

# Transgender Elders: What Providers Need to Know -- and Don't Need to Know

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## Keys to Serving Transgender Elders

Transgender people are widely viewed as exotic, unusual and interesting. Knowingly meeting our first transgender person is almost always a notable event, one that usually spawns a lot of questions: How long have you known you were transgender? When did you have the surgery? What is it like, experiencing life as both a man and a woman? What is involved in changing sex? What does your family say? Transgender people—including transgender older adults—and their significant others, friends, family and allies (SOFFAs) almost always considered such questions rude and intrusive.

Certainly questions of this sort are inappropriate if you are a professional meeting a transgender client or potential client. Yet aren't there things you need to know to provide services effectively? The answer may well be yes, but it takes some prior thought to make sure you ask the right questions in the right way. Drawing on training developed by the Transgender Aging Network of FORGE, a national advocacy organization for transgender people, following are keys to making sure interactions with transgender clients are as professional, respectful and culturally competent as those with nontransgender clients.

Although FORGE's cultural competence training is primarily addressed to providers of healthcare and social services, the concepts outlined here also provide a basis for policymakers, researchers, human resources professionals, students and others to interact respectfully with transgender people. And although the approaches we discuss are appropriate for work with transgender people of all ages, we are particularly concerned here with transgender people ages 50-plus. As a result, we include some observations on distinctive aspects of work with those elders.

## USE THE CLIENT'S TERMS

Human brains are natural categorizers. We automatically sort things into boxes: that's a cat, that's a dog, that's a leaf. We do it with people, too. So it's natural to want to know the difference between the types of transgender people: What's the difference between a cross-dresser and a transsexual? Between a drag queen and a genderqueer? But FORGE doesn't start with definitions, because of the terms paradox: Terms are both crucial and meaningless.

First, why terms are crucial: Providers must find out what terms a person uses and employ that language with clients in order to convey your respect for that person and the providers willingness and ability to be culturally competent. The analogy is when Joan Smith introduces herself as Mrs. Smith. If you then call her Joan without her permission, she is likely to feel insulted and disrespected, starting the interaction off down a path of irritation and noncooperation. The same is true of transgender people. Use the name they give you, even if it doesn't seem to match their appearance or is not their legal name. If you are unsure what name to use, ask what name the client would prefer.

Pronouns also are critical. If the name the person gives and the person's appearance are both either clearly feminine or clearly masculine, use the pronoun that matches the individual's name and appearance—when speaking about them even when they can't overhear you. If you aren't sure what pronoun is appropriate, ask, "What pronoun would you prefer I use for you?" These questions tell the client that you know transgender people exist, and that you acknowledge their individuality and want to serve them respectfully.

Depending on your professional role and the nature of the conversation, you may also want to listen for and echo a person's identity label or how they label a body part. For example, a transgender person who identifies as male may have large breasts; if he refers to his chest during a medical examination, try to echo his language. Again, this conveys respect and acceptance.

In most cases, however, you will not need to know what identity category transgender people place themselves in. Irrelevant details are just that: irrelevant. Just as you probably wouldn't want to hear your physician tell the nurse to "give a flu shot to the old man over there," your transgender client doesn't want to hear, "Go talk to that transsexual over there." It may, however, be appropriate to echo a client's identity term during conversation with them, again to indicate that you are listening.

More importantly, transgender identity labels are, practically speaking, meaningless. Although some people insist that a transsexual is someone who wants or has had genital surgery, whereas transgender people do not want to change their bodies, these definitions are not universal. Indeed, there are hundreds of identity terms in use in the transgender community, and heated debates about who is what or who is entitled to use what term are depressingly ubiquitous. You may naturally want to know what box a transgender client belongs in, but knowing that won't tell you anything else.

## **ASK THE RIGHT QUESTIONS THE RIGHT WAY**

Because transgender people and SOFFAs are at best routinely asked inappropriate questions and at worst treated offensively or even hostilely, they are often on guard when approaching a new service provider. It is therefore up to you, the professional, to prove yourself by asking only appropriate questions and by prefacing potentially sensitive questions with a statement about why you need the answer. An example would be, "Because this program is only open to people ages 65-plus, may I ask you your age?"

