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Elder Transgender Lesbians: Exploring the Intersection of Age, Lesbian Sexual Identity, and Transgender Identity

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This study is the first to examine the experiences and needs of an international sample of current, English-speaking, lesbian, transgender-identified (trans-lesbian) adults around a number of later life and end-of-life perceptions, preparations, and concerns. I analyzed a subset \((n = 276)\) of the cross-sectional data collected from the online Trans MetLife Survey on Later-Life Preparedness and Perceptions in Transgender-Identified Individuals \((N = 1,963)\). I assessed perceptions and fears around aging, preparation for later life, and end-of-life as well as numerous demographic and psychosocial variables. Despite the overall feeling that they have aged successfully, the respondent trans-lesbian population harbors significant fears about later life. I found that this population, while better-prepared than the overall respondent trans-identified population, is still ill-prepared for the major legalities and events that occur in the later to end-of-life time periods.

KEYWORDS aging, cross-dresser, eldercare, end-of-life, gender, gender identity, gender self-perception, later life, lesbian, LGBT, queer, sex, sexuality, transsexual, transgender, trans-lesbian

INTRODUCTION

As the global lesbian, gay, bisexual, and transgender (LGBT) population ages, the intersection of elder status with sexual-identity or gender identity has become a subject of documented importance (Institute of Medicine, 2011; Centers for Disease Control 2013; National Institutes of Health 2013). New books on the subject of LGBT aging have also appeared (Ward, Rivers,
The elder lesbian literature and the challenges that elder lesbians face are well-reviewed in the work of Nystrom and Jones (2012). A review of the literature on trans-aging may be found in Witten and Eyler (2012). Although current reliable trans-population estimates are unknown, Witten estimated that the global population of trans-elers may range between 4,097,020 and 12,291,060 individuals (Witten, 2003). While the subject of LGBT aging is now of increasing interest, most publications embed lesbian or transgender aging into publications on the more general topics of “LGBT aging” or “gay and lesbian aging” (MetLife, 2010; Aldridge & Conlon, 2012; Beeler et al., 1999).

Despite the fact that various researchers have, within the lesbian literature, spent time addressing the inclusion of trans-identities (Birke, 2000; McDonald, 2006; Johnson, 2007; Noble, 2007; Robinson, 2006; Tate, 2012), the research on the intersection of age × lesbian identity × trans-identity is non-existent. Based on the previous population statistics and the fraction of trans-lesbian identified persons in our survey research, I estimate that there may be between 98,421–295,262 such individuals in the United States alone. Given the projected size of this population, it is important that we understand its potentially unique needs during the later and end-of-life stages.

METHODS

This study analyzes cross-sectional data collected from the Trans MetLife Survey on Later-Life Preparedness and Perceptions in Transgender-Identified Individuals (TMLS). The overall respondent sample size was \( N = 1,963 \). Of these respondents, \( n = 276 \) (14.1%) individuals also identified as lesbian; herein referred to as “trans-lesbian.” The detailed survey methodology is discussed in Witten (2013). The survey was Institutional Review Board (IRB) approved by VCU (IRB# B12851).

Survey Structure

The survey instrument was an 83-question, mixed methods, qualitative, and quantitative survey. Survey details are available in Witten (2013). A downloadable copy of the survey instrument is available at http://www.vcu.edu/~tmwitten under the GLBTIQ Archive section.

Statistical Methods and Software

PASW 18–20 (IBM) statistical software was used for the statistical analyses. Significance was accepted at the \( p < .05 \) level. All \( \chi^2 \) multiple comparisons employed the post-hoc Bonferroni test. Welch approximate \( t \)-tests were used,
when necessary, due to unequal sample sizes between the different gender-identity subgroups. The method of interpretive phenomenological analysis was used to identify themes conveyed in the narrative responses (Quinn & Clare, 2008; McFadden, Frankowski, Flick, & Witten, 2013). Qualitative analyses were performed using QSR NVivo 9 software.

RESULTS

The data revealed that the elder trans-lesbian sub-population, while feeling that they have aged successfully, is fearful about their future, insecure about their access to healthcare and the treatment that they will receive as they age, and is ill-prepared for later-life social and healthcare legal problems. Of particular concern to our respondent population were issues surrounding all aspects of later-life healthcare, treatment, inability to live out their respective lives as their true selves, and dementia. Over half of the respondents were over age 50 and, in accordance with other research, more likely to be male-to-female. It is of note that the bulk of the participant fears revolved around gender identity and not sexual identity.

