

Trans Aging

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Andrew adored Mr. Adams. Not only was he lucid -- some days it seemed like nearly all of the nursing home residents weren't -- but he was charming. And so interesting! He had traveled so many places in the world, and had so many wonderful stories he was willing to share.

So he was very concerned when Mr. Adams came to his office one day and asked if he could close the door. Something was clearly wrong. While Mr. Adams wheeled into place, Andrew came from behind his desk to draw a chair close to him. For a while, Mr. Adams wouldn't say anything, just hanging his head down. Then, to Andrew's horror, he saw a tear drip down Mr. Adams's face and into his lap. Andrew took his hand and very gently said, "tell me, please." Slowly, haltingly, his face always turned away from Andrew, Mr. Adams did. Two of the nurse aides had begun making fun of his penis whenever they caught him alone during dressing or toileting. "They've noticed my...um, urine...doesn't come out the end of my penis like, uh, most men's," he said. Plus they made fun of his penis's small size. Gradually they had begun escalating their behavior, trying to make him get an erection through various means, and taunting him when nothing happened. Eventually, two days ago, they had anally raped him with something; he didn't know what.

Andrew was appalled. He discussed Mr. Adams's options with him, but he said no to everything: no reporting to authorities, no seeing a doctor, and no, he didn't particularly want the nursing home to fire the aides, because they might come back and "hurt me." And most emphatically, no telling his nephew, who had been appointed his guardian and was his only relative. "What do

you want me to do?" Andrew asked. "I don't know," Mr. Adams answered. "I just felt I had to tell someone, and you are the only person I ever talk to."

Poor Andrew. He's the nursing home's social worker, in charge of the emotional and psychological well being of the residents. Where does he begin to untangle the complex knot Mr. Adams has just handed him?

One place too many people begin, when presented with anything involving a transgender or intersex person, is genital configuration. We humans like to think there are clear boundaries between the categories we automatically put people into: this one is a gay man, that one is a cross-dresser, and the one over there is a transsexual. For most of us, the baseline upon which many of these categories are built is the genitals: if someone has a penis, he's male; a vagina, and she's female.

Transgender and intersex individuals challenge these baseline assumptions, which is one of the reasons they are subject to so much hostility, not only from the heterosexual, gender-normative majority, but also from gay and lesbian people, as well. Constantly navigating that hostility is one of the primary tasks of transgender and intersex elders. But it is by no means the only one.

Transition

As in the lesbian/gay community, "coming out" is a term used in the transgender community to refer to telling others of one's own or one's loved one's gender identity instead of (or in addition to) one's sexual orientation. However, "transition" is a more important concept for the trans community. Transition usually refers to a process during which a person is perceived as changing (or having changed) hir¹ gender identity from either female to male (FTM) or male to female (MTF) (Bockting and Coleman, 1992; Brown and Rounsley, 1996; Devor, 1997; Ettner, 1999; Israel and Tarver, 1997; Meyerowitz, 2002). Although not all trans individuals

¹ "Hir" and "sie" belong to one of several gender-neutral pronoun systems; they will be used throughout this paper to encompass not only males and females, but also individuals who claim a gender identity outside or beyond "male" and "female."

transition (because many trans individuals do not wish to be seen as definitely male or female, or they are female in some places, male in others, or they identify as trans but do nothing to modify their appearance), it is an extremely significant process for many trans people and their SOFFAs (Significant Others, Friends, Family, and Allies).

As with coming out among lesbians and gay men, transition usually begins with an internal process of questioning or exploration that may be shared, if at all, with only one or a few others (Brown and Rounsley, 1996; Devor, 1997; Ettner, 1999). These days -- depending, of course, on the person's socio-economic access -- it is then likely to move to the World Wide Web, where the transgender person seeks information about gender identity and, possibly, a listserv through which sie can speak with other transgender individuals. Individuals in larger communities may also find an in-person support group to attend. In contrast to gay people's "coming out," however, transgender individuals' transition must fairly quickly go public.