Unfortunately, this seemingly simple advice is deceptive: We frequently ask wrong or unnecessary questions. Let's take the routine intake question, "Are you married?" A healthcare provider asking this question might actually want to know whether someone is available to drive a patient home and provide care after outpatient surgery. On the other hand, a congregate meal provider may need to know the legal status of the couple standing before her, given federal law about who is eligible for services. The hostess at a restaurant, by contrast, has no professional reason at all to ask the question.

Confusion of this sort is particularly rife when it comes to questions about sex, gender identity and sexual orientation. Americans are frequently confused by the differences between those three concepts. Every adult embodies one of each:

- **Sex** is what you are declared at birth, usually solely based on the appearance of external genitalia. (*Intersex* is the current term for individuals whose genitals don't clearly fit into one category or the other.)
- **Gender** is a person's internal sense of being male, female or some other gender. For most of us, our sex and gender line up: We have vaginas and see ourselves as female, or we have penises and see ourselves as male. Transgender people, by contrast, have a gender identity that does not—or, in the case of people who have surgically altered their genitals, did not—match the sex they were assigned at birth.
- **Sexual orientation** is about us and other people. Males attracted to males are gay, and females attracted to females are lesbian. People attracted to those of the "opposite" sex are heterosexual or straight. People attracted to both sexes are bisexual, and people who aren't sexually attracted to others are asexual. Like everyone else, transgender people may be gay, straight, bisexual or asexual. (Some transgender people and their partners use synonyms for bisexual such as *pansexual* or *omnisexual* to avoid reinforcing the idea that there are only two genders.)

A very important caveat with both sexual orientation and gender identity: What people call themselves may not reflect their behavior. For example, a woman who says she is heterosexual may actually have a female lover, and a person who has a male gender identity may dress and appear female. There are many reasons people's identity and behavior may not line up the way we might expect. A few possibilities include denial ("I'm not really gay"); wishful thinking or intention ("My dance card is always full," affirmed by someone who dates only once in a while); and opportunity (the male-to-female transgender person isn't going to go outside the house dressed as a woman until she retires from the job where everyone knows her as a man).

When it comes to asking clients questions for intake, medical history or other professional purposes, it's therefore important to know whether and when you need to know identity (how people think of themselves, or what's inside) and when you need to know behavior (what they do, or what's outside and observable). The difference between the two will become clearer as we talk about choices transgender and other people may make and as we discuss the possible implications for service provision.

## RECOGNIZE AND RESPECT INDIVIDUAL CHOICES

For everyone who provides healthcare and social services—or who otherwise might encounter transgender people in the course of their work—recognizing and respecting individual choices is a fundamental professional requirement. Following are significant areas of choice which professionals should take into account:

**Gender Expression and Presentation.** All of us make choices about how we present ourselves to the world, including what clothes to wear; whether and how we'll wear make-up, jewelry and accessories; and how our hair is cut or styled. In our society, all of these choices are related to gender: Men are expected to make their choices from column A, and women are expected to make their choices from column B. That means our clothing, personal objects, hairstyle and much more are all part of how we express or present our gender.

Transgender people may make all their choices from just one column and consistently present as male or female. They also may deliberately choose from both columns and thus have a mixed, androgynous or fluid

gender presentation. In addition, some switch between columns A and B from day to day, hour to hour, or setting to setting. In some cases, this is necessary because employers, colleagues or family members will not accept or don't know about a transgender person's gender identity. In other cases, personal preference is the reason. An example would be a man who is content to be male out in the world, but prefers to wear women's clothing at home.

This is where your professional role may dictate what you need to know. A psychotherapist may find it useful to know someone's identity, but most providers of healthcare and social services for older adults will find it more useful to know about behavior—about how clients' express their gender. Whether a client's gender expression is consistent with what casual observers would expect is the area where practical concerns may arise:

**Names.** With a few exceptions such as Pat and Sandy, American culture places all personal names in either the male or female column. As a consequence, transgender people commonly adopt a name different from the one they were given at birth. As with anyone who has made a name change—through marriage, for example, or by adopting a nickname—the new name may or may not have been changed legally, and any given piece of identification may or may not reflect the change. Here again, know what you need to know: If you are a healthcare professional, you may need to know the name and sex marked on the person's Medicare or health insurance to ensure that the bill gets paid. If you are providing information and referral, most likely all you need to know is the name the person gives you.

