INTRODUCTION

Background

The historical development of modern day biomedicine, psychology and psychoanalysis is bound up in the complex interactions of a Eurocentric, heterosexual, Judeo-Christian viewpoint. Obviously, restriction of the underlying theoretical construct of sex and gender to the dualistic genital sex model has eliminated all biomedical and psychosocial healthcare research on behalf of both the intersex population (Witten, 2002) and gender-variant individuals (South, 2000).

Clearly, limiting the discussion to dualistic heterosexuality forces healthcare workers to buy into the Judeo-Christian paradigm of the family and consequently eliminates all theoretical constructs that would deal with non-normative sexualities, genders, and the potential variety of combinations that emerge from pairing them off as partners and their embedding into families (both immediate and extended). For example, such a restriction could not realistically attempt to address issues of eldercare for transgendered elders within the family or in any type of retirement, assisted living, or nursing home facility. Assumption of heterosexuality also eliminates any theoretical constructs dealing with the dynamics of aging for non-normative sex and gender roles in a heterosexual society (Adelman, 1987; Butler & Hope, 1999; Currah & Minter, 2000; Grant, 2001; Grossman, D’Augelli & Hershberger, 2000). Given the extensive database of knowledge detailing the importance of social support networks, religiosity and spirituality, and quality of life issues in the “normative” elderly heterosexual population, it would not be a surprise to healthcare workers that these areas need to be addressed in the elderly gender-variant and intersex communities as well.
Defining Gender-variance, Transgender, Transsexual and Intersex

It is impossible, within the brief space available here to address all of the different variants for definitions of transsexual, transgender and intersex. The definitions related to gender-variance, the interested reader should review Witten and Eyler (1999) and the references contained therein. Gender minority persons (also referred to collectively as the “gender community,” T* community, or transpersons) include transsexuals, transgenders, cross-dressers, and others with gender self-perceptions other than the traditional Western dichotomous gender world-view (i.e. including only male and female). Members of some Native American groups would fall into the category of non-traditional Western world-views. The descriptors used by transpersons are varied and dynamic. I will use these general labels as a first approximation for discussion. For a detailed discussion of the intersex condition and intersex definitions, the reader is invited to read the literature at the website of the Intersex Society of North America (www.isna.org) for further details.

FACTORS IMPACTING GERIATRIC HEALTHCARE

Cohort Effects

Based upon preliminary data regarding incidence and prevalence in the US and worldwide populations, I have made estimates (reported elsewhere) of the projected numbers of elder transgender and intersex persons in the US and worldwide. Using these projections, I have been able to demonstrate that there will be an increasing number of elder members of both the intersex and the transgender communities over the next decades. It is also vital to understand that both the intersex and the transgender elder populations contain a number of sub-populations of importance with respect to lifecourse experience.
Looking at these two general populations, we can see that the elders of the intersex population will be likely comprised of a number of smaller cohort populations. Most of the elder individuals will likely have had genital surgery forced upon them at early ages and may have been subjected to hormonal treatments as well. Consequently, they may well be dealing with numerous psychological issues related to the undesired violation of their bodies and the effects that the undesired surgery has had on their lifecourse. Additionally, if they have had hormonal treatments for any length of time, they may well be dealing with the medical consequences of long-term hormonal usage dating back to a period of time when hormone doses were much stronger than those currently used.

For the transgender/transsexual population, as well as the younger old intersex population, individuals will fall into numerous sub-cohorts; themselves further sub-divided based upon numerous factors. For example, for a given younger old transperson, 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 transperson. 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 care giver. 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.

DISCUSSION

Transsexualism and other Gender Identities

Transsexuals experience variance (not deviance) between natal sex and “psychological gender and often seek medical sex reassignment services, including hormonal therapy and genital surgery. Transgenders frequently identify or ambivalent with the “natal” genital sex and often adopt a life-style and appearance that is consistent with their psychological gender self-perception. This is often supported by the use of hormonal medications, but genital sex reassignment surgery is usually not desired (although it may be eventually considered and pursued). Some transgendered persons present as members of their natal sex in certain situations and for practical reasons, such as to avoid premature termination of employment. Cross-dressers cultivate the appearance of the other sex, particularly with regard to clothing. Cross-dressing may be undertaken on a part-time or recreational basis, such as at clubs and social events, and may or may not have erotic significance. Women who prefer men's clothing because of its comfortable or practical nature, but who self-identify as female, are not considered to be cross-dressers.

