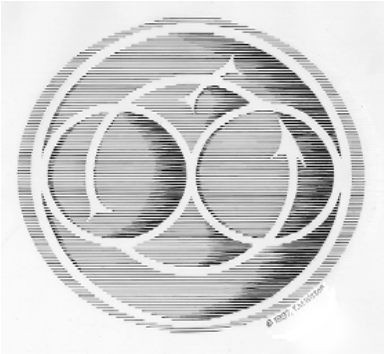

Opening Remarks.

My name is Tarynn M. Witten, Ph.D.[1] and I am speaking to you today on behalf of the Transgender and Intersex elders of the United States of America. I want to thank you, for giving me this opportunity to articulate the issues surrounding the lives of the current and future generations of Transgender and Intersex elderly in this country. For the past 10 years I have been performing research and speaking on behalf of the transgendered of the US. More recently, I have become involved with the Intersex Society of North America, addressing problems of aging in the Intersex population as well. I am here to encourage you to support the development of Federal policy that integrates the Transgendered and Intersex elderly into the community of elders of our country. In this time of great upheaval, a time when the United States emerges as a supporter of diversity, of multiculturalism, and of pluralism, what better way to show this commitment to the acceptance of diversity than to actively implement the very social justice we so proudly represent? With these comments in mind, let me begin.

Speaker's Credentials.

Tarynn M. Witten, MS, MS, PhD (MSW, LCSW, DSW in progress), is a Fellow of the Gerontological Society of America and holder of the Inaugural Nathan W. Shock New Investigator Award from the Gerontological Society of America. She is a member of the consulting consortium of the Healthy People 2010 Project. Furthermore, Dr. Witten serves as the Executive Director of the TranScience Research Institute; the only research institute focused on scientific research on behalf of the aging transgender community and is founder and director of the International Longitudinal Transgender Aging Research Project. In addition, she serves on the Board of Directors of the National AIDS and HIV Over Fifty Association (NAHOF) and on the NGLTF Task Force on Aging. She is a Professor of Biostatistics at Virginia Commonwealth University-Medical College of Virginia Campus, Visiting Professor of Sociology and Anthropology at Virginia Commonwealth University-Main Campus, and has presented over 50 international scientific talks, panels and training sessions on transgender aging issues, as well as an additional 200 talks in other areas. Along with her colleague, she published the first scientific research publication on violence in the transgender community, bringing to light the public health issues of violence against the trans-community. She is listed in Who's Who In International Science - 1989/90, Who's Who In Computing - 1989/90, Who's Who In Health & Medicine-1990/91, Who's Who Worldwide - 1990/93/94, Who's Who In Science And Engineering - 1992/93/94, Who's Who In The South And Southwest

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- 1992/94/97, Who's Who In American Education - 1993/94, International Who's Who of Information Technology 1996/1997, Who's Who In the World 2000, International Who's Who of Professionals 2000, and as one of the Top 2000 Women Scientists in the World 2001. Dr. Witten is the author of over 10 books and 150 peer-reviewed research papers and serves as the Senior Editor of the upcoming book Handbook on GLBTI Aging.

Dedication.

This paper is dedicated to all of the elderly Trans-persons and Intersex persons who have pioneered being a gender variant and/or sex variant elder, and to all of the younger members of these populations who will eventually become part of the elders of this community. This paper is dedicated to Brandon Teena, Debra Forte, Chanel Pickett, Tyra Hunter, Carmen Marie Montoya, and all of the others who have been murdered, denied adequate healthcare, or other basic human rights and, as a consequence of those facts, did not have a chance to live the fullness and the richness of their lives. Moreover, in so doing, they did not have a chance to become a part of the elders of their communities.

Introductory Remarks.

Death is a universal endpoint. Aging is a universal normalizing process. Aging binds us, as humans, across chromosomal context, psycho-social expression, across race, class, gender identity, gender expression, gender perception, ethnicity, socio-economic status, geographic boundary, semiotic representation, linguistic construction, and symbolic valuation. Aging binds us across the ecological landscape of the meta-object fusion of body, sex, sexuality, and gender identity. It is time to abandon the heterosexist patriarchal linguistic constructions imposed upon us and see new ways to express the truths of our beliefs. The linear thinking of Male (M) and Female (F) has forced us to think of a connect-the-dots continuum that still buys into the social constructions of dyadic sex and gender and the subsequent emergent sexualities from that construct. Topology teaches us of the Moebius strip in which there are no sides, no ends. It teaches us that all things, on this strip, can lead anywhere, from any place, and at any time. With this construction, no longer do we need to resort to any of the dominant linguistic paradigms. We accept the continuum and the entanglement of body, sex, sexuality, and gender and instead, we delight in the sensual buffet of opportunity.

By definition, aging is a process, thereby implying a temporal dynamic and removing the implicitly assumed embodied norm of temporal stasis of body, sex, gender, and sexuality. And, as a consequence of this fact, it subsequently demands that we see each other as "flow" in the context of personal history, socio-cultural embedding, and both biomedical and environmental vulnerability, risk, and resilience. No gender identity, no body form, no sex/sexuality triad is necessarily fixed in time and no triad is invulnerable to the ongoing processes of aging. Aging unites us in a way that no other process can. I am reminded by the wonderful literary quotation, "Thy glass will show the how thy beauties wear." This statement applies universally. It does not see categories, prejudices, or fears and hatred. It is universal and it is inevitable.

Brief Epidemiology and Demography of Aging.

The Epidemiology and demography of aging is a complex subject. The simple question of estimating population sizes is non-trivial. Variation between the various countries, through social structures, through linguistic representations, economic development, healthcare delivery, and numerous other factors all interact to affect the age-structure of a particular country's population. It is impossible, within the scope of this discussion, to discuss all of the complexities associated with aging in the US or worldwide. The following remarks are meant to provide a basic understanding of the age-structure of the US as well as the world-wide aging population structure.

