Graceful Exits: Intersection of Aging, Transgender Identities, and the Family/Community

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Tarynn M. Witten
Graceful Exits: Intersection of Aging, Transgender Identities, and the Family/Community

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In a previous series of papers, this author investigated many of the challenges of growing old within the transgender population. Challenges with respect to violence, abuse, and hate crimes were examined as they related to institutional organizations such as the health care system, religious organizations, the military, and the legal system. Medical and general health care needs of transgender-identified elders were also addressed. However, within all of these articles, the central discussion has been around the needs of the transgender-identified elder. In this paper, I revisit the challenges of being an elder trans-person from the perspective of family members and community. I explore how they intersect with constructs of family as well as family relationships. I take on some of the normative aging processes discussed in these earlier papers and examine the overlap of transgender and aging with family/community. Examples are drawn from the author’s field studies and surveys.

KEYWORDS Aging, community, death and dying, end-of-life experiences, family, transgender, transsexual, cross-dressing

INTRODUCTION

When I was asked to write this paper, I was simultaneously honored as well as confident that it would be a relatively easy paper to generate. Given that I have spent over a decade writing and speaking about aging in the transgender population and felt that I certainly had enough resources upon which to draw and to write creatively concerning the proposed topic, I concluded that I should have more than an adequate amount of time and background
to handle what I thought would be a fairly straightforward discussion. What I discovered was far from what I had originally conceived. I found myself mired in how to present, in some sort of organized fashion, the myriad areas and interactions that needed to be addressed in such a paper. In fact, it turned out that this topic could easily be a book in and of itself and that the challenges of understanding the multilayered interactions of aging, transgender identification, and family/community are extremely complex at all levels of psycho-socio-economic and cultural organization.

Consequently, for the purposes of this discussion, I have chosen in this paper to focus principally on Western constructions of identity, family, and society while only briefly mentioning other multicultural aspects of the topic. I acknowledge this bias up front and own that it is but one view of a far more global dialogue that needs to take place. In addition, I will own the fact that I will use a certain set of definitions for various transgender terms/identities (Witten & Eyler, 1999, 2008), understanding that definitions in this area are often politically charged and equally multi-cultural. Lastly, I acknowledge that it is impossible to cover all of the variations within the transgender community and, therefore, I make use of this discussion as a means through which a more varied dialogue around family, community, aging, and transgender identities can be made to happen. With this in mind, let us begin our exploration of the intersection of aging, transgender identification, and family/community.

It is important to understand that there are multiple levels of normative gendered discourse surrounding questions arising in the research on aging. The concept of *gendering* as a subtextual messaging system that adds a layer of discourse is not uncommon in the feminist literature. A simple HighWire search easily locates more than 1000 articles containing the word *gendering*. One can gender knowledge, the body, ethics, technology, relationships, disease, and a variety of other items. How does this impact our discussion?

Coupland (2007) discusses gendered discourses around the problem of aging. The author points out the challenges of social constructions imposed upon the body and the implications of those constructions on how we perceive the importance of various aspects of aging. While this problem has been traditionally seen as one that was strictly experienced by/imposed upon women, Harrison (2008) has pointed out that the pervasive spread of metrosexual attitudes and practices throughout Western cultures imposes a rethinking of the traditional concept of masculinity. Thus, the social semiotics of aging colors our discourse as to what are the important questions with respect to studying the interplay of aging, transgender, and family/community. Calasanti (2004) speaks eloquently to this when she discusses the role of feminist gerontology as it applies to the study of old men.

More important is that the reader keeps in mind that this social gerontology literature still assumes the binary viewpoint and thereby not only invisibilizes the non-normative gender experience but in doing so has
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prevented us from investigating the experiences of aging from the viewpoint of the transgendered and transcorporal experiences. It is also important to examine internal linguistic constructs as seen by the transgender community, a community that has a long and ongoing history of being abused by the health care institution and by health care providers (Witten, 2008). In other words, how is care or family, for example, transgender (Hines, 2007)? Sadly, no body of literature on transgendering aging, health care, or medicine exists. We also find a very small literature on transgendering family. Further research in this area is needed, as it provides insight into perception differences that could lead to stressful confrontations between family members and the trans-identified elder. Thus, the content of this paper proceeds from the hidden assumption that the embodied trans-experiences are at least similar to those of the traditional bi-gendered experiences, despite the lack of supporting evidence that this is true.

Population Estimates of the Elder Transgender Population

It has been consistently difficult to provide accurate information about many of the life-course issues faced by mid- to late-life transsexuals (Witten, 2004) as this group has been particularly routinely epidemiologically invisible (Witten & Eyler, 1999) with many of its members preferring not to reveal their natal sex (Witten, 2003) (i.e., going stealth). However, more recent studies are beginning to provide increasing amounts of information on the needs of this population (Whittle, 2007; Witten & Eyler, 2009; Witten & Whittle, 2004). Current members of the elder trans-community have usually arrived at their elder membership state via one of three different paths. Each of these paths carries with it numerous multilevel life-course influences. The three paths are (1) growing up within a culture that acknowledges transgender identities/nontraditional gender identities as acceptable and growing old within that culture; (2) coming out late in life and being chronologically older when transition occurs, thereby experiencing a short period of time within the gender identity/gender self-expression of choice; and (3) coming out early in life and growing old within the gender identity/gender self-expression of choice as either out or as a stealth transgender-identified person.