One reason it must go public is that trans individuals who wish to modify their bodies through hormones and/or gender-related surgery must (unless they choose to use over-the-counter herbal supplements and/or black market sources) enlist the assistance of at least one physician (Brown and Rounsley, 1996; Ettner, 1999; Israel and Tarver, 1997; Kirk, 1996). These physicians, in turn, often require a trans person to in essence be "certified" as sane and suffering from the DSM IV diagnosis of Gender Identity Disorder (GID) by at least one mental health professional (American Psychiatric Association, 2000; Meyer, et al., 2001).

The second reason many transgender people must go public is that the changes they make to live out their transgender identity are, by definition, obvious to everyone who is able to recognize the person by sight, sound and/or name. At least eventually, those around someone using cross-gender hormones will begin seeing physical changes such as breasts developing on an MTF or a beard developing on an FTM. Listeners will hear the voice changes wrought by testosterone in an FTM, and may take notice of an MTF's attempts to change her

pitch, intonation, and/or speech pattern. Intimates may notice the individual's personal smell changing (Boenke, 2003; Tucker, in press).

More obviously, most MTFs and many FTMs change their wardrobes dramatically, beginning to publicly wear clothes that are widely identified with the gender "opposite" their birth gender. Most transsexuals change at least their first names to something the general public identifies as belonging to their target gender. Many also seek to change their name and/or gender designation on documents such as driver's licenses, school records, birth certificates, and many others, requiring explicit conversations and/or correspondence with multiple bureaucrats (Brown and Rounsley, 1996; Denny, 1994; Israel and Traver, 1997; Sullivan, 1990).

Transitioning in Later Life

A substantial proportion of transgender individuals do not transition until late middle age or beyond (Cook-Daniels, 2002). To some still-unknown degree, this is a cohort phenomena caused by publicly-available information about transgender people reaching a critical mass. Individuals who have struggled with gender questions all their lives may not have realized until now -- with the availability of the World Wide Web and more literature on gender variance -- that there was a name for their feelings and courses of action they could take (Meyerowitz, 2002).

Other elders decide to transition in later life because of life course milestones such as retirement (eliminating the need to transition on the job), children moving out of the house (reducing the need to present a particular family image), or the death of parents (freeing the transgender person/SOFFA from the prospect of coping with their reactions). A health crisis may precipitate transition if it prompts the elder to decide that time to live the way sie wants to is running out. Similarly, an elder may simply reach a point of exhaustion in hir efforts to present himself as a manly man or feminine woman, and decide the charade is no longer worth

upholding. Sometimes older transitioning persons simply declare, “I’ve done everything everyone wanted me to do. It’s my turn now” (Cook-Daniels, 2002).

Many aspects of transitioning are the same whether one is 20 or 70. However, there are some differences for people who transition at older ages.

- **Health concerns.** Statistically, older people are more likely than young people to have chronic conditions such as heart disease and high blood pressure. These conditions may make gender-related surgeries and cross-gender hormone therapy more risky, or even rule them out altogether (Israel and Tarver, 1997; Kirk, 1996).
- **More entrenched social roles.** Many people believe it’s harder to make significant changes in an interpersonal relationship that’s been in a specific pattern for 30 years than it is in a relationship that is, say, only 3 years old. Similarly, it may be more difficult to change speech patterns and physical mannerisms that have been reinforced for 50 years than it is to change 20-year-old patterns (Cook-Daniels, 2002).
- **Dating difficulties.** Particularly for heterosexual MTFs, being single in old age means a sharply reduced dating pool because of the ratio of older men to older women. Lesbian MTFs, however, may also face a constrained dating pool because many older lesbians will not consider dating an MTF; several older lesbian dating email lists the author has contacted even refuse to accept MTF members outright. FTMs may experience difficulties finding someone willing to accept a sexual partner who does not have a functioning penis (Devor, 1997). Certainly, beginning to date again after 30 or 40 years of marriage (in the cases where a trans person’s partnership dissolves during transition) is a daunting prospect for many people.
- **Legal concerns.** Although marriage is an important benefit for adults of all ages, it becomes more critical as disabilities accumulate and retirement and death near (Cook-Daniels, 2004). One elder MTF known to the author is currently negotiating with the Social Security Administration over whether they