Age Range (in years)	Population Size (1999 Estimates)
65+ (United States)	34.7 million
85+ (United States)	4.2 million
100+ (United States)	50,000 – 75,000
65+ (US - projected)	70 million
85+ (US - projected)	Unavailable at publication
100+ (US - projected)	834,000
65-79 (Worldwide)	334,003,000
80+ (Worldwide)	66,699,000
Total (Worldwide)	409,702,000

Table 1: Population size estimates, in 1999, of the over 65 years old population in the United States and Worldwide

United States. 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.

International. The 1998 World Population Profile points out that "every nation is aging. That is, in every country, the average age of the population is increasing as greater

proportions of population reach middle and elderly age-groups." They further point out that during the next 25 years, "the number of elderly living in less developed countries will more than double." Lastly, the report points out that the size of the population of 65 years of age and older in the US and more industrialized nations, in 25 years, will be about 50% larger than the total number of people alive in 1998. US Bureau of Census estimates (1999), for the total world population of individuals aged 65-79 years is 334,003,000 – with an additional 66,699,000 individuals in the 80 years and over range. Hence, the worldwide estimate of individuals in the 65+ years of age group is approaching 409,702,000 people.

Defining Transgender and the Epidemiology/Demography of Transgender. As an epidemiologist/biostatistician, I am mandated – if I wish to use standard scientific biostatistical methods – to put things into categories (boxes if you will) so that they can be counted, correlated, and analyzed for relationships, predictions, and to be used in hopes of answering questions of relevance to the population or populations under study. We have seen how difficult it is to define gender categories. Moreover, the terminology describing the "gender" community is extremely dynamic, not just in the descriptors of gender, but also in the associated body/sex/sexuality associated with a given gender identity. It is critical that, as a qualitative scientist, I honor the dynamic linguistic character of the population and work with those that I study so that my studies can accurately represent the population and subsequently be used by them. In the words of OLOC, "Nothing about us, without us." This makes studying the demography and epidemiology of the transgender population extremely difficult.

Although they are frequently invisible and highly stigmatized within our society (*i.e.*, marginal legal protection, non-inclusion in hate crimes legislation, Witten and Eyler, 1999; Currah and Minter, 2000), transgender individuals form more than a negligible percentage of the U.S. population.

In order to understand this fact, Witten and Eyler (1999) address the definition of transgender stating that "The gender community includes *cross-dressers* (men and women who take on the appearance of the other gender, often on a social or part-time basis), *transgenders* (people whose psychological self-identification is as the other sex and who alter behavior and appearance to conform with this internal perception, sometimes with the assistance of hormonal preparations), and *transsexuals*, both male-to-female (MTF) and female-to-male (FTM), who undertake hormonal and/or surgical sex reassignment therapies. In addition, it includes others with gender self-perceptions other than the traditional (Western) dichotomous gender world-view (*i.e.*, including only male and female), such as persons with "non-Western" gender identities (Langevin, 1983; Godlewski, 1988; Hoenig and Kenna, 1974; Sigusch, 1991; Tsoi, 1988; van Kesteren *et al*., 1996; Walinder, 1971, 1972; Weitze and Osburg, 1996).

Age Range (in years)	Population Size (1999 Estimates)	Hypothetical Transgender Population Size (1% - 3%)
65+ (United States)	34.7 million	347,000 – 1,041,000
85+ (United States)	4.2 million	42,000 – 126,000
100+ (United States)	50,000 – 75,000	500-700 – 1,500-2,100
65+ (US - projected)	70 million	700,000 – 2,100,000
85+ (US - projected)	Unavailable at publication	Unavailable
100+ (US - projected)	834,000	8,340 – 25,020
65-79 (Worldwide)	334,003,000	3,340,030 – 10,020,090
80+ (Worldwide)	66,699,000	666,990 – 2,000,970
Total (Worldwide)	409,702,000	4,097,020 – 12,291,060

Table 2: Population size estimates, in 1999, of the over 65 years old transgender population in the United States and Worldwide

Estimating the Prevalence of Transgenderism.

With regard to population estimates of transsexuality, Tsoi (1988) has noted that, "A...problem confounding an epidemiological survey is that transsexuals tend to congregate in cities and in certain parts of cities, and most of them do not want to be identified." Much of our own research work has further substantiated this phenomenon. Nonetheless, Tsoi has also noted that, in Singapore, (where SRS is well established and transsexuals are not "suppressed,") diagnosed transsexualism is more than eight times more prevalent than in any other country for which estimates exist. Witten has pointed out that estimates of the number of individuals claiming to have "alternative gender identities" in the U.S., as well as in other countries, are confounded by the lack of a control group by which to test prevalence and incidence estimates. Even so, in an international random survey performed by this author and her collaborator, approximately 8% of the 300 respondents identified their gender self-perceptions as something other than 100% male or 100% female (publication in preparation). Taking only the international estimates for post-operative transsexuality as a basis (1%-3%; Langevin, 1983; Godlewski, 1988; Hoenig and Kenna, 1974; Sigusch, 1991; Tsoi, 1988; van Kesteren *et al*., 1996; Walinder, 1971, 1972; Weitze and Osburg, 1996), and using the approximate estimate of 300 million people for the US population, this would imply that there are potentially 3-9 million potential post-operative transsexuals in the US. While this estimate seems overly surprising, I have discussed the rate of gender re-assignment surgeries currently performed in the US and Europe, with a number of the more prominent surgeons worldwide. A number of these surgeons indicate that they are performing 2 surgeries per day, 48 weeks per year, 4-5 days per week. Some of these surgeons state that they have waiting lists upwards of 2 years. In France, the surgical waiting time is now 5

years. If we allow for the more broad interpretation of transgender as including non-surgical and cross-dressing individuals, the estimates increase to approximately 20 million people, depending upon definitional criteria. It is also important to recognize that each of these individuals touches numerous others in his or her life, family, friends, employers, employees, acquaintances, and random individuals on the street. Consequently, support services may well be necessary for many other individuals other than just the actual transgendered persons. This insight identifies the impact of the transgendered population and its needs as being significantly larger than the immediate population of the transgendered alone.

