

OREGON HEALTH & SCIENCE UNIVERSITY

ORAL HISTORY PROGRAM

INTERVIEW

WITH

*Ira B. Pauly, M.D.*

Interview conducted February 18, 2015

by

Maija Anderson

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[Begin Track One.]

Maija Anderson: This is Maija Anderson. I am interviewing Dr. Ira Pauly for the OHSU Oral History program. Today is February 18, 2015, and we are in Dr. Pauly's home outside of Phoenix. One thing we're going to be talking about today is some of Dr. Pauly's experiences with transgender patients. And we're going to be using a variety of terminologies to refer to transgender people, including some that are no longer, no longer used, or no longer preferred. And those are the historical terms. And we understand that transgender is the more inclusive, preferred term for many in the community.

I'm just going to dive right in. Thank you for doing this and welcoming us into your home. Can you get us started by describing your family and childhood and your upbringing?

Ira Pauly: Okay. That would take us back to southern California, where I was born and raised. In fact, my childhood and growing up was concentrated within an area of about five miles. Because I went to grammar school in Beverly Hills, and then Beverly Hills High School, and then UCLA. And as you probably know, those are all very close together. And even after university, completing college, I went to medical school at UCLA, and did my internship there. So I was very ingrained, kind of hometown person.

And I don't know. I was the fourth of four children to kind of a middle-class family. Had two older brothers and an older sister. And we had a very kind of stable family.

So anyhow, I graduated grammar school and went to Beverly Hills High School. I was kind of, I think I was about a year younger than most of my schoolmates. And not as mature, I think, physically, as well as socially. So in those days, I was more interested in playing basketball and football than I was particularly as a student. But I wasn't big enough to make the varsity team until I was a senior. And even then I was like second string, and got to play only when the game essentially was already won.

But I did fairly well academically. And certainly enough to get into UCLA. I did apply to Stanford. And that was the first time in my life I was rejected. Which was kind of a blow to me because you know, I guess that was my first choice. And it was pretty hard to get into. And way back then, you know, they didn't have this SAT scores. So you just pretty much had your GPA from high school.

But anyhow, so I went to UCLA. And I had an interest in medicine from the beginning. So I started as a pre-med student. But as most doctors would tell you, the pre-med subjects of biology and biochemistry and physiology weren't all that exciting. In fact, they were downright boring as far as I was concerned. And as a result, I wasn't all that motivated. And you know, got Bs, okay. But in order to get into medical school, you pretty much have to get As instead of Bs.

So I said well, this isn't going to work out. So I might as well major in something I'm interested in. so I became a history major. American history and so forth and so on. So, and that interested me and I did much better in those subjects. And just got a general, you know, a general

education with history and English and Shakespeare and philosophy and things that had nothing whatever to do with medicine.

And let's see. And then along the way, I kind of pursued my athletic career. In those days, you didn't go from high school to playing varsity. You had to go through freshman football. And again, I played freshman football. But again, I was the smallest guy on the team. And, you know, it was clear that that didn't seem to be a very open path for me, either. So I just then had some more time to pay attention to my studies.

My best friend was a really good football player. And he went on and became captain of the UCLA football team. This would have been 1951, '52, '53.

So I kind of dropped out of the sports arena. I played intermural football with my fraternity.

But anyhow, after a couple of years, he said, "Ira, you really ought to come back. I think you could really make the team." And by then, I'd continued to grow. And now I was like five-ten and 180. That makes me smile when I think of the football players today. You couldn't get a uniform at that size, because they're all giant. They're all six-five and 300 pounds. But back then, the teams weren't that big. Or at least at UCLA. That was before scholarships and it really became more pro-like than it was as an amateur sport.

Anyhow, I went out for football. And that would have been 1951. And again, I made the squad and was second string. And then the next year, '52, the guy ahead of me graduated, so I was able to start. And I was very lucky in catching UCLA, this was the "Red" Sanders era. So we had, '52 and '53, which were my last two years there, we had very good teams. And my senior year, in '53, we won the Pac-10 and went to the Rose Bowl. And I was lucky enough to play on the first string. So that was, that was a kind of highlight.

And then with that background, I applied to medical school. And even though my, I had a pretty good GPA, probably 3.4, 3.5. But the guys that were getting in had 3.8 and 4.0s. But you know, because by then I had become known as a football player, I was the first one to get accepted at UCLA, I was told. So that didn't hurt. They were looking for people who were so-called well-rounded. I wasn't that all well-rounded physically.

So anyhow, that takes you through a little bit of my history.

Anderson: Great.

Pauly: I don't know if you have any more specific questions about that.

Anderson: Could you talk a little bit more about your interest in medicine? Where that came from? And I'd also be interested if you feel, other than helping you present yourself as a well-rounded student...

Pauly: Yeah.

Anderson: I felt like there was some relationship between your athletic career and an interest in medicine.

Pauly: Yeah. There was no one in my family, in fact, I was the first one to go to college, let alone graduate, let alone go to medical school. Actually, my father was a bookmaker, or a bookie. I don't know if you know what that is. But a guy who takes bets on horses. And he was a

stand-up guy. But still, it was a somewhat illegal operation. And he did very well. So we went from being middle-class to somewhat upper middle-class. That's how we moved from where we were living in L.A. into Beverly Hills, because he did quite well.

So it was, yeah, I'm from a Jewish background. And a lot of kids from Jewish families did gravitate toward medicine. Our mothers were kind of wanted something to brag about. But I don't know to what extent it was that or it just seemed like a worthwhile kind of thing to do, to be in a position to be of some help, hopefully, to other people. And be gratifying at the same time.

So that's about all I can recall is my interest in medicine. But as I said before, I didn't take to the background stuff. The kind of pure science part of it. I was more interested in the interpersonal relationship part of what I think medicine ought to be.

Anderson: Is that what drew you to psychiatry?

Pauly: Yeah, I think so. I was better at talking to people than I was with biochemical equations. In fact, I, I felt really comfortable. And I think that made the people I was talking to, so-called patients, at ease with me. And a large part of medicine is taking a history. And in order to be good at that, you have to establish a relationship, rapport, whatever words you want to use to allow people to trust you enough with the details of their past history.

So again, the first two years of medical school are so-called basic sciences where you get all the background stuff, the anatomy, the physiology, the biochemistry. But it's not until the third and fourth year that you get onto the wards and actually have patients assigned to you that you work up and try to get a complete history and do a physical examination and try to arrive at a diagnosis. It's a pretty structured kind of thing. And then once you've decided what you're dealing with, what the diagnosis is, then it was a matter of coming up with a treatment plan.