will grant her spouse of many decades spousal benefits, given that the couple now appears to have an (illegal) same-sex marriage. Courts have decreed that transgender individuals could not claim a spouse's inheritance or sue for malpractice on behalf of a late spouse because their marriages were ruled invalid (Minter, 2001). Other legal concerns that may be more pressing for older than younger transitioning persons include changing Social Security and Veterans Administration records to protect earnings records and benefits (Cook-Daniels, 2002).

- **Employment issues.** Employment is of great concern to many people who transition later in life but before full retirement. Many such persons are in traditionally gender-segregated professions (often chosen decades earlier as a way of hiding or trying to change one's transness), and find the prospect or reality of being the minority gender in that profession untenable. Others lose their jobs due to blatant employment discrimination (which is still legal in most jurisdictions) or end up moving as a way of managing the stress of transitioning. As is well-known, subtle (albeit illegal) age discrimination in hiring is rampant. Some older transgender job seekers face not only that barrier, but also additional hurdles, either because they are visibly trans or because they have chosen to closet their transgender history and consequently cannot declare or must somehow alter their past employment history to avoid revealing their previous name and/or gender (Cook-Daniels, 2002).

Transition and Mental and Physical Health Professionals

As noted, many transgender people are dependent on medical professionals for the hormones and/or surgeries they need or want. In turn, these physicians usually require written certifications (often just called "the letter" in the transgender community) from mental health professionals attesting to the sanity and GID diagnosis of the person in question (Ettner, 1999; Israel and Tarver, 1997; Kirk, 1996; Meyer, et al., 2001). These letters help reassure physicians that the client is unlikely to later change hir mind and sue for malpractice.

The Harry Benjamin Standards of Care (HBSOC), “designed to promote the health and welfare of persons with gender identity disorders,” are probably far more influential in this matter than are malpractice fears, however. The HBSOC is maintained by the Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA). Although HBIGDA only has about 350 members worldwide, the HBSOC influence the actions of thousands of physicians and therapists and guide the lifecourse of tens (if not hundreds) of thousands of transgender people and SOFFAs. HBSOC requires one letter from a qualified mental health professional before starting hormones or (for FTMs) having chest reconstruction, and letters from two such professionals before obtaining genital surgery (Meyer, et al., 2001).

To obtain the letter authorizing hormones, the HBSOC generally require the transgender person to live, publicly and full-time, as their “target” gender for at least three months, or have at least three months’ psychotherapy. Surgery permission letters generally require, among other things, “12 months of successful continuous full time real-life experience” in the target gender, and – at the mental health professional’s discretion – “regular responsible participation in psychotherapy throughout the real-life experience....” (Meyer, et al., 2001).

Not surprisingly, requiring transgender people to navigate through a mental health hoop to obtain medications and plastic surgeries that are freely available to non-transgender individuals frequently creates anxiety, anger, fear, and resentment among transgender people and SOFFAs. They often perceive that the process labels them mentally ill until proven otherwise, and are fearful and angry that – to a degree that is rivaled perhaps only by prisoners and the severely domestically abused – their life choices are under someone else’s control. Many are incensed that a truth they have understood about themselves for decades must be explained to the satisfaction of a relative stranger who, in most cases, has no personal experience with (and may have little professional training about) the phenomena (Israel and Tarver, 1997). These stressful emotions are often exacerbated for transgender people who do have a mental illness, are old and/or in poor health, or have

some other characteristic they fear will be used by the mental health professional to deny them access to transgender-related health care services (Munson and Cook-Daniels, 2003).

