Eli Coleman, Ph.D.
Narrator

Eli Vitulli
Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

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In 1970, the University of Minnesota's previously autonomous College of Pharmacy and School of Dentistry were reorganized, together with the Schools of Nursing, Medicine, and Public Health, and the University Hospitals, into a centrally organized and administered Academic Health Center (AHC). The university's College of Veterinary Medicine was also closely aligned with the AHC at this time, becoming formally incorporated into the AHC in 1985.

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 20th century. AHCs became not only the primary sites of health care education, but also critical sites of health sciences research and health care delivery.

The University of Minnesota's Academic Health Center Oral History Project preserves the personal stories of key individuals who were involved with the formation of the university's Academic Health Center, served in leadership roles, or have specific insights into the institution's history. By bringing together a representative group of figures in the history of the University of Minnesota's AHC, this project provides compelling documentation of recent developments in the history of American health care education, practice, and policy.

Biographical Sketch

Eli Coleman was born in Buffalo, New York but grew up in Montreal, Canada and then Chicago, Illinois. He earned a bachelor's degree in psychology and history at Marquette University in Milwaukee, Wisconsin and his master's in pscyhology at the University of Wisconsin, Oshkosh. He pursued further graduate work at Miami University in Oxford, Ohio, and completed his Ph.D. in counseling psychology at the University of Minnesota in 1978. He became an instructor and then professor in the University's Program in Human Sexuality in 1978. He is the founding editor of *International Journal of Transgenderism* and *International Journal of Sexual Health,* and has served in leadership roles for several of the professional societies in his field. Dr. Coleman became director of the Program in Human Sexuality in 1991 and continues to serve in this position.

Interview Abstract

Dr. Eli Coleman begins his interview by describing his early life, his education, and his move to the University of Minnesota and the Program in Human Sexuality (PHS). He reflects on his first years in the program, its transition into Family Medicine, Dr. Ed Ciracy's impact on the PHS, and the Sexuality Attitude Reassessment seminar. He also discusses the following: the role of churches and seminaries in the PHS; the PHS curriculum and teaching; Don Hoag and Sharon Satterfield as directors of PHS; PHS contributions to HIV-AIDS behavioral research; funding issues; politics surrounding the PHS; John Kelly's work as director; and Dr. William Jacott's leadership of the Department of Family Medicine. Dr. Coleman the reviews his own time as head of the PHS, including the economic problems the Program faced. He describes the development of and changes to the sex offender treatment program, disability work in the PHS, and the Program's work on transgender issues and his work on the Gender Committee. He concludes with the relationship between the World Professional Association for Transgender Health and the PHS.

Interview with Doctor Eli Coleman

Interviewed by Eli Vitulli

Interviewed for the Academic Health Center, University of Minnesota Oral History Project

Interviewed in Doctor Coleman's Office, University of Minnesota Campus

Interviewed on July 9, 2012

Eli Coleman - EC
Eli Vitulli - EV

EV: Thank you, again, for agreeing to the interview.

This is Eli Vitulli with Doctor Eli Coleman in his office at the Program in Human Sexuality [PHS] at the University of Minnesota.

I'd like to begin asking you to talk a little bit about your background, where you were raised, your education, how you came to Minnesota.

EC: Okay. I was born in Buffalo, New York, grew up in Montreal [Canada], and Chicago [Illinois] for my high school years. Then, I did my undergraduate at Marquette University [in Milwaukee, Wisconsin]. I did my master's at the University of Wisconsin-Oshkosh. I did some more graduate work at Miami University in Oxford [Ohio]. Then, I came up to Minnesota to finish my doctorate here in counseling psych [psychology]. I finished that in 1978.

EV: How did you get involved with the Program in Human Sexuality?

EC: When I came here in 1976 as a graduate student, basically all I had to do was finish my dissertation. In searching around for possible dissertation topics, I learned that there was this place called Program in Human Sexuality. I had done some work in sexuality beforehand, but I had done many other things, too, so I wasn't really sure what I wanted to do. I came down and visited with Jim [James] Maddock who was on the faculty at the time. I started to get excited about doing my dissertation in the area of sexuality and use the patient population here as part of my dissertation.

EV: What was your dissertation on?

EC: My dissertation was on the effects of communication skills and counseling on treatment of couples with sexual dysfunction.

EV: What work were you doing in the sort of early years, I guess, the year or two that you began at PHS.

EC: At the same time I started to do my dissertation, I did an internship. I was accepted as an intern. So I was working twenty hours a week as an intern and, then, doing my dissertation at the same time. When I finished my dissertation, they offered me a full time position. So I came on this faculty.

EV: You came in 1978, correct?

EC: No, I came to the Program in 1977, finished my doctorate in 1978. I actually came on full time, I think, around July 1978, but I don't know exactly when I finished all my dissertation, but I didn't get my degree until December. I was appointed as instructor and, then, when I got my Ph.D., it changed to assistant professor.

EV: You came into PHS right after it moved into Family Medicine?

EC: Yes.

EV: Were you aware of the sort of transition and what was happening at that time?

EC: Some, mostly by history. I was hired by the interim director, Don [Donald] Houge. Again, I wasn't around when that decision was made. I started when we were in the department. Don was director until 1979 when Doctor [Sharon] Satterfield started. I was on the faculty before she started and, then, she came in.

EV: I realize you were new and didn't have anything to compare it with, but what was the transition during that period, during Don Houge's tenure, and, also, its sort of move into Family Medicine?

EC: I think the transition was that the head [Doctor Edward Ciracy] of Family Medicine wanted to make this more academically sound. So I think that there was more scrutiny of the staff that were not well academically…academic backgrounds. Then, I was a part of, I think, the clear effort to start to hire people with more solid academic training and background.

Some of the experimental things that were being done here were questioned, particularly the whole Sexuality Attitude Reassessment [SAR] seminar, which was the foundation of the Program. Doctor Ciracy ordered an examination of the SAR and asked for recommendations. So there was a lot of review of the Program and various aspects of it. Some things were decisions that he made by fiat. For example, we used to do nude body

sessions with patients. One day, he just said, "These will not happen any longer." I think that his effort was really to, I wouldn't say stifle, but really to mainstream it more. It was a controversial Program that lots of people questioned what was going on at the Program. I think that he wanted to… He was very open to… For example, I remember there was a question about your using surrogates and he said, "That would be fine as long as you put that into some sort of experimental protocol."

[pause] We're bringing back things that I am remembering now.

I remember we were going to do a SAR for gay men and began to develop problems with that, other than insisting that it be put into some sort of experimental protocol.

EV: It would not be put into…?

EC: That it would be. He wanted more evaluation. He wanted to review things from outside sources and make sure that it was credible.

EV: How did the staff respond to those changes?

EC: Oh, I think that there was a lot of resistance from some of the staff with this interference and oversight. I think that the Program really was… It was under the dean's office and so they handled the bills, but other than that, I don't think that they really had much to say about the Program or got involved. It was left to its own.

The only crisis is that they really ran into such serious financial problems and were in debt. One of the main reasons that it ended up in Family Medicine is that they were willing to absorb the debt. It was really a favor. The dean [Neal Gault], at that time, was very close to the head [Doctor Ciracy] of Family Medicine. So he really kind of did it as a favor. It was also a department that was wealthy and had resources to back it up. Other departments were approached to take it on. I'm not sure that they were not favorable to take it on but, financially, I think it was a problem. I don't know how much of it was philosophical.

EV: You mentioned the SARs.

EC: Yes.

EV: How long did those go on? I assume you don't have those anymore. [chuckles] How long did those continue?

EC: They went on all through the 1980s. When did we do our last SAR? I don't know. It had to have been in the mid 1990s, I would say. The market for them simply dried up. So it was very difficult to get the number of people to keep it going financially. When was it? Maybe it was as long as 2000. That's a good question. I don't know when it really ended. What ended were what we called the public SARs, the ones that were open to lay people and professionals. Anyone could really sign up for a SAR. What did

continue is the SAR for the medical students. Technically, in some form, that still continues. It was only this past year that I actually changed the name of that part of the course. So that part continues to this day and was a part of the required course for first-year medical students.