And I suspect, by the time I graduated medical school, I really had two interests. One was surgery and the other was psychiatry. Well back in those days, it wasn't like it is today where you went from medical school into a specialty. In those days, you had to take an internship, which was an independent year that wasn't necessarily connected with any particular specialty. So even though I had an interest in psychiatry, I knew I had this opportunity to see what surgery was like. So I did take a, what was called a straight surgical internship at UCLA, which had a very good surgical program.

And I was into that for about six months or eight months. And I had to decide whether I wanted to continue in surgery or give psychiatry a try. So I decided I liked what I was doing in surgery, but I was still curious to know what this other specialty in medicine might be like. So I did apply for a post-graduate or residency program. And I got into a good program in the east, in New York City, Cornell Medical Center in the New York Hospital.

So psychiatry is a three-year residency. So that would have taken me to 1959. So after the first year in psychiatry, I thought that I preferred this to what a life as a surgeon might lead to. So I just continued with that.

I think the other thing was I'd lived, I think I mentioned earlier that I lived my whole life in this rather small in diameter area of Los Angeles. And by then I thought well, it would be nice to see what the rest of the world looked like. So I went from the West Coast to the East Coast. And that was, that was kind of an eye opener, too.

But most resident training programs, they really work you pretty hard. I mean, it's not just a forty-hour week. Because you're on call. So I didn't have a lot of time to enjoy what New

York had to offer. But I did enjoy my work with people that had emotional and psychological problems.

Anderson: So moving along, I want to kind of get into sort of the context of your later work with transgender patients. And I think for most people in the United States, the first well-known transgender person would have been Christine Jorgensen, who was transitioned from male to female. And do you remember hearing about her?

Pauly: Yeah.

Anderson: Or do you remember...

Pauly: Yeah. I remember seeing her in the newspaper, you know. And she had big headlines about man becomes woman. And this was done in Copenhagen. Danish psychiatrist there and surgeon. So I do remember that. But I can't really say that that's what motivated me. I'd heard the name and I was, I didn't come to attention and say, gee. It was fascinating. And that's one of the draws, the thing that for me attracted me. Because it's such a dramatic kind of change from the normative process that we all go through. Fortunately, if we're lucky, you're born into a male body and you become masculine and everything, you know, everyone lives happily ever after.

And the folks that don't follow that normative pattern, who are born into either male or female bodies but in their head, in their psyche, they see themselves as a member of the opposite gender. And so they felt this way all their life. The way they commonly describe that is they were born into the wrong body. That psychologically, in their mind, in their gender identity, they've always been this way. So they're really not transitioning from one gender to another. They're already in that gender role. What they're transitioning from is having the wrong body. So they take hormones and surgery so that their body can come into conformity with who they see themselves as being.

But in terms of my motivation, it was quite simple. In your third year of our residency in psychiatry, there's a rotation that's called a consultation service. And that's where all the different departments in a hospital can call upon psychiatry when they have a patient that is not in their specialty field. You know, like someone who's had surgery and they've become depressed or become unduly anxious or sometimes even psychotic. So in order to complete their treatment, they have to treat these people while they're still in the hospital on these other services.

So I was, you know, I took my four-month rotation on that. And one day, I got a call from the department of urology. And they said they had a patient they wanted me to see. And so I went up to the urology service and there was a, I remember there was a ward, they had a male service and a female service. On the male service, they had five or six men in this ward with different beds.

And one of the people on that ward was someone who said he or she was a hermaphrodite. That they basically had physical characteristics of both sexes. And had had some previous surgery to correct some of the discrepancies, as they saw it. And this particular person, who by now was living as a man, and pretty well accepted. I mean to the point where she, he, found their way to a male service and had been sleeping in a male ward for three or four days by the time I came to see this person.

So, and of course she tried to pass herself off as having a medical condition. And it wasn't until I'd talked to her a few times, and by then, I shouldn't say talked to her. Because if you're going to interact with these people, you have to interact with them in the gender of their preference. So if I were to call her a her, or she, that would be the end of any attempt to gain her trust or confidence or rapport.

And by then, this individual had gotten physicians on the outside to have treated her with androgens or testosterone so that a lot of the obvious appearances had changed. The most obvious change to look at such a person is that testosterone grows hair. And I remember this person had a full beard and spoke in a fairly low tone of voice, which is another effect of testosterone, it thickens the vocal cords, so the pitch of one's voice comes down to a lower pitch. That is, more masculine than feminine. And also by then, she had—it's easy to slip back and forth, to get the wrong pronouns. But it's easier than saying "this person." But at the time, this individual had the surgery, she was still a she and had a mastectomy so that her chest was flat. And now she had a beard and a low voice, so externally she was coming into conformity with her gender identity and changing the physical aspect of her—of now I'm going to try to give you, of his body. And was now looking for the genital surgery, which simply meant the removal of the female genitalia, the ovaries, the tubes, the uterus, and vagina. And ultimately, as time went on, because this was not available initially, but ultimately the creation of a penis.

So that's what he was hoping to attain by this particular hospitalization at the New York Hospital where I saw him as someone in my consultation service.

And that fascinated me. Then I, when you see something you don't know much about, you try to go to the literature and find out and read up on it. Well, there wasn't much in the psychiatric literature, because it hadn't become a legitimate diagnosis. So fortunately I, the department where I did my residency, had an extensive historical library. And most of it, the chairman of my department was a guy named Oskar Diethelm, and he was Swiss. So he had brought all of his research material from Switzerland to the United States. And he had a great library. And then continued to collect volumes. So I was able to dig through the literature.

And again, the terminology was an issue, because transsexualism was hardly known as a condition. The German literature in about the mid-nineteenth century begins to talk about such things as transvestitism. And that was, of course, the crossdressing part of it. And then as you got into some of these historical literature, they began expressing that the change of clothing was just the outward manifestation of some, what we now come to know as gender identity problems or transgender issues.

The terminology has evolved, you know, I'm talking about going back now to 1961, when I saw my first individual. So over the last, what, fifty-five years or so, the terminology has evolved.

There was some stuff in the French literature describing a person named Chevalier d'Eon. So in the French literature, there was a term called "Eonism." And that described the same kind of transgender issues that subsequently became known as transsexualism and then transgenderism. And I don't know, I've been out of the field now for maybe, 1995 to 2015, so twenty years. And I know that terminology continues to change.

