Dr. Blanchard offers the case of a patient who complains of swollen, painful fingers. There are at least two different causes of that. It could be osteoarthritis, a breakdown of joint cartilage, or it could be rheumatoid arthritis, an autoimmune disease. "All types of gender dysphoria culminate in a request for sex reassignment or culminate in a desire to live as the opposite sex. But there are different etiologies of transsexual impulses. And not only did they start out different, but even in the end, they preserve the flavor of where they started out. [I]f you compare Jazz Jennings to Caitlyn Jenner, you know, I don't see how anybody could say these are two people who are suffering from the exact same condition."

Blanchard believes sex reassignment surgery is appropriate for some gender dysphoric patients. He claims to have treated trans-identified patients whose dysphoria was largely alleviated by surgical intervention. As head of Clinical Sexology Services at the Toronto Centre for Addiction and Mental Health, Dr. Blanchard saw adult patients and recommended surgery for those trans-identified adult patients he believed it would help.

But—and here's the important point, in his view—he never recommended such measures merely on the basis of a patient's demand. Part of Dr. Blanchard's job was to determine whether patients were likely to

succeed at presenting themselves as the opposite sex; he undertook this evaluation precisely because he hoped they would.

Dr. Blanchard emphasized to me the daily difficulties of trying to present as the opposite sex. It's psychologically wearing, sometimes much more than patients anticipate. "People who don't pass well are going to be subject to stares and possibly hostile comments from strangers. I'm sure it does take a toll on people to have to brace themselves for every trip to the store to get a quart of milk."

For this reason, his clinic only saw adult patients and insisted they spend two years living as the opposite gender in order to be eligible for sex reassignment surgery. The last thing he wanted to do was approve surgery for someone who would later regret it.

"I can't think of any branch of medicine outside of cosmetic surgery where the patient makes the diagnosis and prescribes the treatment. This doesn't exist. The doctor makes the diagnosis, the doctor prescribes the treatment. Somehow, by some word magic or word trickery, gender [activists] have somehow made this a political issue," he says.

But the management of transgender health is not a political issue—or shouldn't be. What irks him about the informed-consent model now in place in so many gender surgery centers is that it essentially "absolve[s] the physician, the psychiatrist, and the surgeon from the responsibility of making the decision."

His clinic's model was appropriate, he says, because patients "sometimes present with symptoms of gender dysphoria that are actually related to other psychiatric problems. Or they will present in a state of a kind of acute, fulminating gender dysphoria without having experienced what it would really be like to live in the world as the opposite sex." Psychiatric patients should not be their own doctors; as the saying goes, a lawyer who represents himself has a fool for a client.

It's an old idea: physicians are not merchants. The shop owner lives by the conceit that the customer is always right; the physician trains to acquire a critical understanding of a patient's needs. Giving in to a

patient's request is appropriate only when it coincides with his professional judgment.

The erasure of this distinction has arguably enabled and accelerated the opioid crisis, with doctors behaving like vendors, rushing to meet an existing demand rather than evaluating its appropriateness and sometimes frustrating it. "*You're in pain? Here's some Percocet.*" "*You're feeling dysphoric? Here's a script for testosterone. Here's a letter for surgery.*"

It isn't hard to see parallels between the medical professionals in both instances: much like physical pain, gender dysphoria leans heavily on a patient's claim about herself. Any medical or mental health professional who fails to ask further questions is essentially handing over the prescription pad to the sufferer.

According to Blanchard, the issues surrounding transgender healthcare have become so politicized that the underlying mental health problem has become completely obscured. "The gender-critical feminists are using language like 'misogyny,' 'patriarchy,' 'male domination,'" he says. And the transgender activists "are happy enough to have the argument in this language, because any language is better than talking about mental illness and clinical management of symptoms."

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One interesting feature of Blanchard's typology is that it completely omits the current crop of teenage girls with no history of gender dysphoria—now the largest group of patients at most clinics in America, Canada, England, and Scandinavia. "Autogynephilia" is an exclusively male phenomenon; researchers have never studied (or even discovered) women who claim to be turned on by the image of themselves as men. And most of the adolescent girls currently identifying as transgender had no history of childhood gender dysphoria.

In fact, Blanchard does not believe the adolescent girls who suddenly identify as trans in adolescence necessarily have gender dysphoria at all.

