

Do Trans People Age Differently? Empirical Findings of International Studies on Trans Identities, Health and Age(ing) ¹

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It is evident that as life expectancy increases, the population of older adults will increase. Older Lesbian, Gay, Bisexual, and Trans people (LGBT) are becoming more visible. It is estimated that approximately five to ten percent of all seniors in the United States (US) identify as LGBT (Grant 2010). This means that within the next couple of decades, there will be two to seven million LGBT older adults in the US.

Little is known about older LGBT people, especially older people who do not identify with the gender they were assigned at birth and/or do not conform with stereotypical binary gender norms. This article focusses on the particular life circumstances, challenges, strengths and care needs of older trans people. While often discussed as a subset of the LGBT population overall, trans people have unique health needs and should be the focus of specific research within gerontology. Survey-based as well as anecdotal evidence indicates that the everyday reality of trans people differs from that of cisgender lesbian, gay and bisexual people in important ways, primarily due to the additional challenges imposed by hetero- and cis-normativity. The intention of the following article is to synthesize what is currently known about trans identities in aging and care.

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Trans Identities and Aging in Research

According to a survey from the Williams Institute at the University of California Los Angeles, approximately 1.4 million people (0.6% of adults) in the United States are trans (Flores et al. 2016:2). The number of gender questioning people is most likely higher than this. A recent study with data from Great Britain, New Zealand, Belgium, the Netherlands and the USA postulates that between 0.5 % and 1.2 % of the total population identify themselves as trans (Winter et al. 2016:392). The available studies show that the trans community seems to be dominated by young people. Rarely are persons over 54 years of age found in the results (James et al. 2016; FRA 2014). The experiences of this population group are usually “concealed” (Brown 2009). Established research on aging has rarely considered questions of gender diversity (Van Caenegem et al. 2015).

One reason for the underrepresentation of certain age groups might be the fact that most surveys have been conducted via online questionnaires². It may be that socio-economic disadvantages that trans people face in their lives (see following section) influence their ability to access the internet at home. Some people may not feel comfortable taking part in specific surveys on shared computers or in shared spaces, where others could discover their gender identity. Besides this, age itself might play an important role in terms of the ability to use a computer and the internet. Invisibility of trans older adults may reflect a need for further efforts to reach out to this population and include them in research. It also may be that added to these disadvantages, poor general and mental health, and experiences of violence lead to an earlier death for many trans people, leading to their underrepresentation among older adults compared with LGB people and the non-LGBT population.

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- 2 The usual age-related decline in participation in online surveys due to lack of Internet access and a lower affinity for technology (see File and Ryan 2014:3; Hanson 2001:14-15) could be less significant for the trans population than for the majority population, since the Internet is generally more important for trans people (among other things, due to the higher level of repression and lack of visibility, online social networks are more important). Socio-economic disadvantages could in turn be a reason why trans people have less frequent access to the Internet.

Challenges in the Life Course of Trans Identities

Socioeconomic Factors

Challenges and disadvantages throughout an individual's lifespan have great impact on the physical and mental health, general well-being, social life and socio-economic status. This section identified several areas in which trans people face higher disadvantages than cisgender LGB people and the general population³. These lifetime disadvantages speak to the importance of addressing trans people as their own target group in research about aging.

With regard to educational background, the analysis of the U.S. Transgender Survey (USTS; n=27,715), which reports on the lives of trans people in the United States, shows that trans people experience discrimination as early as school age and this discrimination often recurs throughout their lives. 17% of the respondents dropped out of school prematurely due to assaults and 6% were even expelled from school because of their gender identity. Those who continued to attend school found themselves in a violent environment. 77% report having been harassed, almost a quarter (24%) were subjected to physical violence and 13% experienced sexual violence (James et al. 2016:131).

Trans people are far more likely to belong to a low-income group or be living in poverty. In another study on U.S. trans identities (Injustice at Every Turn; n=6,450), 44% reported that they are "underemployed", i.e., despite good qualifications, they do not get adequate employment matching their qualifications (Grant et al. 2011:51). The USTS report states that 30% of the participants had lost their jobs, were not promoted or otherwise disadvantaged in the year prior to the study due to their gender identity. 15% were verbally or physically assaulted or sexually harassed at their workplace. 77% reported that they hid their identity or changed jobs because of the work climate. 27% reported that they had been disadvantaged in their search for a job (James et al. 2016:148) Similar numbers are found in the study "Being Trans in the European Union" (BTE study; n=6,579): According to this study, 37% of respondents stated that they had been discriminated against in their search for a job within the last 12 months. This is twice as often as lesbian, gay or bisexual participants experienced it. 27% were discriminated against in their workplace (FRA 2014:27). It is believed that trans people receive, on average,

3 We have used those studies that explicitly differentiate between sexual orientation and gender identity in their results and data evaluation.

lower incomes because of these experiences of discrimination (James et al. 2016:ff.; FRA 2014:121; Grant et al. 2011:2).

