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**Issues of Transgender and Intersex Middle Adulthood**

**Life Course Analysis:**

**The Courage to Search for Something More:**

**Middle Adulthood Issues in the Transgender and Intersex Community**

In this presentation we discuss middle-to-late life issues of the transgender and intersex communities. We demonstrate that these mid-to-late life issues are richly complex, full of courage, coping, risk and resilience, and are grounded in a socio-ecological landscape of systemic actual and perceived violence and abuse. We examine how this socio-ecological environment affects the “normative” mid-life cycle processes. Practical examples are drawn from the author’s field interviews and survey research over the past decade. We close by examining the effects of such a landscape on the middle-age life stage and examine its potential ramifications for old age as well.

## INTRODUCTION

### Overview

#### *Normative Understandings*

Numerous texts and articles have discussed ways of constructing a contextual basis for human behavior (Hutchinson, 1992ab; Robbins, Chatterjee, & Canda, 1998). However, theory does not exist in absentia of context and context carries with it embedded dialectics that impose meaning and values on the context. In fact, one of the primary arguments of feminist science is the fact that modern day science is grounded in a “male” dominated phenomenological approach (context) to the world (Harding, 1987; Smith & Mahfouz, 1994; Keller & Longino, 1996).

The fields of medicine and biomedical research are no less susceptible to contextually based theoretical constructions and to the historical impact of that contextual basis than any other field (Basu, 2000; Cassell, 1998; DeJong, 2000; Doyal, 2001; Fulmer *et al.*, 1999; Gannon *et al.*, 1992; Grant, 2001; Ritzer, 1992; Sands, 2001; Watt, 2001; Weiss & Lonquist, 2000). The same arguments can be made for the contextual evolution of the fields of psychology and psychoanalysis (Smith & Mahfouz, 1994).

The historical development of modern day psychology and psychoanalysis is bound up in the complexity of a Eurocentric, heterosexual, Judeo-Christian viewpoint. Obviously, restriction of the theoretical construct to males eliminates all research on women (Goodnow, 2000a,b and previous references) and on the intersex population (Witten, 2001b). It also eliminates all research on transsexuals, transgenders, and other gender-variant individuals (Jacobs and Cromwell, 1992; Kirk & Rothblatt, 1995; Cahill, South & Spade, 2000; Witten, 2002b; Witten & Eyler, 1999).

Clearly, limiting the discussion to heterosexuality (Fernandez, 1998; Bowles, 1995) buys into the Judeo-Christian paradigm (Witten, 2001a; 2002b) of the family and consequently eliminates all theoretical constructs that would deal with non-normative sexualities (gay adoption, for example), genders, and the potential variety of combinations that emerge from pairing them off as partners (Kurtz, 2000; Littleton *v.* Prange, 2000; Pesquera, 1999; Hull, 2001) and their embedding into families (both immediate and extended, *i.e.*, Kantaras *v.* Kantaras – a transsexual fighting for custody of his two children; Ettner, 1999). For example, such a restriction could not realistically attempt to address the

behavioral, psychosocial, or developmental pathways of children in same-sex parental households. Nor could it address issues of eldercare for transgendered elders within the family or in any type of retirement, assisted living, or nursing home facility (Witten, Eyer & Weigel, 2000). 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; Ahmed, 1999; Ayala & Coleman, 2000; Barrett, 1999; Butler & Hope, 1999; Currah, Minter & Jamison, 2000; Dempsey, 1994; Fulmer, 1995; Grossman, D'Augelli & Hershberger, 2000; Kaminski, 2000; Slusher, Mayer & Dunkle, 1996). These issues are further complicated when one considers the impact of intersex (Greenberg, 1998) on gender roles, gender self-perception, and gender identity as it is perceived by individuals external to the intersex individual. Cassell (1997) elucidates this complexity quite nicely when she states:

“Although I believe gender differences are deep and relatively resistant to change, I am convinced that social factors can explain my findings. To supplement explanations that describe gender as an ongoing social construction, I use the notion of embodiment – meaning the way in which people experience and inhabit their bodies, and the way in which these bodies incorporate and express social information. I argue that certain male-identified death-haunted pursuits, such as surgery, test piloting, race car driving, are embodied occupations, and that the body of a woman who aspires to be subject (she who acts rather than object (she who is acted upon) seems bizarrely out of place to their martial masculine practitioners (Cassell, 1997, pg.12)”.

Cassell's comment accurately reflects the complexities of the interaction between the body, as a physical entity in space and time, as it is self-perceived in an abstract internal way, and as it is understood through reflexive interaction in both a symbolic interactionist construct and a socially constructed metaphor of reality. Hence, the subtleties of meaning evoked by members of the transgender and intersex communities in this context can be difficult, if not confusing to understand (Pryzgodna & Chrisler, 2000). Moreover, in a moment, we shall demonstrate that these subtleties are viscerally provocative in terms of precipitated violence and abuse against these communities and it is within this socio-ecological construct that transgender and intersex individuals must navigate both the normative biomedical processes of aging as well as the concomitant issues arising from their

perceived position as sociologically deviant, not just sociologically, but also biomedically as well.

*Pathologizing Intersex and Transgender: Two Sides of the Same Coin.*

Briefly summarized, intersex is seen as a chromosomal and/or metabolic pathology. The ancient Greeks (Harvey, 1997, pg. 32) recognized that there was a “third sex.” They called it “hermaphrodite”, which is now considered a pejorative term for an individual who displays both sexual organs at birth (actually, the anatomical presentation can be quite varied and does not necessarily require both complete organs to be displayed). The preferred current terminology is “intersexed (ISNA, 2002).” The prevalence of intersexuality is estimated at 1/2000 births. Additionally, it is estimated that there are nearly 65,000 intersex births worldwide per year. Intersexed individuals can be generally categorized into two groups: “genetically intersexed” or “hormonally intersexed.”

We have all been taught that the male chromosomal structure is XY, while the female chromosomal structure is XX. However, it is possible to have a genetic mosaic in which the individual has a chromosomal structure XX/XY. In this case, the individual is said to be “genetically intersexed.” However, it is possible that an individual may be XX (genetically female) and be subjected to elevated in utero levels of testosterone thereby partially masculinizing the individual. Likewise, an individual may be XY and be subjected to reduced levels of testosterone, thereby feminizing the body. These individuals are said to be “hormonally intersexed.” However, an individual can be intersexed in other ways. For example, in congenital adrenal hyperplasia the adrenal glands make too much male hormones and the individual, while genetically female, may appear and develop intersexed. Partial androgen insensitivity is a genetic male fault that causes the testosterone receptors not to bind testosterone as efficiently as they should. Consequently, the individual subsequently develops as an intersexed person. In some small villages in the Dominican Republic, there is an elevated prevalence of another genetic fault in that there are individuals who cannot convert testosterone to dihydrotestosterone, and while born genetically XY, they are born looking female. However, at the onset of puberty, they eventually start looking male. These people are given the name “ouevodolce” (eggs at 12) meaning the testicles descend at twelve years of age.