He believes they are likely a mixed bag of at least three groups: (1) some kids who are going to be transgender no matter what therapy they're given; (2) kids who would naturally have outgrown their dysphoria on their own and proceeded to live as gay adults; and (3) "some contingent of teenage girls who just have borderline personality disorders and who have a kind of faux gender dysphoria, which they have identified as the locus of their unhappiness."

Blanchard emphasizes that in the entire diagnostic history of gender dysphoria—dating back to the 1910s—there is no record of genuine transsexualism or well-established syndromes of gender dysphoria ever passing from one person to another. "People developed gender dysphoria in isolation from models." They didn't need prompting from a friend, a school assembly, or a YouTube influencer to realize their dysphoria; it simply was.

This is a view of trans-identified teenage girls that never fails to infuriate trans activists—much to Blanchard's surprise. "The activists could have gone the route of saying, 'Yeah, there might be some young people who falsely think that they are gender dysphoric, but that's got nothing to do with those of us who are truly gender dysphoric.' But for some reason, they felt the need to circle the wagons."

Although he has watched trans activists grow increasingly powerful and persuasive in the past decades, he does not fault them for it. "Trans activists do this kind of lobbying. I mean, they're activists, that's what activists do. They try to get as much as they can of their demands." What astonishes him is the members of his own profession. "That's where I'm always saying to my colleagues, yeah, yeah, that's what *patients* say. That's what *patients* do. *What's wrong with us?*"

Like Dr. Blanchard, after spending much of his career studying transsexualism and gender dysphoria, Dr. Michael Bailey has arrived at the conclusion that the current trans-identifying teenage girls are not suffering actual gender dysphoria. Their distress rests instead on the false beliefs that they are like transgender people of the past. "It's a mistaken identity," he said.

Dr. Bailey believes that for these teenage girls gender dysphoria is a hysteria much like multiple personality disorder, another historical example of disturbed young women convincing themselves they possess an ailment and then manifesting the symptoms.[9]

For academic psychologists like Dr. Bailey, the entire issue of gender dysphoria ought to be a matter of evidence. Rigorous empirical study should guide diagnosis, understanding, and treatment. Instead, today, the language swirling around the transgender debates has tended to make such science all but impossible.

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Take, for instance, the issue of "immutability." Activists often claim that gender identity is innate and "immutable."[10] Attempts by mental health professionals to help gender dysphoric patients become comfortable in their bodies, therefore, amount to "conversion therapy." If gender identity is the sort of thing that will never change, irrespective of the environmental factors at play, then encouraging a child or adolescent to quiet or overcome the feeling would seem foolhardy, cruel, a form of torture.

But we have scant evidence that gender identity—a person's ineffable sense of her own gender—is immutable. In fact, we have very good evidence that in many cases it is not. Several long-term studies have shown that a majority of children with gender dysphoria have outgrown it.[11]

Why then would so many activists insist on innateness and immutability? Perhaps the answer lies in American anti-discrimination law. The Supreme Court has indicated that the Fourteenth Amendment's Equal Protection Clause protects certain traits such as race or sex but not, say, hair color, in part because the protected traits are "immutable."[12] You could change your hair color if you really wanted to—and you could do so without surrendering anything vital about yourself. That, at any rate, seems to be the principle underlying much of our Equal Protection Clause jurisprudence.

There is a good argument that this is a silly litmus test for offering the Equal Protection Clause's shield to those groups facing discrimination. But because "immutability" has long been a test for those seeking protection, transgender people are sometimes forced to argue that their condition is "immutable" in order to demonstrate that they merit protection, too.

But what is gender identity? It has no diagnostic markers, no measurable signs, no blood test to confirm it. It is a feeling—an attitude. That does not mean that it does not exist. But it does mean that, like many psychiatric ailments, it poses challenges to diagnosis and treatment. When the prospective treatment is an irreversible surgery, the slippery nature of the condition would seem to justify measured and careful evaluation.

If a therapist believes he might be able to help a gender dysphoric patient feel better in her body, Dr. Bailey believes he ought at least to be allowed to try. But the current gender-affirmative therapists leap straight to affirmation. "At best, they're keeping these girls from adjusting to their natal sex. And at worst, they're encouraging them to take these harmful and unnecessary medical steps."