EV: When did they end for laypeople?

EC: I'm thinking maybe as long as 2000 and, then, I think …

One of the things that hurt us was that we started to develop seminars for the public that were supported by grants. They weren't called SARs, but essentially they were SARs starting with the man-to-man sexual health seminars. In some ways, we really kind of ate in until we created our own competition. The significant thing is that the SARs were morphed into other programs and for more targeted audiences with different names.

EV: That seemed to be going on prior to your time. They seemed to have generic SARs or general audience SARs and, then, more geared towards…? Then, it just sort of morphed into…? There wasn't a general thing, and it was all more targeted?

EC: There were general SARs up until, I'm thinking, maybe 2000. Then, they got more targeted.

EV: Did you participate in teaching them?

EC: Oh, yes.

EV: Did the curriculum change over time?

EC: It's always evolving. It was always evolving. [pause] I remember we started to create more regimen from what was taught from one SAR to another. In some of the early days, there was a basic sort of agenda, but there was a lot of individual variability in who the SAR's group leaders were and they could really kind of tailor make the seminar themselves. In some ways, it was like reinventing the wheel each time. Everybody had, like, a different way of doing it. One thing that happened when I was director is that we went to a more standardized kind of format for the seminar. Maybe partly with the invention of Power Point, the seminar was really kind of standardized.

EV: You mentioned Doctor Ciracy did an examination of the SAR. Do you know what came out of that, and what he did, and what conclusion that came to?

EC: [chuckles] I was afraid you were going to ask that. I can't really remember the conclusion so much. I don't think much really happened. I think that it reassured him that it was on some sound principles and was okay. If there were some particular… I can't remember that there was anything dramatic that we changed as a result of that report. I think that it really kind of satisfied him.

EV: That's interesting, because the Archives sort of ended about 1977. [chuckles]

EC: Well, that report is around.

EV: Yes.

EC: I know that report is around. Have you seen that report?

EV: No. Like I said, the Archives that are available, the University Archives, pretty much end…

EC: In 1977. Yes. Well, this was after that. That report, I might even have a copy somewhere in my office, but I know that there would be at Kinsey [Institute, Bloomington, Indiana].

EV: Yes.

I mentioned before we actually turned on the recorder that one of the things I thought was really interesting about the beginning of the Program was how involved the church was.

EC: Yes.

EV: I'm wondering, first starting when you began, what was the role of churches and seminaries and organizations that you saw in sort of like the late 1970s?

EC: I think that it was really diminished by the time I got involved. I think in the early days that they were very involved. They were considered faculty, a part of core faculty. Then, I think that there was more separation; although, they continued to be involved in some of the Medical School training and we continued the training of the seminary students. That training with seminary students, I know continued after I got here. I was not involved in that, but Sharon [Satterfield] was very interested in that. In fact, I don't know if it had an impact, but after she started here, she started some seminary training herself. I wasn't involved in that part of the Program. I never became part of that. There was a certain group of people that were very much a part of that and kind of did that. I don't know when that completely petered out. I would say by the mid 1980s, it just wasn't happening or it was very irregular. It actually transferred over where I think the seminaries tried to keep it going and they would use PHS faculty less and less. It was all economic problems.

EV: I know, at least in the early to mid 1970s, there was like an advisory group or something like that called the Committee on Religion and Ethics.

EC: Yes.

EV: It has different names, I guess. Was that still going when you…?

EC: Not that I was aware of. No.

EV: It would be sort of disappearing by that time.

EC: Yes. Some of the faculty were involved in… For the Medical School, we'd always have to offer an alternative to the SAR for the medical students, so they could go through an ethics and values seminar and that was taught by one of the faculty from the United Theological Seminary [of the Twin Cities]. So that went on for a number of years through the 1980s. Then that stopped.

EV: The Medical School still had their requirement for a course in human sexuality, right?

EC: Yes, the medical students.

EV: Is there not an alternative type of situation now?

EC: No. No. At one point, we went to the curriculum committee and said, "Why are we making exceptions? This is recognized as important. Either say it is or it's not. We don't make optional other labs or courses." So they affirmed that it was important and we stopped doing the alternatives.

EV: Do you know if that was controversial?

EC: Well, I remember with that alternative, there would be, boy, at least ten, fifteen, twenty percent of the class who would take the alternative. How did we stop that? I think partly, too, we changed the nature of the SAR quite dramatically around that very same time, particularly the elimination of small groups. Actually, that might have been one of the concerns that was in that report.

EV: Was this the mid 1980s?

EC: Let's see, now when did they eliminate those small groups? Probably in the mid 1980s. Yes. The use of pornography also went out. We were only using… The amount of explicit films was really reduced. It just wasn't as challenging, I guess. I think for a while, we could still have them write a paper or something like that. I think we used to say, "If you really have a problem with it, we'll discuss some sort of alternative for you." But we started to make it really not an easy alternative. I remember when somebody would come and they would say, "I can't do this," I would really challenge them and say, "Oh, come on." It was a transition. It was a time where they could do some alternative and I don't know exactly when we just started to say, "This is it."

EV: While we're talking about the curriculum, I'm curious about PHS's role in the Medical School curriculum and how it's changed over the time that you've been here.

EC: I'm not sure I understand the question.

EV: My understanding is that PHS has sort of three things that it does, broadly speaking: research, service providing, and teaching and, for a while, as you've been talking about, has had at least a role in the Medical School curriculum teaching about human sexuality. How has that sort of teaching…? Has it changed over time? Is that still the primary function in terms of teaching the human sexuality curriculum?

EC: From the beginning, that was sort of—still is—almost the reason for being is that we were there to teach medical students. Even in the early 1970s, we started really training all kinds of health professionals. We were doing more of that as far as seminary students, or, again, all the SARs for professionals. We had different certificate training programs in child sexual abuse and chemical dependency. We were doing all this work in disability. We were training people. We were doing *a lot* of education, but it was not just for medical students. Still today, most of our teaching probably doesn't involve the medical students. Right now, we're training postdoctoral psychologists. How has it changed the amount that we're teaching the medical students? It's been about the same all the time. I think our focus of our education has just shifted to different things and groups. Also, in the last decade or so, we developed so many more psycho-education for HIV [Human Immunodeficiency Virus] prevention. We're doing a lot of teaching as a prevention measure.

EV: I'm going to ask about specific things, but I'm just curious sort of overarching, what has driven the change and focus of that education aspect?

EC: What has driven the focus of the education? Faculty interest.

EV: To get back into 1970s, could you talk a little bit about the director search that ultimately found and hired Sharon Satterfield?

EC: Again, I wasn't directly involved. She was hired while I was still an intern, so I wasn't really aware of what was going on with that search.

The one piece that was important is that the interim director was hired. He was a statistician. He was a clinical psychologist, but he hadn't really been practicing. He was really a statistician for the department, but he was a very trusted person to Ciracy. I'm sure he was just asked, "Would you do this?" Out of loyalty again, he agreed to do it with no background in this area at all, other than Ciracy knew he could trust this guy and he'd do what he wanted him to do. That was Don Houge. But Don really became very, very interested in the Program and became very interested in clinical work through this. He *really* got into the Program, and he really liked it, and was very important for the Program, because he was able to report back to…again, this trusted soul. He said, "This is okay and I like it." He was very important in that way. He really got into it. He worked on developing his clinical skills. He didn't pretend to really know. He learned from the existing staff. He had the training and background and schoolwork, but he really had to, you know, buff up on this. I think he was a very good administrator and he really wanted the job. They did the national search, and he thought he was really a shoe-

in, because of his relationship to Ciracy, and he was doing a good job. Everything was going well.