Basic Sociodemographics

For those respondents who identified as trans-lesbian, respondents came from the United States (89.4%), Canada (6.2%), Thailand (1.8%), and Australia, Sweden, and Mexico (all at 0.9%). Over half (66%) of the respondents described their living environment as urban and 32.2% suburbs/rural. The respondents were principally Caucasian (93.8%) and Hispanic (1.8%). The age distribution was 18–30 (11.5%), 31–50 (27.4%), and 51 and over (61.1%). Nearly one-quarter (26.4%) of survey respondents stated that they had a chronic illness and 21.9% reported that they had a disability. Median income of respondents was approximately $45,000, which, according to Gallup’s most recent data (Phelps & Crabtree, 2014) puts them well above the global national median of $9,733. However, it puts them below the 2012 median national household income of $51,371 (Noss, 2013). The population is educated with 9.7% having high school or less as their highest degree, 40.3% having some college to a college degree, and the rest having either graduate school (partial or complete) or a specialty degree (chef, locksmith, etc.). A large percentage (45.9%) stated that they were under moderate to extreme financial strain. Of the respondents, 52.8% stated that they did not have enough money or that they had just enough for basic life requirements.

Natal Sex and Gender Identity

Quantitatively, natal sex was based on respondent birth certificate and driver’s license. There was a statistically significant difference between respondents’ reported natal sex on driver’s licenses versus their reports of
natal sex on birth certificates \((p < .05, \chi^2 = 14.085, df = 1)\). I interpret this result as a consequence of the fact that some states allow individuals to change their natal sex on their driver’s license and respondents indicated when they had done so. The qualitative responses captured a much wider description. For example, respondents identified their natal sex as “female with a penis,” “female bodied, chromosomally and genitally male,” “slightly intersexed female,” and many others. Clearly, survey respondents think more fluidly about natal sex and gender identity than traditional academic literature might allow.

Gender identity was assessed both qualitatively and quantitatively. The quantitative question provided the respondent with a list of gender self-perception choices (e.g., masculine, feminine, transgender, androgynous). The qualitative question asked the respondent to describe their gender self-perception on “an average day.” More than 73.2% of the respondents chose a feminine gender self-perception, while 2.7% chose a masculine gender self-perception, and 9.8% chose Transgender/Third Gender. The remainder of the categories represented a total of 14.3% of the responses. As with natal sex, I found that the qualitative responses to gender identity were much broader than the quantitative responses: “I am an androgynous intersex woman,” “female, though born with male anatomy,” “a woman who was born with male parts,” “woman of transsexual history.”

Pension and Retirement

Of the respondents, 61.1% stated that they had a retirement plan. When broken down by age group, the 18–30-year-old age-group was observably lower, with respect to having a pension plan, than all of the other age groups. The largest number of individuals not having pensions occurred in the income levels under $44,999. This group represents 27.2% of the respondents. Individuals that responded to the qualitative component of the pension question indicated that they had a variety of plans (i.e., Roth Individual Retirement Account (IRA)/Simplified Employee Pension Plan (SEP-IRA, 401K, 403(b), Teachers Personal Investment Services-College Retirement Equities Fund (TIAA-CREF), Registered Retirement Savings Plan (RRSP) plans, Canadian pension, military retirement, social security, and SSA disability). Some reported that they had “mortgaged their homes.” Many reported that they were living on “a small pension,” or “disability support pension.” I also asked those who did not have a pension or other plans why they did not have such plans. I received a variety of responses: “[I] never paid much attention to the future until recently” or “Where on earth should I go to get one? I have been living on the money for my retirement for the past three years and when it is gone it is gone.”

Familial Relationship Status

When the respondents were asked to describe their current relationship status, over one-third (31.5%) stated that they were not currently in a
relationship, 51.3% reported being in some form of committed relationship, 11.7% reported being separated/divorced, 1.8% widowed, and 3.6% reported other forms of relationship. Of the respondents, 30.7% indicated that they were living alone. Moreover, of those living alone, when broken down by natal sex, 86% were natal males and 14% were natal females. When asked whether or not they had children, 51.8% said yes with 66.1% stating that they had 1–2 children and 31.3% having 3–4 children. There was a statistically significant difference with respect to having children when birth certificate sex was factored into the analysis ($p < .05$, $\chi^2 = 14.388$, $df = 1$). While only 5.5% of the natal female respondents had children, 46.8% of the natal males had children.