For example, the EU-wide BTE study, which is based on the methodology of the European Social Survey (ESS), reports that compared to LGB respondents in the study, trans people are more likely to receive income in the lowest quartile and less likely to receive income in the highest quartile (FRA 2014:20ff.). The results of the latest study (USTS) show that 29% of the participating trans people live in poverty. This is twice as high as in the US general population, where the overall poverty rate is 14 % (James et al. 2016:140). Even if only few older trans people participated in these studies, it is reasonable to assume that the situation for trans elders is similar, if not even worse.

Health Factors

In an online study (AH-Report; n=2,536) of the University of Washington conducted among older LGBT people in 2011 (AH Report; n=2,536), 174 participants (6.9% of all respondents) identified themselves as trans (Fredriksen-Goldsen et al. 2011:11). 47% of trans respondents stated that they suffered from depression, compared with 32% for LGB respondents, while 39% had anxiety, compared to 26% of LGB respondents (ibid.:26). In the USTS report, 40% of trans people reported having survived at least one suicide attempt, compared to 4.6% of the mainstream population. 82% reported having had suicidal thoughts at least once (James et al. 2016:112). In addition to these already alarming numbers, one third (33%) of the trans seniors surveyed in the AH-Report described poor general health and poor physical health. Compared to the cisgender LGB group, trans seniors are more likely to be physically disabled. The rate of trans people who are considered overweight in the AH-Report is 40%, which is significantly higher than for LGB people (26%), and indicates a higher risk of diabetes, coronary heart disease and osteoarthritis (Fredriksen-Goldsen et al. 2011:23-24). The above-mentioned aspects of education, work and mental health have a significant impact on well-being and on whether and how well a body can recover from discrimination-related stress. Studies on cis gay men show the extent to which social discrimination, socio-economic status and minority stress influence mental well-being and the acquisition of mental illness (on gay men: Drewes and Kruspe 2016:82ff.; Drewes 2015). It is reasonable to assume that the impact of discrimination and minority stress on trans people is even greater, given the overall poorer profile of economic discrimination, general and mental health outcomes for this group.

Other negative factors for life expectancy and quality of life are that trans people are less likely to engage with preventive health examinations, and more at risk of Human Immunodeficiency Virus (HIV). 1.4% of the respondents in the USTS report stated that they were HIV positive, compared to 0.3 % of the U.S. population. Another 46% of respondents did not know their HIV status (James et al. 2016:4). Trans persons are more likely than cis persons to be drug users, more likely to be financially dependent on sex work and more likely to engage in unprotected sex (Grant et al. 2011:65; Auldridge et al. 2012:14-15; James et al. 2016:115).

At this point it should be noted that in the USA, having health insurance or receiving adequate medical care depends heavily on a person's financial resources. Trans people in the USA are particularly affected by insufficient healthcare provision due to lack of health insurance: 22% of the older trans people surveyed in the AH-Report stated that they could not afford to see a doctor in the 12 months prior to the study. Among LGB people of the same age this was 8% (Fredriksen-Goldsen et al. 2011:30). Trans seniors are also much less likely to undergo preventive examinations such as colonoscopy (LGB: 56.1% compared to trans: 42.2%) or osteoporosis screening (LGB: 32.9%, trans: 19.1%) (ibid.:73). 40% of trans people reported that they received inadequate care or were even denied medical assistance (11 % for LGBs) (ibid.:31).

Out of trans respondents to the USTS, 25% reported that they had been denied transition-related medical care and 33% of the respondents had to postpone a visit to a doctor despite illness or injury because they did not have the financial means during the 12 months prior to the study. Out of fear of discrimination, 23% of the participating trans persons did not go to a doctor and 33% reported negative experiences (e.g., refusal of medical care, discrimination) in their search for medical treatment (James et al. 2016:93). The EU-wide BTE study shows a very similar picture: 22% of the participants were discriminated against by medical personnel in the past 12 months because of their gender identity. For example, 26% of the respondents from Germany experienced discrimination in healthcare. These figures suggest that even a form of statutory health insurance such as the one found in Germany by no means guarantees adequate and barrier-free medical care for gender diverse people. In addition to these experiences of discrimination, about half of all participants in the USTS reported that their medical practitioner did not know about trans specific medical care (e.g., hormone administration or hormone-drug interactions) and the patient had to provide this information themselves (ibid.:96). A similar picture can be found in Europe, where 30% of those sur-

veyed reported that medical staff were willing to intervene appropriately but did not have any expertise in the care of trans people (see Whittle et al. 2008).