But, I think that Ciracy also had a real bias against psychologists. So here comes an M.D., a child psychiatrist, married with a little… [chuckles] As he always says, "She walked in with her little child in arms and that was the end of it." She had very good training and background, so she had a lot of the tickets, and she was a woman, and she was, you know, married and had a kid. It was all that normality—not that Don wasn't married. Maybe he was married at that time. I don't know. But that was a woman. That she got the job, he was terribly, terribly hurt and disappointed. Yes.

EV: Did he remain involved in the Program after that?

EC: He did to some degree, but he really kind of went back into the department. I don't remember how… I think he went back pretty quickly and I think it was because he was so wounded. So he kind of went back into the department and went into another area and stayed only remotely connected, I would say.

EV: Do you remember who was on the hiring committee?

EC: No.

EV: Presumably, it was people from the Program as well as Ciracy?

EC: Probably people from the department and probably they had to have included like Herbert [Herbert] Laube or some of the visiting faculty on the search committee. I'm pretty sure Herb was probably on the committee.

EV: What was Doctor Satterfield like as a director?

EC: Well, she came in and was facing, you know, a challenging situation with the Program. There were a number of grants that were supporting a number of faculty that were ending. The only thing that was really kind of going, at that time, was the clinical activity that had some future and ability to bring in some revenue. The people that had those grants were the ones that were still not happy about going into Family Medicine. They just never really got along with Sharon as she came in. I think she felt ignored, maybe, by them. She really tried to find a path to keep them on in ways but they decided to leave. So it was a very difficult situation. She hired other people that mainly could contribute clinically, because there just wasn't anymore grant funding really available. It was all sort of drying up. That was the crisis that she had to face with faculty leaving and really kind of developing faculty that would support her. She was very supportive of me. She was very supportive of the other faculty that she brought on, and I think was rather democratic in her style of leadership. She developed good relations with the Department of Psychiatry. She had a joint appointment in Psychiatry. I think that she was well liked and respected in the Medical School. At a critical juncture, she really saved the… I

don't think they were going to kill it, but there was an attempt of really reducing the Medical School course significantly. She really fought that battle and won.

EV: The Human Sexuality course?

EC: Yes.

EV: Do you know why they were trying to reduce it?

EC: We're experiencing the same thing now. Medical School curriculum goes through some sort of paradigm change in how we're going to do this. Then, there's all this jockeying for really how many hours. It was controversial to begin with, but, also, it was just a fight over hours. She really fought and was able to convince them to… We did lose some hours at that time, but it could have been much worse. She preserved it, and she directed the course for a number of years, not without controversy, but it went on pretty well.

She brought the gender program over from Psychiatry. She was very creative. She went into areas and she took on controversial issues when there was the concept of creating pornography laws in Minneapolis. She would get involved and fight for rights. She really transformed the sex offender program to a much more family based approach and brought in new people, more new faculty with more marriage and family background training. She was very strong. She dealt with the whole sexual abuse, all this panic in sexual abuse cases. She had a nice balance, I think, of recognizing the problems of sexual abuse, but there was a lot of hysteria, at that time. We were treating incest victims in a sort of way and she really changed that paradigm, I think in a very positive direction. So she was very bright. She was very creative. I think she was very effective. She brought on a number of really good faculty. That was really good.

Then, she just started to become rather alienated from the faculty, and I think there were a lot of questions about her judgment and her boundaries with clients. I think she became an embarrassment. She started out very strong and, then, just really went downhill.

EV: What changed between…? What brought about the sort of alienation of the faculty?

EC: I think that the judgments that she was making were not viewed positively. [pause] She was well supported by Ciracy and, again, in his rather dictatorial fashion, there were just really lines of authority and it was really very difficult when we had to bring some of the concerns and ethical concerns. He was really not interested in hearing them. So it was really a very difficult time. Sharon was there and the faculty were on the other side. It could have just really brought down the entire Program. Ultimately, she recognized the lack of confidence that people had, and I think Ciracy started to see it, and she resigned as director; although, she stayed on. Then, there was an attempt to really kind of… All right, let's see if we can all get along. That didn't really work.

EV: Was she seeing clients? She also had a practice during the whole time? I know she was post director...

EC: Right.

EV: So was she also seeing clients as part of her job?

EC: Yes.

EV: Okay. The difficulty with the faculty, the relationship there, was about her own practice and, also, about the way she was directing and steering the Program?

EC: Yes.

EV: Can you talk a little bit about the decisions she made in terms of steering the Program that the faculty disagreed with or had an issue with?

EC: It was really a lot of problems with the boundaries and judgment. She would hire people that she had sexual relations with and so there were these weird dynamics. She would, you know, hire her boyfriends to work when they really didn't have that kind of expertise. Again, with this being such a… It's not like there weren't those kinds of dynamics in the 1970s here, but we worked so hard to get away from that kind of reputation. She was really becoming an embarrassment to us. She had very poor boundaries with her patients. She would be very subjective in her decisions about who gets hormones or not. It just seemed to be very, very subjective. When she was being very over involved with somebody, it was really very messy.

What else? With the division, she really went from being very, very supportive to really trying to be very hurtful. [pause] We found out that she had a voodoo doll of me and was sticking pins in it. It was very crazy.

It was only slowly that Ciracy started to see this. It was already kind of evident by the time she went up for tenure. It was just interesting how she was turned down for tenure and, then, she appealed. She had somebody who had a really good reputation in the University Medical School that went to bat for her and, somehow, she got through. They wanted to get rid of her. It was just a very, very hard process for them to finally get her to resign as a tenured professor. They farmed her out. They were trying to do everything. Then, they really discovered… I think they really felt that she was crazy because of the crazy dynamics here. Then, they'd move her to another department and she was just as crazy and dysfunctional there. Then, they, finally, thought, oh, it's *her*. She really disintegrated.

EV: Did she go up for tenure while she was still director?

EC: Yes.

EV: How long did the bad dynamics go on while she was at the end, I guess?

EC: Well, she must have resigned in, what, 1987?

EV: Yes.

EC: So, it had to have been a year or two. There were a number of good years, as I said. Then, it just sort of went down from there. Some of it was with her marriage ending—that was really very messy—and all of her boyfriends. Crazy.

EV: I want to go back and talk a little bit about, I guess, the good years of her tenure. I'm going to ask later some more specifics about, like, transgender work and the sex offender program. You mentioned that she dealt with a number of controversies. Would you talk a little bit more about what some of those were?

EC: Like the pornography?

EV: You mentioned that, yes.

EC: This is when Andrea Dworkin and Katherine MacKinnon were here and they really tried to develop some anti… There wasn't going to be any pornography in the city somehow. It was just the root of all evil. She just came in there, not like there was anything problematic with this, but it was just so far off from what we knew scientifically. This was the extreme of feminist politics. She would go out on a limb and really kind of try to present the data, what we knew from all the studies on the effects of pornography and present that. She had the kind of credentials to speak to these issues, especially as a child psychiatrist. The fears of all of these children, so she could talk about that very well. She got involved in that. She testified in a lot of cases, mostly for the defense, and she was criticized for that. There was the whole policies and how sex offenders were really being treated and dealt with that didn't really fit. There was a lot of moralism and, you know, trying to find a reasonable path to figure out how to deal with these people, so she would give a lot of testimony that would be helpful in cases that became precedent setting. She helped allow for a lot more outpatient treatment rather than just incarceration. That legacy continues to live on here where other states just don't have much…you know, send everybody to prison.

What else did she really get done? She liked the media. Whenever there were issues, she was happy to sort of present a sound understanding of whatever the issue was. So she did a lot of public education, and I think that was really good. Again, she was always really very level with kind of a balance, I think a very balanced kind of perspective. She was very articulate and effective. I can't think of other things.