**Hormone Use.** Some but by no means all transgender people use pharmaceutical hormones, which initially help shape bodies in more traditionally masculine or feminine ways, causing such things as beard growth and voice lowering in female-to-male (FTM) individuals and breast growth and skin softening in male-to-female (MTF) individuals. Since many of these changes are permanent, some transgender people stop using hormones once they've met their physical goals. Others may stop because they develop a health contraindication or become unable to afford the hormones, which often are not covered by insurance. Some continue hormone use throughout their lives, a practice recommended for those whose bodies no longer generate hormones due to surgical removal of the ovaries or testes. Hormones may be obtained through pharmacies, on the street or over the Internet; some people use herbal alternatives. Healthcare professionals will need to ask about hormone use when asking a transgender individual about medication use in general; social services providers and other professionals probably don't need to know and therefore should not ask.

**Surgery.** Many nontransgender people think there is a single procedure called "transgender surgery," and it involves genital reconstruction. In reality, the most common surgery for FTMs is mastectomy and chest reconstruction; few have phalloplasty or other genital surgery because of cost, frequency of complications and dissatisfaction with the esthetic and functional results. MTFs may choose breast augmentation or facial feminization surgery rather than, or in addition to, vaginoplasty, since the former may be more critical to daily life as a woman. Because of the cost and because many transgender people don't feel the need to change their body parts, we believe that most transgender people do not have gender-related surgery—although no quantitative research is currently available to confirm this impressionistic assessment.

Whether a transgender person has had gender-related surgery has implications for services such as healthcare, homecare or personal assistance which may require disrobing. In such situations, professionals may expect that someone who looks like a woman while dressed will have certain body parts and not others when nude. When a transgender person turns out to have body parts the observer wasn't expecting, the noncongruence can be unsettling and may cause confusion or even anger in the observer. For this reason, many transgender people avoid obtaining healthcare, even when they are seriously ill or injured.

Providers who offer healthcare or personal assistance to older adults they know to be transgender would therefore benefit from knowing ahead of time what surgeries, if any, they have. This helps professionals or aides know what to expect and thus helps them act professionally when the transgender person undresses. If you do not have this information before you see someone nude, it's still critical to remain professional and not act surprised; some transgender people are uncomfortable talking about their bodies; others may forget that their bodies are something a professional may want to be alerted about. If you won't be seeing the person nude, questions about genitals or surgery status are probably irrelevant and none of your business.

**Documentation.** It's hard for most people to imagine how many documents identify them by name and gender. These documents include driver's licenses, birth certificates, passports, car registrations, Social Security records, marriage licenses, employment records, professional licenses, military service and Veterans' Administration records, school transcripts and diplomas, credit cards, bank account records, mortgage documents or leases, medical records, wills, health insurance records and documents for durable power of attorney. Even the most diligent transgender person is likely to have some document that show discrepancies, especially since some states will not change a birth certificate under any circumstances, and others set requirements to change records such as a driver's license or birth certificate which may be financially or emotionally too costly to meet.

Professionals may or may not need to know whether a transgender client has changed a given document to reflect the individual's new name or gender. Certainly, health insurance records and billing must line up, so healthcare professionals should ask client what name and gender Medicare or a health insurer uses for the individual. Remember, however, to never refer to a client by their legal name or gender if they have expressed a different preference.

**Transition.** Transition is the process and time within which a person goes from predominately being seen as one gender to predominately being seen as another gender. Many transgender people never go through a transition, either because they are content to have the world see them in a way that's different from how they identify internally or because they cannot transition due to work, family, health or financial reasons. Some transgender people simply ease into a more neutral or androgynous presentation without an obvious transition.