Older people may be particularly concerned about interacting with mental health professionals if they will be perceived as gay or lesbian post-transition, due to the fact that many "early" gender specialists -- i.e., those older people may have consulted in their 20s, 30s, and 40s -- believed that a sex change was a "cure" for homosexuality. Therefore, a biological male who was attracted to women and wanted to be a woman (and who therefore would likely be a lesbian post-transition) was, by definition, not a candidate for a sex change (Meyerowitz, 2002). Similarly, people who had borne or sired children were sometimes viewed as not a "real" transsexual, due to the obvious fact that they had functioned sexually in their birth gender. These beliefs, while now officially repudiated by the HBSOC, are still adhered to by some practitioners. For instance, in 1994 office staff of one surgeon frequently used by transsexuals flat-out refused to continue a discussion with the author about the possibility of sex-change surgery once it was revealed the potential client had borne a child.

Cost is a related issue. Almost no public or private health insurance system will pay for gender-related surgery (which can cost anywhere from \$6,000 to over \$100,000, depending on what procedures are done), and many will not pay for "cross-gender" hormones. Since insurance coverage of mental health care is still universally inadequate, adding a mental health gatekeeper to the mix only heightens what many perceive to be an already insurmountable financial barrier (Israel and Tarver, 1997).

Early Transitioners and Non-Transitioners in Later Years

Of course, not every older transgender person transitioned late in life; many have been living in their gender of choice for decades, and no longer face the challenges enumerated above. Others never went through transition. However, these people still face challenges unique to older transgender people.

Some of these challenges relate to what was required by the gatekeepers when the then-young elder transitioned. For many years, psychiatrists and other professionals required transsexuals to divorce their spouses (which, indeed, is still occasionally mandated by surgeons and even governments before a sex change can be completed). They often frequently encouraged transsexuals to move to a new place and construct a personal history consistent with their new gender (Meyerowitz, 2002). These practices resulted in trans people losing even more of their social and interpersonal support systems than might otherwise have been the case. The isolation in turn made transsexuals even more dependent on the professionals for help in shaping their emerging self-images. Unfortunately, sometimes these professionals held quite negative opinions; Meyerowitz (2002) says of the gender specialists in the United States, "In the mid-twentieth century the more vocal psychologists and psychiatrists were less inclined to sympathy. As they saw it, transsexuals were not only mentally ill but also willfully annoying" (p. 107; for other examples, see de Savitsch, 1958; Lothstein, 1983; Money & Ehrhardt, 1972). We can only speculate on the long-term impact these provider practices and attitudes may have had on individuals who decades ago went "stealth" (that is, did not disclose their gender change) and have since had little to no contact with other trans people; Claudine Griggs' *S/he: Changing Sex and Changing Clothes* (1998) may illuminate the possible consequences.

Health Care Issues in Later Life

A transgender individual's involvement with the health care profession does not end once transition is completed, due to the fact that most transgender individuals who use hormones to alter their bodies continue to use those hormones – and, therefore, regularly consult a physician for new prescriptions – for life (Israel and Tarver, 1997; Kirk, 1996). Very frequently, these physicians have little or no training in cross-gender hormone therapy or other transgender-related medical issues, resulting in the transgender person bearing the burden of

doing medical research and educating his own physician or simply accepting care that not only is not ideal but that may, in fact, be harmful. This risk may be greater for older persons.

Transgender elders also experience fear and difficulties seeking treatment for non-trans-related medical problems. Although some MTFs are financially and physiologically lucky enough to sculpt bodies that even health care professionals perceive as biologically female, most naked transgender bodies bear body parts, scars, or other physical evidence that may contradict or cause questioning of what was perceived to be the patient's gender when she was clothed ("non-congruent" bodies). In other words, many transgender individuals do not have the option of keeping their gender history a secret from health care professionals. This, in turn, opens transgender people to everything from casual questions to blatant discrimination or abuse by those professionals. For instance, the documentary *Southern Comfort* details the death of Robert Eads, a female-to-male, from ovarian cancer, who many physicians refused to treat because of their discomfort with his transgender body (Davis, 2001). Transgender individuals' "non-congruent bodies" may also lead to embarrassing, disrespectful, and perhaps even hostile treatment in sex-segregated health care settings such as hospitals. Even SOFFAs have reported problems accessing quality, respectful healthcare as a result of providers' transphobia (Munson and Cook-Daniels, 2001).