As such, intersex can be medicalized in the context of being a sanctionable pathology (Weberian sense) that, because it is of the body (see Table [1]) it can be dealt with, in this

case by surgical intervention. However, this “intervention” can create profound later-life difficulties for the intersexed individual (Goodnow, 2000a,b; Witten 2001a). However, the dichotomy of mind/body vis à vis individual versus group/society automatically pathologizes trans-phenomena as they are of the mind. Such an association is inherently a stigmatization as rational positivist science cannot “touch” – with any instrument currently known – a discernable “body-bound” explanation for trans-behaviors; thus, unable to ground trans-phenomena within the historic Western biomedical, monotheistic, heterosexual, Eurocentric traditions of medicine. Consequently, the healthcare system, with few exceptions, pathologizes trans-behaviors and intersexed bodies – “right mind/right body vs. wrong mind/right body or right mind/ambiguous body (Cassell, 1997)”. Unlike the pathologization of intersex via medicalization, “trans” is invisibilized, as well as pathologized, through a classification of mental pathology (302.85, 302.6 - DSM-IV; APA, 2000, p. 849). This is further evident from the denial of healthcare coverage. For example, respondents to the TLARS (TranScience Longitudinal Aging Research Study) stated that

“My insurance specifically excludes TS care, so I’m having trouble with money for medical care. Oregon Health plan excludes mental health, so I can’t afford therapy, which I need for surgery. I obtained an inappropriate surgery because I lied to my M.D. about being a TS. I did this because the last time I told a medical professional (University student mental health counselor) the truth they wanted to institutionalize me. I had serious complications from the surgery, possibly because I was on birth control pills because I could not get testosterone.”

Another respondent reported that

“Notations re: gender are always disclosed in medical records. Whenever insurance applications are filled out, an authorization for release of all medical records is included. Once the info is disseminated to the insurance carrier, all hope of confidentiality is lost...providers are not TG friendly.”

Additionally, there is the inability to access Medicare/Medicaid coverage (Cahill, South & Spade, 2000) and the legal system’s failure (see <http://www.nglftf.org/library/index.cfm> for current Civil Rights and Hate Crimes maps) to respond to violence and abuse against the trans/intersex communities. For more on transgender hate crimes see <http://www.gender.org/remember/about/core.html>.

*Transgender and Intersex Violence and Abuse: What is Known?*

Witten and Eyler (1999) point out that population estimates for the gender community are difficult to obtain and verify, due principally to the currently highly stigmatized nature of transsexualism, transgenderism and cross-dressing identifications and behavior, as well as the lack of available resources for the gender community in many geographic regions. (The latter phenomenon leads to the choice of private solutions, such as “passing” as the other sex without medical or mental health assistance, and therefore to “*epidemiological invisibility*”.)” Similar data is available on an international scale (Witten *et al.*, 2003).

By means of example, Witten and Eyler report that in a sample of 174 individuals (sample biased towards middle to upper-class individuals and having age range 22-79 years) there was a high degree of violence and abuse suffered. With regard to the definitions of abuse that most accurately described these situations (respondents  $n = 135$ ; multiple answers permitted), results were as given in Table [2]. Sadly, much abuse and violence is suffered prior to the age of eighteen years old. Of the 86 respondents, 60 of them stated that they had suffered some sort of violence or abuse (multiple choices could be checked) prior to age 18. Furthermore, the top perpetrators were the father, another adult followed by a relative, the mother, and finally a peer. The implications of this multiple violence and abuse for health services personnel is also discussed in Witten and Eyler (1999).

Respondents were also asked to identify whether or not they had ever told another person about the violence, abuse, or mistreatment that they had received, and to whom these events had been reported. Of the  $n=121$  participants who answered this question,  $n=93$ , (77%) indicated that they had told others of their abuse experiences, and  $n=28$ , (23%) stated that they had not. With respect to reasons for non-reporting, ( $n = 132$ ; multiple responses permitted)  $n = 28$  (21%) indicated that they were afraid to report for fear of reprisal by the perpetrator,  $n=14$  (11%) feared abuse by the medical/legal system,  $n=5$  (4%) were unable to report,  $n= 38$  (29%) felt that it would not make a difference if they had reported the incident or incidents,  $n=10$  (8%) wanted to protect the perpetrator, and  $n=22$  (17%) indicated that there had been reasons other than those listed in Table [3].

In addition, several items were included which pertained any acts of abuse, mistreatment or violence that had occurred in social settings. Typically, such acts take place in the workplace, on the street, in bars, or in any other public, interpersonal scene. Religious

institutions, educational settings, other public environments, organizations, or institutions were also included in this section. When asked whether or not the respondent had had any acts of mistreatment, abuse, or violence perpetrated against them in social settings, survey participants responded as follows: Yes (= 89; 66%), No (= 42; 31%), and Not Applicable (= 4; 3%; n = 135).

### Stigma and Reports of Transgender Life Experiences

The Witten and Eyler survey asked the respondents to share, if they were willing, some examples of their real-life experiences with respect to violence and abuse. The survey participants, in response to open-ended questions, reported the following vignettes. Many respondents experienced abuse during childhood or adolescence which they attributed to being a “different” child, as well as violence which was less specifically targeted:

“Step father used to beat me because as a child I didn't play with the boys or get into manly things. I wanted to play with the girls. I didn't play school games--I was a “sissy.” I got a broken nose for 1959 Christmas.” --- 52 year-old transsexual woman

“My early experiences in cross-dressing were discovered...and reported to my father. He caus[ed] me great embarrassment in front of the whole family. The second [time] I was caught resulted in a private consultation where I was issued the ultimatum: Stop dressing or be sent to a psychiatric institution...”

“I watched my father physically beat an older sibling on numerous occasions and did fear physical abuse as well as emotional abuse from dad. Because of this we were never close though I worked hard at conforming to dad's desires for me (Varsity football, college scholarship, the military).” --- 38 year-old biologically male cross-dresser

Many study participants also reported multiple-victimization as well as victimization/abuse across the lifecycle. Consider the following response by a 43 year-old gender-blended individual (respondent's errors are retained without editing):

“At the BE-ALL weekend [a cross-dressing event] in Detroit I was verbal abused while walking from my room across the courtyard when I was [illegible] by two men. I was verbal harassed often. Beaten by my mother... I was raped once by [illegible] in college.”

Social victimization included harassment in employment settings, with its attendant confusion for the victim for example, consider the following response by a 45 year-old biologically male cross-dresser:

“... I got involved with a professional who wanted to ‘tutor’ me. I had already identified myself as bisexual, and when gender play was offered, I willingly went along... But it was exploitive and embarrassing and my boss paraded his power in front of the company.”

This same individual also reported a history of intra-familial abuse as well as an associated sense of loss persisting into adult life:

“If my brother had been helped in his [sexual orientation] when he was young, he would have been a better person. Maybe I wouldn't have been such a ‘victim’ at a young age. And if I had different avenues of gender expression, maybe my life would have been different.”

Other respondents who had experienced abuse throughout childhood and adult life expressed a defensive and cynical worldview, as did the young adult female-to-male transsexual who simply stated: “*People have tried to kill me since I was a child.*”

Furthermore, reports of social mistreatment, including street harassment and violence, are so prevalent in the gender community that many individuals begin the transition process (from female to male, or male to female living) with a mixture of joy (due to the anticipation of being able to be true to their deepest self-perceptions) and dread (regarding the potential consequences):

“I have been one of the lucky ones. I've only experienced verbal abuse/harassment. I hope to start transition within a few months. We'll see what happens then.” --- 35 year-old male-to-female transsexual

#### Transgender Hate Crimes Violence.

Individuals who responded as having suffered some sort of violence were asked a series of clarifying items that addressed whether or not the respondents believed that any of these acts of violence constituted “hate crimes” (*i.e.*, that the acts occurred because of hatred of the respondent's race, gender, sexual orientation, or gender presentation, multiple responses were allowed). Of n=143 responses, n=101 (70%) stated Yes, n = 23 (16%) indicated No, and n=19 (13%) chose Not Applicable. At this time, correlations between type of violence and perception as a hate crime are not available.