For those who do transition, the process is public. Everyone who has seen the individual—and in the case of FTMs and some MTFs, people who only know the individual's voice—can and will notice the changes. This means that those in transition are subject to a tremendous amount of curiosity, questioning and, possibly, concern. It also means that those around the transitioning person—especially spouses or partners, parents and children—likewise face curiosity, questions and hostility, even though they may themselves still be trying to come to grips with the gender change.

Because many transitioning transgender people use hormones to help them look more masculine or feminine, a healthcare provider involved often involved. And because many healthcare providers use established standards of care to guide treatment of transgender patients, a mental health professional often is involved, too. The standards recommend that a physician approached to prescribe hormones for a transgender person should require the person to individual a letter from a mental health professional who has treated the person for a period of time. Surgeons specializing in gender-related surgeries often require letters from two mental health professionals.

The gatekeeper role therapists thus play can create problems. ) If they cannot afford the psychological therapy a physician sets as a prerequisite for hormones or surgery, transgender people may buy hormones off the street or the Internet or may inject silicone—a medically dangerous practice some use to shape their bodies. Unmonitored hormone use can have serious health implications that can be prevented with competent care.

Transgender people who do see therapists may not reveal past traumas or current mental health issues because they fear the therapist will use that information as justification for denying approval for hormone use.

Transitioning in midlife or later is common, often taking place when the individual's children move out, when the person retires or has a health scare or when the person's parents die. Professionals who have a transitioning client may nonetheless find it useful to think of the process as equivalent to adolescence in psychosocial terms. The new hormones change the person's body and may lead to mood swings. Like a teenager trying to figure out what kind of woman she wants to be, an individual who is transitioning may experiment with different clothing styles and roles, some of which may strike observers as age inappropriate or even offensive.

Also like teenagers, people who are transitioning are negotiating changes in all aspects of their lives, including family, work and social relationships. For all these reasons, people going through a gender transition are often very self-absorbed, an attitude that may be upsetting to their friends and family. In addition, when an individual who is transitioning is a member of a couple, the partners must renegotiate both their private sexual relationship and their public presentation as a couple. In a few cases, this is complicated by a simultaneous change in the transgender person's attraction to males, females or both.

**Partnership Status.** Transgender people, just like everyone else, may be partnered or not. They may be celibate or may have multiple partners. Partners may accompany a transgender person throughout the individual's gender exploration and transition or may enter the transgender person's life later on. Given this fact, the question "Are you married?" which appears routinely on intake forms is probably the most misapplied. With same-sex marriage legalized in some states and with the Defense of Marriage Act ignoring these marriages on the federal level, this question is even more useless.

Here are some of the questions we may really want answered when we mistakenly ask someone if they're married: Do you live alone? Are you sexually active? Who provides your emotional support? Is there someone who would care for you in an emergency? Is there someone you want us to notify in an emergency? If you were hospitalized, is there anyone who might challenge your partner's right to visit you? For income eligibility purposes, do we count your partner's income? Are your legal documents such as durable power of attorney and will in order? If you were widowed, would you be eligible for survivor's benefits? Are you available to date? Here, especially, know what you need to know, tell why you need to know it, then ask the right question.

**Self-Revelation: Coming Out.** For a transgender individual, self-revelation—coming out—means that others know about the person's gender history, sexual orientation, or both. Some transgender people choose not to tell some or all of their associates their birth sex. Sometimes, self-revelation is not a choice: This is the case for transgender people who have not had genital surgery but who must disrobe in front of others in a healthcare setting or in other situations. Other times, transgender people are accidentally or intentionally exposed by someone who knows their gender history and tells it to others against the transgender person's will.

Such exposure also may happen when a transgender person has to produce a document that includes a former name or gender marker, a not unusual circumstance when seeking healthcare and social services. Many service providers already adhere to strict confidentiality procedures, but extra care should be taken with transgender clients to ensure their gender history or status is not shared with others, unless this information is crucial to the client's care or safety. It's also a good idea to go over confidentiality procedures with transgender clients, to help them feel more confident their privacy will be protected.