[break in the interview]

EV: Another major contribution was her rescuing the transgender program from Psychiatry where they were really ready to get rid of it and follow Johns Hopkins

[University] with that report that came out in 1979 [by Meyer and Reter, Sex Reassignment Follow-up, *Archives of General Psychiatry, 36,* 1,010-1,015]. She not only fought for it here, but also was outspoken against that study. She developed the whole protocol. There was no protocol for counseling, and she really developed the whole protocol for our transgender program. We put a tremendous amount of energy into that.

Was there another major thing that I thought of as an accomplishment? The one thing I was going to say is that while she was very good in terms of hiring people and getting the Program pulled together and had a good relationship with everybody in the community, she never was really able to develop her own line of research.

That was what was really hurting her in terms of being able to get tenure. Other than her teaching and the clinical work she was doing, she wasn't meeting any of the criteria for tenure. I remember she put together all of her things with the media. She was interviewed by *60 Minutes* and this and that. She puts together a collage of all of her media appearances and presents that to the tenure committee as evidence of her contribution. Today, that would be really…but even then, that was just rather incredible. I think one of the main reasons, too, that she did get tenure was because she was a woman.

EV: How so?

EC: Because at that time, the University had not a very good record of promoting women, so she caught right at that cusp of, I think, arguing discriminatory… That was the basis of her appeal was that it was discriminatory because she was a woman. They were at a time when that they were running scared about that. They may have been bending over a little backwards, I think.

EV: It's an interesting problem with tenure and the different kinds of work that people do. In universities, some of which gets recognized for tenure while others do not. [chuckles]

EC: Again, it was not that she wasn't making contributions, but they weren't necessarily of the kind of criteria that were being used at that time. She was having to be very creative to do that.

EV: Out of curiosity, and to follow up on something you said before we briefly broke… I know that Andrea Dworkin and Katherine MacKinnon taught a class at Minnesota while they worked in the area.

EC: Right.

EV: Was there interaction between them and PHS?

EC: No. No. No.

[laughter]

EV: Obviously, during Satterfield's tenure, it was the beginning of HIV-AIDS [Human Immunodeficiency Virus-Acquired Immune Deficiency Syndrome] in the U.S. [United States].

EC: Yes.

EV: How did PHS, I guess, respond to that? When did the Program start to get interested?

EC: It didn't respond. That was true of a lot of sexology, at that time. It was really a shame that we didn't really respond.

EV: Do you know why? Both here and sexology at large?

EC: I think there was still… Some of it is just the interest of the faculty. They didn't come from the sexually transmitted infection point of view. They were more interested in treating sexual dysfunction, gender. I always said, "Sexologists were all about liberating people's sexuality." We were in the area of sex offender, which most sexologists never touched. So that was really kind of unusual. We had to be concerned about containing in that sense. I think that that's some of the factor of why we didn't get really very involved. We didn't get involved until probably around 1988, when we received the first amfAR [American Foundation for AIDS Research] grant to do the work with the transgender population.

EV: So your entry into AIDS research was through the trans population?

EC: Yes.

EV: That's interesting.

EC: Yes. That was through the influence of Walter [O.] Bockting coming on as a post-doctoral fellow and his interest. He ended up doing his whole dissertation on HIV prevention. I was able to be…because he wasn't faculty, and we were working together a lot on that, we were able to secure that first amfAR grant. Then, shortly after, in 1988 or 1989… When did [B.R.] Simon Rosser come? He came with a very strong interest in HIV prevention and, then, really moved us much more into HIV. Then, the money was coming. So funding also drove some faculty into working… We did work with the Hmong, we did work with African American women. We developed all of these interventions funded first from amfAR, then from the state, and then federal funding.

EV: What was that first grant you got about, out of curiosity?

EC: [pause] Was it needs assessment or was it the real beginning of All Gender Health? That's a good question. [long pause while Doctor Coleman reads document on his computer] We actually had a grant to establish a counseling center in 1989 when I got a grant from the Ford Foundation. [chuckles] I don't even have the 2001 to 2004… This must have been it [unclear]. I don't think I have it on my CV [curriculum vitae].

EV: [chuckles]

EC: Let me see if I can quickly go to Walter's. He did most of the… I was the P.I. [principal investigator]. [pause] It was 1992 to 1993.

EV: Oh, wow. Okay.

EC: This was All Gender Health, HIV Risk Reduction Program for Transvestites and Transsexuals: $69,000 was funded in '92 and '93. I'll have to put that on my vitae.

[laughter]

EC: Thank you.

EV: Yes. I'm glad I could help.

EC: What did I say? The other one was…we set up a counseling center. We had a counselor over at the Delaware Street Clinic. We got funding from the Ford Foundation to do that. Maybe that was our first venture was really counseling rather than any kind of prevention. When does science funding start? Science started in 1996 and, also, our work with African American Women started in '96. So we were very late. Very late.

EV: How did that work progress and change over, I guess, the last fifteen years. [chuckles]

EC: When I became director in 1991, the clear mandate from the dean was, you know, that this had to become much more of a research center.

EV: PHS?

EC: PHS. At that time, we didn't have any funding. We had funding for educational things, but there was just nothing in terms of research. So that became my mandate. We had started the post doc program, so we started to train people. We get going in the early 1990s with some of these health department interventions…not much research kind of thing, but we're getting going. Actually, in 1995, we have a real crisis, because of the economics and people are… The other thing that Sharon did was that she really built up the whole clinical services, so we went from grant support to…the clinic sustained us. We were able to build faculty. We did scholarly work. We published a bunch of things and they were all funded out of our back pocket or they were just like case studies and things like that. So we were publishing, but the funding was coming from our clinic

operations. We did have a bunch of funding in the early 1980s from educational activities, training grants that help support our work. But the clinic really sustained us and it sustained us all through the 1980s which were a *horrible* time for funding in sex research. Then, when the AIDS epidemic hit, we were then able to engage in getting that kind of funding and move from basic, like some sort of intervention demonstration thing, to going from foundation to state to federal grants where we were doing some very high quality research. That's where we stand today is that we have half of our income coming from federal grants and half of it from clinical. When I took over, it was nothing. It was all clinical revenue and maybe a little bit in education.

EV: So AIDS funding was sort of the beginning of that?

EC: Yes.

EV: That makes sense, given the climate in the '80s.

EC: Yes, but we did not jump on it in the early days. But there was funding in the early days for AIDS but not sex. We would have had to have gotten our heads around doing HIV stuff and that's not where our heads were at.

EV: When did grants start becoming available for, I guess the prevention, the more sexuality part of HIV?

EC: I think it was there in the 1980s. The eroticizing safer sex stuff was going on, you know. I think there was room for it; although, most of the behavioral research was really about how many partners, condoms, not so much of a sexual health focus. That's what our main contribution really was in the 1990s, really developing interventions that were really based on a sexual health framework.

EV: Can you talk a little bit more about that?

EC: Yes. When we got into it, we had the fundamental belief that this was a sexual problem, in a way, that people couldn't communicate. They weren't comfortable with their sexuality. They didn't know how to negotiate. They weren't comfortable with their bodies. A lot of risk behavior, we felt could be explained by some of these deficits in sexual… So we developed a model, a sexual health model of HIV prevention, which… We really started that and articulated it and published it and all of our inventions were based on that model, which was a very different model than the health belief model**,** theory of reason-action model, and all the other kind of cognitive behavioral approaches. It's really kind of, yes, coming of age. I think that we were really pioneers. We took what we knew from helping people with their sexual dysfunctions and their sexism, their identities, and whatever, and realized that that's what they needed in order to really engage in safer sex. We would develop interventions that would help them with that. Of course, we still had to have the dependent variable of less risky sexual behavior.

EV: That model is different than the model that had been more in use at the time?

EC: [unclear] model, yes, at the time.

Through that funding, we had to do it for HIV reasons, but we were able to, you know, learn a lot about the populations that we were studying, about their sexuality in general, too. The funding came from HIV, but we were learning a lot, understanding the sexuality of people.