Many indigenous peoples also recognize genders other than male and female. For example, Tewa adults identify as women, men, and ‘kwido’, although their New Mexico birth records recognize only females and males. Persons with such non-Western gender identities are also gender minority individuals, although discussion of the cultural and anthropological aspects of gender variance is beyond the scope of this paper. It is also difficult to provide data-based
information about some of the health issues faced by elderly transsexuals, as this group is particularly “epidemiologically invisible” (Witten, 2002) with many of its members preferring not to reveal their natal sex due to perceived and real risks and stigma associated with being “out.” In contrast, most “out” (i.e., publicly identified) transsexual, transgendered or cross-dressing persons are young adults; many have chosen to be involved in political activism on behalf of the gender community. Nonetheless, in an era in which forecasting the health of elderly populations is increasingly more important discussion of quality of life issues faced by older transsexuals and other gender minority persons should not be further deferred. For an excellent general overview of aging issues in the LGBT community, see South (2000). Issues of health for the LGBT are extensively discussed in the Healthy People 2010 (2000) and Companion to the Healthy People 2010 document (2001).

FINDING A PLACE: QUALITY OF LIFE ISSUES FOR OLDER TRANSSEXUALS AND TRANSGENDERS

Contragender Medical Care

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).

Despite the increased medical risks that may accompany gender transition for older persons, the physical (morphological) realities of aging may facilitate social gender transition. For example, women and men share more physical similarity during the elder years than at any time since childhood. Loss of facial skin tone produces a softer appearance for many genetic males, and the natural diminishment of circulating estrogens, accompanied by a shift towards andronization of the hair follicles, facilitates the production of new beard growth in FTM transsexuals. Furthermore, the loss of muscle mass and increased body fat content which is experienced by both male and female elders often results in phenotypic gender convergence of the body habitus (i.e., women and men appear more alike than previously with regard to body fat distribution, girth and posture). These physiologic alterations are clearly advantageous to transsexual persons who begin the transition process later in life, as they may obviate the need for excessive weight reduction (for genetic males), body building muscle development (for genetic females) and minor cosmetic procedures (for both).

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.

**GENDER VARIANCE AND SOCIAL ADJUSTMENT**

Quality of life issues for older members of the gender community often center upon the degree of social integration which the individual has been able to achieve earlier in life, or on the personal flexibility and resilience available for the development of new relationships during the later years. Community resources and acceptance of persons with non-traditional life paths can also be crucial. These needs are similar to those of elderly non-transgendered persons who find that social network support and community resources are important for the ongoing maintenance of well-being. Data for the elderly transsexuals and transgenders is unavailable at present.

It is been previously documented that elderly persons frequently develop a high degree of spirituality, though not necessarily a great desire to attend traditional church or other religious services. Although the patterns of participation in religious activities among gender minority persons are not currently known, recent survey research has revealed that a majority do self-
identify as being a part of a traditional religion or as being highly spiritual (Witten & Eyler, unpublished data).

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.)

Body Image

Gender transition later in life may enable the individual greater freedom of expression as her/his true self. Furthermore, the normal bodily changes of aging will be partially offset by hormonal and surgical therapies. Specifically, breasts that develop in mid-life or the elder years, due to cross-gender hormonal administration, will not begin the ptotic process until very late in life. Genital (labial or scrotal) ptosis will also be greatly postponed for individuals who have experienced genital reconstruction during the elder years. Conversely, the other normal changes of aging (e.g., body habitus, dermal integrity) will be experienced equally by transsexuals and their gender congruent peers, and the bodily changes associated with sex reassignment surgery, even if strongly desired, may represent a positive stressor for the elderly client. Geriatric care managers who are providing mental health services to older transsexual persons, are well-
advised to prospectively address this potential with their clients, and to remain alert for more specific questions and complaints during (and especially after) the gender transition process.