A related issue in trans medical care is trans people's dependence on health professionals not just for access to medical interventions such as hormone therapy, but also in the process of seeking legal recognition of their gender identities (Cook-Daniels 2016:294-295). In many countries, either a statement by a physician, or forced sterilization, is a prerequisite for legal recognition of a trans person's gender (i.e., changing the first name and/or gender marker in official documents). As a result, physicians can act as 'gatekeepers' preventing many trans people from achieving legal gender recognition. In the USTS, only 11% of the respondents reported having been able to change their first name and gender marker on official documents (James et al. 2016:82).⁴ Many trans people who have not changed their legal name or gender are confronted with the danger of being 'forcibly outed' because their official documents do not match their gender presentation. Psychologists and psychiatrists may be similarly influential in determining whether a trans person is given access to hormone treatment or gender affirming surgeries. In many countries, access to these interventions requires diagnosis with a mental illness, contributing to further pathologization and stigmatization of trans experience (Cook-Daniels 2016:295).

Cook-Daniels (2016) discusses additional barriers that older trans people may face to accessing medical examinations or receiving assistance with personal care. Some trans people are able to exercise discretion about when, and to whom, to reveal their trans identity. However, particular medical and aged care procedures (i.e., receiving assistance with bathing), may require that the person providing the service sees the genitals of the person receiving the service. According to the above-mentioned NTDS report, only 21-23% of the male-to-female (MtF) and none of the female-to-male (FtM) respondents had undergone gender affirming bottom surgery, due to the large number of possible complications. Some trans people who have not undergone such surgeries face the risk of having their trans identity involuntarily revealed in the context of a medical examination or assisted personal care. Cook-Daniels observes that this reality may discourage trans seniors from seeking medical care (see under *Health Factors* above). Ignorance on the part of caregivers

4 It needs to be noted that not every trans person wants to legally change their given name and/or gender marker, nor does every trans person wish to undergo any other social, physical and/or legal changes.

about the treatment of trans people may be one reason why this group less often agrees to home care or placement in an inpatient facility, even if this is recommended to them (ibid.:294). Furthermore, it should be noted that even if a normative physical alignment has taken place, in the case of later nursing care, earlier transition-related surgical interventions require appropriate treatment. Visible scars, or required hormonal medication, may lead ignorant nursing staff to demand an explanation which can result in unwanted conversations about the individual's trans history.

(Family-)Networks

Further differences between trans people compared to cis LGB and non-LGBT people can also be found in social and family life. 18% of trans people interviewed said they were parents and 14% lived with a child in the same household, compared to 34% in the general population. Of those participants who lived their trans identity openly in front of their children, 21% said that the children did not talk to them because of that. In addition, 40% of all trans respondents did not receive positive support from their family (James et al. 2016:ff.). Even though trans seniors are more likely to have children than older cis LGB, the probability of feeling lonely is higher than in the cis LGB comparison group. In particular, rejection by the family and limited contact with one's own children, or even a break-off of contact, can lead to a life situation that is characterized by an above-average degree of isolation, especially in old age (Fredriksen-Goldsen et al. 2011). Nevertheless, a recent study by Eroshva et al. (2016) showed that trans seniors have more opportunities than cis LGB seniors to build a social network in diverse communities (ibid.:114). In the study of 1,913 older LGBT respondents, including 136 trans identified participants, trans seniors were found to have the largest network size (median=54.5). Other aspects of diversity that go beyond the category of gender identity, was also most prevalent in trans networks (under control of other variables, including network size) (ibid.:107ff.).

Discussion

The data presented reveal a variety of barriers to a good quality of life for trans seniors, which are rooted in the discrimination that is observed over the lifespan of gender diverse people. Older trans people who – like others – are confronted with challenges of old age, such as a reduction of their social

network and increasing restriction of mobility, need a considerable number of coping strategies and social resources to deal with these challenges. Discrimination, a stressful environment at school and at work, financial worries, social exclusion, and a lack of medical care can lead to greater levels of psychological and physical stress. If we look at the studies by Fredriksen-Goldsen and others, the situation is only partially comparable to the lives of cis LGB seniors. Trans seniors are confronted with mental health problems and pathologizing, discriminatory experiences with medical professionals. Doctors and psychologists often misuse their power as decision-makers and gatekeepers during medical and legal procedures associated with transition (Fredriksen-Goldsen et al. 2011; FRA 2014; Elder 2016; Cook-Daniels 2016). Experiences in psychotherapeutic care that trans patients report in qualitative studies are often described as traumatic. A small improvement in trans people's experiences with psychotherapeutic support has been observed in recent years; however, there is still much more work to be done in this area (Elder 2016:182-183).