Results of the WTNAS (Washington Transgender Needs Assessment Survey; Xavier & Simmons, 2002) are equally disturbing. The WTNAS study reports 26% harassment, 18% intimidation, 17% assault with a weapon, 14% sexual assault/rape and minor percentages in other areas such as police entrapment, police sweep, blackmail/extortion, and unjustified

arrest. Of the n=89 TLARS respondents who indicated that they had experienced an act of social mistreatment, abuse or violence, n=62 (70%) indicated that they had suffered some form of street harassment or verbal abuse at some time in their lives and n=16 (18%) had suffered an act of rape or attempted rape. Survey items also addressed the reporting of social violence, and satisfaction with the response. Of the n=89 respondents who had experienced social violence, n= 20 (22%) indicated that they had reported these occurrences, n= 66 (74%) stated that they had not done so, and n=3 (4%) indicated that they had “sometimes” reported these crimes. Of the (n = 22) survey participants who had made reports to the appropriate authorities, n = 8 (35%) expressed satisfaction with the action taken in that case (or cases) while n= 15 (65%) reported dissatisfaction.

Given that the Witten and Eyler results were based upon a sample biased towards the more advantaged of the transgender population, it is within reason to conclude that – in point of fact – the situation is significantly worse for the bulk of the unreported population. The likely validity of this assumption is born out by the recent results of the Washington Transgender Needs Assessment Survey. In this study, n=109 victims who fell victim to violence or crime were instructed to check any and all categories of motives they thought applied to their experiences. The WTNAS data is reported in Table [4].

Sadly, violence and abuse against the transgender community continues. The high profile murders of Tyra Hunter, Brandon Teena, Debra Forte, Chanel Pickett, Tyra Hunter, and Carmen Marie Montoya serve to underscore the ongoing problem. Estimates as to how many other transgender-related murders go unreported are currently unknown. Nevertheless, as we have pointed out earlier, high profile homicides (in which hatred of transgenderism is believed to be the motivation for murder) are reported in the media. As is common in hate crime assaults, these episodes involved severe violence (such as multiple stab wounds, strangulation, and genital assault) but in contrast to the norm for investigation other hate crimes (*e.g.* neo-Nazi attacks) response by the law enforcement and medical providers was allegedly sub-standard in several of these cases. Furthermore, as anti-transsexual violence and related criminal behaviors are not reportable as hate crimes, investigating police often do not consider bias as a pertinent motivation. Additionally, most transgender people conceal the difference between their social and biological genders from the general population (and since this discrepancy is usually discovered only post-homicide by the investigating law enforcement agencies) it must be assumed that these few highly

visible cases represent the “*tip of the iceberg*” with regard to severe (and sometimes fatal) acts of violence against this community.

Results from the work of Witten and Eyler (1999) have demonstrated the profound public health hazard associated with the violence and stigma against the transgender community. However, their research supports the argument that the stigma extends into other areas as well. In particular, it has profound impact on the financial and medical well-being of this population. While the sample population from our longitudinal study was both reasonably well off financially, it was only through this success that they were able to pay for the necessary drugs and other medical interventions necessary to both begin and subsequently maintain the transition. The wave 1 TranScience Longitudinal Aging Research Study (TLARS) respondents replied as follows: Of the n= 175 individuals who answered the employment question, responses were as follows: n= 15 unemployed, n = 12 employed part-time, n=131 employed full-time, n=10 retired, and n=7 receiving disability. Individuals were also asked to describe their most recent employment, with the following results: n=9 corporate executives, n=85 managerial or professional positions (*e.g.*, accountant, engineer, scientist, lawyer, etc.), n=19 service occupations (*e.g.*, cook, child care worker, police, firefighter, etc.), n=0 farming/forestry/fishing related employment, n=14 precision production, craft, and repair (*e.g.*, mechanics, phone repair, locksmith, etc.), n=16 operator, fabricator, or laborer (*e.g.*, typesetter, assembly worker, crane operator, taxi driver, etc.), n=10 independent freelancer or consultant, n=7 students, n=3 receiving alternative income, and n=19 “other”. Results from the Washington Transgender Needs Assessment Study (2000) document significantly lower educational levels, 42% unemployment, and significantly lower income-earning levels (48% of the WTNAS respondents state that they could not afford care, 29.6% state that they have either no insurance or insurance that does not cover the transgender healthcare related needs). Additionally, in the WTNAS study, 37% of those employed worked as service industry workers, 14.5% as private sector office workers, 5.5% as sex industry workers, and the rest in other categories, with only 9% working as private sector professionals). Clearly, the type of employment will have significant impact on the mid-to-late life issues, of both the transgender and intersex populations.

Before we move into the details of the mid-to-late life experiences from the field research, let us take a moment to put this violence and abuse into a life-cycle context. First, violence and abuse are prevalent in the transgender community (Witten and Eyler, 1999;

Lombardi *et al.*, 2001; Russell, *et al.*, 2001). If we assume that undesired surgical intervention to alter ambiguous genitalia is also violence and abuse perpetrated against the intersex person, then while no real estimates can be made as to how many surgical interventions are being performed, it can be reasonably speculated that there exists a high degree of abuse and violation in the intersex population as well. This is consistent with the remarks of Cheryl Chase and with the statistics of the ISNA (2002) website.

Failure to respond to the violence and abuse, along with the denial of coverage, serves as sanctioning hatred and violence through absence of policy and, in doing this, serves to allow/sanction by silence societal policing of this visceral “deviance.” This is evident in the lack of prosecution of numerous transgender murders over the past decade.

With this contextual sociology in mind, let me now provide a brief overview of the normative knowledge of the launching phase (Carter and McGoldrick, 1999, p. 287) and follow that discussion with the results of a small field study of a group of mid-to-late life trans- and intersex persons. From this discussion, we will see that while the normative heterosexual life cycle phases provide us with some useful information, and while the results of studies on lesbian and gay populations further our understandings of midlife issues, the transgender and intersex populations carry with them a unique collection of confounding issues that make their mid-to-late life cycle particularly complex and rich with potential learning experiences and history.

## MIDLIFE ISSUES

### Normative Knowledge

Midlife, as seen by most individuals in research, is a time in which a number of tasks must be completed and a number of issues must be faced. One of the life cycle tasks of this period is the completion of the “launching” phase. Carter and McGoldrick (1999, p. 287) address this issue with respect to launching of children and significant realignment of family roles. Tasks of this phase include becoming a couple again, developing adult relationships with adult children, accepting new family members through marriage and birth, and the resolving of issues with, providing for, and finally the burying of their parents. It will be important, in the upcoming field discussion, to keep these tasks and issues in mind, as we shall see that these supposedly “common/normative” processes are not generative across all population types. Carter and McGoldrick’s discussion, while it does give mention to the particular issues of the Gay and Lesbian environment (Carter and McGoldrick, 1999, p.302-

303, and Chapter 20) still quite clearly predicated its analytical constructions upon normative Judeo-Christian, Western biomedical, Eurocentric constructions of sex and gender roles and the concomitant definitions of what it means to be a family and to have adult relationships within that context. As such, it is illuminating to note that this text tacitly perpetuates, for its reader, a means with which to buy into this very stereotype and, as such both marginalizes and invisibilizes those with atypical sex/gender/sexuality constructions. Such a phenomenon is not, as we have already documented, uncommon in the healthcare literature.