These problems intensify as the transgender person ages and begins to experience more acute and chronic conditions and disabilities, resulting in increased contact with health care professionals and institutions. Particularly worrisome to many transgender elders is the prospect of needing intimate personal assistance from paid aides or, even worse, needing to reside in a nursing home (Cook-Daniels, 2002). Although many elders dread the "indignity" they perceive to be associated with these services, the services represent actual danger for transgender elders such as Mr. Adams, who often fear encountering insensitive or prejudiced aides when they are most physically and emotionally vulnerable. Transgender elders who use hormones also worry that if they are confined to a health care institution, that facility may deny them their hormones. Consequently, transgender elders may be resistant to accepting health care in even life-threatening circumstances

(Middlebrook, 1998); Kay (1998) presents a fictional exploration of the psychological and social implications of the death of a previously-undisclosed transsexual.

Transgender elders who have not transitioned to the gender “opposite” their birth gender also may dread contact with health care professionals and institutions. For example, a butch woman may worry that a nursing home will require her to throw out her wardrobe and instead acquire and dress in “female” attire. A male cross-dresser may resist seeing a physician for a medical problem, fearing that the doctor or nurse will notice and remark on his shaved underarms and legs.

Legal and Financial Issues in Later Life

Those who serve elders know how crucial legal documents – powers of attorney, living wills, marriage and divorce papers, pension documents, birth certificates, wills, etc. – can become in accessing services and benefits elders need and in carrying out elders’ wishes (see Dubois, this volume). As with all other elders, transgender people and SOFFAs may need assistance or support in getting these documents in order. However, there are issues unique to transgender people and their families of which service providers and advocates should be aware.

One area critical to transgender individuals and their partners is legal marriage and all its accompanying benefits such as access to Social Security and other pension systems’ survivor benefits, inheritance rights, the right to make emergency medical decisions, the right to hospital visitation and same-room nursing home placement, etc. (Cook-Daniels, 2004; Minter, 2001).

One type of legal marriage involving a transgender person occurs when a couple was married pre-transition, when they were “heterosexual.” Although one partner’s transition turns the couple into a “same-sex” pair, it is widely believed that the marriage remains valid, under the presumption that only the parties to a marriage can dissolve it. In another variation, some apparently same-sex couples have obtained legal marriages

because they used birth certificates showing that legally, the couple consists of a female and a male. In still other cases, a seemingly heterosexual couple has married even though both members of the couple were born the same sex (a fact they may not disclose to those issuing the marriage certificate). However, few of these types of marriages have been tested in the courts or through application to Social Security or other programs, and the results of those that have been tested are mixed; in some cases the marriages were upheld and consequent rights were granted, while in other cases the couple's marriage was ruled invalid and benefits were denied (Minter, 2001).

Another area in which transgender elders and SOFFAs may need assistance is ensuring that all Social Security, Veterans' Administration, pension, life insurance beneficiary forms, and similar records do, in fact, reflect the transgender person's current name and gender designation, to ensure that services and benefits are not held up when they are needed because of confusion over who is applying. However, the full implications of these changes need to be carefully considered; as mentioned earlier, the Social Security Administration contacted one transgender elder concerning her "same-sex marriage" when her wife applied for benefits. Apparently they noticed that the elder had previously changed her name and gender designation on Social Security records. Although other couples have sailed through these bureaucratic waters, the importance of Social Security benefits to most elders' financial well being suggests that this is an area where much more thinking and advocacy needs to be done.