So that's how I first got interested. And I was able to, I don't speak or read either German or French. But a lot of my patients who I was taking care of in the hospital, or former patients, were German or French. So I was taking all these old volumes that had dust on them from the old German and French literature. And had my patients, you know, we weren't into the cyber world at that point. You just couldn't punch a few buttons and get all the things that you wanted to get.

So I would have, I remember having three or four different patients translating these articles in German. And they did it by hand. Fortunately they had pretty good handwriting. So I got to know the literature pretty well. And then began to see that well, there were a few of these cases. Again, it's such a dramatic thing that it's worth a case report. This was before, you know, if you were trying to get some research information, you had to interview a hundred of these people to get some statistical analysis. But there weren't that many around, so you dealt with just a case here and a case there. One from Sweden, one from Denmark, a couple from Germany, some from France.

And so, with that one person that I got started with who was on the urology service, I got a pretty good grasp of what the history of this phenomenon was.

And then I got to the American literature and there were two or three articles. One was by a man named D.O. Caldwell. And he was a physician. He was not a psychiatrist. But he wrote a paper about a couple of patients that he'd seen. And he was the first one in the English literature that used the term "transsexualism."

So was it you or Morgen who said they had read this article that I wrote? My first article was in 1965. But I think I credited him with the term. So that was a very brief article.

Then there was another one, this would have been now in the mid '50s now, I think. An author named Lukianowicz wrote about gender identity problems.

And then there was a brief article by someone named Harry Benjamin. And in those days, it was in a somewhat obscure journal. I don't quite remember which journal it was. But it had his address. And it was an address that was about five blocks away from the hospital that I was working at. So I looked up his name in the phone book and told him that I was a psychiatry resident, and I had a little experience with a transgender, transsexual patient. And was there any way I could come over and talk to him, because I had read—he was an endocrinologist. And a lot of these folks, the first step in the physical transition is taking the contrary hormone. In the male to female case, we're talking about estrogen. In the female to male instance, we're talking about testosterone.

So he said sure, you know, I see these patients of mine every Wednesday afternoon. So if you want to come here at noon, we can have lunch, and you can attend to these people with me. And that would have been about the last six months of my time in New York.

So every Wednesday afternoon, through the generosity and mentorship of Harry Benjamin, I was able to see probably more transsexual patients than any psychiatrist in North America. Or, for that matter, in the world. Because everybody, sometimes from Europe, and certainly from anyplace, he was seeing people from as far as San Francisco, Los Angeles. They would all come to him because he was the only person that was comfortable treating these folks with the contrary hormones.

And there was some stuff in the literature that said this was unethical, you know. That you shouldn't be taking somebody with a normal body of one sex and trying to help them transition into the physical characteristic of the opposite sex. But he was very comfortable with it. And he was able to justify this in my way of thinking by these folks seem to be happier living in this gender role opposite to what the biology of their body might dictate.

And that became pretty apparent to me. As I got to know the patients, they uniformly described being happier into the gender role that they felt they were in from the very beginning. And that the only thing that needed to be done as far as treatment was concerned was to get the body on board with the gender of their choice.

And so I would say over that six-month period, I would see maybe six, eight transsexual patients every Wednesday afternoon for about six months. So by the time I finished that, as I say, I had a fair amount of clinical, face-to-face experience with this.

The first paper I wrote was, I wanted to, in order to get some kind of statistical information, I felt like if I could collect 100 cases, and I could just count up, you know, the characteristics that these people had. Something about their family history, they would all have been worked up physically so that you could test their genetic status. And none of this was abnormal in terms of the genetic markers that were available back then fifty years ago.

So I published my first paper, and probably my best paper, because I was very obsessive about it. I kept on struggling to get that hundredth patient by reviewing every literature that I could find that might have a case report. And then I had some of these case reports myself that I'd written about a few of the patients that Harry allowed me to see on my own so that I could get enough information. Not just watch him give the hormone injection, which is what he basically did.

So that was the beginning. I think I completed that paper in about '63. But it wasn't published till '65. I had to go through a few journals because, again, it's pretty much like the issue with therapeutic abortion. Some folks just don't see this as anything but bizarre. And you know, immoral, or unethical, or whatever you wanted to call it. And anyone who presumed to treat them was equally crazy.

So I think the third journal that I submitted it to, it was accepted. And I think it was the *Archives of General Psychiatry*. It wasn't the top-rated journal.

But what was really positively reinforcing was within about a month of that article having come out, I received postcards from about a thousand doctors from all over the world. In those days, again, before computers, if you were interested in an article that was written in a journal you read, you would send that person a postcard, please send me a reprint of your article in the *Archives of Psychiatry*, issue so and so, 1965. And so you would get these reprints from the publisher. And you know, I got a hundred reprints, which I didn't think, that would be enough. But I remember, I would come to the office and it was so pleasant to see stacks of postcards asking me to send them a copy of this article. And so I had to rush to get another 500 or so copies.

So that was, so I became, as a result of that one publication, I became somewhat known to other people, other specialists. Some of them psychiatrists, some of them endocrinologists, some of them surgeons. Because the nice thing about this from the point of view of the medical profession is that the complete treatment of this condition draws upon the services of psychiatrists, psychologists, endocrinologists and surgeons, plastic surgeons, urologists. People who began experimenting with the physical transformation.

And this, as you can imagine, was a very challenging kind of thing. It's not your routine gall bladder or appendectomy. It's a rather challenging and, to the plastic surgeons, creative kind of opportunity.

So. I'm probably going on and on. I don't know how much of this—I hope you can edit this thing down.

Anderson: Oh, it's wonderful. I want to ask you about, you joined the University of Oregon Medical School faculty. And we have 1962?

Pauly: Yes.

Anderson: That was a little bit after, so right after your residency was completed?

Pauly: Yes. Immediately after, yeah.

Anderson: After you met Harry Benjamin and some of his patients.

Pauly: Yes.

Anderson: How as that, and I know you said you were recruited by George Saslow. Can you describe that?

Pauly: Yeah. Sure. Let's see. I never really thought I was headed for any kind of academic career. I was interested in clinical aspects, which meant taking care of folks. But in my senior year of residency, I developed an eye condition called glaucoma, which simply means increased intraocular pressure. And if untreated, you can, it can lead to blindness. So I caught it fairly early and it was treatable with medication that would lower the intraocular pressure.