What Carter and McGoldrick do provide us with is a means by which we can examine the complexities of the launching phase for the intersexed and transgender individual within the framework of how the normative society views the launching phase. In essence, the transgender/intersex community can serve as a countersystem (Lyng, 2001) with which to examine the underlying definitions of the life cycle roles and issues presented by Carter and McGoldrick. It is beyond the scope of this discussion to address, in any extensive fashion, all of the similarities and differences. In order to provide an insight into this stage of life cycle development and to highlight some of the salient features of this stage, we will now present the results of some recent field interviews with members of the mid-to-late life LGBTIQQ community.

## RESULTS

### The Players<sup>i</sup>

Babes, the designated Lesbian hangout, sits on a corner in Carytown, VA. Inside Babes it is stark, most of the walls painted black and beige, a single disco reflector ball hangs from the black dance-room ceiling waiting to be given life. Friday nights, the crowd is dense, the air smoky, and the music loud. On Tuesdays, it is far more quiet, far less smoky, and the only place in town for the LGBT crowd to hang out and mingle with a relative degree of safety. In the back of the main dance area sits a large circular table, seating ten, that has become the designated meeting place of the transgendered of the area.

This evening, sitting around the table are Tracy (51 year old male-to-female, post-operative, transsexual), Istvan (48 year old, gay male), Rebecca (45 year old male-to-female, pre-operative, transsexual), Lance (55 year old, male cross-dresser), Paula (54 year old, male-to-female, post-operative transsexual), Noreen (58 year old, male-to-female, pre-operative, transsexual), Janice (48 year old, male-to-female, post-operative transsexual), Stan (57 year old, female-to-male, post-operative transsexual), and Marissa (33 year old, male-to-female,

post-operative transsexual). In the booth next to us sit Carl (43 year old, gay male), Kristin (57 year old, lesbian female), and Allie (50 year old, lesbian female). Barry (43 year old, female-to-male transsexual) provided commentary on the pre-final version of this manuscript. Cigarettes burn, dinner plates rattle, and the air is rife with multiple conversations that weave in and out of each other, some dropping away only to return at a latter point, others intermingling with whatever the main stream of consciousness happens to be at the moment. During a lull in the conversation, I whip out my notepad and inform my table colleagues that I have volunteered to write an article on mid-life LGBT issues for the American Society on Aging and I ask them if they are willing to provide some personal anecdotes to ground the story in reality. Nods of heads indicate yes, as long as I use no names; to which I readily agree. I pose the following question: *“What is it that you worry about now that you are in the middle part of your lives?”*

#### The Field and Survey Data and Discussion

It is no surprise that the answers differ between the different respondent categories. And yet, they do fall into certain themes: Financial stability (short and long-term), Social isolation (partnership and community), Safety, Healthcare, Independence and Living environment. Intertwined with the gender/sexuality issues is an emergent theme of ageism illustrated by Istvan’s comment *“The young ones don’t want to talk to you. They feel that you are not knowledgeable. You haven’t been Queer long enough.”*

Tracy responded with a strong nod of the head and recounted a story in which some teenager at the local grocery store had called her an *“old tranny hag”*. Notice the multiple agent-target “isms” embedded in this statement. There is the ageist comment “hag” (not only ageist, but a commentary on the body and lack of usefulness and youth/beauty). Moreover, it is coupled to the pejorative “tranny” (which carries with it numerous “isms” including the inherent social segregation due to both perceived social deviance and age). David Valentine (2000), in his recent doctoral dissertation points out that the common binding of the transgender community is violence and abuse. This sense of social isolation and of being a target is critical to the understanding of the basis of operation of the transgender community. It is important to understand this common binding as it affects the life cycle of all transgender and intersex individuals.

Data from the Gerontological literature contains a well-documented fact base supporting the argument that social conditions (Kubzamsky, Berkman, and Seeman, 2000),

social network support (Everard et al., 2000; Pinguart and Sorenson, 2000), socio-economic status (Rautio, Heikkinen and Heikkinen, 2001), and even social role (Krause and Shaw, 2000) can all have significant impact, positively or negatively, on mortality, morbidity, health status, depression prevalence (overall psychological well-being, Zhang and Hayward, 2001), successful aging, and numerous other life course outcomes that are of current importance in the Healthy People 2010 Project. The results of these studies can be summarized as follows, the lower the income, the less social support (friends, spiritual activity, supporting organizations, neighbors upon whom one can depend, for example), the less habitable to social conditions (isolation, poor environment), the less education, the higher the risk for psychological dysfunction, long-term poor quality of life, poor health status, increased morbidity and mortality, and the less likely to be “a successful ager” in the sense of the MacArthur Foundation’s Successful Aging Project.

In the upcoming discussion, we will address both intersex and transgender violence. With that in mind, let us examine some recent research in transgender violence and abuse.

#### The Problem of Transgender Stigma and Violence

In and of itself, violence and abuse need to be stopped, no matter what the situation. However, the impact of the type of trans- intersex related violence and abuse can be measured across the life cycle in that early and mid-life violence and abuse can have direct impact on health, well-being, and quality of life in the mid-to-later life years. Stallings et al. (1997) elaborates a theory of well-being involving life-events and psychological well-being (see also Turner, 1996). For example, Bengtsson and Lindstrom (2000) demonstrate that childhood misery can have significant effects on mortality in old age. Dressler and Bindon (1997) examine the effects of social status, social context, on arterial blood pressure, finding a direct link between blood pressure and the other two variables. Kraaij, Arensman, and Spinhoven (2002) demonstrate a profound relationship between negative life events and depression in elderly persons. Kubzansky, Berkman, & Seeman (2000) illustrate a significant relationship between social conditions and stress in elderly persons. Pinguart & Sorenson (2000) demonstrate that there is a significant relationship between socio-economic status, social network, and competence on subjective well-being in later life, while Rautio, Heikkinen & Heikkinen (2001) further strengthen the understanding by demonstrating a significant relationship between socio-economic factors and physical and mental capacity in

elderly men and women. Turrell *et al.* (2002) demonstrate the effects of socioeconomic position across the life course and its effect on cognitive function in late middle age. Based upon the data presented in the previous sections, it is not difficult to posit that the trans and intersex populations are at a significant disadvantage when it comes to biomedical and psycho-socio-cultural well-being given the degree of difficulties that they face.

Yet, despite the magnitude of problems, many trans and intersex individuals not only cope, they survive and are successful. No work has been done on the coping strategies, the resilience, and spirituality/religiosity of these communities and how they positively affect the outcome of the trans/intersex lifecycle. For example, as Barusch (1997) posits, could mid-to-late life members of these two communities recast their viewpoint to see themselves as “not old and poor” but “fortunate and blessed?” While there is research performed on life-cycle aspects of poverty among older women (Choudhury & Leonescio, 1997; Clark et al., 1996), and while there is some understanding of the older Lesbian condition (Ayala & Coleman, 2000; Butler & Hope, 1999; Fulmer, Shenk, & Eastland, 1999; Grant, 2001; Kaminski, 2000; Kehoe, 1989), little is understood about how this literature can – if at all – impact our knowledge of the transgender/transsexual/intersex woman in her life cycle. One could, for example, hypothesize that social control and definition of sex and marriage (Littleton *v.* Prange, 2000; Hull, 2001) as well as other gender/sex/body type roles (see the previous discussion on embodiment and right mind/right body vs. right mind/wrong body, Cassell, 1997) could easily lead to confusion and conflict for transgender/transsexual and intersex persons in their daily life course. Such confusion could, as Krause & Shaw (2000) postulate, lead to problems with role-specificity and feelings of control that, they demonstrate, can have a significant affect on mortality.