For brevity, in the upcoming discussion, the term "*transgenders*" will be used to signify the entire gender community, unless otherwise specified. I would also like to point out that many indigenous peoples recognize genders other than male and female. (For example, Tewa adults identify as women, men, and 'kwido', although their New Mexico birth records recognize only females and males (Jacobs and Cromwell, 1992). Persons with such " non-Western" gender identities will also be considered as belonging to the gender community.

Defining Intersex and the Epidemiology/Demography of Intersex

An immediate impulse definition is to define sex as meaning "*birth sex*;" that thing that it says on your driver's license. When we say, "birth sex" we are making the hidden assumption that we are saying the "sex defined by the genitalia seen, by a person authorized to interpret the genitalia as displayed at birth." We gave already remarked that it is clear that this definition is made within the cultural context of the baby's birth. In Western culture, which has the biblical norm of sex already deeply and incontestably embedded within it (embodied norm, Cassell, 1997), the only way to interpret the genitalia is within this biblical norm and hence as either anatomically male or female. The medical community, which is given the legal obligation and sanction of enforcing this norm serves, not only as the judge, but also as the perpetuator of the biblical norm/sex construct itself. We can easily see how this perpetuation of the norm can happen, when we look at our student responses from the earlier section. These students will become members of the next generation of physicians, nurses, and medical professionals who will be teaching the upcoming generations the medical truths that are institutionalized and sanctioned by the socio-cultural imperative of Western biomedical science and rational thought.

We have already touched on the fact that even the ancient Greeks 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, hence an abstract "continuum" of sex). The preferred current terminology is "intersexed (http://www.isna.org)" 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. Why consider intersex? After all, the prevalence is small and therefore the population is relatively unimportant. However, the intersex population is a perfect illustration of the real world application of a number of sociological constructs that are currently in force. Let us take a moment and look into the concept of intersexuality in a bit more detail.

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." In addition, it is possible that an individual may be XX (genetically female) and be subsequently 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 are located above the kidneys make too much male hormones and the individual, while genetically female, may appear and develop intersexed. An interesting side effect of this genetic fault is that 30% of these individuals will have a chance of being bisexual and/or homosexual (Intersex: A Training Video, ISNA, 2000). 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.

Because the Western medical culture specifically, and the Western culture in general, is steeped in the biblical norm of sex, the concept of multiple genitalia or atypical genital anatomy has been deeply and profoundly problematic for the medical establishment. Up until very recently, intersexed children were "sexed" as soon after birth as was medically reasonable, a practice that continues to be sanctioned by the American Pediatric Association, despite voluminous protestation on the part of the ISNA and other agencies. Current estimates are that sexing operations are performed five times per day across the United States alone. The term "sexed" is a verb that is used to mean that these children were subjected to genital surgery to remove the "non-dominant" genitalia. Hence, a baby with a "micro-phallus" and a predominant "vaginal canal" would be sexed as a woman, the micro-phallus removed surgically or surgically "sized" (thereby risking permanent sexual response reduction). This "sexing" operation is intended to "fix" the child. The fixing is intended to bring the child out of social deviance and within the accepted norms of society. Clearly, this is an obvious example of how the sociological concept of a system policing deviance within the system. The Western biomedical society handles the situation in which a person deviates from the biblical norm of sex (the socially mandated norm) by fixing the child. Unfortunately, this normative view has surgical and psychological consequences and it has lead to many problems for these intersexed

children; the most famous of them is the very recent case of John/Jane (Goodnow, 2000b). Briefly, as Goodnow describes it

> *"At eight months, his name was Bruce. Then a gruesomely botched circumcision obliterated his penis. In 1967, at 22 months, Bruce was surgically castrated and renamed Brenda. The sexual switch was made on the advice of a renowned researcher who said gender identity is malleable and largely shaped by upbringing. Known in medical annals as the "John/Joan" case, its reported success became a treatment model for other infants with genital anomalies. Feminists saw it as proof of "nurture over nature." At 14, Brenda finally learned the truth -- that she and her brother, Brian, were born identical male twins. Determined to bring this hell to a close, Brenda renamed herself David, underwent a painful double mastectomy and began the long road to reclaiming her true sexual identity*."

What is a sorry statement is that these operations are performed, primarily because our culture demands it, and they are primarily cosmetic and often for the benefit of psychological stress reduction in the parents of the intersex child.

Age Range (in years)	**Population Size (1999 Estimates)**	**Hypothetical Intersex Population Size (1/2000)**
65+ (United States)	34.7 million	17,350
85+ (United States)	4.2 million	2,100
100+ (United States)	50,000 – 75,000	25 - 37
65+ (US - projected)	70 million	35,000
85+ (US - projected)	Unavailable at publication	Unavailable
100+ (US - projected)	834,000	417
65-79 (Worldwide)	334,003,000	167,000
80+ (Worldwide)	66,699,000	33,349
Total (Worldwide)	409,702,000	204,851

Table 2: Population size estimates, in 1999, of the over 65 years old intersex population in the United States and Worldwide

As medicine is empowered to decide, what is or is not an illness and how it is treated, so it is empowered to protect that decision. It does so by using its political power and by using its ability to affect legal interpretation of concepts and constructs deemed to be within its purview. This is important, as altering and/or changing sex has profound socio-cultural-economic impact. What makes a man a man and a woman a woman? For example, can a transsexual be protected under

the Equal Opportunity Employment Law? Does Affirmative Action apply to a male-to-female transsexual who claims she was not hired because she was a woman? Is it considered sexual harassment if fear of being raped by a male-to-female transsexual employee of a company causes a lock to be put on the women's room door at a corporate office? Can a female-to-male transsexual legally marry a genetic female? If a male-to-female transsexual is allowed to marry a genetic female, does this mean that two genetic females should then be allowed to marry legally? Should intersex be added as a "sex" choice option on all survey forms? What about "transgendered" or "transsexual?" If hormone replacement therapy is covered for genetic (XX) females, should it not be covered for those who choose to take on the lifestyle of genetic females? Is it acceptable to define the body, and sex in terms of a genetic definition only, based upon our knowledge of the existence of intersexuality? Is privacy of medical records guaranteed to all gender, sex, and sexuality identities or only those that are socially sanctioned? All of these, as well as numerous other profound legal and ethical issues arise when we deal with the question of sexing the body and its consequences with respect to. The interested reader is encouraged to examine some of the following references as a starting point (Angier, 1997; Beh, Glenn, and Diamond, 2000; Greenberg, 1998; Kurtz, 2000; Littleton *v.* Prange, 2000).