But the bottom line was, I had gotten deferments from military service. I'd graduated as an ROTC graduate. So I was commissioned. But they were more interested in having me come in as a physician than as a first lieutenant on the front lines of Korea someplace. So, but when I developed this eye condition, they didn't want any part of me in the military. So I was relieved of that responsibility.

So I kind of felt well here I found two years that I otherwise would have been in the military. So I kind of, I was kind of, by virtue of the research I was doing, I had something that would interest a department chairman if he was of a rather tolerant mind. So anyhow, I reached out and I had interviews in Florida and Virginia and Oregon. And I was a West Coast guy. So I was kind of looking to get back to the West Coast.

And I interviewed with these three medical schools. And George Saslow was on a retreat in a program, I can't remember the name of it, but was getting experience with group therapy, which was kind of a novelty back then. And he was interested because he had developed a program at the University Of Oregon Medical School called therapeutic community, where the primary form of treatment was interaction with a full ward of people where group therapy was not just a small group of six or eight or ten, but a whole ward full of people. And they were looking for someone who would become the ward psychiatrist.

And I had almost no experience with this as a resident, because our program was oriented towards individual, one-to-one therapy. And I don't think I'd ever saw a group. But he explained it and said, "Well, this is what our need is."

And I said, "Well, you know, I have to confess, this will be kind of an extension of my residency, because this is an area that I don't have any experience with."

So he was in Maine at this program. And I went up to see him there. And we hit it off pretty well. And he's a fascinating guy. Probably the brightest guy, certainly the brightest physician I had ever met, the brightest psychiatrist. And he was just a fountainhead of information, and a very supportive guy. And so I had no hesitation in accepting his offer to come and join him as an instructor in psychiatry. And that would have been, it started in July of 1962. So that's how I made my way back out to the Pacific Coast.

Anderson: What was the medical school like then? What was the environment like in your department? Who were your colleagues there?

Pauly: Well, first of all, it was a small department. I think there were only three or four. I was like the fourth or fifth. And it had recently developed that, the two important people that came with George Saslow to the medical school when he took the chair there, which was probably only maybe two or three years before, were psychologists. Joe Matarazzo and his wife Ruth. And there was a third one named Art Weims, I think. So they came together and got this program started. And then after a couple of years, Joe Matarazzo was able to interact with Dean Baird and develop his own department of psychological medicine.

But anyhow, I was able to bypass that. And I developed a good relationship, particularly with Ruth. Because she still remained as the psychologist looking after patients on the psychiatric service. But you know, there were two or three other. Mike Baird, who was the son of the dean. He was an internist. But he became very interested in psychiatry and began seeing patients clinically there. And there was another guy named Dwayne Denny. And he was an internist, he was a psychiatrist who was also attracted to internal medicine. And then there were two or three other graduates. I think at that time we only had three spots each year for residents. It was a three-year program. So we never had more than nine residents there at any one time.

But George was very generous in allowing us to develop our teaching skills. And you know, you taught first and second and third-year residents [medical students] who learned the basics of psychiatry, which was interviewing. And that's what George's skill was, to teach interviewing techniques. And he was a master at this. And anytime he gave a lecture, he would always interview a patient who would demonstrate the characteristics, whether it would be depression, anxiety, schizophrenia, what have you. And he would interview these patients in front of a whole class of first, second, third-year medical students. And it was, you know, it was like theater live. He was able to get these folks to open up, despite the disadvantage of seeing all these faces in the audience. And was able to get them to tell their story, to tell their history, to talk about their present illness and their symptoms.

So by the time that sixty-minute interview ended, as a result of talking to Joe Smith or Jane Doe, you had a demonstration of what the condition was like, at least as experienced by this one person who showed all of the characteristics of whatever the disorder was that was the lecture for the day.

And he was, yeah, we were expected, at least I was expected as a junior faculty member to sit in on this. And at one point I said, "George," maybe I called him Dr. Saslow, I'm not sure, at that point in time. I said, "How about me trying this?"

And he hesitated. And he said, "Well, sure. Why don't you take the next lecture on," the most difficult patient to interview would have been a schizophrenic person, because they were totally unpredictable, quite often. And as a result of their diagnosis, their psychosis, they were delusional or hallucinating. And it was risky.

But anyhow, I finally got a chance to do it. And I was kind of imitating him. So it turned out quite well, and I was able to do a lot of this interviewing. So my role as, I guess any faculty person, there are three mainstays. One is your clinical ability, how well you interacted with patients and treated them. And the other was teaching. And my stock as a teacher rose pretty rapidly. And then the third component that you're evaluated on is research. Research and publication.

So I started there in 1962 as an instructor. Then you work your way up the academic ladder. It takes four or five years to go from assistant professor, associate professor, to full professor. And then the top of the rung, I suppose, is to become chairman of a department.

So anyhow, George was a superb teacher. And I really enjoyed working with him. The only downside was that he was not all that great a businessman. And he thought teaching was a privilege, and that we couldn't be concerned about salary.

Well by now, I was married and had a few kids. I think I went there in 1962 as an instructor at \$9,000 a year. Now, having said that, in those days you could amplify your base salary by seeing patients. And you could double what your salary was by seeing patients. But in those days the fee was like twenty-five dollars an hour. I don't know what it is today, probably ten times that amount for an hour's time.

Even though I was promoted and got small raises, my salary didn't, barely paid my expenses. And so as a result of my publication in 1965 of this first paper I wrote, by then there were a few places in the country that were developing gender identity centers. And one of the most well-known, the most well-known, was in Baltimore, Maryland, at Johns Hopkins. And a fellow there named John Money was a psychologist. And he had, they were doing work in the gender field, basically with hermaphroditic folks who had a kind of ambiguous genitalia. And they found that the sex of assignment and rearing kind of trumped whatever else, whatever ambiguities physically or even genetically.

So they had experience with these, some of these people that, most of these ambiguous genitalia patients could not have, did not have a functioning penis. So they, over a period of time, came to recommend that these people be operated on. And to have whatever rudiments of male genitalia remove and create a vagina. And to raise these folks as female. And they had a lot of experience with that. And so they were in the gender business. And so it was a natural place for this transgender, transsexualism diagnosed to be treated at. And they had begun to develop programs for these folks, primarily with the clinical work being done by John Money, the psychologist.