Questions of resilience, coping strategy, spirituality, and religiosity bring to the fore questions of social network support, peer-relationships, support groups, network structures, and friendship circles. Little work has been done in these areas either. While it is clear that these two communities are epidemiologically difficult to sample in a meaningful way (either cross-sectionally or longitudinally), it is critical that we begin to understand the intersex and trans-communities from these perspectives as well. Such information can not only inform us as to how we might strengthen the abilities of those who are unable to cope or are having a hard time coping, but perhaps the results of such a study could be of wider use, as

techniques derived from new knowledge could inform the Geriatric and Gerontological communities as a whole.

Finally, it is important to understand how the “normative” life course biomedical changes of the human body, as mediated by cross-hormonal/surgical intervention, plastic surgery, and “atypical” chromosomes/metabolism, can affect long-term quality of life and life cycle passage. In the transgender community, little is known about long-term mortality/morbidity rates (Assherman, Gooren, & Eklund, 1989). Christmas *et al.* (2002) point out that growth hormone and sex steroid effects bone metabolism and bone mineral density in healthy aged women and men. There is no research on the cross-hormonal effects on bone in trans-persons, nor is there any research on atypical metabolic effects on bone in intersex individuals. Anecdotal evidence in the transgender community among male-to-female transsexuals indicates that there well may be loss of height and bone mass. However, there is no formal research in this area. Financial aspects of the trans-person’s/intersex person’s life also can play a part in lifespan development (Vitt & Siegenthaler, 1996). Out-of-pocket healthcare costs also have an effect on medical treatment and hence on numerous mid-to-late stage life course factors. With these basic concepts in mind, I would now like to focus on the issues surrounding growing older in the transgender and intersex population.

#### Mid-to-Late Life Issues: The Field Study

It is hard to undo the Gordian knot of emergent themes. Nor should we necessarily attempt to do so, as it is this very reductionist approach to understanding human nature (sex, gender, sexuality) that imposes an historic lens of the type we discussed earlier in this paper. Denying complexity and interaction is to deny the very nature of the transgender/intersex lifecycle experience. Moreover, it is this very complexity that differentiates the trans/intersex trajectory from the normative dynamics discussed in Carter and McGoldrick.

Financial stability implied greater access to healthcare. Strong social circles implied less worry about “*who would take care of me if something were to happen?*” They also implied an ongoing degree of independence. As Nancy Nystrom of Michigan State University’s Lesbian Aging Project points out,

*“Midlife Lesbians begin to worry about getting older. In particular, they worry about three things. First, can they keep their housing? Will they be able to maintain the housing that they have? This implies second, keeping their independence. Will they be able to take care of themselves? And this implies third,*

*a certain quality of health. However, independence is the key and it is maintained through health and housing. Notice that it is not about money, about finances. And, while partnering is important, it is on the side.”*

Finances make health and independence more possible. Certainly, meeting someone with whom to partner was critical, not just in diminishing worry about healthcare-related issues, but also in diminishing social isolation as well. Istvan is worried about “... *meeting the right person. As you get older, you worry about what will happen to you if something bad were to happen in your life.*”

Carl, Kristin, and Marissa echoed this sentiment as well. Beyond the worry of having a partner to advocate for you if you are ill, hospitalized, or incapacitated, is the well-established Gerontological knowledgebase supporting the fact that social support has a major impact on long-term quality of life. Social isolation can have a strong negative impact on morbidity and mortality. Moreover, even if someone in midlife is fortunate to find a partner, there is still a fear of loss due to lack of rights. Fear of loss due to lack of rights was also frequently mentioned. Istvan did not hesitate to point out his fear of “*family members challenging (his) partnership, if his partner were to become severely ill, disabled, or to die.*” Carl states that, “*I have a great fear of being wiped out by biological family, even though my partner and I have sewed everything up with legal documents. They (the biological family) could just back a truck up to the house and empty it. And that scares me to death.*”

In and of itself, this statement informs us of a complex interweaving of midlife issues. The gravity of Carl’s statement is magnified further by the continuing comment that “... *to solve this problem, I maintain two houses, in case I will need to go somewhere.*”

Paula, Noreen, Tracy, and Lance all echoed similar sentiments thereby indicating that this is an important midlife theme and not an isolated incident.

Partnership also brings with it interpersonal issues and worries. Judy Bradford, Director of the Survey Research Laboratory at VCU and head of the Lesbian Health Project points out that

*“Intimacy issues among Lesbians at midlife are in every midlife lesbian’s mind. ‘Lesbian bed death’ is a great fear. How does one transition from a hot sexual relationship with a companionship component, to a relationship that is based solely upon friendship? How do you handle a lesbian couple who are both menopausal and what is the sexual response about?”*

Judy Bradford's research has demonstrated that independence and social support are critical issues that have been seen in her study as well.

*“Social support in the sense of community in which they don't have to return to the closet (so that they don't have to become sexless and genderless), where there are open, joyous places to maintain their ability to be a Lesbian is paramount in midlife Lesbian worry.”*

The idea of social isolation, not just in terms of partnership, but also in terms of community cannot be overemphasized in its importance. Community is seen as a complex interaction of friendship circles, social support networks, and a more generalized “*ecological*” community. For the transgendered, the lack of social interaction is frequently found to be one of the greatest sources of difficulty. Marissa was forbidden to see her brother, when she finally outed herself to her parents. Janice and Lance further emphasized the importance of a sense of community and a need to have peers. Most transgendered people have a personal story about loss of a wife, of children, of parents, or of all of them, or they know a transgendered person who has suffered such a loss. Support groups are few and far between. Lack of trans community in most geographic areas means a dearth of social supports. This is particularly true in most countries outside of the United States. Consequently, a large number of transgendered individuals use the web chat rooms as a place in which to derive a sense of community, kinship, friendship, and social support. Despite some trans-people finding support online, many do not because of race, class, age, and gender barriers. However, social isolation is not limited to the transgender community. Istvan's experience is worth of note.

*“Loss of friends to death or to moving away from the area is gut-wrenching. It represents a loss of safety and companionship as well as diminishing the chances to find a partner. It is like being in a closet with the walls closing in.”*

For the intersex population, which has an approximate prevalence of 1/2000 births worldwide, many adults have a hard time finding anyone who knows about intersex or who is willing to talk about it.