We have now seen that there are varieties of ways by which we can define "sex." We have seen that there is chromosomal sex, anatomical/morphological sex, and reproductive sex to name a few. Further, we have seen that these definitions are "*somatic*," of the body. Moreover, by virtue of this fact, these definitions are inherently tied to how the body is understood, seen, displayed, characterized, and embodied within the sociology of a culture. Further, these definitions arise out of the application of scientific rational principles to the study of the human being. These principles are primarily reductionist in nature. They separate the mind from the body and, in making this separation, validate only that which is of the body. As we shall soon see, when we move into aspects of the mind, this validation becomes whimsical at best. More often, matters of the mind, when dealing with sexuality and gender, can become dangerous when they step outside of socially sanctioned norms. Let us now look into the defining of gender.

Problems with Population Estimates for the Transgender Community. The Problem of Stigma and Violence

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*".)" By means of example, Witten and Eyler (1999) state 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 follows (see Table 3 following):

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

Table 3: Prevalence of violence types among respondents of the ILTTA Study

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 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 Life Experiences.

The Witten and Eyler (1999) survey asked the respondents to share, if they were willing, some examples of their real-life experiences. 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 did this 43 year-old gender-blended individual:

"*At the BE-ALL weekend [a cross-dressing event] in Detroit I was verbal (sic.) abused while walking from my room across the courtyard when I was [illegible] by two men. I was verbal (sic.) 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:

"*When I was entering the workforce, 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.*"

---45 year-old biologically male cross-dresser

(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

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 (Table 4 below). At this time, correlations between type of violence and perception as a hate crime are not available.

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

Table 4: Prevalence of respondents citing violence as hate crime related (TLARS Study)

Results of the WTNAS study 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 of 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 (1999) 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. This conclusion is born out by the recent results of the Washington

Transgender Needs Assessment Survey (2000). 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 reports that

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

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 I 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.

With these basic concepts in mind, I would now like to focus on the issues surrounding growing old in the transgender population.

Issues of Transgender Aging.

Transgender elders not only require the same care as all older adults, they also need care – and face obstacles – specifically related to their gender status. Witten, Eyler, and Weigel (2000) address much of the healthcare needs of this population in some detail.

These needs are further addressed in Witten, Eyler, and Weigel (2002) and in (http://www.asaging.org/LGAIN) and are included in this document as Appendix I.

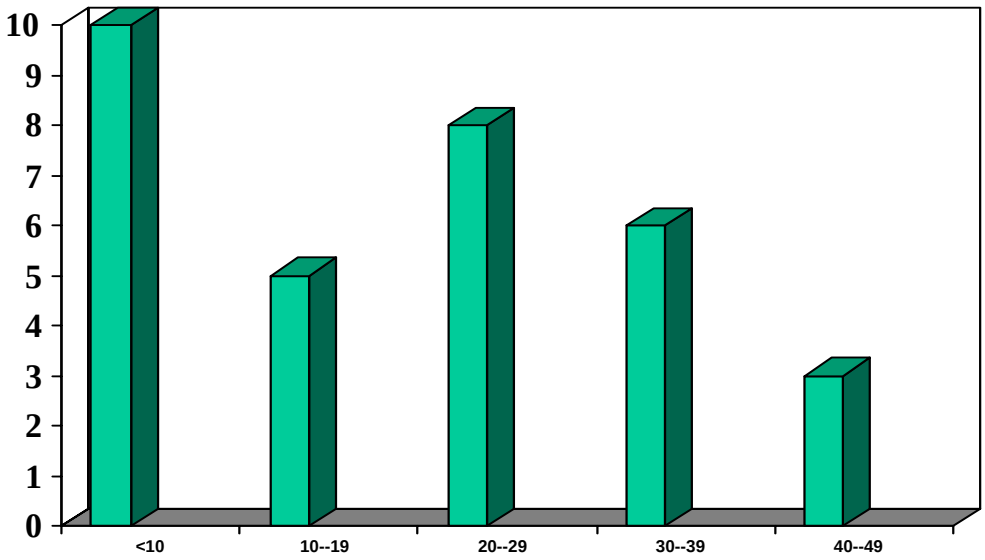
It is a well-documented fact that social conditions (Kubzamsky, Berkman, and Seeman, 2000), social network support (Everard et al., 2000; Pinquart and Sorenson, 2000; Grossman, D'Augelli, and Hershberger, 2000), socio-economic status (Rautio, Heikkinen and Heikkinen, 2001; Pinquart and Sorenson, 2000), 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.

The importance of healthcare in the US is clearly stated in the government's push for the implementation of the goals of the Healthy People 2010 project, Chapter 1 entitled "Access to Quality Healthcare," of the Healthy People 2010 Project (2000, http://www.health.gov/healthypeople/Document/tableofcontents.htm) states that a primary goal of the HP 2010 Project is to "*improve access to comprehensive, high-quality care services*." In particular, the chapter authors go on to state "*Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States*." While the stated goals are admirable and are well documented, unfortunately the HP 2010 document does not address "*all persons in the United States*." Page 1-13 of the 2010 document states, as its goal in clinical preventive care, "*to increase the proportion of persons with health insurance*." It then illustrates data from the 1997 National Health Interview Survey (NHIS), CDC, and NCHS showing the percentages of individuals under the age of 65 years having health insurance. The table incorrectly identifies "sex" as "gender" and lists only the options of male or female as data collected. Later on in the same table, it indicates that sexual orientation data was not collected. This tacit assumption of the Western biomedical model of gender automatically dooms the HP 2010 project to failure in that it cannot possibly address the needs of those who could be generally classified as alternatively gendered as it not only does not include collection of data relevant to the transgender population, but it does not address the specialized needs of that population.