All of the lifelong challenges discussed above contribute to the disproportionate difficulties that trans seniors may face in accessing quality care in old age. The BTE study assumes that, due to the above-mentioned challenges and experiences in the healthcare system, this population group has the highest probability of recurring discrimination experiences among the subgroups under the umbrella of LGBT (FRA 2014).

Despite the almost incalculable experiences of discrimination, violence, rejection, and psychological problems, a recent study on trans and aging points out that trans seniors do not necessarily experience the phase of old age negatively, but rather assess their life situation as peaceful (Porter, Ronneberg and Witten 2013). This is made possible by personal identity development and the accomplishment of the developmental psychological task of ego integrity. Also, increased resilience due to overcoming life crises and the positive experience of self-activity in one's own social networks seem to work towards a positively experienced second half of life (Porter et al. 2016). Additional results of a qualitative study conducted in Germany⁵ show how the diverse expressions of sexual and gender identities shape the lives of LGBT older adults who are in need of care. It became apparent that the experiences of everyday nursing care are directly influenced by biographical events and access to self-help structures for care receivers and reactions and

5 „GLEPA – Gleichgeschlechtliche Lebensweisen und Pflege im Alter“, at the Alice Salomon University of Applied Sciences Berlin

attitudes of the carers. It was also observed that trans seniors in need of care make use of biographic experiences in order to act in self-determined ways in care settings (see Lottmann 2018).

From the LGBT community, concrete demands are sometimes formulated, which are used on the basis of the presented data for the further development of regular medical services. Advocacy for GLBT Elders (SAGE) and the National Center for Transgender Equality (Auldridge et al. 2012) have drawn up an action plan that shows how the needs of trans seniors can be better taken into account and their quality of life improved. In particular, they call for a culture of anti-discrimination through mission statements and the visibility of LGBT people in medical and nursing institutions. Additionally, they advocate for further education and training to improve the awareness of all medical personnel about the concerns and interests of trans people, especially regarding their rights to privacy, dignity and self-determination. In addition, as can be seen from the above-mentioned results on trans and HIV, trans senior citizens must be given special attention in HIV awareness campaigns, as they have been and are still exposed to a high risk of infection with HIV. Furthermore, some authors call for sanctions for misconduct or denial of services by medical providers (Auldridge et al. 2012:34ff.; Porter et al. 2016).

Due to the growing visibility of the aging trans community, both outpatient and inpatient geriatric care facilities will be confronted with this topic. Within the framework of the LGBT Senior Studies at the Alice Salomon University, knowledge of the living environments not only of older cis lesbians and cis gays, but also of trans people, was considered essential for a sufficient care quality (Linschoten et al. 2016). Understanding of LGBT issues by nursing staff is necessary to ensure that neither those in need of care nor their relatives have to hide. In this context, LGBT personnel in nursing homes are of great importance, as they are to be understood as a resource for these facilities. The “Pink Passkey” care quality label developed in the Netherlands is an instrument for implementing trans-sensitive care in both institutional and inpatient facilities, not only in metropolitan but also rural regions (see *ibid.*). In the development of diversity-sensitive care labels such as this, it is recommended that LGBT associations and organizations be involved (*ibid.*:239). Since spring 2018, the Schwulenberatung (Berlin Gay Council Center) has been offering the “Diversity Check” for the first time for care facilities. This is a quality seal created for the German care landscape, which was developed in cooperation with community organizations and is explicitly informed by trans life experiences and the needs of this community.

The limited empirical evidence on trans people in general means that there are still too few concrete recommendations for action for this vulnerable population group. Methodologically, the existing studies under the label LGBT do not differentiate between the respective population groups. Merely adding a "T" to the chain of letters in order to appear inclusive or to postulate more comprehensive results is a common but insufficient practice. Instead of including that group, exactly the opposite happens: the invisibility of trans people is preserved and the everyday experiences of discrimination as well as the specific living conditions of this group of people are neglected. The experiences of LGB people in nursing care and, to a greater extent, the experiences of trans seniors with healthcare facilities make it clear that "the debate about how discrimination and experiences of discrimination are to be thought about is far from over. Even though many social scientists pretend that intersectional thinking is a standard procedure, we still encounter insufficient studies. For example, too many studies still speak of 'age(s)' without examining the intersections" (Castro Varela 2016:63). Scientific research has too often ignored the situation of LGB and trans people (Lautmann 2016:43; BMFSFJ 2016:68ff.). The perspective of trans seniors must finally find its way into nursing and aging research.

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