This is not to say that financial issues were not important. However, financial issues were almost inseparable from health and independence issues. Noreen states, “*I am lucky, I have my healthcare benefits through the VA. It isn't great, but at least I have them.*” However, everyone around the table was worried about what would happen if their healthcare coverage were lost (most transgendered, who have healthcare coverage, have it through their work) for some

reason. Moreover, finances were also intimately tied to life decisions. Noreen stated, *“I will have to worry about making a decision. Do I save for surgery or for retirement?”*

Rebecca heartily agreed. Noreen is also worried about *“how to pay for the house when I retire and how will I handle paying for healthcare?”* It is particularly crucial to understand that nearly all transgender related healthcare costs are not covered by healthcare insurance of any kind. Hence, transgender related medical expenses are out of pocket expenses. If we take the monthly hormonal costs and add them to the costs of pharmaceuticals typically associated with the ongoing mid to later life aging processes, these costs can have a great impact on the fixed income of older transgenders. It is also important to realize that, within the trans-population, different sub-populations will have different healthcare related problems. For example, female-to-male transsexuals who have had mastectomy will always have the problem of secrecy within the healthcare system. *“Either his chest scars are obvious, or his genitals give him away. Thus, accessing normatively sexed and gendered healthcare services is nearly impossible,”* points out Barry. Barry continues

*“Add to this the difficulty of FTMs who have taken only hormones but could not afford or do not want surgeries. Billy Tipton comes to mind as one who never accessed healthcare in his lifetime, and probably died prematurely because of it. There are scads of FTMs who suffer in isolation because they refuse to subject themselves to medical scrutiny, possible mistreatment, and ridicule. Also, there is Robert Eads who recently died of medical neglect, after seeking help from at least 20 doctors who refused to treat him for ovarian cancer.”*

Witten, Eyler, and Weigel (1999) discuss issues of elder care for the transgenders, transsexuals, and cross-dressers. Related health cost issues face intersex individuals. For example, Cheryl Chase, former Executive Director of the Intersex Society of North America (ISNA, 2002), points out that the expense of treating osteoporosis in agonadal intersexed individuals can be frequently problematic. Moreover, Judy Bradford points out that, *“for lesbians, even ones with substantial incomes, there is a fear of ending up in a place where there are no gays, especially once you spend down your resources to be able to enter a nursing home facility.”* For transgenders, this problem is magnified, not just in the lack of appropriate care facilities, but also in the lack of medical knowledge currently available on how to manage mid to late life healthcare issues in the transgendered population. For the cross-dressing population, Lance points out that the issues may not be quite as medically dire. Lance points out that being a cross-dresser is like walking the line between hetero and transgendered. *“As long as I live as a ‘het’, I’m okay.”*

Lance is not worried about retirement. For the intersexed population, midlife is a time when they are coming out and coming to grips with what has happened to them. *“The surgery designed to ‘fix their genitals’ almost always creates shame (surgery is used to hide intersex bodies), damage to sexual function and feelings of betrayal by trusted adults.”* says Chase. Chase goes on to say that, *“In fact, the people we have spoken with experience early genital surgery as mutilation.”* These problems must be treated and there are few therapists willing to deal with the intersex population or who even know how to handle their problems.

However, for the cross-dressers, secrecy may be a big issue. The impact on the marital status, on the family and on the social ecology of the cross-dresser could be profound. Secrecy is also a critical issue for the intersexed population. Chase tells the following story

*“A college student visited the university clinic for back pain problems. When the doctor discovered that she had been treated for the intersex condition he wrote, in capital letters on her chart, ‘Ambiguous Genitalia.’ The student stopped attending the clinic because of the reasonable expectation that she would be treated as a freak.”*

Chase continues with the statement *“Such treatment is frequent, not an uncommon story. It makes you feel like a freak and it keeps you away from medical care.”*

While secrecy affects all who have non-normative bodies they cannot hide, like transsexual and intersex people, secrecy was, in one form or another and to one degree or another, an important issue to all of the discussants. Secrecy for the purposes of marital stability, for the purposes of receiving appropriate healthcare, for job security, and hence financial stability were all-critical to the lives of all who sat around the table. Transgenders have no legal recourse against discrimination, nor are they included in hate crimes legislation. Emergent from these themes is the little addressed issue of the mid-life issues [concerns] of the significant others (SOFFAs), the partners (Cooke-Daniels, 1995), the spouses, and the children in LGBTI families. The interplay of aging and non-traditional sexualities, coupled with non-traditional family structures can have a great impact on the social ecology of a relationship.

Intergenerational issues were also a priority around the dinner table. Nearly everyone had one or more elder parents/relatives about whom they were worried. For some, showing up as the “new” self could create problems for the other family members as well as for themselves. Rebecca asked, *“What happens at a funeral? Everyone knows they had a son. How do I*

*show up and explain myself? How do we handle the life crisis issues?"* Marissa's brother has a brain tumor. *"My parents have forbidden me to come home. They will not let me talk to him. I can't go to see him. I can't go to the funeral. How am I supposed to handle this?"* Lance's parents don't even know about Lance. The resultant crisis, should they ever find out, was clearly a very disturbing prospect to Lance.

It was a somber table when the discussion finally closed. We had started in the sunlight and ended in darkness. I asked for last thoughts. Kristin said, "LGBT people are in denial about aging, their own mortality." Heads nodded in assent. Tracy added, "LGBT immortality syndrome?" More heads nodded in agreement. However, perhaps Paula made the most telling statement of all: "Just because you don't open the mail doesn't mean you don't owe the bills. You need to pay towards your future in installments."

## DISCUSSION

From a macro-sociological perspective, it is well documented that "health" is intimately tied to position in the power hierarchy. That is, top people live longer than bottom people. Marmot (1986)'s now well-known Whitehall study of more than 10,000 British civil servants over a two decade period serves to document this fact by pointing out that there "was an obvious 'gradient' in mortality from top to bottom" of the study hierarchy (Evans *et al.*, 1994; Marmot, Kogevinas & Elson, 1987). Hertzman (2001) further elaborates upon this phenomenon by stating that, "... examples show that major shifts in the health status of whole populations over time do not necessarily depend upon the implementation of public health or medical control measures against specific diseases." They point, instead, to a profound linkage between health and the social environment including levels and distribution of prosperity in a society." Hence, social environment as mediated by position in the power hierarchy profoundly affects health status.

Tightly integrated with this status in the hierarchy or "socio-ecological embedding" is the "critical role of early experience in influencing health and well-being over the course of the life cycle (*ibid*)" Our research, and the research of others has demonstrated that the transgender and intersex community have a socio-ecological environment that carries with it implicit issues surrounding violence and abuse. These issues are not only historic for a given individual, but must also be dealt with on a day-to-day basis. We have demonstrated that the impact of psychosocial, biomedical, temporal-cultural issues all have an impact on the life

course of a transgender and/or intersex individual and that these factors impact the generative processes of aging as a human being.

The impact of our previous discussion is not localized only to the current cohort of transgender and intersex persons. It extends into the future generations to come. For example, in 1999, in the United States, the size of the age 65 years and older population was 34.7 million individuals. This sub-population represents approximately 13% of the total population of the United States. There were 4.2 million people who were over age 85 years. The age 65 years and older population is projected to reach over 70 million individuals over the next three decades. Centenarians, individuals 100 years old or more, represent a special component of the aging population. They are the fastest growing segment of the aging population. The second fastest being the 85 plus year old population segment. For centenarians, the current estimate is 50,000 – 75,000 individuals. This group is expected to reach 834,000 by the year 2050. Moreover, 90% of the centenarians are women and 10% are men. This prevalence rate is approximately the same or a little higher than that of other industrialized countries. Based upon estimates of the demographics of the U.S. population as a whole and of the demographics of the transgender and intersex populations it is possible to construct a reasonable demographic of the aging transgender and intersex populations. Back of the envelope calculations demonstrates that the numbers of potentially older transgender and intersex persons is not negligible (Witten, 2002b). Furthermore, if we allow for the more broad interpretation of transgender as including cross-dressing, non-surgical, gender queer, and non-Western gender, then these estimates would increase substantially. Additionally, it is important to recognize that issues associated with transgender and intersex persons must, by their very nature, include the numerous lives that these people touch such as former partners, parents, children, current partners, friends, employers and employees, as well as random individuals on the street. Thus, the issues that remain unresolved in the mid-life will be carried forward into the late life, further confounding the developmental, biomedical, and socio-cultural issues of that later stage.