In the preceding discussion, my research colleague and I have demonstrated the profound public health hazard associated with the violence and stigma against the transgender community. However, 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 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. 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 (Figure 1 below)



This, despite the fact that the population is not under educated (Figure 2). The overall study population is similarly educated and more well-off due to the preponderance of executive males in the population.

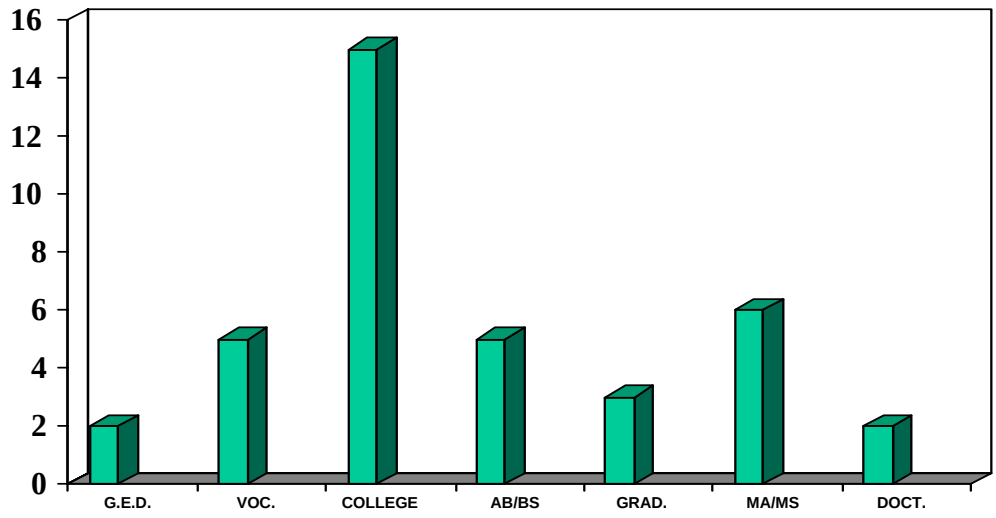


Figure 1: Education breakdown of respondents in the TLARS survey

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 prescription 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 significant problem in the transgender population, 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. 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 inevitable outcome is compounded by the lack of understanding of the special needs of the transgender community in all levels of service agency. Both the TLARS and WTNAS studies report a preponderance of respondents suffering from stigmatic experiences when seeking professional healthcare. The respondents cited that confidentiality, experience/qualifications, need to educate provider, safe environment and cost/economics as primary concerns. One respondent 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*."

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.

Midlife Aging Issues.

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?"

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*".

It is hard to undo the Gordian knot of emergent themes. 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 transgenders, 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."*

Related health cost issues face intersex individuals. For example, Cheryl Chase, Executive Director of the Intersex Society of North America (http://www.isna.org), points out that the expense of treating osteoporosis in agonadal intersexed individuals can frequently be 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 (http://www.luckymojo.com/tkintersex.html). *"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."*

Cheryl 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, 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.

Closing Thoughts On Aging.

The Gerontological literature is replete with documentation supporting the importance of social network structure (family, spirituality, friends, to name a few items) on the morbidity and mortality rates of heterosexual elders. There is no reason to believe that these results do not apply to non-traditional gender identities, gender expressions, sexualities, sexes, and body forms. TLARS research indicates that nearly 50% of the respondents are living alone (a significant risk factor for the elderly), and only 10% of the

respondents indicate that they are either living with or have children (a potentially deleterious factor indicating diminished social support networks). Among the transgendered populations, it is reasonable to assume that while spirituality may or may not be an important component of their lives, there is little formal outlet for religious interaction and support, as transsexuality in particular, and transgenderism in general, are highly stigmatized within the traditional Judeo-Christian-Islamic religions. Lack of access to religious support, emotional, physical or otherwise, is also a significant risk factor for the elderly). Among transgenders, divorce is very high (estimates are not available, however TLARS results indicate that 20% of the respondents were separated and another 10% were divorced). This further exacerbates the diminished social support network structures well known to be critical in the later life.

There are numerous questions that remain to be addressed, and which will be the subject of further white papers from this organization. Among them are questions of multicultural impacts on health, within the aging population of the transgendered and the intersexed. Certainly, the AHRQ has, along with other NIH and HHS components, documented the inequity of healthcare treatment both by race and by sex, among todays healthcare service agencies. It is clearly worse, as we have seen in the previous discussion, among the transgender and intersex populations. The profound effect of inequitable healthcare among the normative populations serves as a least upper bound for how bad it is among the non-normative LGBTI populations in general and the transgender and intersex populations in particular. Reports from both the TLARS study and the WTNAS study indicate that the situation is far worse than that seen in the normative populations. Given the increasing size of the transgender and intersex components of the aging US and worldwide population, it is clear that these population components can no longer be denied either their existence or their needs.

With this in mind, it is important to briefly address some policy suggestions.

Policy Suggestions.

The Federal government needs to develop an inclusive policy with respect to the aging intersex and transgender population. In particular, it needs to focus on three major intervention strategies and the partial list of intervention items below:

(1) Development of Services

a. Specialized retirement, assisted living, nursing home facilities with staff that are trained for and sensitive to the needs of the intersex and transgender elders
b. Implementation of policy that allows for coverage of transgender and intersex related medical treatments (hospitals, doctor visits, psychological examinations, home healthcare, etc.) via Medicare and Medicaid
c. Implementation of policy that mandates private insurance carriers must also cover such medical treatments
d. Development of social service programs that support the needs of the transgender and intersex elders through the development of strong social

support networks (day care centers, senior centers, case management agencies)

(2) Development of Advocacy Programs

a. Creation of specialized components of such agencies as National Institutes on Aging, Administration on Aging, Medicare, Medicaid, and other government agencies dealing with aging and the elderly whose mission is to advocate for and help educate others in the needs of the intersex and transgender elders
b. Inclusion of the transgender and intersex population in all hate crimes legislation
c. Acceptance that LGBTI violence is a public health problem and must be dealt with as such
d. Development of legislative policy and legal policy protecting the transgender elderly against the dual threat of transphobia and ageism.

