Transgender Aging: The Graying of Transgender

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My friend John, a 64 year-old female-to-male transsexual stared at a healthcare survey he had recently been asked to fill out. It asked his gender and then gave him the choices of male and female. John looked at me and said, “I think they mean sex, but that wouldn’t even work and even then they didn’t include the options of intersex and transsexual as a choice. Moreover, if they meant gender, then the choices should have been masculine, feminine, and transgender at least.” John’s resignatory comment illustrates the ongoing demographic invisibilization process transgender individuals undergo during the course of their journey (Witten & Eyler, 1999). Couple this with the typical marginalization suffered by the elderly in the U.S. and you are faced with a growing population of persons (Witten, 2003) who suffer from significant degrees of healthcare (Witten & Eyler, 2004) and eco-socio-political injustice and inequity (Witten, 2004ab, Witten & Whittle, 2004).

Within the worldwide older adult population, transsexuals, transgenders, cross-dressers and other persons whose gender expression or identification is not seen as the “traditional” male or female represent a substantial minority group. Members of some Native American groups (i.e., Tewa Indians of New Mexico) might fall in this category as would the Fa’afafine and Fa’afatama of Tonga and Samoa, the Hijra of India, Pakistan and Bangladesh, the Maori of New Zealand, the Mak Nyah of Malaysia, and the okama, gei bli, bur’bli and ny’h#fu of Japan. Issues surrounding estimation of transgender prevalence and the subsequent estimation of the elder transgender population are discussed in Witten (2003). However, Witten (2003) was able to demonstrate the population size is not negligible. The descriptors used by trans-identified persons are varied and dynamic. We will use these general labels as a first approximation for discussion.

In an era in which forecasting the health of elder populations is increasingly more important and where issues of healthcare inequity (Institute of Medicine, 2003) are being touted as critical to address, discussion of quality of life issues faced by mid-to-late life transsexuals and other gender minority persons should not be deferred. It is difficult,
unfortunately, to provide data-based information about many of the healthcare and related issues faced by elder transsexuals, as this group is particularly “epidemiologically invisible” (Witten & Eyler, 1999), with many of its members preferring not to reveal their natal sex due to perceived and real risks and stigma associated with being “out.”

For the transgender/transsexual population individuals will fall into numerous sub-cohorts; those sub-cohorts then further sub-divided based upon numerous factors. For example, for a given younger old trans-person, time of transition (hormonal and surgical modification) can be important to understanding the aging process. There are many ways to arrive at the endpoint of being an older trans-person. A person may be elderly when they choose to transition or they may already have transitioned earlier in life and now are older in their contra-gender identity and body, having dealt with a longer duration of lifespan in the already transitioned state. Thus, one individual is old, but has lived only a short period of time within the contragender roles, while another is old – having lived a long time within the contragender roles. Each of these individuals may or may not be hormonally or surgically modified. And, as such, their lifecourse experience as elders will be different and require understanding from the geriatric case manager and caregiver. Currently, Female-to-Male (FTM) transsexuals usually self-identify during their teens, twenties, or thirties, often following a period of years of lesbian identification. However, male-to-female (MTF) transsexuals and transgenders more often attempt to suppress their self-perception of gender variance for years or decades, and therefore frequently present for medical sex reassignment services during mid-life or older age.

Transgender elders face not only the normative problems of aging but also, due to their contragender hormone use and other possible gender re-alignment surgeries, face problems evolving from the conflation of such alterations with the normative aging processes. Confounding these biomedical processes are a constellation of psycho-social and eco-legal-political factors that further exacerbate the biomedical condition due to numerous factors such as elevated stress, experiences of perceived and actual violence and abuse (Witten & Eyler, 1999; Lombardi et al., 2001; Witten, 2004ab), loss of social
network support, loss of income, and divorce/loss of children (Witten, 2004b, Witten & Whittle, 2004).

Biomedically, little is known about long-term effects or morbidity/mortality risk changes from use of contragender hormones and genital or other surgery, as related to the canonical age-related diseases of osteoporosis, cancer (breast/prostate), stroke, cardiovascular and cerebro-vascular disease, and oral health. Additionally, good clinical judgment must be utilized when starting a gender journey later in life due to the potential consequences arising from normative aging processes. Smoking cessation should be emphasized due to elevated risks associated with hormone use and smoking.