These life cycle stages are further confounded by all of the standard demographic and socio-economic variables such as socio-economic status and race. A recent study (Battle, Cohen, Warren, *et al.*, 2002), just released - through the NGLTF - gives one of the first and largest glimpses into a national, multi-city sample of Black gay, lesbian, bisexual and transgender people. The study examines family structure, sexual identity, political behavior,

experiences of racism and homophobic bias, and the policy priorities of more than 2,500 Black GLBT people that attended Black Gay Pride celebrations in nine cities during the summer of 2000. Support for racial differences can also be seen by examining the data of the WTNAS. Results from the Washington Transgender Needs Assessment Study (2000) document significantly lower educational levels, 42% unemployment, and significantly lower income earning levels (48% of the WTNAS respondents state that they could not afford care, 29.6% state that they have either no insurance or insurance that does not cover the transgender healthcare related needs). Additionally, in the WTNAS study, 37% of those employed worked as service industry workers, 14.5% as private sector office workers, 5.5% as sex industry workers, and the rest in other categories, with only 9% working as private sector professionals). Clearly, the type of employment will have significant impact on the later life issues, not only of regular aging, but of transgender related aging as well.

For those who are elders on a fixed income, transgender medicines and interventions can be problematic at best, as they are not covered under Medicare (Cahill & Jones, 2001). Additionally, current estimates (Crystal *et al.*, 2000) show that expenditures averaged 19.0% of income, for full-year Medicare beneficiaries alive during all of 1995. Higher burden subgroups, included those in poor health (28.5% of income), older than age 85 (22.4%), and with income in the lowest quintile (31.5%). Financial breakdowns for the TLARS show that, for female-to-male transsexuals (n=32 in the first wave of the study), the bulk of the respondents made less than \$30,000/year with a significant amount making less than \$20,000/year. Note that this inequity is true despite the fact that the population is not under educated. The overall study population is similarly educated and more well off due to the preponderance of executive males in the population.

The fact that Wave 1 of the TLARS study is a best-case scenario is again born out by the results of the WTNAS study showing that only 6% of the WTNAS respondents had college degrees and another 6% had graduate or professional degrees. Results of the WTNAS study are similar to the TLARS female-to-male transgender component. However, the WTNAS reports additional critical information in that 19% of all of the WTNAS participants reported that they had been evicted during their lifetimes and 64% stated that they were evicted for non-payment of rent.

To put the impact of the additional medical (pharmaceutical) treatment into perspective, the post-operative male-to-female transsexual is typically taking at least one

gender-related medication. Typically, this medication is not covered under insurance. The average charge for this hormonal medication can range from between \$40 and \$100 dollars/month. Given the already meager fixed income available to a large portion of the transgender population, this additional medical burden can be oppressive. Pre-operative or peri-operative transgenders are typically taking upwards of two prescriptions per month, increasing their fiscal burden proportionally more. In addition to the medication charges, there are additional gender-related medical charges including psychological evaluations, ongoing physiological tests for liver damage or other hormonally mediated damage, medical intervention due to unexpected medical interactions of hormones with other age-related medications, interactions with current HIV/AIDS medications, and other unforeseen medical complications. It is of particular importance to note that the portion of the population of age greater than fifty years old is the fastest growing portion of the population with respect to incurring AIDS/HIV. Given that HIV/AIDS is a growing problem (Bockting, Rosser, & Coleman, 1999) in the transgender population (more so in the sex industry workers at this time), given the increasing success of drug cocktails that prolong the lives of HIV/AIDS victims, it is not unreasonable to assume that the transgender population will have a growing number of individuals who are on age-related prescriptions such as high blood pressure medicines, cardiac related medicines and/or pulmonary medicines, simultaneously on hormones, and in need of HIV/AIDS drugs all at the same time. Moreover, given the demonstrated preponderance of the lack of medical coverage in both the WTNAS and TLARS surveys, given the large proportions of the population with marginal to no income, and given the stigma associated with being transgendered – as seen by the data on violence, abuse, and hate crimes presented earlier – it is not unreasonable to project (based upon the cited research references with respect to social support networks, socio-economic status, *etc.*) that the long-term quality of life and the success at meeting the HP2010 goals will be marginal to non-existent given the current federal policies with respect to the transgender population in general and the elders of that population in particular.

This combination of socio-economic factors negatively impacts all facets of the transgender population's daily lives. It is clear that there is increased stress due to violence/abuse, fiscal impoverishment, healthcare delivery stress, lack of insurance stress, and stigma associated with self-identifying with the transgender population. The scientific literature in Gerontology and Geriatrics has repeatedly demonstrated that these factors have

a significant negative impact on health, quality of life, functional capacity, mental status, etc. Low-income levels lead to inability to purchase necessary hormones, increasing the likelihood of illegal hormone purchase and use of dirty needles that can lead to HIV/AIDS. Concomitant low-income levels lead to poor housing and subsequent increased risk for substance abuse, depression, suicidal behavior patterns, and risky sexual behaviors such as participating in sex industry work. Moreover, the stigma of transgender makes access to assisted living and nursing home facilities beyond the reach of many and is certainly a fearful situation for most. This further diminishes the potential elder care facilities available to the aged of the transgender population. Little is known about elders in the intersex community. It is not unreasonable to argue that there will be both significant similarities and differences between the two communities. However, there is no reason to doubt that unresolved issues in an intersex person are also carried forward in time and will need to be dealt with in the later years.

### CONCLUSION

In this paper we have presented a study of the mid-life issues of the transgender and intersex communities using the socio-ecological grounding of violence and abuse across the lifespan as a framework within which the transgender/intersex person must not only navigate, but also eventually emerge. Using the sociological argument of lifespan health effects as mediated by power inequality in the socioeconomic/political hierarchy of society, coupled with the inherent violence and abuse suffered by the transgender/intersex community, we have demonstrated that these populations are at risk for significant problems, in a variety of areas; risks that may well exceed those of the “normative” control populations. Within this framework, we have examined the similarities and differences between the transgender/intersex countersystem and the “normative” population aging dynamics. Based upon the results of both quantitative data and qualitative field interviews, we have illustrated the validity of the countersystem and demonstrated how examining that system allows us to develop a richer understanding of the complexities of middle and later life-cycle dynamics. We have seen how the stigma and social isolation of being trans- and/or intersex identified leads to significant social isolation and that this isolation, coupled with the generative processes of aging, the concomitant risks associated with the transgender/intersex lifestyle, and the fiscal insecurity associated with these lifestyles are profound covariates with respect to what would be expected life cycle issues for a normative control individual. We

have briefly addressed the little information available on cross-cultural factors in mid-life cycle processes by examining the results of the TLARS study (Caucasian, upper SES) and of the WTNAS study (Black, lower SES) and demonstrated that the TLARS study provides an upper bound for how good things can get, thereby allowing us to postulate that things are at least that bad or worse in other populations. There are little to no data on international populations, with respect to mid-to-late life aging issues in the transgender and intersex communities (Witten *et al.*, 2003). This author's anecdotal experience with these communities in Europe and Asia supports the conjecture that things are significantly worse, for the most part in most countries, when compared to the United States. This is particularly true in Thailand and the Phillipines where most transpersons are street sex industry workers and there is a high incidence and prevalence of HIV/AIDS.