But then the surgeons became very interested in it. As I mentioned earlier, the challenge of creating the genitalia of the opposite gender intrigued a lot of folks. And so they developed the first gender identity clinic in the United States. The problem was, they couldn't find a psychiatrist to be willing to go in and run this program. And Money, what's his first name, but anyhow, he was not a very easy person to work with. Plus, he wasn't a physician. Anyhow, to make a long story short, they wanted someone in the psychiatry department. And no one was particularly interested in doing that. Plus, no one had any experience with it.

So having written this paper—anyhow, I got invited back there to interview for the job at Johns Hopkins. Which was at the top of the ladder as far as recognized and esteemed medical schools in the country. Johns Hopkins was right up there with Harvard and Yale. And little old Oregon was way down the ladder as far as any kind of prestige nationally.

So I did go back there. And it was fascinating. But I could see that the dynamics were so tense between [John] Money and the surgical department, the psychiatry department, that it was—I think I probably could have handled it. They offered me the job and I said I need to, well, this is a big move, my wife, and by then we had four kids. I need to go back home and discuss this with my wife.

And in that process, I guess Dean Baird got wind of the fact that I had gone back for an interview. And he called me in the Monday of, the Sunday I got back. And we talked. He said, "I understand you went back to Johns Hopkins."

I said yeah, I had a good experience back there.

He said, "Well, did they offer you a job?"

And I said, "Yes, they did, and I'm thinking about it."

He said, "Well, Ira, we don't want you to leave. And I'm doubling your salary." So I went from like \$9,000 to \$18,000.

So anyhow, I decided to stay where I was. And I'm glad I did. Because I was getting enough clinical experience with gender dysphoric patients -- see, that's another term, gender dysphoria -- that were being referred to me. So that in a relatively short period of time that I had available to see private patients, I focused on these folks with gender identity problems. And then it blossomed out to people with sexual issues. And then, even further, to folks with sexual orientation issues, or homosexuality.

So I stayed there in Oregon from 1962 to 1978. And then at that point, as I mentioned, the academic ladder went instructor, assistant, associate, full professor, which I became. But I was foolish enough to think that I wanted to become a chairman, which is a totally administrative role. You get considered for it based on these three pillars: research, clinical, teaching. But once you get, if you become a chairman, it's entirely an administrative issue, where you try to hire people and develop a department. And so forth.

But anyhow, at that point I was offered the chair of the University of Nevada Medical School, in '78. Which I stayed at for the rest of my academic career, that went through 1995. I had roughly sixteen years in Oregon, and sixteen years at the University of Nevada. And I kind of, and it was in those two places that I continued my work with transgender people. And I got into the literature. You know, writing about it. Because again, in an academic world, if you wanted to be promoted, you had to usually have at least three or four or five publications [per year] in addition to being evaluated for your teaching performance and your clinical skills.

So there you have it in a nutshell. What is it, '62 to '15, what is that, fifty-three years or so? And I kind of retired, you know, from the medical school in 1995. So for the last twenty years, we took sabbaticals in New Zealand and Australia. And so I worked down in New Zealand for a few years. And then came back and worked in the state hospital in Reno, Nevada. And became the medical director for the Northern Nevada Adult Mental Health Service and felt, and I kind of retired from that role in about 2010.

So here we are. Five years retired and, again, quite removed from the topic of my interest earlier in my career.

[End Track 1. Begin Track 2.]

Anderson: Well, we've taken up the time that we asked you for. I do have some more questions, if you have time.

Pauly: Sure.

Anderson: We could take a break, if you need to get up and stretch.

Pauly: No, I'm good.

Anderson: You're good?

Pauly: Just getting warmed up.

Anderson: That's outstanding. Can you describe your interactions with your transgender patients in Portland? Or even if you were aware of sort of a community of transgender people who are out there?

Pauly: Well, there is a community. But I didn't, I interacted with them as individuals. And I know that in some places, including Reno, that a lot of these individuals would be seen in groups. Like supportive groups. The AA model of people with experience of a particular condition like, say, an alcoholic, is helping other folks who are trying to shake the habit. And they get support from this homogeneous group of people. I never, so my experience was pretty much one-to-one. But it was fun, you know, I became quite, unlike other doctors kind of remain aloof from their patients. But these folks were, among other things, very grateful because they had great difficulty getting a physician to empathize with their situation, let alone treat them. And prescribe hormones and refer them to the surgeon for surgery.

So the word got around. So I probably treated everybody in the Portland area on a one-to-one basis. And then things kind of expanded to include sexual orientation concerns, or homosexuality. And there was some similarity, although they're opposite, they're not the same condition. I mean, your typical homosexual would never dream of having his or her genitalia removed. On the other hand, transgender people have a preference. And that gets very confusing. Because the more common condition was thought to be the male to female. So you have a male physically who has a feminine gender identity. And now this person living as a woman usually wants to have sex with a biological male. So from a gender point of view, that's a hetero-gender-role situation. But a physical point of view, you have two genetic males having sex with each other. So I would not think of that as homosexuality, even though it is from a physical genetic point of view.

And then to complicate the situation even further, some of these biological males who are now living as women want to have a relationship with another woman who these individuals consider to be homosexual. But in fact from a physical genetic point of view, it's two different, you know, it's a male and a female. So it gets quite confusing to talk about. But just like people who don't have a gender identity problem, some of them are homosexual and some of them are heterosexual.

We tend, too often we think that a male homosexual is effeminate. And therefore his relationship with a partner, he has a person who takes the masculine role. But you know, it is confusing, but it's different.

And the other thing is that you can view transgenderism as a body image issue. And the body image issue is here I can see that my gender identity is male. No, my, yeah, my gender identity is female, but I'm genetically male. And so we developed a scale to evaluate people's perception of their body. And in the male to female situation, the offending organs were all of the secondary characteristics. Such as, if we're talking about a man, the penis and scrotum. The lack of breasts, the beard, all of these things were excruciatingly painful. And these are the parts that they needed to get rid of and to transition into the role of their preference, rather than the role of their physical body.

So we had some criteria above and beyond, you know. The Harry Benjamin Gender Dysphoria Association, which evolved over the early years, they developed criteria for who

would be accepted for sex reassignment surgery. And they had to be evaluated rather extensively by a psychiatrist or psychologist and show evidence of having been successful in living in the opposite gender role. Or in the gender role of their preference, I should say.

So the ones who demonstrated that ability, you know, answered all the questions of the interviewer, much as I'm doing here today in a way that seemed acceptable, would then get a referral to the few surgeons in the country that were performing this procedure.