If you're thinking Dr. Bailey might land himself into trouble for these views, I can assure you, he knows. "You know, there's a kind of progressive language police now and part of the function is to keep people off balance so that they're always apologizing and never asking questions and also to prevent people from being able to have clear conversations about things," he says. "I have heard even 'transgender' is problematic to some people. I don't know what the correct language is and I don't really care."

But he *does* care. I can hear it in his voice. What he won't do is alter the language he employs to render his professional judgment. He isn't above changing his mind in the face of evidence; scientists do that all the time. What he won't do is knuckle under.

THE NON-AFFIRMATIVE PSYCHOTHERAPIST: LISA MARCHIANO

Lisa Marchiano is a Jungian analyst, a social worker, and a widely published author. Like a lot of therapists in North America and Europe,

she began to notice a surge in adolescents identifying as transgender in the last five years, apparently out of nowhere. But unlike most of her colleagues, she greeted this phenomenon with skepticism. She never doubted the distress of the teenage girls claiming gender dysphoria. But as a profound admirer of the power of the unconscious, she was also well aware of the mind's ability to deceive itself.

"I think the human psyche is very susceptible to these kind of psychic epidemics," she told me. "It happened with lobotomies. It happened with multiple personality disorder. It happened in Germany in the 1930s and 1940s. Human beings are susceptible to psychic contagion. We just are. Any of us."

When we feel psychological distress, she says, we want to explain it in a way that will prompt others to take it seriously. "So if you manifest [distress] in some novel way that no one's ever heard of before, the likelihood is you're going to be dismissed. But if it fits into a prescribed narrative, the unconscious latches onto that. It has explanatory value for you and you receive care and attention."

This is the idea developed by historian of psychiatry Edward Shorter, and popularized by journalist Ethan Watters: Patients are drawn to "symptom pools"—lists of culturally acceptable ways of manifesting distress that lead to recognized diagnoses.[13] "'Patients unconsciously endeavor to produce symptoms that will correspond to the medical diagnostics of the time,'" Watters credits Shorter with discovering.[14] "Because the patient is unconsciously striving for recognition and legitimization of internal distress, his or her subconscious will be drawn toward those symptoms that will achieve those ends."[15] Many social contagions are spread this way.

Hong Kong, for instance, had never experienced an epidemic of what Westerners call "anorexia"—girls, captivated by a belief that they are fat, engaging in self-starving. Not until 1994, that is, when local media widely publicized the story of a girl whose tragic death was interpreted by news outlets as an example of an unfamiliar Western ailment called anorexia nervosa. An outbreak of girls presenting with symptoms soon

followed. It wasn't that no one in Hong Kong had ever thought to starve themselves before 1994; it was simply that only when anorexia became a "culturally agreed-upon expression of internal distress did it become widespread."[16]

Similarly, gender dysphoria has entered our symptom pool by way of the internet, *Vanity Fair,* and various popular television programs, like *I Am Jazz*. They have helped elevate gender dysphoria from something you might never have heard of to the first or second thought that pops into your mind when you see a boy clopping around the house in his mother's high heels. "Our early 21st century symptom pool includes the notion that children can suffer extreme distress as a result of being born in the wrong body," Marchiano wrote.[17] Once gender dysphoria entered the symptom pool by way of a few highly publicized cases—lo and behold—parents, therapists, and doctors began seeing much, much more of it.

A lone sympathizer with parents facing the predicament of suddenly trans-identifying teens, Marchiano began counseling them in 2016. She avoids conversion-therapy bans by not seeing adolescents. Very often, parents have told me she is the only therapist they could find who didn't insist they immediately affirm their daughters' self-diagnoses.

It's fair to say Marchiano has a love-hate relationship with her profession. She believes strongly in the power of therapy and analysis; the problem is that too few seem to be engaged in it. "The whole premise of therapy is that you explore," she told me. "It's that you open things up and you approach a symptom with curiosity. Affirmation is the exact opposite of curiosity. It's saying, *I already know what this is*. It's taking things at face value."

In fact, Marchiano says, genuine therapy pushes patients to question their own self-assessments. It does this with the explicit purpose of making the patient stronger. "If I work with someone who's really suicidal because his wife left him, I don't call the wife up and say: 'Hey, you just have to come back!' That's not the way we treat suicide," she said. "We don't treat suicide by giving people exactly what they want. We treat

suicide first of all by keeping people safe, and by helping them to become more resilient." We ought to treat gender dysphoria that way, too.