Individuals, who pursue gender transition later in life, face different challenges than do their younger peers, and also possess certain advantages. Quality of life issues may be affected by a constellation of medical and social considerations. These issues are both similar and dissimilar to those encountered by non-transsexual elderly persons. In this section, we will briefly explore the realities influencing quality of life for older transsexual, transgendered and cross-dressing individuals.

Two types of individual will be considered. The first is the older trans-individual who transitioned earlier in life and has experienced a significant portion of the adult lifespan as a contra-gendered individual. Here, questions relating to long-term stress (Kraaj et al., 2002), negative life experience, long-term exposure to hormones, transition in midlife can profoundly affect socio-economic status for the transperson. While this can have numerous immediate effects, it also has long-term effects (Turrell, 2002). Alterations of the oral environment, saliva production for example, due to use of estrogen could have potential implications for long-term risk of cardiovascular disease.

Persons who undertake gender transition during mid-life or the elder years are more likely than their younger peers to experience difficulties related to physical health status. Ill health, especially cardiac or pulmonary dysfunction (Aronow, Ahn, and Gutstein, 2002), may preclude eligibility for surgical procedures including breast or
genital reconstruction. In addition, persons with moderate or severe hypertension or other conditions of old-age may be poor candidates for estrogen therapy. Similarly, androgen supplementation in female-to-male (FTM) transsexuals and transgenders may exacerbate depressed HDL cholesterol and increase coronary artery disease risk. Androgen supplementation is also a risk factor for the development of polycythemia, a potentially life-threatening condition, but may benefit FTM individuals with pre-existing anemia or loss of bone mineralization. While much is known about pharmacology of aging and about hormones and aging, little is known about the interaction of “normal” aging processes and cross-hormonal treatment, from a physiological, psychological, and biomedical perspective. Only recently has any significant work been done on the mortality and morbidity rates for transsexual and transgender patients on cross-hormonal treatment (Asscherman et al., 1989).

Healthcare and personal assistance services are more complex for persons who are transgendered than for those who are transsexual and post-operative. Apparent mismatch between genital anatomy and gender of presentation can result in difficulty in obtaining medical services, practical nursing care, or even appropriate funereal arrangements (as in the case of Billy Tipton, whose female genitalia were “discovered” by the mortician and sensationalized in the tabloid press). More recently, Tyra Hunter, a pre-operative male-to-female transsexual was refused appropriate and timely medical care by Washington, D.C. paramedics who, when arriving on the scene of a hit-and-run car accident involving Ms. Hunter, discovered her transgenderism. Believing that her gender incongruity implied that she must also be homosexual, the paramedics refused to render treatment because they thought that Ms. Hunter might have AIDS. The case of Leslie Feinberg, who was forced to leave an emergency room when his female anatomy was discovered, is also well-known in the gender community. Many healthcare personnel consider transgenderism (or transsexualism or cross-dressing) to be evidence of psychiatric pathology, and inappropriate psychiatric referrals may result.

The financial aspects of transsexual and transgender healthcare are also affected by gender discrimination. Many FTM transsexual and transgender adults begin gender
transition after years of lesbian identification. Survey data (Eyler and Witten, unpublished) indicates that incomes well below the national average are commonplace, most likely as a result of gender and anti-lesbian discrimination. Conversely, MTF transsexual and transgendered persons tend to be older at the time of transition, and to have enjoyed decades of male privilege and income. Nonetheless, attempts to transition in the workplace are at times met with dismissal; only one state and a handful or municipalities provide legal protection from employment discrimination based on gender presentation. This fact is significant in light of the truth that whether or not women are impoverished by adverse later-life events depends upon their economic resources just prior to the event; and that their financial resources in old age depends very much on their long-term economic status throughout their adult lives (Choudhury & Leonesio, 1997). While this has immediate relevance to the problem of financing healthcare costs, both short and long-term, it is also pertinent to general long-term lifecycle issues such as housing (Liebig, 1996) and retirement (Vitt & Siegenthaler, 1996).

Physical functioning, such as that required for the performance of the usual activities of daily living, is generally unaffected by gender transition or sex reassignment surgery, as far as we currently know. Progression to ADL dependence in the transgender population is unstudied and important. Exceptions include cases in which post-surgical recovery is complicated or prolonged, or in which empathic, non-judgmental personal care assistants are unavailable during the post-operative period.