Launching phases may be disrupted by children who, having to deal with the parent's identity change, cut communications with that parent or the family as a whole, thereby isolating the parent from the future interaction with the child, future potential for needed family support from that child during late mid-life to late-life transformation, and decreased social support network through familial isolation, not only of the child but of the potential grandchildren as well. Married couples, in which one of the pair identifies and transitions to transgendered, now must deal with not just the task of becoming a couple again, but redefining what – if any – the relationship will be. Thus, the whole construct of the family must now be redefined (Boenke, 1999), not just the normative relationships between the members. What does it mean for the former “Dad” to now be female and how does the adult child create an adult relationship with the person who is now “Dad and yet not Dad?”

The dynamics of marriage of the children, new relationships for the transgendered parent and the non-transgendered parent are now altered. The person who once was “Dad” and is now female, or the person who once was “Mom” and is now male, may choose to re-partner with a partner of the same or opposite sex, thereby creating a new sexuality with which the adult child must now deal. Confounding this new development are the issues of explaining the changes to potential grandchildren who may or may not be old enough to comprehend the changes or care about them. Marriage of the adult child now is no longer about getting the parents to accept the new partner, it is now also about helping the partner to deal with coming into a family in which a “parent-in-law” is now a transgendered person.

For intersex persons, family may well be yet another non-normative structure. Children might be adopted. They might find out about their parent as a result of having to deal with the hospitalization of that parent or gender identity confusion that leads to transgender on the part of the intersex parent. The intersex adult may well be dealing with issues arising from surgical sexing that was undesired and that may have had a profound effect on the intersex person's life history. Thus, the intersex child is also potentially dealing with the conflict between the morality of taking care of the elder parent and dealing with the anger towards that parent or parents for having the intersexed child surgically sexed.

Mortality issues are also confounded by transgender and intersex issues. Both transgender and intersex individuals are now, at this time of their life, dealing with elderly parents who may or may not be accepting of changes, who may or may not have been accepting of past changes, and who may now need help from the transgender or intersex child either on an infrequent or chronic basis. Clearly, unresolved issues can create conflict between the expected morality of taking care of the parent and the hurt and anger/hatred of the child for lack of love, acceptance, support, and even disinheritance. Additional complications can include the parent's demand for help and concomitant refusal to allow the child to appear before the parent in the child's new identity. Death of a parent can remove all chances of the adult child's receiving acceptance, acknowledgement, or of being able to resolve issues associated with not just normative life issues, but issues related to being transgender and/or intersex identified.

Individuals who transition in mid-to-late life are placing themselves at financial and social risk, as we have seen in the previous qualitative examples. Such a risk can impact a family in which the primary wage earner, who might also be transgender or intersex identified, is now outed and loses his/her (zee's) job as a consequence of that outing (whether voluntary or not). Hence, the previous family structure is now destabilized, not just through the actual issues of transgender/intersex, but through the subsequent loss of financial support and perhaps the social isolation as well. It is particularly important to take note that, during the launching phase, there is an increase in spirituality and religiosity (Jones, 1996) of the mid-life parent. Many of these transgender and intersex individuals now, because they are "out," no longer have access to the traditional spiritual dwellings of their past lives as most traditional religions and spiritualities see non-normative sex, gender, and sexualities as not only unacceptable, but a sin. One study participant told this author that she

(male-to-female, postoperative transsexual, 33 years old, Caucasian) wanted to attend her former Baptist Church. She was told that the only way that she could be a member of the parish was if she realized that she had (a) sinned and if she (b) promised to remain celibate. Thus, the transgender/intersex person is frequently isolated from family, friends, job, and spiritual support network.

Transgender and intersex persons must go through a great deal to survive. Those that manage to live long lives as transgendered or intersexed persons 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 mid-to-later stages of the life cycle. Understanding how members of the 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 person to not just simply survive, but to also have a satisfactory quality of life.

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### Legends for Tables

- 1) Table 1: Biomedical pathologization of transgender and intersex.
- 2) Table 2: Prevalence of violence types among respondents of the TLARS Study.
- 3) Table 3: Prevalence of respondents citing violence as hate crime related (TLARS Study).
- 4) Table 4: Prevalence of percentages of category of violence or crime motive, as perceived by the victim, in respondents of the WTNAS.

Variable	Condition	
	<i>Intersex</i>	<i>Transgender</i>
Body <i>v.s.</i> Mind	Body <sup>ii</sup>	Mind
Origin of condition	Genetic/Physiological	Unknown, probably multi-factorial
Psychological Designation	No DSM IV-TR codes. Condition is considered to be a medical condition.	DSM IV-TR code “Gender Identity Disorder” with exclusive statement that client displaying intersex condition is not to be classified as having gender identity disorder <sup>iii</sup>
Intervention	Operation typically performed at birth. Frequently performed without consent of parents and undesired by child.	Operation desired by individual and typically beyond individual’s ability to attain due to numerous psycho-social and financial constraints.
Medical Coverage	Typically covered under most healthcare plans	Not covered under any healthcare plan
Social Acceptability	Socially reasonable with marginal stigmatization	Socially highly stigmatized

Table 1

Violence Type	n =	%
Physical	62	25%
Emotional	91	37%
Sexual	26	11%
Neglect	35	14%
Exploitation	11	5%
Not Applicable	22	9%

Table 2: Prevalence of violence types among respondents of the TLARS Study

<b>Violence Type</b>	<b>Percentage of Respondents</b>
Street Harassment	48%
Followed/Stalked	41%
Mugged	29%
Beaten	39%
Sexual Harassment	23%
Sex Abuse/Attempt	15%
Rape	6%

Table 3: Prevalence of respondents citing violence as hate crime related (TLARS Study)

Category of Motive for Crime as Applied to WTNAS Respondent Experience	Percentage of WTNAS Respondents
Homophobia	41.3%
Transphobia	33.9%
Don't know motive	27.5%
Economic gain	20.2%
Domestic violence	10.1%
Racism	8.3%
Other motive not listed	4.6%

Table 4: Prevalence percentages of category of violence or crime motive, as perceived by the victim, in respondents of the WTNAS.

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<sup>i</sup> All names have been changed and all individuals have had a chance to read their descriptions and commentary and to approve their anonymity or to alter details so that they feel comfortable with the description. No ages or sex/gender/sexuality descriptions are altered.

<sup>ii</sup> We say that intersex is body oriented as it is currently determined to be a genetic disorder. This is not to say that there are no psychological issues associated with the intersex conditions. Similarly, it may be that transgender will be found to have a strong genetic component. However, currently, it is considered of the mind.

<sup>iii</sup> A recent Finnish study has demonstrated that the distribution of psychological disorders among a small cohort of pre/post-operative transsexuals is no different than that from a random selection of the population (as based upon MMPI responses). While this is a small study and needs to be replicated, it clearly points to the fact that GID is not a disorder that should be “stigmatized.”