(3) Development of Education Programs

a. Funding of research on behalf of the transgender and intersex population
    i. Medical and social gerontology/geriatrics
b. Training of specialty medical, nursing, social work, and other healthcare providers
    i. Development of programs to educate and sensitize healthcare workers to the intersex and transgender population and its needs
    ii. Scholarship/Graduate Fellowship/Medical Fellowships
    iii. Facilitation of the development of specialty medical training programs in Geriatric Transgender and Intersex Medicine
c. Funding for outreach programs to catch the younger generation of intersex and transgenders to assist them in long-range life planning

Closing Remarks.

In closing, as my Rabbi friend would say, “Let me tell you a story.” On Unit 1 of the BSH is a 93 year old female Polish Jew. Rachil, with whom I have become friends during my time as an intern at the BSH, said to me the other day, “Let us promise to be friends when we are 80.” “But Rachil,” I replied, “You are past 80 and I will not be 80 for another 30 years?” Rachil looked at me with all of that wisdom that comes from life experience far beyond mine and, with a quiet smile of understanding said, “Then I shall wait for you my friend.” It is my profoundest wish that all of us, those that live within and outside of the dominant paradigms have the opportunity to reach 80 and to have such a friend.

In conclusion, on behalf of the Transgender and Intersex elders of the US, I would urge you to adopt inclusive Federal policy that not only brings the Transgendered and Intersex elderly into the fold of the elders of the US, but also does so with the full respect for diversity, equality, and for the social justice principles upon which this country was first founded.

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APPENDIX I
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Quality of Life Issues for Older Transsexuals, Transgenders, and Cross-dressers: Information for the Human Services Professions

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Abstract. Gender minority persons include transsexuals, transgenders, cross-dressers, and others with gender self-perceptions other than the traditional Western dichotomous gender world-view (*i.e.* including only male and female) such as members of some Native American groups. In this paper we address some of the quality of life issues confronted by older members of this epidemiologically invisible minority population, particularly the concerns of elderly transsexuals. The case history of an older transsexual client is discussed in this context, and suggestions for social workers and members of other human services professions are provided.

Keywords. Quality of life; HIV; AIDS; geriatrics; aging; elderly; sexuality; gerontology; violence; victims; transgender; gender; transsexual; cross-dresser; assisted living; support networks

Case History: James Retires from the Workforce and Becomes Susan.
Female-to-Male (FTM) transsexuals usually self-identify during their teens, twenties, or thirties, often following a period of years of lesbian identification. However, male-to-female (MTF) transsexuals and transgenders more often attempt to suppress their self-perception of gender variance for years or decades, and therefore frequently present for medical sex reassignment services during mid-life or older age. The following is the case history of "James," who, following retirement and relocation in another city, was at last able to undertake gender transition and become "Susan".

Throughout most of his adult life, James lived in a mid-size Midwestern community, in which he worked as a skilled tradesman. Aware of his "difference" from an early age, James attempted to maintain a masculine facade, bolstered by traditionally masculine behaviors and life-style choices. (Susan later remarked, " James drank a lot in order to cope.") He did not disclose his feelings of contra-gender identity, but married a woman with whom he was able to have a sympathetic and largely companionate relationship: " We worked together, adopted a child, raised foster children." Following the death of his wife when he was 57 years old, James began to more seriously reflect on his self-perception and future possibilities. He was eventually able to seek consultation with a reputable transgender mental health services program, whose

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psychotherapists concurred with his self-diagnosis of transsexuality. At the age of 61, James began estrogen therapy, and following the transition of his youngest foster son from the family home to the military, was able to move to a larger community following his sixty-third birthday. James was able to share his female identity with his foster son, who was fully accepting, and was supportive of his father's longer hair and other appearance changes.

Prior to entry into a retirement community in his new city, James obtained a legal name change to Susan, and was issued a new driver's license with an updated photograph and designation as female. She obtained medical care both for ongoing gender transition support (principally hormone supplementation)and for maintenance therapy for hypertension and chronic lung disease. Susan easily developed friendships in her new surroundings, and joined a group of women residents who went out together each morning for exercise-walking and coffee. She did not share her history of having lived as a male with her new comrades, and was easily accepted as a peer by her new female friends.

Upon initial presentation to his family physician (affiliated with a transgender medical program) James had stated that he was pleased with the initial results of the estrogen protocol which he had been using, especially the breast development, but did not wish to pursue any surgical sex reassignment surgical procedures. However, following full life-style transition and integration into the social milieu of the retirement community, Susan became interested in obtaining female genital reconstruction. She first made this desire known to her physician following a dance at the senior center, at which she had danced with an older gentleman, who had kissed her hand. At that time, she began to consider the possibility of entering a heterosexual relationship, and including female genital lovemaking, if this were medically possible.

Concurrent with her development of a social network of primarily older women peers, Susan began her search for a nurturing religious environment. Although she had not disclosed her natal sex to her new companions, it was her desire to locate a religious community in which she could live openly (and be welcomed) as a transsexual woman. Following dialog with other transsexual and transgendered persons, she began attending a congregation of the Metropolitan Community Church, a Christian denomination that serves primarily gay and lesbian Christians and their families. She was easily accepted in this community, and became a deacon the following year.

Susan underwent genital reconstruction surgery at the age of 63, supported by friends and family. Within a year, she formed a partnered relationship with a member of her church, a woman who, following 35 years of marriage, was coming out as bisexual. Following the eventual breakup of that relationship, Susan left the church and began exploring Buddhist philosophy.

At the time of this writing, Susan is 65 years of age, active in the Buddhist community and with friends and family. Her hypertension and pulmonary disease have remained stable, and she states that the decision to undertake gender transition, although much later in life than she would have preferred, has greatly improved her quality of life. She is happier than ever before, and has a sense of completion arising from deep personal fulfillment.

Discussion: Transsexualism and other Gender Identities

Susan's case illustrates many of the decisions and difficulties confronted by persons who undertake gender transition in later life. This paper contains information for social workers and members of other human services professions who may provide therapeutic or support services for older gender minority clients. Although the focus of this discussion will be on the experiences and needs of older transsexuals, other gender minority identities, including transgenderism and cross-dressing, will also be briefly discussed.