Although cross-dressers do not usually seek contragender hormonal services, middle-aged and elderly cross-dressing persons often experience difficulty in obtaining appropriate healthcare services due to privacy concerns. For example, most MTF cross-dressers remove leg and body hair in order to appear as normal women while dressed en femme. The need to seek medical care often forces the dilemma of whether to disclose one’s personal behavior to the physician or other practitioner, or whether instead to attempt to postpone services until the body hair has re-grown. In those cases, in which a chronic illness is present, avoidance of medical care for any length of time can have serious consequences. Situations in which the cross-dressing individual requires
emergency (cardiac, for example) or long-term care (nursing home, rehabilitative care, for example) can be problematic for similar reasons.

Psychosocial issues pervade the life of a transgender-identified individual. Normative aging dynamics include decline of social responsibilities, end of child-rearing, reduced income due to retirement, normative deterioration of physical strength and health and a decline in social networks. These factors are magnified for trans-identified individuals as they risk loss of economic status, loss of access to qualified services – healthcare and other – and frequently see a decrease in the social support networks including loss of friends, family, significant others and as well as access to religious and spiritual organizations. During later life transitions, individuals may be dealing with issues of shame, lack of support and a sense of loss of “lifetime experience.” Individuals are frequently concerned with financial stability, safety, independence, living environment changes and their consequences (Witten, 2004b). Elder transgenders must face the normative socio-eco-legal processes of case management, government support services, utilization of home health and community health services, retirement, adult day care, assisted living and continuum of care/nursing home care all within the context of the actual and perceived stigma/marginalization of their transgender status. Moreover, all of the negatives are further exacerbated by the stigma associated with being a transperson of color, race, ethnicity, immigrant and/or disability or having HIV/AIDS status. Caregivers must be acutely aware of the impact of these factors as related to increased depression, anxiety, alcohol/drug/substance abuse, suicidality and other related mental health issues, all of which are common in “normative” elders.

Gender transition at any age requires physical, legal, and social adaptation. Although advice available within the gender community to persons beginning this process often emphasizes the physical aspects (e.g., how and where to obtain appropriate hormonal and surgical therapies), the other components of the process predominate in many cases. Important steps include legal name change and revision of pertinent documents (including driver’s license, passport, insurances and governmental records, employment and educational records, and financial documents). In many states, the birth
certificate sex can also be legally changed following genital reconstruction surgery (including sex reassignment surgery). Furthermore, the prevailing belief that changing one partner's sex will invalidate a legal marriage is not accurate; existing marriages can not be forcibly dissolved by the government of the United States. However, a case challenging this legal tradition is currently pending in the State of Texas (Pesquera, 1999).

Family relationships may be altered following the older person's “coming out” with regard to his or her gender identity. Fatherhood and motherhood, siblingships, grandparenthood and other aspects of the family constellation may be reevaluated during the gender transition process. Children and young adults are usually (though not always) accepting of gender change. Young children may respond well to being offered an actual or fictitious reference to provide even a tangential “model” for transgenderism (such as Dustin Hoffman in the film, “Tootsie” or Robin Williams as “Mrs. Doubtfire.”) Children ages 4-7 often still practice magical thinking to a higher degree than their older peers, and frequently have the least difficulty in accepting cross-dressing, transgendered and gender transitioning adult relatives (Ettner, 1999). Therefore, concerns regarding the appropriateness of disclosing gender minority behaviors to grandchildren and other young relatives are unwarranted; however, young children are also vulnerable to the prejudicial attitudes of their parents, and may react negatively if their parents are rejecting of a grandparent or older relative.

Although gender transition among the elderly, and within the context of a very long-term marriage or partnership, is still relatively rare, experience with middle-aged couples in which one partner is transgendered or transsexual suggest several possible patterns. Many spouses or long-term partners of transgenders or transsexuals will choose to maintain the relationship as their husband, wife or lover changes gender presentation, genital sex, or both; however, many others will not. Couples who do maintain a marriage or partnership may need to “redefine” their relationship. (More versatile persons can maintain a sexual relationship; other couples become “friends”, “sisters” etc.)
Questions of marriage, partnership, non-traditional family structures, sexual expression and personal rights become more complex as legal implications now impact such scenarios through the new contragender identity (Witten & Whittle, 2004). Family dynamics change as transgendered parents must now be taken care of by their children. Issues of elder maltreatment, abuse, neglect and self-neglect must be carefully monitored.