Anderson: Was there anybody at OHSU who was performing those procedures at the time you were there? Or were you having to refer people?

Pauly: There was no one there. So we, the closest surgical program was in San Francisco. And then in Colorado, a surgeon named Beaver came on board. And most of the transsexuals in the country were referred to him, because he developed his own private clinic someplace in Colorado. I forget exactly where. So there really, there weren't even much in the way of any endocrinologists. So I, as a psychiatrist, were given these patients either prescription for estrogen, if we're talking about the male to female situation, or injections of testosterone if we're talking about female to male issues.

But as far as interaction with a community is concerned, I gave lectures, I think, to various places that invited me to speak. And of course I was writing papers. You know, often you would submit a paper to the annual meeting for the American Psychiatric Association. And if your paper was accepted, then you would participate in the annual meeting. And then hopefully get your paper published. So as a result of these kind of things, I became known nationally. And therefore a lot of patients were referred to me.

And I was one of the founding members of the Harry Benjamin Association that included people in, not only in the United States, but in Europe, who were—and the more things were written, the more people realized that they had seen problems like this. And what seemed to be extremely rare, like one in 400,000.

And at first we thought that this was exclusively a male to female situation. But by virtue of my first individual was actually a biological female to living and wanting to live in the male role. So I knew from the very beginning that it was not exclusively a male to female issue. And now it's come to be that they're almost one to one.

So, let's see. What was the question?

Anderson: Oh, you answered it. You answered it. It was great. Something that, I read your 1965 paper. Something I'm interested in that I think you alluded to was some patients feeling that once I transition, my life will be perfect or all my problems will go away. And how, how did you address the sort of expectations people might have? And then, how did, did you have a role in sort of seeing them through after they transitioned?

Pauly: Yes.

Anderson: And what their life would be like?

Pauly: Yeah. The ones I personally evaluated and followed were the ones who lived fairly close by. In Portland. Or later, Reno. And what became very important were follow-up studies. You provided this rather, at that time, at least, and still, I think, to a certain extent, a rather

controversial treatment. And the proof of the pudding was how do these people actually do living after sex reassignments? Or how successful were they? How employed? You know, how often of them were successful economically, as well as socially?

And they were doing this work in Sweden. And one of my colleagues in Sweden was performing follow-up studies. Because they had a cohort of patients that they provided treatment for. And they followed them. And I'd say about 90 percent of the ones that were followed over time, and we wrote a paper on this that's in the Swedish literature, but the vast majority of them did very well. And they seemed happy and content.

But, you know, there were some who didn't do well. There were a few suicides. There were people who decided after the sex reassignment that they wanted to go back and live in their original biological status. And I think maybe you could attribute that to the evaluators not having done their job by recommending these people. But you know, at the time, and I think even to the present time, all that you have is the subjective kind of his that the individual gives you. And by now, these folks know what the dialog should be. They know what to say and what history to give. I have no way of proving, either with transgender patients or, for that matter, any of my psychiatric [patients], because the basic tool is to take a history and do a mental status examination. Or maybe order some psychological testing. But when it comes right down to it, you're left with the veracity of the patient and whether they give you the truth or an accurate history. And by now, it's pretty well known that what you're supposed to say, theoretically what the evaluator wants to hear.

And that's why this real life test of living for a couple of years before. I mean, that becomes the meaningful thing. And get people who know the individual to come in and say, "Yes, I've known this person before, during and after, and they're doing much better." So you're looking for some corroborative information. And so I think we're not relying entirely on what the individual tells us.

And then we began developing tools like the body image scale, which I touched on. So I think we're getting better at it. But let's face it. You know, let's forget about gender dysphoria. The general population has problems, you know. People who aren't transgender commit suicide. And so whether the incidence of this is greater in the transgender population than it is in the general population, there are no statistics available to prove that. But it's not a 100 percent thing. And that's why the criteria for providing the surgery becomes an important issue.

And sometimes the transgender patient is impatient about having to wait the two years. They want it done yesterday. And so that makes it somewhat complicated. But at best, you do the best you can. And I think the Harry Benjamin Association, which is now called the Association for Gender Health, or something like that. That's after my time of being active in this community of professionals who are interested in this condition.

Anderson: I'm wondering if you could talk a little more about something that came up when we were preparing for this interview and talking to transgender activists about the idea of gatekeeping. And they were very aware of this sort of tension between, they don't want to be put into a box and given a psychiatric diagnosis, necessarily. But at the same time recognizing they need a diagnosis to get the care that they want.

Pauly: Yeah.

Anderson: And in some cases, as you said, having a script that they want to follow to get the result they want.

Pauly: Well, and that's a very real issue. And something that has evolved over the years. When I first got involved, there was no psychiatric disorder. There was no name for it, even. Then gradually transsexualism evolved as the correct term. And it usually involved the psychiatric or psychological profession, because it was not viewed so much as a physical disorder. It was viewed as a behavioral issue.

And so, and it was such a controversial... It was very much like therapeutic abortion, where some people were passionate in favor, and just as passionately opposed. I remember seeing editorials that blasted physicians who would be involved in this kind of treatment.

But in order for it to be taken seriously as a treatable condition, it had to appear as a diagnosis. And so finally, I think somewhere in the mid-1970s, we got, we followed the prototype of homosexuality. Homosexuality had to be viewed as a condition, if anyone was to want treatment for it. So it crept into the diagnostic and statistical manual of the American Psychiatric Association. And that kind of legitimized it as a condition that could be described and have statistics.

And so likewise, we tried very hard to get transsexualism, as we called it then, to be in the diagnostic and statistical manual. I think that the third or fourth edition, we did include it under a rubric called gender identity disorders.

But a lot of the transsexual community did not like being referred to as having a psychiatric disorder. Because they didn't view it, this is who they were, you know? They didn't feel that this was a pathological condition. They just felt they wanted to live their life as they felt they were inside, rather than how they appeared on the outside.

And interestingly, and then subsequently, the homosexual community got homosexuality removed as a disorder. So it wasn't pathological anymore. And I'm sure that, as far as I know, in the DMS current edition, it's still there as under the rubric of gender identity disorders. And maybe they're calling it transgender instead of transsexual. I know the terminology has evolved.