Familial and Other Social Support

I asked who is likely to be a person’s primary caregiver in the event of major illness or when the need arises. The survey respondents were given a set of choices and asked to choose only one response. Of the respondents, 23.1% stated that they were not sure who would take care of them, 44.4% stated that they expected a significant other/spouse or partner would be their caregiver, and 11.1% expected an adult child to take care of them. All other choices were less than 6%. Natal females reported that they expected a parent, sibling, or paid in-home healthcare worker to take care of them. Natal males reported that they expected a spouse/partner/significant other, friend, or adult child. Also of interest is the fact that of the respondents who were not sure who would take care of them, 92% were natal males.

End-of-Life Preparations

Respondents were asked to check off which of a list of later life/end-of-life (EOL) decisions that they had completed. Of the respondents, 47.8% had completed a will (natal males 85.2%, natal females 14.8%). Additionally, 39.8% had completed a living will (natal males 79.1%, natal females 20.9%), 38.1% a durable power of attorney (natal males 80%, natal females 20%). All other possibilities (ethical will, prearranged funereal/cremation or other EOL ceremony, purchase of long-term care insurance, informal caregiving arrangements, other) were less than 10% each.

Putting Affairs in Order

Only 15% of the respondents stated that they had definitely tried to get their affairs in order while 82.1% of the respondents stated that they had some sense of urgency about getting certain things completed in life. Survey
respondents were asked to identify with whom they had discussed their end of life care and treatment. In order of rank total, the respondents checked: (a) Partner/spouse (43%), (b) Nobody (31%), and (c) Friend (23%). All other choices were 15% or less.

Paying for Later and EOL Care

Respondents indicated that they planned to use the following payment options for later and EOL care: 61.1% Medicare, 47.8% health insurance, 44.2% personal savings, 21.2% not sure, 23.9% Medicaid, 15.9% assistance of family, 15.9% long-term care insurance, 4.4% other, and 8% friends. Respondents were allowed to check multiple responses; therefore it is likely that some percentage of the respondents were using multiple methods to pay for their later-life/EOL care. Study results showed that nearly one-quarter of the respondents (21.2%) were not sure how they would pay for later-life and EOL care.

Concerns Around Aging

TMLS respondents were also asked to rank order a list of their concerns about aging. The top four were, in order of total rank: (1) Becoming unable to care for myself, (2) becoming dependent on others, (3) becoming confused or demented, and (4) becoming sick or disabled.

Over one-quarter (27.6%) of the respondents stated that they were extremely concerned or very concerned that, at some age, they would be unable to function independently because there was nobody to help take care of them. Over one-third (37.5%) of the respondents stated that they were extremely concerned or very concerned that, at some age, they would be unable to function independently for lack of financial resources. Respondents also stated that they were extremely or moderately concerned (57.5%) about being able to function because of physical limitations.

Dementia

From the literature (Anderson, 2013), I estimate that of the current cohort of trans-elders there will be between 1.3–4.1 million trans-identified adults who will develop Alzheimer’s disease (AD). Using these estimates, we are looking at a potential population size of 183,000–578,000 trans-lesbian individuals who will develop AD. Fears around dementia manifested most in those respondents with feminine gender self-perceptions. “Dementia is my worst Fear. My father had what we thought was Alzheimer’s and it was so hard on everyone. I would hate to do that to anyone and I do worry about it” or
“I am a woman with a penis. What will they do to me in a nursing home? What will happen if I cannot defend myself because of dementia?”

Death and Dying

Many trans-lesbian respondents feared their last days would be disrespected and that last wishes would not be carried out. “I am already scared of death. I don’t want to die. Being transsexual, I worry I will die thanks to some bigoted doctor . . . or something bad will happen to me and they will let me die because I’m transsexual.”

Others worried about dying alone.

AS A TRANSWOMAN I AM CONCERNED THAT MY SONS NOT MY DAUGHTER MAY TOTALLY ABANDON ME. I AM CONCERNED THAT MANY OF MY MILITARY FRIENDS AND AQUAINTENCES WILL NOT ACCEPT ME AS A WOMAN. I AM AFRAID THAT IF I ALTER MY BODY TO BE MORE FEMININE IT WILL CAUSE ME GREAT DAMAGE. I LIVED FOR A LONG TIME AS A VERY MASCULINE MAN. I WANT TO LIVE OPENLY AS COMPLETE A WOMAN AS POSSIBLE. THIS CONFLICT TEARS AT ME INTERNALLY.