My area started out in chemical dependency and intimacy dysfunction in the early 1980s. There was no funding for that. Through that, I started to see this phenomenal of compulsive sexual behavior, so I describe this phenomologically through clinical experience and developed that and, then, through our studies started to look at that construct as a variable in HIV prevention. So we've been able to understand that as a major variable in risky sexual behavior. Now, we have federal funding that is looking at it very basically with the implication for HIV prevention, but still looking at the basic kind of phenomena. It's still a struggle for us. That's a big advantage that we got that, but the money is still coming out of that HIV pot, and we're still struggling to study the things that we're really interested in. HIV, we've done a lot of work in it. I'm not sure that it's really… It was Simon's passion, but I don't think it's been Walter's passion. It just gave him a vehicle to study transgender.

EV: That's pretty common, at least for trans populations, right, the money is in HIV-AIDS research? Is that the place, I guess since the 1980s, where most of the money is for sexuality research?

EC: Yes.

EV: Have there been changes in that role or state for research grants?

EC: There's been some support of some basic epidemiological studies of behavior, but it's still hard to shift to looking at the other aspects. We've been really trying to lobby for different review sections. The problem is that NIH [National Institutes of Health] is still very disease focused and the sexual disorders have never… There was a lot of interest in the 1970s, and they funded a lot of stuff on sexual dysfunction, but never since. They just left it to the pharmaceutical industry. They have never really gotten back into that. Even though it's a recognized disorder, it doesn't fit into any real area. So it's still a problem. We need to kind of solve it now before there's the perception that HIV really doesn't deserve much money anymore. Then, all of a sudden, the big source of our funding gets dried up.

EV: Is lobbying and work in pushing for funders something that PHS has been doing for a while?

EC: Yes.

EV: What does that look like or how do you do that role, I guess?

EC: Well, I'm not sure that we've done it very well. We've been strategizing. We work through our project officers. I think they're sympathetic, and we keep on talking it up. We had a group of program directors, sexuality programs, and we were going to write a white paper, and it never got off the ground to really articulate this need. Currently, I work with CDC [Centers for Disease Control and Prevention]. I'm just on the bandwagon to have a sexual health report similar to the IOM [Institute of Medicine] report on gay, lesbian, bisexual… That has had a *tremendous* impact. We now start to see funding not just around HIV but funding that is just around GLBT [gay, lesbian, bisexual, transgender] health issues. So if we would get a report like that, one of the recommendations might be that there be a study section on sexual health. It's gotta happen. We're not lobbyists, but we keep on pushing. Walter is on review committees. A lot of them try to explain that they're receiving proposals that are not really HIV but it's just because sexuality gets dumped on them.

EV: [chuckles]

EC: So there isn't a good vehicle for supporting broader sexuality research.

EV: Okay. That's what I understand

EC: Yes.

EV: Sort of to go back to the vague timeline that we've been working with… [laughter] I saw a couple articles in the Archives that, in the mid 1980s, the state Republican Party had a platform that condemned PHS.

EC: Yes.

EV: What happened with that?

EC: Well, as long as I remember, in those early years, we were always on the platform of the Republican Party to not condemn but to disallow funding to the Program. What they never seemed to realize is that we never really received state money directly for the Program. For years and years, we received about $50,000 a year through the dean's office. Now, you could say that that money was state money going through the dean's office to the Program. Most of what we did get was always very self-supporting and we were proud of that. In some ways, it was a good defense, because we said, "We're not getting funding from the state." There was I think her name was Marilyn Johnson who was the person that just kept on…was a champion for getting that on the Republican platform. I don't know exactly when it dropped off, but it seems like it dropped off in the late 1980s.

EV: Do you know when it was put on originally?

EC: No. No. It was on when I got here. It never really had any impact. It just was something that… Platforms do not necessarily have any teeth to them. They just are an articulation of what we stand for. There was Walter's All Gender Health. When was this? Ten years ago? I don't know. They hired a theater group called the Safer Sex Sluts.

EV: [chuckles]

EC: Some Republican congressperson got ahold of that and was attaching an amendment to some bill that would prohibit funds for HIV prevention not only to the Program but to the University. It never made it out of committee. That was a bit of a scare. That's the closest… Like Keynesians do, they are still battling. It kind of comes up in bills, trying to attach some amendment, to deny funding to the institute by the Legislature. It never got more than being on the platform.

EV: Have there been any problems beside the one that you just talked about with the State Legislature, presumably the Republicans. [chuckles]

EC: Only that one other thing over that. There's been no problem. Never with the Legislature. You've heard that we were, in the early years, called to the Board of Regents…

EV: Yes.

EC: …but never to the Legislature. Maybe there was with Sharon. We started to really testify at the Legislature. We were called upon. Then, in the 1990s, we were getting funding from the Department of Health not directly through the Legislature. At one time, I got some funding directly from the Legislature for the study of medications for sex offenders. I think we had no real problems.

EV: After Satterfield left, John [Jack] Kelly was the interim director?

EC: Yes.

EV: How did he become director? Why was he the interim?

EC: Jack was the associate head of the department. He was double certified in family medicine and psychiatry. He had always been…

[break in the interview]

EC: …a bit of oversight for Ciracy, because he was a psychiatrist, and Ciracy would trust Jack's opinion of things. He became kind of a mentor, too, to Sharon and certainly got involved with some of the problems that started to evolve. He was on the gender committee, so he had that involvement. If he got involved, I don't know, right away, but he was kind of pulled in.

EV: The gender committee, that was…?

EC: That Sharon established.

EV: Okay, okay.

EC: So then, when Sharon left, Ciracy, in his style again, appoints someone he can trust to take over. We were so clinical. We had a lot of patients, so he had some interest in what we were doing. Doctor Kelly was only here, I would say, at most, a day and a half a week. He was very part time. I was associate director under Sharon, but when Sharon left, they took away my title as well. With Jack, I continued to operate and, on a day-to-day basis, I was really running things under his direction. We worked very well together. He was very supportive. Everybody liked him. He appreciated what we were doing. What was his contribution? He just really was a good administrator. Things were managed. We hired people during his tenure. Having the associate head, again, trusted by Ciracy, gave us an incredible cover.

The interesting thing was that there was a whole review, internal review, of the Program that went on—I think Jack chaired it—in 1986 or so, again trying to figure out what was going on.

EV: So while Satterfield is still… ?

EC: Yes. We ended up producing two internal reports. Again, we weren't working together, so she prepared her own kind of report and the rest of the faculty pulled together our report. Yes, it would be interesting to go back and look at that. Doug [Douglas] Fenderson was the chair of that—no. There was another big internal and external review in 1995 while I was director. That was at a time, too, that they were just really wondering about do we want this Program. What should we do with it? Where is it going? And there were financial problems.

EV: What came out of the review in 1987?

EC: Again, I think that it was the support for, you know, the continuation of the Program. They had to resolve this struggle within the faculty, and a lot of focus on the gender program. Sharon was off there, and the rest of us were another place.

EV: How so?

EC: [pause] It was how she was doing things. Her boundaries, her capriciousness in decision-making were really a problem for the rest of the faculty.

EV: In terms of the All Gender Program…?

EC: It didn't come until later.

EV: Okay.

So Kelly seemed to have been here for a while.

EC: For four years and the reason was that he didn't quite know what to do with the Program, so that was some of the delay. I was *clearly* the heir apparent. He had, as I said, a real distrust and almost disdain for psychologists.

EV: Ciracy?

EC: Yes. So I think the idea of having a psychologist run the Program, he just really didn't trust that. Then, there was the issue that I was gay. I think that there was just no way he was going to have a gay psychologist running the Program. So he kept on delaying and delaying the search process. It was a very frustrating time because here we were with an interim director and just my own personal frustration that here I am really kind of running the place with this absent director and, you know, no recognition for it or compensation for it, but just really trying to keep it going and being very supported by the faculty. Jack…we worked very well together as a team and he had a lot of confidence in me. So that was not a problem, but it was with Ciracy. He finally conceded to do… He could have just appointed, but he did a national search. The committee recommended me, and I know he was really not happy. We got along. He was always very respectful. It was just a matter of prejudice, I think. When he needed to offer me the job, discuss the terms of my appointment, he said to me, "I want you to know that this is not a program in homosexuality."