Gender minority persons (also referred to collectively as the "gender community") include transsexuals, transgenders, cross-dressers, and others with gender self-perceptions other than the traditional Western dichotomous gender world-view (*i.e.* including only male and female) such as members of some Native American groups. (Langevin, 1983; Satterfield, 1988; Godlewski, 1988; Hoenig and Kenna, 1974; Kröhn *et*

al., 1981; Kockett and Hahrner, 1988; Sigusch, 1991; Tsoi, 1988; van Kesteren *et al*., 1996; Walinder, 1971, 1972; Weitze and Osburg, 1996).

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

Many indigenous peoples also recognize genders other than male and female. (For example, Tewa adults identify as women, men, and 'kwido', although their New Mexico birth records recognize only females and males (Jacobs and Cromwell, 1992)). Persons with such non-Western gender identities are also gender minority individuals, although discussion of the cultural and anthropological aspects of gender variance is beyond the scope of this paper. It is also difficult to provide data-based information about some of the health issues faced by elderly transsexuals, as this group is particularly "epidemiologically invisible" (Eyler, Witten and Cole, 1997b) with many of its members preferring not to reveal their natal sex. In contrast, most "out" (i.e. publicly identified) transsexual, transgendered or cross-dressing persons are young adults; many have chosen to be involved in political activism on behalf of the gender community. Nonetheless, in an era in which forecasting the health of elderly populations is increasingly more important (Manton, Singer, and Suzman, 1993) discussion of quality of life issues faced by older transsexuals and other gender minority persons should not be further deferred.

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

Persons who undertake gender transition during mid-life or the elder years are more likely than their younger peers to experience difficulties related to physical health status. Ill health, especially cardiac or pulmonary dysfunction, may preclude eligibility for surgical procedures which are not strictly necessary in the biological sense (and therefore medically elective) including breast or genital reconstruction. In addition, persons with moderate or severe hypertension, pathologic hypercoagulable states or history of thromboembolic disease, uncontrolled diabetes mellitus, or unusually complicated pharmacologic regimens, may be poor candidates for estrogen therapy. (However, MTF genetic males with prostate disease may benefit both medically and socially from treatment with estrogens.) Similarly, although androgen supplementation does not cause hypercoagulability in female-to-male (FTM) transsexuals and transgenders, it may exacerbate dyslipidemias (e.g. depressed HDL cholesterol) and increase coronary artery disease risk. (In these cases, usual medical therapy consists of treating the dyslipidemia, as would be done for a genetic male, rather than reducing the androgens below the normal male range. In severe cases, cessation of androgen supplementation may be undertaken if phenotypic transformation has been completed, bone mass is adequate for osteoporosis prevention, and this option is acceptable to the patient.) Androgen supplementation is also a risk factor for the development of polycythemia, a potentially life-threatening condition, but may benefit FTM individuals with pre-existing anemia or loss of bone mineralization. While much is known about pharmacology of aging (Roberts *et al.* , 1996) and about hormones and aging (Timiras *et al.* , 1995), little is known about the interaction of "normal'" aging

processes and cross-hormonal treatment, from a physiological, psychological, and biomedical perspective. Only recently has significant work been done on the mortality and morbidity rates for transsexual and transgender patients on cross-hormonal treatment (Asscherman *et al.* , 1989).

Healthcare and personal assistance services are more complex for persons who are transgendered than for those who are transsexual and post-operative. Apparent mismatch between genital anatomy and gender of presentation can result in difficulty in obtaining medical services, practical nursing care, or even appropriate funereal arrangements (as in the case of Billy Tipton, whose female genitalia were "discovered" by the mortician and sensationalized in the tabloid press). More recently, Tyra Hunter, a pre-operative male-to-female transsexual was refused appropriate and timely medical care by Washington, D.C. paramedics who, when arriving on the scene of a hit-and-run car accident involving Ms. Hunter, discovered her transgenderism. Believing that her gender discongruity implied that she must be also be homosexual, the paramedics refused to render treatment because they thought that Ms. Hunter might have AIDS. The case of Leslie Feinberg, who was forced to leave an emergency room when his female anatomy was discovered is also well-known in the gender community. Many medical and nursing personnel consider transgenderism (or transsexualism or cross-dressing) to be evidence of psychiatric pathology (although this is not supported more extensive clinical experience), and inappropriate psychiatric referrals may result. The experience of transsexual, transgendered and cross-dressing persons in long-term care facilities is currently undocumented.

More recently, the appearance of HIV/AIDS in the transsexual, transgender and cross-dressing population has been of increasing concern. Persons who suppress their contragender identity during adolescence or early adulthood at times enjoy "second adolescence" behavior patterns, including risky dating and sexual acting out (Witten and Eyler, 1997b) when they do begin to socialize in the true psychological gender. Although it is not yet clear how the risk of HIV infection compares for transsexual and non-transsexual single, middle-aged and older adults, the burden which infection places on transsexual or transgendered persons is greater, due to the competing medical demands it creates. HIV infection in later life too frequently leads to situations in which middle-aged or elderly persons are living with the burden of financing both the medical treatments associated with the chronic conditions which accompany later life stages and also antiviral chemotherapy. The need to obtain and pay for contragender hormonal therapy (as is often the case for transgenders and transsexuals) or transsexual surgical services compounds this problem.

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

Despite the increased medical risks that may accompany gender transition for older persons, the physical (morphological) realities of aging may facilitate social gender transition. For example, women and men share more physical similarity during the elder years than at any time since childhood. Loss of facial skin tone produces a softer appearance for many genetic males, and the natural diminishment of circulating estrogens, accompanied by a shift towards andronization of the hair follicles, facilitates the production of

new beard growth in FTM transsexuals. Furthermore, the loss of muscle mass and increased body fat content which is experienced by both male and female elders often results in phenotypic gender convergence of the body habitus (*i.e.* women and men appear more alike than previously with regard to body fat distribution, girth and posture). These physiologic alterations are clearly advantageous to transsexual persons who begin the transition process later in life, as they may obviate the need for excessive weight reduction (for genetic males), body building muscle development (for genetic females) and minor cosmetic procedures (for both).