But as a teacher of medical students, what evolved for me was the normative path of gender identification. How we came, most of us, came to be identified with who we were physically, genetically. And this is still, you talk about genetic predisposition. And then having some postnatal environmental factors. So that's just a not-so-subtle way of saying we really don't know how this happened. There may in fact be a gender identity center in the brain that is either stimulated or not stimulated by hormones. The geneticists say that the basic resting state of the embryo is female. In order for the male condition to occur, it has to have the addition of testosterone, which is stimulated by the Y chromosome.

But it's still not, I'm sure that genetics will get to the point where they can possibly see if there is, in fact, a genetic component to this. But as far as I know at the present time, that kind of sophisticated technology and science is not in place.

Did I answer your question?

Anderson: Absolutely. I want to circle back to the teaching role again. The body image scale that you mentioned, you developed that with Thomas Lindgren?

Pauly: Lindgren, yeah.

Anderson: Can you talk about your mentoring of him? Or—

Pauly: Yeah.

Anderson: --other students who might have gone on to careers in transgender patient care?

Pauly: Yeah. Most departments have a clerkship program. So that in your third or fourth year, you have an experience of, it can vary from four weeks to six weeks, a rotation in psychiatry. Then, in addition to that, some of the medical students want to get some experience in research. So Tom Lindgren came to me one day and he said, you know, he had read the paper that you alluded to and was interested in that. And so we were trying to find something more objective than just the subjective history that the patient gave. We wanted to find out how these folks felt about their different body parts.

So we developed a scale on thirty body parts, some of which were gender-related, and some of which weren't. And we had them rate how they felt about these different body parts on a scale of one to five. One being very satisfied and five being very dissatisfied.

So, as you would expect, the gender-defining parts were, if it was a male, and he, penis and scrotum, they were very dissatisfied. And voice was another issue. And so forth. So we were able to develop a scale that showed that gender dysphoric folks were dissatisfied with this group of gender-defining items in it. So that, you know, that gave us something a little bit more objective to hang out hats on from the point of view of evaluation or diagnosis.

And Tom and I developed that over the course of a summer. And that scale can be used for anyone, you know. If I'm dissatisfied with my body and I feel I'm overweight, then I register something closer to four or five. And there are other body image disorders, like there are folks who have anorexia. And these people, more often with women than men, see themselves as being obese, when the rest of the world sees them as being not. But it's like a delusion, you know, I'm fat, when I'm really not, but I have to lose weight. So that's another example of what you might call body image issue.

There are some patients who have body dysmorphia where, I remember treating a woman who had two breast enhancement procedures. And she, I mean, she had a breast that was like 42-D, E, it was off the scale. And yet she wanted to have larger breasts. And I said, you know, you already have breasts that are larger than 99.9 percent of the human race. Why would you—

But, again, so I was not willing to sign off on referring her to a plastic surgeon. Which, fortunately he required before any further surgery was going to be done. But these are just a few examples of people who have a, I suppose, at one level, you can identify this condition as a body image problem. That the body does not come into conformity with one's concept of oneself as an individual. As a gender identity issue.

Anderson: So you've mentioned a couple of times that as your career continued, you started meeting with homosexual patients as well as the transgender patients.

Pauly: Yeah.

Anderson: Can you talk a little bit more about any interactions you had with the gay community in Portland, in the area?

Pauly: Not anything formally. But individual folks, they were, say, gay. But they were not comfortable with their own homosexuality. They wanted to conform with being heterosexual. And for a while there they were beginning to treat this, there was a word for it. Where they were gay, but they wouldn't accept their own gayness and wanted to see if they could alter their own sexual orientation. And there are all kinds of behavioral methods. There was obviously no medication that would do that. But I think this was before more tolerance evolved in the community, where gay people no longer had to be ashamed of their sexual orientation.

And over the years, this did happen. And now I guess the Supreme Court is going to tell us whether gay marriages are legal or not. But whether they're legal or illegal, they happen. And some of the states are already recognizing that. So that's just an example of the tolerance.

And what is in common with the, and often the groups are gay, lesbian and transgender. They have banded together, to some extent, even though it's not a homogeneous group of folks. It's just what they have in common is that their condition is atypical. And also where tolerance for them varies. But certainly over the generations, over the years, over the decades, we've all become more tolerant toward these situations.

But I know there was an instance in Portland where we had a small psychiatric chapter called Portland, I think it was the Portland Academy of Psychiatry. And I was the president of that for a couple of years. And I think someone who was lobbying in the state government to reverse some of the restrictions about homosexuality. You had mentioned his name a couple of times.

Anderson: George Nicola.

Pauly: George Nicola apparently came to us as a group. And I was able to get some consensus. I think there was like fifteen or twenty of us. And we said yeah, that's a reasonable thing to do. And I'd forgotten all about it until George called me maybe a couple of months ago and kind of thanked me for helping him to you know, eliminate the restrictions and the illegality of homosexuality. So we talked. And he was the one that mentioned your program. And the oral history and whether I would be willing to have this interview. I said sure. You know, it's a nice, I'm honored to be among the number of folks that you see as being appropriate for this kind of honor, as I would view it.

Anderson: Well, thank you. We're honored to be able to speak with you. I have just one or two more questions. And I think I may check with Morgen to see if we've covered everything adequately. So what finally drew you away from Portland to Reno?

Pauly: Well, I think I had mentioned earlier about this so-called academic ladder. So I had become a full professor. And I would have been happy, George Saslow retired. I would have been happy to continue on. And I did throw my hat in the ring. But the search committee gave the position to James Shore, who was George Saslow's successor. And then moved on and became a chairman in, I think it was Colorado. And you know, from time to time, one of the residents that I treated— That's an interesting slip. One of the residents who graduated from our program moved to Reno. And the department of psychiatry was just getting started at the University of Nevada. And they'd had a two-year medical school and were now transitioning into a four-year degree granting. And they were looking for a chairman of the department. And since he was on the search committee, he mentioned my name. And I went down for an

interview. And they offered me the job. And so we moved our whole family from Portland to Reno. And that was 1978. And we've been there ever since. So...

Anderson: And then you retired from clinical practice quite some time ago.

Pauly: Well, I retired from the medical school in 1995.

Anderson: Okay.

Pauly: But then I took a position in New Zealand at a clinical program for anxiety disorders. And lived there for a couple of years. And we had a home down there. So we removed winters from our life by going to New Zealand during our wintertime up here and catching their summertime. So we did that. And we bought a home down there. And by then, our kids had all grown. And it was just Ann and I, my wife and I. And even though I wasn't working fulltime, I took some consulting jobs down there, at what we call here rural clinics. You know, go out to outlying areas who can't, don't have enough business to hire a fulltime psychiatrist, but might have a clinic that treats them primarily with primary care folks, and has the specialist come in a day a week, or something like that. So I did that.