EV: Hmmm.

EC: I snapped back. I said, "I know the name of the program."

EV: Did he technically have the final say on who to appoint?

EC: Yes, always. A committee can recommend. He could start the search all over again. You know, they had to rank the candidates. An administrator is not very smart to go against…but they really do have the power to say, "Start the search again," and choose somebody else.

EV: When did he leave?

EC: He left in it must have been 1991. Hmmm…or 1996?

EV: So there was some overlap? How was your relationship with him when you were actually director?

EC: Good. Good. Yes, he was tough. He was straightforward. I think he respected me and supported me for promotion. That was before I was director, tenured. Then, just

before he left and I saw the handwriting that he was going to be done, I'm pushed to go up for promotion. It was a little early. But I knew that I'd have his support. So…yes. It was very good. It was very good until we got into some challenges. For the most part, it was good. I think he warmed up to this place. Of course, we were starting to get grants. We were doing all the right things. He had to hand it to me that I really did it, you know.

EV: [chuckles]

EC: I always felt respected by him—and then he was fired. Then, we got a new head who was just very, very supportive. Well, first it was the... no… Then, we got Bill Jacott and he was head for five years. That was very good. You never know with a new head or whatever what's going to happen, but it's all been good.

EV: Did you face other challenges or direction shifts when you first became director besides what you already talked about: switching to more research?

EC: I think there was definitely some challenge with being a peer to, all of a sudden, being the boss. In particular one faculty member really never… It was very difficult for her to kind of make that transition. So that became a difficult relationship. She was getting up to retirement, too. But it was a difficult relationship. She finally left and that was a relief to everyone. She was isolated from most of the faculty, too. There was some triangulation with some of the faculty. It was not good. We're very good friends and colleagues now.

EV: Hmmm.

EC: It works better when I'm not her boss.

[laughter]

EC: Yes, that was hard.

The other really hard time was in 1995. We were facing real economic problems. The demand from Ciracy was that we had to lay people off, and I had to kind of choose. It was really very, very difficult. People were put on six-month contracts. It was a horrible time, but we all pulled together and got through it. I had to lay off one of the senior faculty members and that was really very hard on everybody.

EV: What precipitated the economic difficulties at that time?

EC: It was that we were still very reliant on patient-care dollars to support, and it just was not adding up. The deficit was just kind of growing, so we had to increase our productivity. So we all had to see more patients as part of the strategy. We rose to the occasion but it also was a real kick-start. The only one way to get out of doing that much clinical work was to get some other support, and it really forced the faculty to go out and

get grant support. It was in some ways, a good kick in the teeth. Yes. We all pulled together.

EV: You talked a little bit about the sex offender treatment program.

EC: Yes.

EV: I'm wondering if you'll talk a little more about that starting, I guess, in what it looks like… You said during Doctor Satterfield's directorship, it changed.

EC: Yes.

EV: What it was like before and how it was changed.

[break in the interview]

EC: We started our work in sex offenders in about 1977. Bill [William] Seabloom was hired part time and started an offender group. Again, it was before I came. I'm not sure exactly how or why it got started. It was something that I wasn't really aware of very much. It was just like one group and I wasn't working in that area. I knew very little about treating sex offenders. I remember being very naïve and trying to treat some men, not successfully. It was a very individual focus. The men were being seen for treatment over a long period of time.

When Sharon came in, I don't know if she was concerned, or it was just the fact that she brought Margretta Dwyer, whom she knew through other colleagues out east. She came on the faculty in 1981. She started looking at the sex offender program. Ironically, she was interested in that area for some reason. I'm not even sure why. Her training was as a marriage and family therapist, so saw things much more systemically. When did she take over? Almost immediately, I think, she was given the responsibility of running that program. She worked with Bill and they would do a group together. She started bringing in this kind of working with the family, working with a couple rather than just dealing with them as an individual. Sharon was very supportive. I don't know that the ideas came from her or anything, but she got it and gave Margretta a lot of carte blanch to really kind of develop it the way that she wanted. There was no system to it. It was just Bill doing his thing in the group. She brought a lot of regimen in and structure to the sex offender program, besides being really a pioneer in giving treatment with more of a system than the individual.

I think one of the hallmarks of our program was how we dealt with fantasy. At that time, they were doing a lot of aversive conditioning and trying to eradicate all these deviant fantasies. Margretta never believed in that. She would get a lot of flak for that stance, about how we would deal with sex offenders and their fantasies. Again, Sharon being very sex positive understood it and was very supportive of that approach.

[pause] What else is there to really say about the sex offenders?

EV: That model was different from sort of the national standard of how to treat…?

EC: I think in those two respects. Or another way of looking at it is a lot of people that went into that field almost came out with more of a corrections point of view and they came at it from the positive sexuality view. It was really quite different. Again, it was an area, like HIV, that the sexologists were just not too interested in wading into. So it was left to people that were oftentimes very uncomfortable with sexuality. It just fed into these people are deviant and we need to try to exorcize them kind of thing.

EV: I saw in the beginning that the program, or at least the people who were working on this, was working with the Minnesota Security Hospital [in Saint Peter, Minnesota].

EC: Yes.

EV: Did that relationship continue over time?

EC: Not a lot. Who was working with the Security Hospital?

EV: The name Ian McIndoe came up in the archive a couple times. For some reason, I think those people had something to do with it. At least from the archival records, that seemed to be where the initial work around sex offenders was placed, I guess.

EC: Hmmm. I don't remember him. Bill was a part of the original people. He was actually doing more work at Lutheran Social Services with juveniles and started working with juvenile sex offenders. He was working here, but he was, also… Sharon liked what he was doing, and we brought him over for even more time and started developing this adult program, but knew that we needed more help. That's why Margretta was brought in to do that.

I don't know the relationship at the State Hospital. People from the State Hospital, I know, were involved in some of our training. We had this program in family sexual abuse in the late 1970s. It ended about 1979. Some of those people were part of the faculty at those training programs. Other real connections, I don't know.

EV: The program has continued to do work for sex offenders since then?

EC: Yes.

EV: Has it changed how that program has been structured or worked?

EC: You know, I think that so many of the fundamentals are all things that really Margretta put into place. I'm not sure that it's really fundamentally different. I think we pretty much do the same thing. We refine things. But I just think it was really laid down very well by Margretta. It became a *big* part of the Program, and it still is. We had seven or eight groups that were running, and I think we have six or seven now. Margretta really

built it up from nothing and, frankly, it was a moneymaker. All these people were mandated to treatment. They were all self-pay. Insurance wasn't paying for it. Now, more insurance pays for it, but at that time, it was very self-pay. It was lucrative. Yes. But I don't think it's changed much.

EV: I know, again in the early years, the Program did a lot of work around disability.

EC: Yes.

EV: I know that was in part was tied to Ted [Theodore] and Sandra Cole who left before you came.

EC: Yes.

EV: I'm curious if that work continued after they left and when you were around.

EC: It really didn't. It just died with their leaving. The other problem is that Sandra and Sharon…it was like oil and water.

EV: [chuckles]

EC: Sandra… she's just an extreme narcissist and she's always feeling… I just saw her two or three days ago.

[chuckles]

EC: It's always a complaint about how she has been left out no matter what. How much of it was Sharon… She'll go on about how she was completely ignored and might have stayed involved possibly, even from Michigan somehow, but really felt very, according to her, unwelcome. I never witnessed it, so I really don't know. Sharon either liked you or… She mostly liked people, but if she didn't, then that was the end of it. They were two strong personalities, so I can imagine that didn't work.