This approach doesn't discount the possibility that a patient's self-diagnosis of gender dysphoria may be correct—it only requires that a therapist not stop there. Patients claiming gender dysphoria, she says, ought to be treated according to the same therapeutic principles as any other troubled patients. "When someone walks in and says, '*I think I want to leave my marriage, that's why I'm here.*' I don't know what's going on. We have to listen and find out, and the way that I work, that could take months of listening. This idea that a kid's going to come in and tell us that they're trans and that within a session or two or three or four, that we're going to say, '*Yep, you're trans. Let me write you the letter.*' That's not therapy."

Marchiano believes suicide statistics are often employed by gender therapists in a manner that is both irresponsible and unethical. "It's essentially emotional blackmail," she told me. "It's being used to force parents' hands to do something that they don't feel comfortable with." But there's something else she's even more worried about: Insisting that an adolescent who doesn't transition is likely to kill herself—that notion can also easily fall into the symptom pool, too. It may have already. "When you tell a group of highly suggestible adolescent females that if they don't get a certain thing, they're going to feel suicidal," she says, "that's suggestion, and then you're actually spreading suicide contagion."

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I met Lisa Marchiano at Vedge, a trendy vegan restaurant in Philadelphia, a few blocks from Rittenhouse Square, near where she practices. It isn't hard to see why her patients like her. She has an obvious lack of pretense about her, right down to her unvarnished gray curls. Although she has a string of Ivy League degrees to her name, and a number of highly respected publications under her belt, they don't impel her to jargon, nor to curry favor with the gender ideologues who seem to be

guiding her profession. She makes no effort to break and bind the arc of her thought merely to conform to current cultural standards.

She has spoken with hundreds of parents whose teenagers suddenly identified as transgender, and she has much to say on the subject. For one, being a teenager—perhaps especially a teenage girl—is never easy. Adolescence comes with the mandate to strike out on your own, form your own identity, and detach from your parents. "So the thing about a trans identity is it kind of does double duty because it allows you to separate from your parents," she said. "Like, 'I'm so different from my mom that I'm not even female.'"

At precisely a cultural moment when American parents are maximally disinclined to allow their children ever to experience negative emotions, here come their shaky teens, beset by them. Unprepared to weather the trials of adolescence—romantic relationships, the pressures of schoolwork and parental expectations—teens scramble for any excuse to duck them. "Parents become so worried about the kid that they no longer expect them to do well in school. Like, 'Oh, you're feeling anxious or dysphoric today? Stay home.'"

Why then are so many gender-affirmative therapists insistent that they are doing good? Many claim to be saving lives when they encourage a child or adolescent toward gender transition. Marchiano explains the mentality of these affirmative therapists this way: "You cannot let yourself imagine that it might be a mistake because then you'd have to accept that you've been participating in something truly awful."

But, Marchiano believes, they are. In fanning the flames of an epidemic, mental health professionals are withholding the independent judgment and therapeutic help that confused adolescents desperately need. If anything, "affirmative therapy" encourages a confused adolescent's most dangerous impulses.

Marchiano considers the implications for a moment. "I think the last holdouts in all of this are going to be the parents who transitioned their children," she says. "They'll never be able to admit that maybe they did something wrong."

THE PSYCHIATRIST: DR. PAUL McHUGH

By this point you may be wondering, what *is* gender dysphoria? Yes, it's a feeling of profound and persistent discomfort with one's body—but that simply restates the question. Surely psychiatry has more to offer than the *DSM*'s list of symptoms, which amount to this: gender distress is distress about gender.[18]

Johns Hopkins University distinguished professor of psychiatry and behavioral sciences Paul McHugh has an answer. Gender dysphoria is an "overvalued idea" or ruling passion. This is "an idea held by many people in the world, but held intensely by the patient or the person, who is making a life of that idea," Dr. McHugh told me. Many people believe that it is good to be thin, for instance. Many adolescent girls believe it's better to be a boy. But for anorexics and those with gender dysphoria, those ideas become all-consuming.