The needs of older members of the gender community are similar to those of their non-transgendered peers with respect to the significant life transitions of the elder years. Loss of the spouse or significant other (and longstanding friendship group) due to death, decreased ability to maintain a private residence, loss of driving capability, transition from an independent residence to an assisted living environment (and ultimately to dependent nursing care) serve to erode personal control and are significant issues in the lives of all persons who survive to become the “oldest old.”

In the case of transsexual, transgendered and cross-dressing elders, these challenges are compounded by issues regarding disclosure, privacy, isolation from transgendered peers (due to a more specialized [minority] community social system which is further decimated by aging and death of its members), specialized healthcare needs, and the potential for ostracization and judgment by the healthcare professions and other care providers. (Within the gender community, transsexuals who have undertaken sex reassignment surgery at earlier life stages may not experience these difficulties, due to congruence between gender presentation combined with elimination of historical ties to the pre-transition life which occur with the passage of time. However, transgenders, cross-dressers, and transsexuals who undertake transition during the elder years must make numerous decisions with regard to sharing confidential (and potentially sensational or ostracizing) personal information with their caregivers. In addition, post-operative transsexuals must confide with their physicians and other healthcare professionals with regard to past medical history, or risk later exposure. (For example, an MTF woman who has completed sex reassignment surgery in her youth will still retain her prostate. Ideally, she should receive routine prostate examinations by a healthcare provider who is familiar with her past medical history. If this option is not available to the patient, her prostate...
may be perceived as a “rectal mass” during routine physical examination performed upon
hospital admission.)

Public Health officials and practitioners can best assist older transsexual, transgendered and cross-dressing clients by providing them with information regarding
the importance of routine healthcare (including preventive services), arranging referrals
to providers who are empathic and supportive to members of the gender community, and
educating others involved in the clients’ care with respect to the realities of human gender
diversity. (This latter endeavor must include medical, nursing, and social work
colleagues, as well as unskilled and semi-skilled assistants.) In addition, facilitation of
support group formation for older members of the gender community (Slusher et al.,
1996), education of leaders of existing groups (such as those operated by religious
organizations, gay/lesbian/bisexual networks) and specific inclusion of transgendered
persons in visible roles within retirement communities, health center sponsored programs
and other service networks, may positively impact quality of life within the gender
community.

Intergenerational dialogue must be established. The young transgendered must be
made aware of the lifecourse issues of aging. Attention to the needs of the gender
community with respect to biological, medical, psychological, and socio-legal-cultural
facets can be best served through a comprehensive and holistic approach, including
family, provider, and community education and the development of appropriate
professional and community networks. Public health and social policy development on
behalf of both the transgendered elder (including the assurance of nondiscrimination with
regard to quality healthcare services, privacy, confidentiality, respectful treatment and
care-giving, and personal safety) is also strongly needed. In addition, violence against
members of the gender community shares many similarities with violence against genetic
women, anti-homosexual (and other hate crime) attacks, and family violence which
occurs when a child (or other family member) is “different.” It is often complicated by a
lack of access to routine health care services and by inadequate response when
victimization occurs. In addition, the current lack of comprehensive information about
this aspect of family and social violence presents additional barriers to the design and implementation of both preventive and recovery services in this community. If society and the Public Health community is to respond adequately to the problem of social violence, and if the transgender community is to be able to protect itself from violent crime, accurate, scientifically reliable data on violence prevalence is needed, so that the necessary resources can be put in place to help the victims and to punish the perpetrators of violent acts. In order to improve gender-based violence prevention efforts, a better understanding of the etiologies of gender (and transgender) related violence must be obtained.
References


All of the above papers are available as free pdf downloads at the TranScience Research Institute website [http://www.transcience.org](http://www.transcience.org) in the Research Archives section. The author can be contacted at twitten@vcu.edu. If you are interested in participating in the ongoing longitudinal research effort in support of transgender aging (as either a study participant or collaborator) or know of someone who might be, please contact the author for further details.