Membership within a specific one of these three cohorts plays an important part in the life-course aging experience of the transgender-identified person (Witten, 2003). In addition to the above three age/experience cohorts, we also have the historical context or era cohort (Cutler & Bengtson, 1974; Finkel, Reynolds, McArdle, & Pedersen, 2007). For example, individuals who came out as transgender-identified in the 1990–2000 historical period of time will have a different historical experience from those who came out in the 1940s through 1960s and, therefore, these age × historical cohorts will have
potentially different needs, potentially different ways of self-expression, and potentially different social support systems.

With all of these facts in mind it is impossible to estimate the actual national (U.S.) and/or global number of transgender-identified individuals due to fear of persecution, abuse, and lack of legal protection (Taylor, 2007; Wilson, 2002; Witten & Eyler, 1999) and, therefore, it is impossible to estimate the actual number of elder transgender-identified persons. Witten (2003) produced a hypothetical estimate of transgender population sizes (65 years and older) for both the United States as well as worldwide, arguing that there could be as many as one million transgender-identified persons aged 65 and older in the U.S. and between 3.3 and 10 million globally. If these estimates are even close, then the number of trans-identified elders in the U.S. is approximately one-third the size of the elder U.S. population of African ancestry and approximately the same size as the U.S. elder Asian population (Thompson, 2008). Thus, these population sizes are neither insignificant nor do they allow us to claim ignorance (Kidd & Witten, in press), but rather they shame us into realizing our hegemonic heterosexism as researchers who continually buy into the normative definitions of gender (Butler, 2006; Witten, 2004, 2008b) and who continually misunderstand or do not desire to understand the complex and broad spectrum of relationships between sex, gender, sexuality, and intimacy in these populations (Witten, 2008a) particularly as related to the life-course aging process. Consider, for example, the ongoing conflation of gender with natal sex even within the traditional scientific research journals (Witten, 2004). It is important to note that Witten’s estimates most likely underestimate the population sizes as they do not include multicultural identities such as those of North America (Jacobs, Thomas, & Lang, 1997; Earth, 2006), Pan-Asia (Teh, 2001; Winter, 2006), South America (Kulick, 1998a, b; Lancaster, 1998), Middle East (HRC, 2006), and Africa (Mukasa, 2006; Winter, 2006). A more comprehensive summary of the different identities can be found in Witten and Eyler (2008, 2009).

AGING, TRANSGENDER IDENTITIES, AND FAMILY/COMMUNITY LIFE

Included in the discussion about the intersections of aging, transgender identities, and family/community life are six major issues. These issues focus on social support systems, intimacy and relationships, living arrangements, violence and abuse, health care issues and concerns, and end-of-life challenges of transgender aging adults. It must be noted, however, that although important, information about spirituality/faith/religiosity, substance abuse, and transgender subgroups (e.g., incarcerated transgender adults and transgender adults who have developmental disabilities) will not be covered in this manuscript as they move beyond the scope of this paper.
Social Support Systems/Institutions from Mid- to Late Life

Midlife to later-life to end-of-life challenges in the normatively accepted gender identity (male and female) population are multifaceted and frequently entail a complex interaction of numerous components including the individual, the family (defined in a multiplicity of ways), friends/significant others, health care workers, and legal representatives as well as other institutions, including community entities/or ganizations, the criminal justice system, (Aday, 1994; Linder & Meyers, 2007; Mara, 2002) and the armed forces (Kubzansky, Berkman, & Seeman, 2000; Setterston, 2006). Moreover, these components are mediated by such factors as the individual’s race (Starks & Hughey, 2003), ethnicity and sex (Gornick, 2007; Krieger, 2003), socioeconomic status (Singh-Manoux, Ferrie, Chandola, & Marmot, 2004) and retirement status (Kim & Moen, 2002). Coupled with the above interactions, such support systems are frequently temporally dynamic evolving as the life course evolves (Bloom & Canning, 2007; Mirowsky & Kim, 2007; Yang & George, 2005).

Given the abovementioned complexity in the normative life trajectory, it is not surprising that the introduction of nontraditional life choices such as alternative gender identities or gender self-expressions frequently exacerbate the already normative complexity at a time when such complexity is neither necessary nor desirable (Cahill, South, & Spade, 2000; GLMA, 2000; Perlmutter & Sperber, 2001; Shankle, Maxwell, Katzman, & Landers, 2003; Velkoff & Kinsella, 1998; Witten & Eyler, 2009). In addition to all of the previously mentioned details during this later-life period of time, transgender-identified persons are frequently dealing with such factors as ageism coupled with transphobia (Auerbach, 2008; Kidd & Witten, in press) on the part of many social institutions such as religious organizations (Kidd & Witten, 2008b), the military (Witten, 2006, 2007), and most important, the health care delivery system (Belongia & Witten, 2006; Grant, 2001; Witten, 2008). Transphobia can manifest in the form of violence and abuse against the trans-person from individuals, organizations, or whole institutions as previously mentioned. Moreover, as transgender violence is not considered a hate crime in most U.S. locations, we have no real data to determine the prevalence of such crimes, perceived or actual. Kidd & Witten (2008b) extensively review the literature on violence and abuse against the transgender-identified population and provide extensive statistics, discussion, and anecdotal evidence to support that the prevalence is significant and that the crimes are more often than not heinous.