Nearly every TMLS question also afforded respondents with the opportunity to provide their own words about the particular question. I asked, “We would like to know more about your worries and concerns about aging. Please feel free to write as much as you would like to tell us. What are your worst fears/concerns about aging as a person who is GLBTIQ-identified.” Many wrote of discrimination by caregivers, fears of cruelty and abuse, fears of being homeless, of dementia, and fears of not being allowed to live their final years as their true selves (all responses are reported as written and anonymized where necessary).

If I have to go into a home, as a tall non-op who might have thinning hair by then, I might be treated as male. I worry I might be socially isolated.

I need to wear a wig. If I am in a retirement home or nursing home, I am unlikely to be able to maintain a feminine appearance. If I can’t continue to take hormones, I may get hairy again.

I also asked the question, “To what do you look forward as you age?” Many spoke of “a peaceful death.” Other trans-lesbian respondents had a variety of positive responses (McFadden et al., 2013). Some stated that they looked forward to the opportunity to complete their respective journeys so that they became actualized. Others spoke of growing old with their respective partners, families and friends.
PERHAPS GREATER RESPECTS LEAVING LEGACIES BEHIND RECONCILIATION WITH MY CHILDREN WATCHING ALL 3 OF MY CHILDREN GROW AND DEVELOP.

hopefully to someday to have enough money to get srs before I die. want to be the woman I’ve always been completely when in death

Still others spoke of darker matters. Some spoke of self-euthanasia or suicide rather than living to a point where they arrived at in their later years:

Will I be treated with dignity? Will I be respected? Will I be in a defenseless situation at the mercy of those that do not or are unwilling to understand me being trans? … Not much hope here for me getting old. *Will I have to kill myself so I do not have to face begging from the state for crumbs?*

Many trans-lesbian-identified participants stated that they would prefer to die at home rather than be in a palliative care or nursing home facility. Further examination showed these respondents to be fearful of the type of care that they would receive; would they receive the right pain-killers, would the care be respectful, would they be abused or violated, would their gender identities be respected, would they be allowed to live their last moments with grace and dignity.

My biggest fear is that of being broke, no place to live and all alone and, as a consequence as usual being denied assistance because I am transgender (even though I am technically intersex Klinefelters)

My biggest worry is that we will be denied care. My experiences with the medical community have not been good in that regard. I have been ignored by ER staff and treated with contempt by doctors due to my gender.

Yet, in the face of all of the fear, there was a strong sense of resilience and hope (McFadden et al., 2012; Witten, 2013). “It has given me inner strength and resilience & great coping skills regarding stress which are helpful to aging well (TMLS, 2012).”

It has helped by come to know myself very well, and to advocate for myself and my family. It has helped by insist on being respected by others. I’m not afraid to insist that I be treated fairly and with dignity.

Many respondents wanted to pass on wisdom to the younger generations. They spoke of the need to get an education, of long-term financial planning, of living true to oneself, of the importance of relationships and of being generative.
Aging in the GLBTIQ community is not easy. It takes much long term planning. Do not assume that the heteronormative mechanisms will work for you. Be very proactive.

Be yourself. accept/love yourself just as you are in this present moment; connect with other kindred spirits; take in care and support; treasure positive relationships and move on from relationships that do not honor who you are.

**DISCUSSION**

As there is no literature on the intersection of lesbian sexual identity, gender self-perception and age, particularly at later and EOL stages, this article provides a first look at how the “independent” variables of lesbian sexual identity, gender self-perception and age—mediated through natal sex—might alter later-life and EOL preparations and perceptions. I find that the major population concerns revolve around gender-identity and only involve sexual identity when it adds further complexity to an individual’s identity.