Sharon was interested in not so much physical disability; she was interested in cardiac rehab and sexuality. She had some conferences on that and brought that. That was an interest of hers. But the interest in spinal cord injury or any of the other disabilities… There was so much spinal cord injury with the Coles, not exclusively, but cerebral palsy and things like that. Yes, it was really unfortunate that that part of the Program didn't continue, but there just wasn't a champion faculty that was really interested in that area. So it just sort of died.

EV: Yes, that's too bad.

EC: Yes.

EV: You mentioned this a number of times, but I want you to talk about the work that the Program has done around transgender issues. You mentioned a number of times the work that was done around this in psychology prior to it being brought into psychiatry. Can you talk about if you knew what that was like prior to it being pulled into…?

EC: Not very well. The only thing that I kind of know is that they really did very little counseling or therapy. It was mostly evaluation to detect that true transsexual and, then, offer them hormones and surgery. I think that's one of the contributions that Sharon had—although, controversial. Today…really encouraging much more therapy and recognition of psychiatric comorbidity, not that that's causing the gender dysphoria, but in terms of adjustment and adaptation with people. A lot of them are really, especially back then, you know, were isolated. They were stigmatized. They were abusing alcohol and drugs. She really started the whole idea of more group therapy. This place, though, always had such a strong belief in groups. I don't think she had that experience necessarily before she came here, but she really saw that as probably advantageous for this population so that they would really get the kind of support… She started the potlucks trying to build, not just through therapy, a sense of community in some of the isolation.

I did that with the crossdressers. They were so isolated, so we would have potlucks for them. It was really the genesis of the formation of City of Lakes Crossdressers.

EV: When was that?

EC: Well, I was doing it in 1978, 1979. I don't know when CLCC [City of Lakes Crossgender Community] really finally got off the ground. Maybe by 1981 or 1982. We kind of created this. That was Sharon's idea, too, not to just be a mental… but to open the doors to just socializing. So she brought in the group, the involvement with the families. Of course, we were making everybody divorce at that time.

[pause]

What else? Why don't you ask me some more?

EV: Out of curiosity—there's some obvious things here—what prompted the divorce mandate?

EC: It was two things.

At that time, whether right or wrong, it was very paternalistic or maternalistic trying to protect people. Here we had to issue people letters so that they wouldn't get arrested and get in trouble with the law or get into whatever. So in order to get them to assimilate into society… Society was hardly recognizing, tolerating this transition stuff. It was illegal to be married to the same gender—or at least we didn't want to be perceived that we were promoting a violation of the law or that people would get into trouble because of that. They didn't need that kind of problem. The other aspect of it is that, at that time, most of

the relationships would end. The partner couldn't deal with this or the other person didn't want to continue in that. It was just helping people kind of come to terms with that and, also, there was the concern over lawsuits, too.

I remember back then when you were doing marriage counseling, you would always worry about being sued for what would be called alienation of affection, that you would do something to destroy the relationship, and that you could be held accountable for that. So there was a lot of fear about reprisal against the therapist for really destroying the marriage. So there was really a push to get the person to take responsibility for that themselves and terminate the relationship before we intervened. Then, the partner couldn't say that we killed the marriage because we put this person on hormones. So we would at least get them to sign a statement that they knew we were doing this rather than doing it behind their back and whatever. Again, we were protecting ourselves but, also, people would be on a speeding locomotive not realizing what chaos…and they wouldn't work with their partner. They would probably end up being denied visitation if they didn't do this in some sort of orderly fashion. That's at a time that Sharon's going to court. Another thing that she did really well is going to court to defend these crossdressers from being able to parent their kids. They would lose custody. Transsexuals would lose custody over these kinds of issues.

EV: When did the requirement for divorce…?

EC: About, I would say, 1987. I think we were really challenged by the community that this was really a totally unfair and stupid and paternalistic kind of thing and that there was evidence of couples remaining together. We would say, "We don't know of any couples that have stayed together." And we didn't.

[chuckles]

EC: But, then, we started to see them. There was a patient of ours that maybe we even denied, but they stayed together. So we said, "Oh, yes, well, okay. We don't care." So we dropped that requirement; although, we kept that they would have to sign the awareness…not approval but awareness.

EV: Do you know what prompted Doctor Satterfield to bring that into PHS?

EC: The marriage?

EV: Sorry. The trans work.

EC: She had worked with John Money. She had done some work at Maryland before she came. We thought that she came with all of this experience, but we sort of discovered that maybe she had handled a handful of cases before she came, that she was not all that experienced. [chuckles] But she had a compassion. I don't know where that really came from at all. I think she talked about it, at least sometimes. There was a bit of gender variation within herself and maybe she even thought about that, that sometimes

she was a woman in a man's world. I never saw her as… She was very feminine. So I don't know where that really came from.

EV: Was the Med School still doing surgeries for her?

EC: Not at that time. No. That had stopped. You know, the surgeon just left. Everybody always says, "I had to… challenge Dallas…." She just said, "They've stopped surgery." Thank you. She didn't stop surgery. The surgeon *left,* and we didn't have a surgeon! [laughter]

EV: Who was the surgeon? Do you know?

EC: Markland.

EV: Colin Markland?

EC: Yes.

EV: It's very hard to find information about that program. [chuckles]

EC: Colin Markland. I don't know if he's alive.

EV: I did already try to find him. He disappeared.

EC: He went to Wisconsin.

Did you find Lloyd [K.] Sines?

EV: No. That name sounds a little familiar.

EC: Lloyd really was the last…he really was the one that was running it before it was handed over. I'm pretty sure he was a psychologist. I don't know if he was a psychiatrist. Lloyd Sines had it right at the end. Maybe I was trying to search for his name and his name actually just came to me right now as we're talking. Again, Sharon has so much of this information. That wasn't my area. I wasn't paying attention to that so much.

I was with the crossdressers. I did all the stuff with crossdressers in those early years and gay married men and gay men, of course. That was my interest.

EV: What work was being done with those groups here?

EC: Well, with the crossdressers, again we saw this isolation. We would put them in groups. We had these kind of support groups as well, just really helping them find a comfortable way of expressing their cross-dressing and deal with it with their relationships, etcetera.

[pause]

EV: So there was more service provision in that area?

EC: Yes.

EV: How did you get involved with transgender more broadly?

EC: It was, again, just seeing patients who would come in. As that program grew, I was pulled in to be on the gender committee, even though I didn't have a lot of clinical experience. I wasn't seeing a lot of those patients. I was seeing the crossdressers. If they were transgender or more gender dysphoric, then they'd go with Sharon. But I was on the Gender Committee and learning. I didn't know anything. Whatever I knew, I was learning from Sharon. She was the expert. [pause] Those were wild. Those were just really wild.

EC: [chuckles] What was the Gender Committee exactly?

EV: Well, it would be made up of a multidisciplinary team of psychiatrists, physicians. The one unique thing of it was to have a—that was Sharon's idea—transgender person, layperson, on the committee. Sometimes, it was a little crazy, because it was like a former patient. I always felt that that was a good perspective to have on the committee, but it was just this pressure cooker situation where this poor person had to come in and kind of present before the committee and state their reason for appearing before the committee. It was a test. Obviously, they should have been prepared in therapy to make sure that… These people just couldn't walk in out of the street. We would help prepare them for the committee and make sure that… Like if it was Sharon's patient, she'd have to step out of the role of the chair. It was hard with all the… You just always left there with an enormous headache. It was just so stressful making those, it felt like, life and death decisions.

EV: Was the decision about providing access to hormones?

EC: First hormones, then surgery. They'd have to come back, you know, for surgery.

EV: When were they prescribing, I guess, psychiatrists or someone, the doctors, for the hormones here?

EC: She was. Sharon was prescribing the hormones.

EV: What was the relationship between that committee and people actually being able to get surgery, since there wasn't a surgeon here anymore?