Trans Social Support Networks in Families and Communities

As has been discussed in numerous articles (Witten, 2002, 2004, 2007, 2008), social support is a key concept in social gerontology; there is empirical evidence of its relationships with health, well-being, and quality of life in old...
age” (Fernández-Ballesteros, 2002, p. 645). Moreover, as I have repeatedly stressed, social support can impact many facets of health from self-reported health to perceived quality of life, to cognition (Holtzman et al., 2004; Witten, 2004) and takes on many forms from simple relationship activity to caregiving (Everard, Lach, Fisher, & Baum, 2000). Although some work has been done in the area of social support networks for elders of the gay, lesbian, and bisexual populations (Grossman, D’Augelli, & Hershberger, 2000), no work has been performed on social support networks of elder transgender-identified individuals. Since, at the later stages of life, most social support traditionally comes from family, friends, and allies along with health care and religious organizations, understanding how others interact with and address the consequences of being associated with the trans-identified elder becomes critical to understanding how to optimally address quality of life for the elder trans-identified person.

In a traditional marital relationship, depending upon the partner’s desire to stay in the relationship or not, economic factors will need to be navigated. How the partner chooses to deal with the public view of her relationship could obviously add to an already strained set of relationships. If these challenges are occurring during the wife’s menopausal period, this could also add new challenges to an already very complex scenario.

While the state cannot force a divorce, should it happen, the partner stands to lose many marital and inheritance benefits. This could have potential impact on the partner’s financial status and, as we have discussed in various articles (Witten, 2004; Witten & Eyler, 2008), have significant impact on the partner’s late-life quality of life, mortality, and morbidity. The partner may also see a reduction in social support network as common friends no longer interact with him or her.

Furthermore, embarrassment over the partner’s situation might cause the partner to withdraw from commonly used institutional resources such as church groups, women’s organizations, and other community resources. Depending upon the partner’s willingness to be open about the situation, the partner might be forced to find alternative health care facilities so as not to have to disclose any more than necessary to those individuals that had been traditionally part of the health care support network. As I have summarized in previous discussions (Witten, 2004) social support networks are known to be critical to the quality of life (Rautio, Heikkinen, & Heikkinen, 2001; Seeman et al., 1987). Thus, reduction in such networks would also lead to a potential increase in mortality and morbidity and a reduction in quality of life for the partner as well.

At this point, it is true that transgender later-life stages are complex and that transgender-identified individuals frequently interact with a complex network of support individuals, organizations, and institutions that are both normative (medical care facilities, etc.) and non-normative (GLBT free clinics, etc.). More often than not, the normative organization and
institutional interactions are negative to neutral at best (Witten, 2008b; Witten & Eyler, 1999). With the previous dialogue in mind, we may now examine how the dynamics of this complex hierarchy of interacting sub-networks impacts those individuals, organizations, and institutions that are contained within the support network of the trans-person. But why is this research important in the first place? That is, why is it important for us to study the systems that interact with trans-identified individuals and organizations from the perspective of those same individuals and systems? As motivation for our investigation, let us now consider some short quotations from the TranScience Longitudinal Aging Research Study (TLARS) (2007).

**Transgender Intimacy/Relational Family and Community Life**

I don't want to visit my father's grave and see a woman's name on the headstone. I can't deal with that, especially because he changed his birth certificate to say “F” and has also changed his last name. It's like he was denying we even existed. How can I even talk to him now? It was hard enough to deal with him as a woman, but this?

While the preceding example is actually a fusion of two different TLARS Study respondent comments, it accurately portrays some of the difficulties and complexities of the intersection of aging, transgender identities, and what we might term the normative family construction. In this particular quotation, the child's father moves to become female. This is perceived as not only denying the family but also as denying the child's embodied needs around having a father that meets the traditional requirements of fatherhood and the socioculturally implied masculinities implied for that role. This quotation hints at intergenerational issues between the child and the parent, potential isolation on the part of the family and the trans-identified father, and the potential for the lack of later-life family care giving support (Smith, 1998) if the isolation develops into a situation in which the family refuses to communicate with the transgender-identified parent. Many questions arise here. Is the father, in her transitioned state, now a widow and not a widower? If so, how does the literature on widowhood and spousal bereavement and morbidity/mortality apply to her? And what about the wife? Is she also a widow? Is she dealing with the father's transition and exit during menopause and, if so, how does the simultaneous biomedical, psychological, and transgender stress impact her? Moreover, through that increased stress, how will the family dynamic change? Literature on normative later-life isolation and its correlation with later-life increases in depression, increases in morbidity, and increases in mortality demonstrates the importance of a variety of social support mechanisms from family to religious/faith/spirituality groups to friendship groups to family. Different support mechanisms may be important
within different racial/ethnic groups. However, the essential fact remains pretty much the same. Isolation is not good for a person in later life. This also raises the question of what, if any, alternative coping skills do transgender-identified individuals develop—in the face of isolation—in order to cope with the social and economic losses often spoken of in the trans-community at large? Anecdotal evidence shows a high use of computer chat rooms among individuals who can afford computers. However, a significant number of transgender-identified individuals (across all age brackets) live slightly above, at, or below poverty level and cannot afford computer access, much less Internet charges (unpublished results from the TranScience Longitudinal Aging Research [TLAR, 2007] study).

What's in a Name?

What we call an object contributes through social construction to the way in which the object is seen and the way in which we interact with it. Appropriate labeling can be a problem (Boynton, 2004) in a number of situations and can lead to a variety of problems for those who are involved with support of elder trans-persons. Simple questions of how children should refer to someone can create stress between family members and friends. Consider the following example from the TLAR (2007) study:

Ellen is a 55-year-old, post-operative, male to female (MTF) who has been living full-time as a woman for approximately 10 years. She has three children and is expecting her first grandchild. She has discussed the question of how she should be referred to with the daughter-in-law. The daughter-in-law is comfortable with calling her “grandpa” and states that she will “explain things when they need explaining.” The son is not so comfortable, and this has created stress between Ellen and her son as well as between the daughter-in-law and the son.