**Passing.** *Passing* refers to a transgender person's ability to be perceived socially as having the gender with which the individual identifies – an MTF being perceived as a woman or an FTM being perceived as a man. Ability to

pass is in the eye of the beholder, so it varies depending on the observer. It's not uncommon for a transgender person to be called ma'am by the retail clerk in one department and sir by the clerk in another department.

Passing is a binary concept: Here, too, there is column A and column B. People routinely assign others to either a male or a female box, not realizing there are further options. But the transgender people may not see their gender in these limited terms. That's why gendered compliments and statements such as "you look so handsome today" should be avoided unless you are sure how someone identifies—and their looks won't tell you that. Although there are numerous exceptions, FTMs when they are clothed generally pass as males more often than MTFs pass as females. Conversely, because a far lower percentage of FTMs than MTFs have had genital surgery, FTMs are less able than MTFs to pass when they are undressed.

The implications of not passing as male or female in public can include violence, ridicule, questions, and rudeness. The implications of not passing "on the exam table" include all or the above, plus: refusal to serve (or, if insured, pay); and an assumption that all medical conditions are transgender-related. Again, fear of discrimination or problems in the health care setting may lead a transgender elder to refuse to seek or accept health or personal care.

**SOFFAs.** Significant others, friends, families and allies of transgender people have limited choices when someone they know decides to transition or reveals a previously-unknown gender history or identity. Basically, they can accept the knowledge, make the necessary cognitive adjustments and move on; actively resist or oppose the plans or information; or end the relationship. Usually SOFFAs go through a transition of their own as they gain more information, work through their feelings, and figure out how the changes affect them.

Unfortunately, the public nature of a gender transition means that SOFFAs may have to do all this work in full view of others, as many transgender people do not tell others of their intentions until they are ready to start making visible changes. Sometimes SOFFAs get asked even more intrusive questions than do transgender people. This is because many people who worry that it would be inappropriate to ask a transgender person intimate questions apparently have no such qualms about asking the person's partner, family or friends.

## **TAKE YOUR CURIOSITY ELSEWHERE**

We expect people we hire to provide the services they have promised to provide; we do not expect to provide services to them. The same is true of transgender people: If healthcare or social services professionals ask transgender clients to educate them about transgender issues, these professionals have stepped outside their proper role and have done the clients a disservice.

That's why providers must curb their curiosity when they serve transgender clients, asking them only for the specific information needed to properly serve them as individuals. Professionals can take their curiosity to the library or the Web. FORGE's Transgender Aging Network sponsors a listserv specifically for professionals, providing a place where they can safely ask questions and seek advice. To sign up, send an email stating your interest to [loreecd@aol.com](mailto:loreecd@aol.com) or visit [www.forge-forward.org/tan](http://www.forge-forward.org/tan).

After a professional has served a transgender client, it's acceptable to say, "I'd love to hear more about your life sometime, if you would be willing." Many transgender people are prepared to do this sort of one-on-one education if the professional in question has been respectful. Better yet, providers can find a local transgender support group or locate other professionals who specialize in transgender issues and ask them to provide in-service training. Either approach will increase the number of professionals who understand transgender people—and that will enhance the well-being of the transgender community.

## **PARTNER WITH CLIENTS**

Providers should keep in mind that transgender clients know much more about being transgender than the provider does. Clients may or may not want to educate professionals about the broader issues, but they expect to be asked for their advice and preferences when providers face a gender-related decision about their treatment. For instance, if a transgender elder needs residential care in an assisted living or skilled nursing facility with shared rooms, the care manager should ask the elder about preferences for a male or female roommate.

Transgender people know quite well that they confound systems based on a male-female dichotomy. Chances are good they have already found a way around the problem, or at least know how they'd like to have it handled. So professionals should ask the client when they encounter a question of this sort which they don't know how to answer. Chances are good that if the client's transgender knowledge is combined with the providers professional knowledge, it will be possible to come up with a respectful, workable solution that meets everyone's needs.

Although transgender clients of healthcare and social services may seem to be "the most different" from the average client, if providers and professionals apply good general practice principles—follow your client's lead, know and tell why, take your own needs elsewhere, and partner with your client—they will automatically be operating in with respect for transgender people. And cultivating those four keys principles should help providers better serve all clients.