Unless Medicare begins truly providing full prescription drug coverage, the cost of hormones will continue to be an issue for low-income transgender elders. Many transgender people also have their blood tested regularly to monitor hormone levels and related health issues; this lab work, too, may represent a significant portion of a low-income elder's budget (Israel and Tarver, 1997).

Social Concerns

Many transgender people find that once their transition is complete, the only people who know of their transgender history are their sexual partner(s), their children, and one or two physicians. (However, sometimes even these key individuals do not know; for stories of three such families see Cook-Daniels (2001), Kay (1998), and Middlebrook (1998).) Even for such non-disclosing or "stealth" transsexuals, however, this comfortable status quo can change literally in an instant due to the onset of an acute medical problem or the death of a partner. The implications of a health care crisis include the possibility of health professionals' refusal to treat a transgender person, having to fight to be placed in the appropriate sex-segregated room or ward, and having to explain to multiple health care providers why one has a "non-congruent" body.

The death of a mate who is transgender can present serious challenges to the widow/er, who may be called upon to "explain" hir partner's body to multiple professionals whose job it is to attend to a death, and possibly to those from whom sie will later seek benefits (Cook-Daniels, 2001; Kay, 1998). The death of a transgender person's non-trans mate does not, mercifully, require the transgender person to immediately out hirself, although that may become necessary in the course of handling post-death business. A mate's death does, however, mean that the older transgender person is now more vulnerable to the possibility of needing personal care assistants (given that sie has lost the "usual" caregiver, hir spouse) and, with time, may face the prospect of dating and having to "come out" to potential sexual partners.

It is at the time of such crises that a transgender elder or SOFFA may suddenly seek services or support after many years of avoiding services advertised as catering to transgender people.

Implications

Let's return to Mr. Adams and Andrew. *Are* Mr. Adams's genitals of concern? It is conceivable that a constellation of medical conditions could lead to a "normal" male having the genital conditions we see here. A

simple question along the lines of, “Has the size or function of your penis changed in the last few months or years?” should quickly determine whether a new medical condition has developed that may need addressing.

If there has been no recent change in his genital status, chances are good that Mr. Adams is a normal FTM and/or intersex person. FTMs of all ages are still very unlikely to have a phalloplasty (the surgical construction of a penis) because of exorbitant cost, dissatisfaction with current surgical procedures, or a belief that one can be male without having a penis. FTMs are more likely to have a small organ, previously known as a clitoris, that has been stimulated into growth by testosterone. In some cases, FTMs have a procedure done called a metoidioplasty, in which the clitoris is released from its “hood,” thereby gaining additional length. FTMs may also have a surgery done that creates a scrotum out of the labia majora. In most of these cases (and, indeed, in some cases of phalloplasty), the urethral opening will not be moved, creating a scenario similar to what Mr. Adams has described (Sullivan, 1990).

Alternatively, Mr. Adams could be intersex. Although there are many different intersex conditions, one of the most common ones -- estimated at one in 2,000 births -- is hypospadias, in which the urethral opening is in the perineum or along the penile shaft (Frequency, 2004).

If genitals aren’t a concern, many individuals’ next question will be about Mr. Adams’s identity -- is he FTM or intersex? Like the question about genitals, the identity question serves the questioner’s curiosity and desire to put everyone into neat boxes far more than it serves the individual being asked. Worse, trans people’s identity labels tell the observer nothing. Terminology in the transgender community is *hotly* contested: any given “transsexual” may have had or not had surgery; a “cross-dresser” may identify as female, male, bigendered, transgendered, or something else entirely; a “genderqueer” may be the most masculine-looking person you know; and many people with a “trans history” refuse to identify as anything other than “female” or “male.” In addition, many transgender people call themselves “intersex” to reflect their belief that they were born with a biological condition affecting their gender, and many “intersex” individuals have never heard the term, both because it is a new one (such individuals used to be called “hermaphrodites”), and because *many*

intersex individuals have never had a discussion about intersex issues with a health care provider or anyone else, since their parents kept their status (and, often, the fact they had genital surgery as infants) a secret, due to shame and the advice of health care professionals (Intersex Society of North America, n.d.).