Sexuality and Intimacy

The greatest obstacle to sexual expression among older adults (particularly heterosexual women) is the lack of availability of suitable partners. Consequently, a MTF transsexual person who undertakes gender transition later in life is more likely to experience sexual isolation or deprivation than would have been the case prior to this transformation (i.e., when the individual had been perceived as male). In addition, the current cohort of elderly women has been primarily socialized to believe that female sexual behavior is acceptable only within the context of marriage, and possibly for the exclusive purpose of procreation as well. However, persons who change gender presentation later in life may share in these perceptions to a lesser degree than do their non-transsexual peers. Furthermore, sexual expression may be positively enhanced by the newfound congruence between the body and the psychological (true) self.

Information specific to sexual concerns of single, elderly cross-dressers is currently unavailable. Middle-aged and older MTF cross-dressers who are currently in heterosexual marriages have usually reached equilibrium during the course of the relationship, though this may have taken years to achieve. Women who are unaware of their husbands’ cross-dressing behavior at the time of the marriage and who discover it at a later point may respond by leaving the marriage, by attempting to place limits on the context of the presentation en femme (e.g., only at home, or only at cross-dressing parties) or by embracing the cross-dressing as a sign of empathy with the feminine aspects of the psyche.

With regard to the mechanics of sexual functioning following sex reassignment surgery, few generalizations can be made. Orgasmic capability is preserved in the majority of FTM
genital reconstructive procedures and in many MTF surgeries as well. However, the sexual response cycle usually requires a greater length of time among elderly persons than among their young and mid-aged peers. The effect of sex reassignment (and in effect, post-operative genital retraining) is not yet known. For elderly female-to-male transsexuals, genital reconstruction (including the placement of an implantable penile prosthesis) may result in a more reliable erectile capability than that which is commonly experienced by elderly genetic males. However, the strength and integrity of the genital dermis may be reduced, relative to earlier in life, and may therefore compromise post-surgical recovery. Male-to-female transsexuals may also experience a lack of resilience of the neo-vaginal lining and labial skin. In addition, the vaginal vault is usually less distensible among transsexual women than their non-transsexual peers. The effects of aging on this phenomenon (as well as the initiation and duration of estrogen therapy and the timing of surgery) are not currently known.

Despite the aforementioned obstacles to sexual expression, most transsexual persons experience a positive development of personal sensuality when they are able to live in congruence with their deepest self-perception. Patterns of sensual expression are usually present across the life-span, with sexual behavior serving also as a vehicle for the basic human need of the sense of touch. When touch is absent, severe psychobiological stress and symptomatology can result. The increased sensuality experienced by transsexual and transgendered persons who are able to achieve a sense of bodily wholeness may serve to enhance physical and mental health by providing additional capability for healthy touch. Cross-dressing persons who are able to integrate temporary role change into healthy partnered or social relationships may similarly benefit.
Healthcare professionals can assist clients in this regard by validating the sensual expressions and potentials of their elderly clients, offering sexual counseling and education when needed, and assisting other family members in accepting the gender presentation and sexual expression of their older relatives. Increased education for healthcare professionals serving these communities, regarding gender diversity and sexual expression among the elderly, may also be needed in order for professionals in inpatient, chronic and acute care settings to provide appropriate and compassionate care for their older clients and patients. Dispelling myths regarding elder sexuality, providing information regarding the usual physical changes of aging and the human sexual response cycle across the lifespan, and offering interventions which address sexual expression in cases of physical disability, may also be particularly useful for social workers and other professionals who provide care to older persons.

Assisted Living and Social Support

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
Geriatric care managers 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.

CONCLUSIONS AND CLOSING THOUGHTS

Transsexuals, transgenders, cross-dressers and other persons whose gender expression or identification is other than the “traditional” male or female represent a substantial but epidemiologically invisible minority group within the worldwide elderly population. Quality of life issues for this community have as yet been but marginally addressed within the medical and sociological literature (Docter, 1985). The intersex elder community remains invisible and there is no literature available on elder issues and intersex. The absence of detailed discussion within this paper further magnifies the need for greater research in this area. Attention to the needs of the gender and the intersex communities with respect to biological, medical, psychological, and socio-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. Health and social policy development on behalf of both the transgendered and the intersex elderly (including the assurance of nondiscrimination with regard to quality healthcare services, privacy, confidentiality, respectful treatment and caregiving, and personal safety) is also strongly needed (Witten, 2002).
REFERENCES


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BIOSKETCH

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