The two previous stories emphasize the importance of the question of labeling and the potential confusion that can arise within the family. How does one refer to Ellen when Ellen is out with her grandchild, out in the real world where the true answer could out Ellen and lead to serious ramifications for the family? These stories also indicate how we still need the binary labels of the traditional Western view of natal (birth) sex in order to feel comfortable within our traditional boxes. As the younger generations of trans-persons, gender queers, androgynous persons, cross-dressers, transvestites, third gender, bi-gendered, omni-gendered, gender benders, and others continue to push the continuum of gender identity and gender self-expression (the TLAR Study 2007 has more than 50 gender labels in its response list to the question: “What is your gender?”), the binary labels will become even more difficult to apply and could create significant difficulty for social identification. Where
is the line drawn between a self-identified gay male queen who does drag, takes hormones and is 50 years old with breast implants but who goes home to his male partner and the non-operative self-identified transgender person who takes hormones, has breast implants, and feels as if he wants to be more of a woman but for the moment is happy with his genitals as they are? And, in our discomfort with the continuum, we find ourselves reacting strongly to those who transgress the normative gender definitions (Witten, 2004; Witten & Eyler, 1999). Consequently, the violence against transgender-identified individuals becomes what Kidd & Witten (in press) have termed global trans-genocide. Couple these dynamics with typical ageist behavior patterns, and it becomes clear that the elder transgender-identified person frequently endures a great deal of psychological and social abuse.

Labeling also has impact in a number of other areas of the support system and its interaction with the transgender-identified individual. For example, once the sex of a person is labeled, then consequent gender identities and sexualities are assumed and all forms of intimacy (Cooney & Dunne, 2001) are then defined within that construction. We will see how this impacts later-life support systems. In order to understand much of the frame in which trans-persons function, it is important to take a few moments to discuss the issue of violence and abuse against the transgender community.

Living Arrangements for Aging Transgender Communities

Addressing the living arrangements for elder trans-identified individuals is neither a trivial nor a small problem. As we have seen from the previous discussion, many scenarios exist for which there could be a need for specialized living arrangements for an elder trans-person. Care can range from in-home care (family, friends, neighbors, hired), day care, elder-sitting care at a facility, rehabilitation care, temporary nursing home care (long-term, short-term), hospital care, palliative care, and others. However, choice of housing, in and of itself, has significant importance for the aging process.

The geriatric and gerontological literatures have clearly demonstrated the importance of living environment for the elderly, particularly with respect to perceived and actual quality of life (Bongaarts & Zimmer, 2002; Evans, Kantrowitz, & Eshelman, 2002; Hellström & Sarvimaki, 2007; Kelley-Gillespie & Farley, 2007). However, given the significant number of trans-identified individuals who live near, at, or below the poverty level in the U.S. (Lombardi, Wilchins, Priesing, & Malouf, 2001; Witten & Eyler, 1999) as well as worldwide, it is not unreasonable to assume that later-life housing issues will become problematic for this population. Coupled with the stigma of transgender identification and the “We don’t have that kind of client here” belief demonstrated by so many eldercare facilities (Belongia & Witten, 2006), it is also not unreasonable to assume that even the more well-to-do elder...
trans-persons may find it difficult to find adequate living arrangements partially in later life. With the increasing movement to age in place or to age with one’s family (Ball et al., 2004; Chapin & Dobbs-Kepper, 2001; Gilleard, Hyde, & Higgs, 2007; Sabia, 2008), and given that many trans-persons are marginally connected or are disconnected from their birth families, we can hypothesize that trans-elders will experience growing difficulty with respect to aging in place with family support. In the case where they do have some support and are living at home, caregiving support might become difficult as caregivers may find transgender identification to be sinful (Kidd & Witten, in press) and, therefore, caregivers may be unwilling to provide care or are intolerant/insensitive or even abusive if they do provide such care. Lack of in-home care could then force the elder to have to move to a new location or to seek out alternative care at another facility. This can have potential ramifications for the trans-elder who must now deal with all of the challenges associated with moving to a new location and giving up the comforts of the prior housing, familiarity with the environment, doctors and other health care personnel who are known (and thereby do not require any explanations/disclosures), distancing from the family, and other potentially psychologically disruptive consequences.

As trans-elders age, there may come a time when members of the family or other social network members may have to make decisions about placing their loved ones into an assisted living or nursing home environment (Barker, 2002; Guberman et al., 2006; Heller, Caldwell, & Factor, 2007). The complexity of experiences around dealing with placing a person in a nursing home (Courts, Barba, & Tesh, 2001; Ryan, 2002), questions of whether or not it is the right time to put the elder in the nursing home (Bennett, Smith, Victor, & Millard, 2000), along with the associated reactions to transgender identification are likely to create increased levels of stress for the family (Kammer, 1994) or for members of the trans-elder’s social support network.

Many elders feel abandoned by their family/loved ones, feel insecure or lonely, and feel as if they are living in jail when placed in such community nursing home environments.