EC: All they would get is their letter, and they didn't have to get their hormones from Sharon. They could go anywhere that we would approve. Then, they'd have their letter for surgery.

EV: How did that committee, or the program in general, evolve over time?

EC: Well, I don't think that they still have the patient appear before the committee. It's all done in a review, but, otherwise, I think it's a very similar process of reviewing the case and people voting. It's an interdisciplinary group. The therapist has to present. There's kind of a peer review of the process. But, I think the big change is, first of all, the requirements have been relaxed and they have been made much more explicit and clear to everyone. We'd always get complaints that we would engage in bait and switch techniques. We'd do this and, then, we do that, and, then, we'd say, "Weelll, you still haven't done… I think you need to do something else." So lots of efforts of really kind of defining what the criteria, the goals would really be and have more clarity about that. I haven't been on the Gender Committee for, I think, fifteen years or something like that. It's kind of a mystery what's really going on. [pause] I know that they've had a community advisory group. They really try to review those criteria and carefully get input. They've been trying to develop good relations, having community advisory people to… There's so much mythology that sort of gets spread around. They do this. They do that. It's really nice to have people in the community to say, "Now, wait a minute. They don't do that. They may have done this with you, but they don't do that." I think it's still a struggle. There is still this gatekeeper role and there are people in the community that will use a much more informed consent model. I think that our philosophy is still a more… I think we're much more biased to assess and recommend therapy before, but I think that people are, you know… Where they might have waited a year or two before they went on hormones, I think a lot of them are getting it within three to six months now.

EV: Here?

EC: Here, yes.

EV: When did the community advisory group get instituted?

EC: I would say around 1988 or 1989. There was a real attack on the program by patients, so there needed to be a lot of listening and looking at trying to find some solutions, better ways of doing things. I think one of the results of that was people don't appear before the committee. That was not being perceived as very helpful. The greater clarity, really writing down the…so that people didn't think they could…making things very clear. [pause]

Walter took over that program. He would be far better to talk about the whole evolution. He overlapped Sharon, so he saw all of that and started to develop the… Mike [Michael] Metz was actually coordinator for an interim period of time. Then, Walter took over and has been the coordinator ever since.

EV: Did he change some of the way the program functioned?

EC: Yes.

EV: How so?

EC: Well, changes in the criteria, the clarity. [pause] But the reality is that it's just an elaborated form of the way that Sharon set it up.

EV: Hmmm.

You mentioned the sort of controversy, you said I guess in 1988 or 1989. I saw in the Archives a couple… I think they were mostly *Daily* news articles; there might have been a [*Minneapolis*] *Tribune* article there, too.

EC: Did I get the date right?

EV: It was 1992.

EC: Oh, 1992.

EV: So I'm wondering if that was a separate…?

EC: There was only one.

EV: Do you mind talking a little bit more about that and what some of the concerns raised by people were? You said some of the ways that things changed, but was there sort of a specific internal review that happened?

EC: Yes. Yes, we did an internal review. Did we do an external review? I can't remember. We formed the community advisory group. We had to do a lot of listening and trying to change some of the more onerous or irritating sorts of… The big complaint was this bait and switch kind of thing, that people didn't know what the criteria really were. There was just all of this like confusion. Then, I think we would just start to really be *very* clear with people. If you want hormones tomorrow, they're out there, but don't come here. Here's our program philosophy.

EV: Yes.

EC: And just not take people on. Find out what their expectations are, really explain how we approached things, and do we have a deal here? I think that helped clear up a lot of the problems, as well as getting rid of the marriage requirement. That was a big thing at that time. That was one of the things that was a rallying cry. It was really awful. So getting rid of some of those things helped. I can't remember all of those little details, what really got changed. Walter would be much more… I went out to meet with patients

and just listen and assure them that, again, we would really take a look at it and try to solve these things. But, at the same time, we weren't going to become a hormone- or surgery-on-demand place.

EV: What has been the relationship between PHS's criteria and the way that you designed this program and the wider programs and philosophies throughout the U.S. for treatment of trans folks? I know there's no, like, overarching one, but different clinics, different doctors have different philosophies around it. Have there been discussions on a national level between the different relationships?

EC: Well, the revisions of the Standards of Care… Certainly, we were very involved in that, so lots of discussion of how we develop a set of standards that really work for everybody. The *big* challenge of the Standards of Care, this revision, was really trying to find a way to merge what is referred to as the informed consent model and—I don't know what the other term is—the more traditional approach. That was really very difficult but very pragmatically… If we did not find a way to recognize the validity of an informed consent model in the Standards of Care, I think that we would have made the Standards irrelevant.

EV: Hmmm.

EC: There's a lot of mythology over what informed consent models are and, also, they're evolving. I think that, in my view, the models are converging. I think the informed consent people have started to see that maybe they weren't all quite ready or that they needed a little bit more…

[pause]

I'll tell you something that I still… I think that both Walter and I really… Some of the difference, though, was really her capriciousness. She was also very insistent on people really dealing with a lot of their issues before readiness for hormones. But I think that we really wanted people to… It wasn't about hurdles to clarify identity, but we just had the belief that… We saw so many train wrecks, you know, two years post the high and people were so unprepared. They transitioned. They lost their job. They lost their family. We really felt that they needed to kind of deal with all of their issues and not see the hormones and surgery as the solution to a lot of their problems, but really more as the icing on the cake. I think that we've come to realize… I don't work with Walter as much on this. Even though we worked on the Standards of Care, I'm not sure exactly where he is. I think that I feel like we've probably…that there really is a place to get people going on some of the…that some of the problems might just resolve or that they are just more able to address them, and that they can actually do more therapy as long as they know they're not really being, you know, evaluated for that. But, since I've been really not treating people for a long time, I don't know.

I thought of this the other day. If I ever went back into seeing people, I think I'd need some help to get my bearings again about what's the best way of doing it. I feel out of it.

EV: I would think, especially in the trans area stuff would be moving very fast…

EC: Yes.

EV: … over the past couple of decades. [chuckles]

EC: Yes, yes. And certainly, from the Standards of Care, we have no requirements for psychotherapy, even though I believe in it. I'm an advocate for that. I really believe in therapy. But there is no scientific evidence that shows that that is necessary.

EV: Hmmm.

EC: So that's the way it is. But I think if I'm going to take responsibility, I'm going to probably choose to want people to do more therapy than minimally really is required.

EV: You mentioned your work and Doctor Bockting's work on the Standards of Care. I'm curious what is the relationship between WPATH [World Professional Association for Transgender Health] and PHS?

EC: Well, there's a close link. They're separate organizations. Starting with myself as president [of WPATH, 1999-2003] and trying to [unclear] the program. The secretary/treasurer was non-functional and the organization was really a mess. So we suggested that we sort of take over the administration of the organization here. That's been going on for quite some time now. Then, "Bean" [Beatrice E. Robinson] becomes the executive director and Walter [Meyer III, MD, 2003-2005] follows me as president, so we've been very involved with the organization and, yet, we're separate.

I just realized I've got to get going.

EV: Okay. Yes. I got almost to the end. My only other question was considering there wasn't a lot of archival material for all of your tenure here, is there anything I didn't ask about that you thought was important to put in the record, I guess. This could be a big question or it could be a little question depending on how you want to answer it. [chuckles]

EC: Yes. I'd have to think about that. We focused a lot on sort of the early years rather than the latter years. So I'm sure there's some other aspects that we could really focus on. There's the whole move into more advocacy for sexual health, our establishing these two endowed chairs in sexual health, which is really, you know, incredible and pioneering in the country, and all the faculty's involvement and all the professional organizations taking on real leadership roles. I don't know… Those are just some things that come to mind.

[pause]

EV: Well, thank you very much for this.

EC: Yes.

EV: It was really interesting.

EC: Is there going to be an ability to see the transcript?

EV: Yes.

[End of the Interview]

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