The labels an individual uses for himself are, however, *critical* in one way: knowing and consistently using the label, pronoun, and name an individual prefers is crucial to conveying respect and support for the right of self-determination. And self-determination and respect is exactly where we *should* be when we deal with trans elders and SOFFAs (and everyone else!): what do *they* believe they need help with? What issues do *they* identify as problematic and not problematic? What outcomes would *they* like to see?

Further questioning of Mr. Adams could lead us in many directions. Exploring his fears of reporting the aides or the assault might reveal previous traumas that need treatment. Further exploration of why Mr. Adams doesn't want to tell his guardian what has happened might lead to a discovery of more abuse or exploitation, or could indicate a long-standing history of shame and/or family secrets. A discussion about Mr. Adams's feelings of isolation and where his interests lie could lead to hooking him up with the local "armchair travelers" group or arranging for nearby schoolchildren to come by and listen to his magnificent stories.

If it did turn out that Mr. Adams was at a point in his life where he wanted to connect with other people who are "like him" in regards to being transgender and/or intersex (particularly if he wants age peers), we do have some options. Many urban areas have a transgender support group, and it is possible they would welcome Mr. Adams, particularly if transportation for him could be arranged (note, however, that frequently FTMs are scarce in such groups; a few areas do have FTM-specific groups). Only one local area -- high in the Pacific Northwest -- is known to have a group of older trans people who meet, and theirs is an informal network of friends that get together whenever someone has a party. There is also an online support group, ElderTG, for trans and intersex people and SOFFAs age 50+, that provides a virtual support group (for further information, see the website <http://www.forge-forward.org/tan/index.php>). An excellent way for individuals and organizations to support trans elders is to teach them how to use email and provide them with some computer

access so that they can connect with others, even if it's only by email. Finally, some SAGE-like organizations actually do include aging trans individuals, and make an effort to be trans-sensitive (Milwaukee's SAGE is one of those).

Professionals like Andrew who discover they're working with trans elders also have an email-based resource: the Transgender Aging Network (TAN), which sponsors a listserve focusing on announcements, new resources, ongoing research, and peer-to-peer advice. This can be accessed through the TAN website, which also contains further educational resources (<http://www.forge-forward.org/tan/index.php>).

Conclusion

Ultimately, however, what Mr. Adams most needs is what we all most need: someone to hold our hand, listen to us carefully and respectfully, trust and honor our self-assessments, and help us exactly how we say we need to be helped. Given most professionals' lack of personal contact with transgender people and their subsequent reliance on stereotypes and outdated theories, however, professionals serving transgender, intersex, and SOFFA elders need to be especially careful not to fall into the all-too-common trap of substituting their own agenda for this simple, client-driven one.

At the same time you are determining the individual transgender elder's needs, nevertheless, it can help to keep in mind some of the unique issues transgender elders and SOFFAs face that are not shared by other elders under the larger "LGBT" umbrella. To recap, these issues include:

- The public nature of a gender transition precludes the typical LGB "coming out" pattern of controlled disclosure, and exposes the elder and hir SOFFAs to the comments and reactions of even relative strangers.

- "Non-congruent" bodies mean that accepting any health care or personal assistance services delivered when the client is partially or fully naked exposes the elder to caregivers' reactions and stereotypes, which may cause trauma and/or result in the elder refusing to accept care.
- Legal identity and related paperwork issues may need to be addressed to ensure the elder and hir SOFFAs access to earned benefits and supports.
- Because trans elders have almost universally been forced into mental health care "whether they needed it or not" in order to effect their gender transition, they may carry significant animosity toward the idea of seeking mental health care.
- Because of hormone, surgery, and related medical costs and because of loss of family-based and job-based financial support due to transphobia, older trans people and their SOFFAs may have more severe financial concerns than the "typical" older LGB.



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