Violence and abuse and their subsequent mental health consequences are a serious, frequent, and lifelong experience in the transgender-identified population (Witten, 2004; Witten & Eyler, 1999). Witten and Eyler (1999) report that in the TLAR (2007) study, 91% of the respondents stated that they had suffered perceived and actual violence and abuse during their lifetime. These violence and abuse results are supported by the work of Lombardi and colleagues (2001) and the Washington Transgender Needs Assessment Survey (Xavier & Simmons, 2001). Similar results have been reported by Kenagy
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(2005) for Philadelphia and for Los Angeles (LACCHR, 2006). More recent results from the Virginia Transgender Health Initiative Study (VTHIS, 2007) add additional support with 40% of the VTHIS respondents reported being physically attacked since the time they were 13 years old, including 45% of the female-to-male and 36% of the male-to-female respondents. Witten and Whittle (2004) discuss violence and abuse against transgender-identified elders and demonstrate a wide variety of violence and abuse forms. Given the established gerontological literature on the long-term negative impact of violence, abuse, and other negative life events (Bengtsson & Lindstrom, 2000; Kraaj, Arensman, & Spinhoven, 2002; Kubzansky, Berkman, & Seeman, 2000), and the preceding discussion on the incidence of violence reported in studies of transgender violence (see also Kidd & Witten, 2008), it is reasonable to hypothesize that those individuals who identify as members of the transgender community might be at greater risk for increased negative life events.

Moreover, while there are a number of newer publications on violence against the transgender community (Kidd & Witten, in press; NCAVP, 2005), there are no currently known statistics on partner-partner abuse (Heintz & Melendez, 2006) or other forms of trans-elder abuse (Cook-Daniels, 1995) within the trans-identified community. Part of the problem, along with the challenge of remaining stealth, is the challenge of negotiating what it means to be a partner and the consequent sexualities associated with such nontraditional relationships. For example, many researchers report violence and abuse in the gay and lesbian communities. However, does that include couples in which there is/are one or two FTM-identified individuals or MTF individuals? Witten and Eyler (1999) speak to the public health consequences of such violence and note that the implications of nontraditional relationships in nursing homes, assisted living environments, and other traditional eldercare environments, where evidence of elder abuse exists, can be profound. Moreover, transgenderism is not covered under any sort of abuse or violence law in most states, and it is not something that is readily reported by transgender-identified individuals due to the potential for violence (Kidd & Witten, in press; Witten & Eyler, 1999). Given the potential for lack of cultural competence/insensitivity as addressed in Belongia and Witten (2006), it is not unreasonable to assume that the potential for elder abuse is increased when it comes to eldercare facilities and their interaction with transgender-identified individuals. This may be further enhanced if the facility is faith-based.

Many other forms of abuse exist. We know very little about them, but can only hypothesize. For example, some families deal with parent-child abuse in which the parent may or may not be transgender-identified and/or the child may be transgender-identified. Consider the following example from the TLAR Study (2007) qualitative modules:

Frank is a 68 year-old transman (his preferred description of being FTM) who has lived with full surgical realignment in his target identity for over
30 years. Frank’s 90 year-old father Bob lives alone in his own home and has COPD (chronic obstructive pulmonary disease). He requires Frank’s daily visitation and support. Bob’s unresolved anger at Frank’s transition leads him to abusive behaviors against Frank. Frank finds he is increasingly unable to control his own anger and has had numerous shouting matches with his father—recently having to restrain himself from hitting Bob.

Of course, abuse can be more subtle. For example, denial of access to grandchildren and isolation from the family can be seen as familial abuse, particularly in view of the fact that the gerontological literature reports the now well-documented relationship between negative life events and mortality/morbidity as well as the negative impact of isolation (Dean, Kolody, Wood, & Matt, 1992; Lee, 1987; Pinquart, 2003). Furthermore, the importance of family has been shown to have significant impact on positive aging in the elderly (Adams & Blieszner, 1995). Although we have only anecdotal evidence around degree of isolation within the community, there is strong reason to believe that those individuals who identify as transgender later in life go through significantly long, if not permanent, periods of isolation. In addition, they often lose important friends and support systems (Chappell, 1983)—all of which are important in later life and which are known to contribute to positive aging when they are in place.

Abuse might arise from well-intentioned actions. For example, it is possible that issues of disclosure might conflict with issues of health care. A transgender-identified patient might be forced by hospital staff or other health care staff into a position that would bring on disclosure of some sort and then give rise to a plethora of unintended consequences for all parties concerned. Consider a scenario in which an FTM individual, still going through menopause, refuses to allow hospice staff (who insist on keeping her clean) to wash below the waist because she does not wish them to find out that she is menstruating. However, because of the need to maintain a certain degree of cleanliness, the hospital staff attempts to force the client to allow them to wash him.

The works of Witten (2004) as well as Kidd and Witten (in press) clearly argue that various forms of abuse are all potential facets of transgender mid-to later-life course dynamics, and they must be further studied from both the trans-elder’s perspective as well as that of the family so that we may be better able to develop intervention and training plans to address the needs of this growing community of elders. Community organizations that work with the GLBT communities must be sensitized to the symptoms of various forms of trans-elder abuse and how to approach them. However, it is also important that researchers discard the traditional constructs as the only forms of abuse and begin to explore how transgender abuse may lead to heretofore
unthought-of forms of abuse as exemplified by our previous example with the FTM hospice client.

Transgender Health Care Issues and Concerns

In addition to understanding violence and abuse of the transgender aging population, it is important that researchers and practitioners become acquainted with health care issues for aging transgender individuals. In particular, I will discuss the implications of HIV/AIDS on aging, transgender identification, intersex-identified individuals, and finally, but possibly most importantly, privacy and respect for transgender aging individuals in the health care system.