And after we got back from New Zealand, I worked for the state mental health program. And there's a state hospital we call Northern Nevada Adult Mental Health Service. And I worked as the clinician there. And became the administrator, the director. The medical director of the hospital. So I did that all the way up to 2010.

Anderson: Great. So how are you spending your time these days?

Pauly: Uh, how am I spending? Well, first of all, we live half the time down here in Arizona. So we get out of Dodge when it starts getting cold up in the, up in Reno. And you know, we have fun with our children and grandchildren. In July, we've got a family reunion of all sixteen of us down on the Oregon Coast where we used to go when they were kids. We went to, just south of Seaside at, just south of Cannon Beach at Arch Cape and rented a home down there.

So, you know, it's more oriented toward our kids and grandkids. And I play a little golf down here. I go in my hot tub every morning and try to stay in some kind of semblance of shape. But, you know, do a lot of reading. And just kind of lay back--

Anderson: It sounds great.

Pauly: --and try to stay healthy as best I can.

Anderson: Is there anything you wish I had asked, or that you'd like to expand on more?

Pauly: Not really. I think we touched on a whole bunch of stuff. I think the bottom line was, looking at the deviations from the normative process of gender identification, take us back to well, how does one develop their own sense of who they are? Or, for that matter, how does one develop their own sexual preference? You know, you go from the unusual to the more common. I'm trying to avoid using the term "abnormal" because as we've seen, homosexuality is approaching 10 percent of the population. And now, I think, transgenderism is, at one point I

remember seeing one in 400,000. But I'm guessing it's a lot closer to one in 10,000. I don't know if there are more accurate statistics. You probably have to go to the Swedish literature, because they have probably a small group that stays pretty inbound, or, but so we still don't know.

What we do know is that kids develop, boys develop a sense of being masculine and girls develop a sense of being feminine from as early as two years. And there's a lot of child psychologists are trying to understand how this happens.

But again, you know, it's not unusual for, these transgender folks often are viewed early on as, the males are viewed as sissies. And the girls who feel more masculine are viewed as tomboys. And again, as they grow older, some of these sissy boys, as Richard Green calls them, grow up and they don't become transgender. But some of them do. And likewise, in the female populace, the so-called tomboys may grow up to be more masculine than the norm of females. But they wouldn't dream, they don't necessarily have a higher instance of homosexuality. And certainly don't have a high, some of these so-called tomboys do, that's the early manifestations of people who, as adults, want to live in the opposite gender role. But it's far from crystal clear.

But what is clear is that that identification, that becomes fixed pretty much by the time you're three or four. And there was a time when some of us, where the patients didn't accept their condition, wanted to overcome this. Just like the gay people, the few who were ashamed and embarrassed wanted to convert to be heterosexual. And there was the occasional transgender person that wanted to go back to accept himself in the gender role that was consistent with what his body said. And some of us tried to help out in that regard. But I personally tried to do that with a couple of patients. And the only thing I really accomplished was to kind of push them into a psychosis. So that, by trial and error, I learned that I certainly didn't have the ability to help them with that problem.

But I think society has come around to accepting that we're all individuals. We all have our own peculiarities. And tolerate someone who's a bit different. But, yeah, there's still a lot to learn. And maybe we'll find out that there is a gene on the 83<sup>rd</sup> chromosome or whatever. I'm not that up with the genetic technology that's evolved. But I think it's still an open field. And that's what makes it exciting for people who are looking to make some kind of contribution to the psychiatric literature or the genetic literature and how basically people help society cope with these issues. And it comes down to a matter of tolerance whether we're talking about transgender or sexual preference. Therapeutic abortion. These are all issues that have become more accepted. And sometimes they're rejected out of hand because of some sexual, I'm sorry, because of some religious conviction or whatever other bias people have. But it's nice to see these folks are now treated with respect. They're not viewed as freaks.

Of course, it's not an easy road to follow. And I'm sure any transgender person would tell you that their life has not been an easy one. And especially to get the kind of medical care they want. But they, for the most part they do live more happily.

There's a *People* issue that has this marathon, or this decathlon star, Brenner—

Anderson: Bruce Jenner.

Pauly: Bruce Jenner on it. And it said, "He's finally happy." And that came out last month, I think. And he's come out with his transgender issue. And the subtitle was, "He's finally happy." So I hope that that's the case with these folks who finally can live the life they want to, and feel better about it than being trapped in the wrong body, as they see it.

Anderson: Morgen, is there anything you want to jump in with at this point?

Young: I just had one final question. And I was wondering if you came across Alan Hart, who was Oregon's first known female to male transgender individual. Went to the University of Oregon Medical School and transitioned in 1917. And there was a journal article published by a U of O Medical School faculty member, Alan Gilbert. Are you familiar with any of that?

Pauly: Did you say 1917?

Young: 1917.

Pauly: No. I wish I had seen that. Where was it published again?

Young: I'd have to look up the journal name. But the article was "Homosexuality and its Treatment."

Pauly: Yeah. But you're saying that this was, in fact, a gender dysphoria or a transgender issue.

Young: Right. Dr. Gilbert treated Alberta Hart. She requested he perform a hysterectomy, and he did. And then Hart lived out the remainder of his life as a male.

Pauly: No, I did not see that. And as far as I knew, the first published female to male, as we referred to it, was the patient I described in the New York Hospital. That was in 1961 or '62, when it was finally published. And again, because the terminology wasn't there. I mean, I'm sure that if it were under the transsexualism gender, transsexualism name or diagnosis, that I would have come across it. Because I was reviewing the literature. But I was primarily reviewing the psychiatric literature. And I certainly was not familiar, that would have been a fascinating bit of information to have, because that's where I did my initial work there in Portland.

Young: Yeah, Dr. Hart, I think he was a radiologist, has become a big figure in the gay and trans community in Portland. And OHSU is very familiar with this history, because this is such an early—

Pauly: Well listen, if you could, I'd be fascinated, if you could make a copy of that article, I'd be very interested in seeing it.

Young: Yes. We can absolutely do that. But that was my only question. So, thank you so much.

Anderson: Thank you so much for doing this. We really appreciate it.

Pauly: Yes. Well, it's been my pleasure.

[End Interview.]