Dr. McHugh does not doubt that those under the sway of an overvalued idea are suffering real distress. What he doubts is that they have accurately located its source. An anorexic, for instance, often becomes taken with the notion that if she simply lost more weight she would at last be happy with her body. But in fact, she'll never get there—not by starving herself, at any rate. Pursued this way, happiness will forever be like the beach ball caught in a current, always bobbing out of reach.

No amount of subtracted weight will deliver the bodily comfort the anorexic seeks because her weight was never the real problem. In Dr. McHugh's view, mental health professionals must endeavor to change the anorexic's wrong view of her body—not the body itself. "Policy makers and the media are doing no favors to the public or the transgendered by treating their confusions as a right in need of defending rather than as a mental disorder that deserves understanding, treatment and prevention," he wrote in 2014.[19] From this statement alone, one might guess that Paul McHugh has won his share of detractors.

For decades, Dr. McHugh was psychiatry's most prominent scourge. In 1979, as psychiatrist in chief at Johns Hopkins Hospital, Dr. McHugh shut down the gender identity clinic, which performed

sex-change operations. In his view, the hospital had "wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it."[20]

This is a controversial view. Drs. Zucker, Blanchard, and Bailey, for instance, all believe sex reassignment surgery is worthwhile and salutary for at least some adult patients. The problem with gender surgery, according to Dr. McHugh, is not that it can never satisfy a patient or alleviate dysphoria. The problem is that doctors have no way of knowing who will be healed and who will be harmed by it. "Well, I know this," he told me. "That some people are satisfied and live happily ever after. And some, of course, get suicidal, depressed, and regretful. And nobody can tell the difference between the ones in the beginning that will and will not regret it."

Even Dr. McHugh's critics admit that scientists have yet no reliable means of predicting who will be helped and who will be hurt by a gender surgery. For Dr. McHugh, that alone is sufficient reason to pull the plug, and limit these surgeries to controlled experiments overseen by an institutional review board. The medical profession should never have flung open the gates of surgery merely to appease a clamoring public.

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I met Dr. McHugh in his book-laden Baltimore home, a white brick American Moderne set in the leafy Guilford neighborhood abutting Johns Hopkins Medical School. At eighty-eight he is stunningly sharp and erudite, able to quote long passages of Matthew Arnold from memory and scan his considerable mental microfiche of psychiatric literature, never failing to provide an accurate citation.

In the 1980s, Dr. McHugh became a leading opponent of recovered-memory therapy, in which psychoanalysts claimed to have discovered the latent source of patients' multiple personality disorder in past childhood abuse. Dr. McHugh believes multiple personality disorder is a

phony ailment and recovered memories are iatrogenic—a Greek word meaning "brought on by the healer"—implanted by the therapeutic process that purports to discover them. Often the fake memories were of childhood abuse, and Dr. McHugh traveled to Rockville, Maryland; Manchester, New Hampshire; Providence, Rhode Island; and Appleton, Wisconsin, offering expert testimony to exonerate wrongfully accused defendants.

Dr. McHugh believes the current transgender craze is similarly encouraged and improperly treated by a psychiatry profession overtaken by fad. Whereas in all other areas of medicine experimental procedures performed on human subjects must be overseen by an institutional review board, gender surgeries are not. And they *are* experimental, Dr. McHugh insists, pointing to the poor evidence quality of the studies on which they are based.

One key difference between this and past psychiatric crazes is that the transgender epidemic seems primarily induced by peers and the media and schools. Today's teens don't wait to talk to a therapist to find out what's wrong with them. They simply park themselves in front of a screen, Google "Am I trans?" and self-diagnose from the list of symptoms. If anything, therapists are merely exacerbating or encouraging a problem already begun.

But Dr. McHugh believes the transgender craze will likely end as the multiple personality craze did: in the courts, with patients suing their doctors. Some of these teenage girls, he says, "will wake up at age twenty-three, twenty-four, and say, 'Here I am. I've got a five-o'clock shadow, I'm mutilated and I'm sterile, and I'm not what I ought to be. How did this happen?'"

Of course, even if this transgender epidemic does represent yet another psychic craze, that doesn't explain *why this?* So many crazes have come and gone. Serial killing is vanishingly rare; mass shootings, on the rise. Bulimia may be in decline, while cutting and suicide sharply spike. Other fads died off, while this one took root. Why? What's in the national drinking water?