HIV/AIDS, AGING, TRANSGENDER IDENTIFICATION, AND FAMILY

HIV/AIDS status can also impact the family. Second adolescence is an oft experienced phenomenon among early-stage MTF-identified individuals (Bockting, Rosser, & Coleman, 1999). Internationally, transgender-identified persons with HIV/AIDS are persecuted significantly (Earth, 2006; Human Rights Watch, 2006). Elders of the community were not trained in today’s modern-day safer-sex methods and will often fail to use protective methods. Given the growing incidence/prevalence of HIV/AIDS in the transgender-identified population and given that people over 50 years old are a rapidly growing population of HIV/AIDS individuals (Manfredi, 2002; Whipple & Scoura, 1989), it is critical that elder trans-identified individuals learn safer sex methods as soon as possible (Melendez et al., 2006). However, the implications for the family are obvious. The stigma of having an HIV-positive family member, the stigma of having a trans-identified elder in the family, along with any other age-related problems, can elevate family stress levels and cause isolation from normally utilized resources. These effects are further magnified by racial and cultural factors (Nemoto, Operario, Keatley, & Villegas, 2004). Family members may be forced into relationships with organizations and individuals for which they are entirely unprepared and for which they are significantly uncomfortable. For example, having to deal with a trans HIV support group or having to take the elder to an HIV clinic, be seen going into the clinic, and subsequently having to explain the situation at church or other group organization can be awkward for family members.

Elder trans-identified persons often become isolated from their marital family and perhaps from their former social support network. For those individuals who have chronic illnesses and who need some form of caregiving interaction, this can set up a conflict for the family or normative caregiving organizations who may believe that such things as sex/gender changes are a sin or who are simply uncomfortable with such changes. On the one hand,
the family members, despite their difficulties, may still wish to care for their trans-elder family member. This can be especially complex when dealing with the dyad of transgender and positive HIV/AIDS status. More complex yet are the implied sexualities seen by the public in such a scenario. An MTF who sees himself as she and who contracts HIV via sexual relations with a genetic male is seen as gay rather than heterosexual. For the traditional Western family structure, the implications for the family are obvious and complex. The wife must deal with whatever rumors are heard. Is she a lesbian? Is the MTF husband gay? What do the children do, particularly if they are in those stages of psychosocial development when peer identity is centrally important in their lives? How will the family’s spiritual organization deal with the family developments?

**Transgender and Intersex: Intersections of Aging, Mind, and Body**

While the DSM IV-TR (APA, 2000) states that it is not appropriate to diagnose an intersex-identified individual (Greenberg, 1998) as transgender, it is quite possible that the two diagnoses may coexist (ISNA, 2008). This is particularly true for an intersex-identified individual who has been surgically sexed during infancy (Goodnow, 2000a, b; Greenberg, 1998) and who may, during some period of life, come to grips with a growing disconnect between the body and the mind’s self-perception. Such a disconnect not only leads to challenges for the individual but also to conflict with the parents around the imposed surgical sexing that has now led to the intersecting diagnoses of intersex and transgender. One can easily imagine a variety of scenarios in which the challenges arising from this conjoint diagnosis fuse with being an elder of this community. In fact, it is fairly safe to say that most of the areas of previous discussion are also relevant to this group as well. Again, however, there is no published research in this area. I can only point to gedankt experiments that could be used to motivate dialogue and research in this area.

**Privacy, Disclosure, and Respect and the Transgender Aging Process**

Privacy versus disclosure becomes a big issue in general (Tse, 2007) and would clearly be a problem for trans-elders. Lack of respect for the needs of the trans-elder, and difficulty in maintaining personal control and in maintaining contact with the elder’s support network can easily increase the stress of the elder and in doing so the stress of the social support network/family. Such challenges could easily magnify already stressful or painful feelings for family members. Potentially, issues regarding disclosure, privacy, isolation from transgender peers (due to a more specialized [minority] community social system that is further decimated by aging and death of its members),
specialized health care needs, and the potential for ostracization and judgment by the health care professions and other care providers may also arise during this time period. Numerous problems can occur when health care professionals/caregivers do not understand the impact of the transgender identity on the various processes of pre-death and, even while trying to provide quality health care, violate the dignity or advanced planning for dying and death of a transgender person due to ignorance or through willful intent.

Consider the following example from the TLARS Wave I:

Jane is an 87-year-old male-to-female (MTF) transsexual woman who has been living in her true gender identity for over 15 years, but who never received genital surgery. She lost contact with her only son at the time she transitioned and has no remaining friends or family. She has been admitted to hospice care for terminal cancer and has problems with incontinence. Because of the aggressive nature of the cancer, Jane is in a great amount of daily pain and must be medicated. The hospice wishes to have her use a Foley catheter to manage her incontinence. However, she refuses and is wetting the bed, making her caregiving difficult. Upon arrival, she vigorously fought with the staff over changing her underwear, creating much stress among the hospice nurses who did not understand that her reluctance was due to the fact that, despite her female identity and life, her genitalia were still male in appearance.

Legal issues around who has legal rights could well impact natal family members as well as families of choice. Furthermore, multicultural, multiethnic and multiracial factors can also confound and magnify an already complex and difficult scenario.

End-of-Life Challenges and Intersections

We have now seen how assorted institutions such as health care intersect with the family, transgender identity status, and the processes of aging. Let us close our discussion by examining end-of-life challenges and how they may or may not be mediated by these same factors. It is important that we keep in mind the discussion up to this point as I will be drawing on a number of the concepts that I have developed.