Physical functioning, such as that required for the performance of the usual activities of daily living, is generally unaffected by gender transition or sex reassignment surgery. Exceptions include cases in which post-surgical recovery is complicated or prolonged, or in which empathic, non-judgmental personal care assistants are unavailable during the post-operative period.

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

Gender Variance and Social Adjustment

Quality of life issues for older members of the gender community often center upon the degree of social integration which the individual has been able to achieve earlier in life, or on the personal flexibility and resilience available for the development of new relationships during the later years. Community resources and acceptance of persons with non-traditional life paths can also be crucial. These needs are similar to those of elderly non-transgendered persons who find that social network support and community resources are important for the ongoing maintenance of well-being. (Stallings *et al.* 1997 address these issues for the non-transgendered elderly. See also Turner, 1996; Magai and McFadden, 1996; and Thompson, 1996). Data for the elderly transsexuals and transgenders is unavailable at present.

It is been previously documented that elderly persons frequently develop a high degree of spirituality, though not necessarily a great desire to attend traditional church or other religious services (personal communication to TMW at the 1997 Gerontological Society of America Meeting). Although the patterns of participation in religious activities among gender minority persons are not currently known, recent survey research has revealed that a majority do self-identify as being a part of a traditional religion or as being highly spiritual (Witten and Eyler, unpublished data).

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

Family relationships may be altered following the older person's "coming out" with regard to his or her gender identity. Fatherhood and motherhood, siblingships, grandparenthood and other aspects of the

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

Although gender transition among the elderly, and within the context of a very long-term marriage or partnership, is still relatively rare, experience with middle-aged couples in which one partner is transgendered or transsexual suggest several possible patterns. Many spouses or long-term partners of transgenders or transsexuals will choose to maintain the relationship as their husband, wife or lover changes gender presentation, genital sex, or both; however, many others will not. Couples who do maintain a marriage or partnership may need to "redefine" their relationship. (More versatile persons can maintain a sexual relationship; other couples become "friends", "sisters" etc.) In the former case, loss of the previous sexual orientation (as a heterosexual woman or lesbian; experience with male-FTM couples is currently very limited) can be difficult for the non-transitioning partner. She may adjust by drawing a distinction between her relationship (which has changed) and her sexual orientation (which has not): "My husband is becoming a woman, but we're going to stay married."

A Response from Social Work and other Hunan Services Professions
Human services professionals can assist their older clients who are transsexual, transgendered, cross-dressing, or whose gender identities or expressions are other than male or female, through adopting an awareness of the diversity of human gender and maintaining a knowledge of appropriate sources of information regarding transgender medicine and other appropriate resources. Other specific aspects provider concern are discussed below.

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

Sexuality and Intimacy: The greatest obstacle to sexual expression among older adults (particularly heterosexual women) is the lack of availability of suitable partners (Brecher,1984). Consequently, a MTF transsexual person who undertakes gender transition later in life is more likely to experience sexual isolation or deprivation than would have been the case prior to this transformation (*i.e.*, when the individual had been perceived as male). In addition, the current cohort of elderly women has been primarily socialized to believe that female sexual behavior is acceptable only within the context of marriage, and possibly for the exclusive purpose of procreation as well. However, persons who change gender presentation later in life may share in these perceptions to a lesser degree than do their non-transsexual peers. Furthermore, sexual expression may be positively enhanced by the newfound congruence between the body and the psychological (true) self.

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

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

Despite the aforementioned obstacles to sexual expression, most transsexual persons experience a positive development of personal sensuality when they are able to live in congruence with deepest self-perception. Patterns of sensual expression are usually present across the life-span (Brecher, 1984; Whipple and Scura, 1989), with sexual behavior serving also as a vehicle for the basic human need of the sense of touch. When touch is absent, severe psychobiological stress and symptomatology can result (Colton, 1983). The greater sensuality experienced by transsexual and transgendered persons who are able to achieve a sense of bodily wholeness may serve to enhance physical and mental health by providing additional capability for healthy touch. Cross-dressing persons who are able to integrate temporary role change into healthy partnered or social relationships may similarly benefit.

Social workers can assist clients in this regard by validating the sensual expressions and potentials of their elderly clients, offering sexual counseling and education when needed, and assisting other family members in accepting the gender presentation and sexual expression of their older relatives. Education regarding gender diversity and sexual expression among the elderly may also be needed in order for professionals in inpatient, chronic and acute care settings to provide appropriate and compassionate care for their older clients and patients. Dispelling myths regarding elder sexuality, providing information regarding the usual physical changes of aging and the human sexual response cycle across the lifespan, and offering interventions which address sexual expression in cases of physical disability, may also be particularly useful for social workers and other professionals who provide care to older persons.

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

In the case of transsexual, transgendered and cross-dressing elders, these challenges are compounded by issues regarding disclosure, privacy, isolation from transgendered peers (due to a more specialized (minority) community social system which is further decimated by aging and death of its members),

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

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

CLOSING THOUGHTS

Transsexuals, transgenders, cross-dressers and other persons whose gender expression or identification is other than the "traditional" male or female represent a substantial but epidemiologically invisible minority group within the worldwide elderly population. Quality of life issues for this community have as yet been but marginally addressed within the medical and sociological literature (Docter, 1985). Attention to the needs of the gender community with respect to biological, psychological, and social aspects can be best served through a comprehensive and holistic approach, including family, provider, and community education and the development of appropriate professional and community networks. Health and social policy development on behalf of the transgendered elderly (including the assurance of nondiscrimination with regard to quality healthcare services, privacy, confidentiality, respectful treatment and caregiving, and personal safety) is also strongly needed.

The experience of Susan (nee James) demonstrates 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. Our experience suggests that members of the healthcare and helping professions can assist in this actualizing process. 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, transgendered, and cross-dressing elderly persons to live long and vital lives. Social workers engaged in case management on behalf of elderly 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.

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