Pre-Death

In pre-death stages, issues of reminiscence, finding life closure, and preparing to face death are typically of paramount importance. During this stage, psychological, social, legal, and spiritual factors must be faced. Issues of reminiscence can create stress and grief, not just for normative reasons but also for reasons around loss of life experience in the non-birth body.
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gender-identity role, desire to forget one's past in the birth body identity role, and conflicts created by the reminiscence process. Components of this stage often include such items as

1. facing fears about dying,
2. making choices around dying,
3. making amends,
4. having wishes respected,
5. dealing with pain and symptoms,
6. coming to grips with the fact that a hospice/hospital/or nursing home is their final home,
7. honoring spiritual and non-spiritual preferences,
8. preserving autonomy and control,
9. minimizing stress for SOFFAs (Significant Others, Friends, Families and Allies),
10. preserving dignity,
11. maintaining hope,
12. accepting help,
13. ensuring family support,
14. remaining in the moment,
15. creating positive days,
16. putting legal affairs into order,
17. resolving friend/family differences,
18. using remaining time wisely,
19. communicating openly,
20. living fully until last moments, and
21. maintaining continued support of the health care team and SOFFAs.

During this stage, family caregiving can create stress for the caregiver(s) of the trans-identified elder by continuing conflicts regarding gender transition begun earlier in life as well as through normative challenges such as lack of respite care as we have previously mentioned. Thus, honoring the identity in the face of the consequences can also create ethical, biomedical, and moral/spiritual dilemmas. This may be particularly true if the dying individual is in prison where there may not be facilities to honor the dying with dignity in their transgender identity or if the individual has severe cognitive challenges/mental illness and cannot voice their needs sufficiently. In addition, transgender elders who choose to make use of their veteran’s benefits may find that the military system has no place for them when it comes to end-of-life needs for the veteran and family members.

During this stage, legal aspects of the end of life must also be faced. Construction of legal wills, ethical wills, durable power of attorney, and advanced directives can all be impacted by various aspects of the transgender identity. Name changes and marital status may or may not be respected based
upon both federal and state law. All of these issues must be navigated within the context of the multicultural and multiracial factors that also impact the dying individual.

The goals of palliative and hospice care are to meet everyone’s right to live and die free of pain with dignity, right of self-determination, providing families with the necessary support to allow these to happen, providing support for the client’s loved ones, and being available to clients of any age, religion, or race regardless of illness. This may not be the case for individuals who are trans-identified and their loved ones due to social negativity and a lack of understanding around the needs of such individuals and their SOFFAs. For example, during a recent study by this author and her graduate student, one nursing home facility director identified transgender as “a homosexual thing,” while another indicated that “these people are not patients in her nursing home.” In another of the author’s studies, a 22-year-old student nurse reported, “I would not be willing to treat a transsexual client. It’s a sin!”

Family dynamics also influence end-of-life experiences for older transsexual, transgender, and cross-dressing persons. Family caregiving can create stress for the transsexual/transgender caregiver by continuing conflicts regarding gender transition begun earlier in life. 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 transgender 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 partner changes gender presentation, genital sex, or both; however, many others will not. As we have already seen, families can become separated over gender changes with children no longer speaking with the transgender parent. Couples who do maintain a marriage or partnership may need to redefine their relationship. However, that relationship may not be public knowledge but must now be explained in the end-of-life stage of the spouse.

A number of post-death issues do not fall under the umbrella of normative cultural rituals and rules. For example, apparent mismatch between genital anatomy and gender of presentation can result in difficulty in obtaining medical services, practical nursing care, or even appropriate funeral arrangements (as in the case of Billy Tipton, whose female genitalia were discovered by the mortician and sensationalized in the tabloid press). The case of Leslie Feinberg, who was forced to leave an emergency room when her female anatomy was discovered, is also well-known in the gender community. The experience of transsexual, transgender, and cross-dressing persons in long-term care facilities is not currently well-documented, although anecdotal evidence suggests significant difficulties and sometimes
abuse of different types. During a recent study, the author found a significant resistance (27 of 29 [93%] of the elder care facilities contacted) toward participating in a one-hour training workshop on transgender elder care.

Family and significant others of the trans-person will have to deal with funeral issues. In the case of casket ceremonies, issues of open casket may provide difficulty if the significant others and family have not resolved any issues with the deceased’s new identity and public presentation. Similarly, memorials and gravestones may be requested by the deceased to be in the new name and gender identity. This could create family problems of how to explain to others such as grandchildren. Again, how the family chooses to deal with any unresolved issues may impact the last wishes of the transgender deceased. For example, grief counseling and the management of grief is not only impacted by the normative loss issues but also how those losses are impacted by the deceased’s new gender identity. How individuals will explain the situation when using community support services such as grief or other counseling and crisis intervention may also be problematic. Again, dealing with the military system may provide difficulties if the deceased has had legal name changes and surgery or if the marriage is viewed as null and void due to the gender change.

Postmortem autopsy can also present problems if the coroner’s office insists on recording the death certificate in the birth sex (natal sex) of the individual or if the autopsy outs the trans-identity. Furthermore, inconsistencies between the deceased’s legal documents (i.e., sex, gender identity) and the new identity can pose numerous potential burial problems as some funeral homes have refused to bury transgender-identified individuals in their new identity.

In addition to dealing with grief issues during the post-funereal period, individuals may be dealing with unresolved anger issues. For example, children may be dealing with unresolved anger at the parent’s transitioning, the loss of the parental role (father/mother), and the subsequent loss of that parent as well. This situation is aggravated by the survivor’s anger and grief over not being able to resolve those issues due to the loss of the parent who has died.

Research has 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 include self-identify as a part of a traditional religion or as being highly spiritual. However, many traditional religions refuse to acknowledge trans-identified individuals and, in fact, a number of them identify transgender status as sinful thereby denying the deceased and family/SOFFAs access to spiritual solace and support of both the religion and the community support network of members of that worship group.
Significant others will likely have to deal with legal/insurance problems related to carrying out the deceased’s last wishes. In addition, they may have to deal with will-related issues and problems of insurance payment in the face of mismatched birth sex identities or through an unwillingness to pay on the policy due to the transgender status of the policyholder. Payment to the significant other may become a problem in states that do not recognize the marriage or the will in the face of perceived same-sex or transgender couples. Equally, issues of marital/spousal/partner inheritance may be problematic due to varying state laws. Social security claims by the former spouse may also be problematic without accurate documentation as may other otherwise legitimate legal claims.

Gerotranscendence and dying well, in the gender community, are profoundly tied to the integration of the gendered self along with all of the normative aging processes. The transgender identity can often add psychosocial and biomedical complexity that can impact the end-of-life processes. Health care providers should be aware of the needs for integration of gendered identities and be prepared to provide respectful quality health care services not just to the transgender-identified elder but to the family and social support network as well.

The life course of the trans-identified person is a complex tapestry of interacting normative and non-normative processes. The same can be said for members of the trans-elder’s social support system. End-of-life issues, for the transgender-identified person, involve a complex interplay of biomedical and psychological dynamics embedded within an intricate landscape of sociopolitical and cultural contexts that may range from cultural acceptance to political and cultural invisibilization and marginalization. Thus, the ending of the life course exists in an entangled state with that of significant others, friends, family, and allies who are voyaging through their own aging processes. May we all exit transcendent, gracefully, as well as tranquilly.

CONCLUSION

With a growing number of transgender members now in the seventies-to-nineties age range, it is critical that the transgender community address issues of later life through end-of-life care. Moreover, this is a discussion that needs to be an intergenerational discussion, and it needs to take place as the current young cohort of trans-identified individuals begins its journey toward becoming trans-elders.

As I have pointed out, persons whose gender expression or gender self-identification is other than the traditional, Western binary male or female represent a substantial, growing but still epidemiologically invisible minority group within the worldwide elderly population. I demonstrated
that this population is on the order of magnitude in size of many of the traditionally defined minority populations and that it is important that government organizations (both national and international) formally recognize this minority status. Throughout this paper, I have pointed out that future generations of trans-identified individuals will bring further complexity to the construct of family, being an elder, and the legal/religious consequences at the end of life particularly as the next generations of transgender-identified persons continue to blur the boundaries of the current dominant social constructions of sex, gender, and sexuality.

Quality-of-life issues for the international, elder, trans-identified community have been but marginally addressed within the medical and sociological literature. Attention to the needs of this community with respect to biological, biomedical, psychological, and social aspects must take place via an all-encompassing holistic methodology that recognizes the magnitude of and is inclusive of family in all of its traditional and nontraditional forms, health care providers (traditional and nontraditional), the wide variety of spiritual and/or religious involvement of the community, and potential involvement with the military and/or other government institutions. Community education coupled with the development of appropriate professional and community networks (McGhee, 2003) is also essential.

Health and social policy development on behalf of the transgender elderly (including the assurance of non-discrimination with regard to quality health care services, privacy, confidentiality, respectful treatment and caregiving, and personal safety) is also strongly needed. Extrapolation from the non-Western literature shows that, in most cases, even in countries where nontraditional Western gender identities are accepted, eldercare and the related social support network are not necessarily addressed as an area of any importance.

In most Western and many non-Western nations, transgender-identified persons must go through a great deal to survive. Those who manage to live long lives as transgender-identified individuals must have developed coping and survival strategies that were highly effective in the face of all that is against them. Understanding these coping and survival strategies can potentially benefit the normative population, particularly if these strategies can be extended to any individual in the middle to later stages of the life cycle. Similarly, the family and other members of the social support network must have also developed a range of skills that have allowed them to deal with the multilayered complexities of this intersection of aging, transgender identification, family, and community. Understanding how members of the elder transgender-identified community manage to live fulfilling lives can also help us to better understand the abilities of the human being to deal with complex difficult situations and to resolve them in a fashion that can allow the individual to not just simply survive but also to have a satisfactory quality of life.
The experiences of those cited in this manuscript as well as those of many other elder transgender individuals, who may or may not have chosen to remain anonymous or below the radar, demonstrate that older transsexuals can maintain personal dignity, autonomy, and positive social connections while seeking integration of the physical and psychological elements of the authentic self (Boenke, Lev, & Xavier, 2003). Families and social support group members of these individuals also maintain the same dignity and authenticity in a system that does not truly support nontraditional gender identities or gender expression.

Members of the health care and elder care helping professions can successfully assist in making this process real. It is to be hoped that additional joining efforts between the gender community and their professional and personal caregivers, families, and friends will enable all transsexual, transgender, and cross-dressing elderly persons and their significant others, friends, family, and allies to live long, vital, and successful lives.

Social workers and other caregivers engaged in case management on behalf of elderly trans-identified clients, in the provision of individual and group therapy and in planning and placement services in hospital, home care, extended care, and hospice organizations, are ideally situated to facilitate this process and, ultimately, to bring about lasting change.

Worldwide, it is hoped that in countries where nontraditional genders are accepted, policies will be implemented to address the special needs of those community members. In countries where nontraditional genders are not accepted, it is hoped that individuals who must remain stealth can find health care advocates as they age and that international organizations such as the World Health Organization (WHO) will recognize the trans-identified population as a globally persecuted and marginalized minority facing a paucity of support. Moreover, global aging organizations such as the Gerontological Society of America, the International Gerontological Association, and the American Geriatrics Society are to be encouraged to work with WHO and other organizations to develop policies to address the needs of transgender-identified elders and their social support networks of this global community.

REFERENCES


Aging and Transgender Identities


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