Sociodemographically, I found that while trans-lesbians were overall financially middle-class or better, there were many feminine trans-lesbians (natal males) who made less than $45,000/year and who had no pension plans. I hypothesize that these individuals were likely to have either lost their jobs, retired on marginal income, or found jobs at a lower pay-scale due to their having transitioned and the consequences of that transition. I also hypothesize that those feminine trans-lesbians who reported being under minimal stress and strain are likely to have come out later in life (I did not ask about this) because they were supporting families and children and therefore are likely to have waited before transitioning; transitioning either in retirement or after the children had left the home (Witten & Eyler, 2012). This would have allowed them greater time to build up savings and to have invested in retirement. Study results showed that those individuals who claimed the masculine trans-lesbian identity (natal females) were financially the worst off of all gender identity groups with respect to financial status, despite their level of education or age. I postulate that the societal disconnect between the hetero-normative binary and the transgressive behavior of being masculine-identified and at the same time being lesbian-identified creates an overall social presentation that makes it difficult for these individuals to function in a way that would allow them to obtain jobs that provide a significant level of income.

A significant number of respondents reported having no retirement. Some reported that they had not given thought to later-life retirement issues, others simply had no income to put towards retirement, and still others used what little money they had saved for retirement to self-actualize. Given the
levels of later-life financial and retirement preparation, it is not surprising that nearly 25% of the respondents were not sure how they would pay for later-life and EOL care and that nearly 50% of the respondents were depending on some form of governmental support (Medicare/Medicaid). These results are consistent with those of Nystrom and Jones (2012) who report that “27% of the lesbians in the National Lesbian Health Care survey between the ages of forty and sixty report that they are under-insured ... 16% of the lesbian respondents reported that they could not afford any health insurance” (p. 149). Thus, the trans-lesbian population is fiscally less prepared for later life than their natal female peers in the lesbian population.

Familial and social relationships were found to be equally complex. I observed a diversity of relationship statuses, with nearly one-third of the respondents stating that they were living alone. In a study conducted by SAGE NYC, 42% of the lesbian respondents lived alone compared with 21% of their gay male peers (Nystrom & Jones, 2012, p. 150). By comparison, Jones and Nystrom (2002) found that 39% of their lesbian respondents lived alone. This large percentage of “aloneness” in both trans-lesbian and natal lesbian populations is of note as it has implications for eldercare outreach programs. As “loneliness” is an important mediator of quality of life, the fact that such a large population lives alone opens up the need to examine aloneness versus loneliness in the both the natal lesbian and trans-lesbian population.

I note that there is a significant difference, by natal sex, in whom the respondents expect to “take care of them as they age.” Natal male trans-lesbians were depending on partners and adult children. This is not surprising as this group had the largest number of partnering and adult children responses. However, the natal female trans-lesbians were depending on parents and siblings or the healthcare system as this group had the fewest responses to the partnering and children components of the survey. Given the complexities of relationship status within the legal system, many factors can impact how the relationship functions in later and EOL scenarios. Nystrom and Jones (2012) report that many old lesbians state that “… they have powers of attorney and wills in place to insure that their estates are handled according to their wishes” (p. 152). The fact that very few of the trans-lesbian community members in this survey had made legal preparations indicates the potential for many later-life challenges to occur for which members of this population will be unprepared.

The complex interaction between gender self-perception, body status, and self-perceived sexuality was a worry for some not just for their own care but for possible ramifications for the care of their respective partners:

Dignity of care and discrimination based both on perceived sexual orientation and also how both mine and my spouse’s care will be affected due to my trans status. This includes both bias/discrimination issues as
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well as will they know how to provide care for certain medical differences required due to my being trans? (ie hormones, dilation if still active/needed etc.) Also how this will affect my spouse’s care as she could be the “innocent victim” of discrimination due to her association with me.

One-third of the respondents identified with a traditional Western religion. This is important because later and EOL decisions often evolve from a complex interplay of ethical, cultural and religious beliefs, family relationships, socioeconomic status, and public policy (Witten & Eyler, 2012). For example, mainstream literature on religion suggests that having a relationship with a religious leader or spiritual counselor is a positive predictor for end-of-life discussions (Blank, 2011). End-of-life planning helps to uphold the integrity of the person’s wishes and increase peace of mind in later life and EOL. Failure to discuss EOL decisions can also decrease the quality of death experience (Larson & Tobin, 2000). Trans-elders have a history of discrimination when it comes to religious institutions (Porter, Oala, & Witten, 2013). The multiple stigma of being a trans-lesbian and old may well make the interaction with faith-based organizations even more difficult. There is no literature that attempts to dissect the impact of these multiple stigma. I hypothesize that the negative interactions with faith-based organizations, coupled with the innate challenge of discussing one’s end of life needs, explains why few respondents had definitely tried to put their affairs in order and talk with others about their deaths, despite the fact that over 80% of the respondents felt a sense of urgency about getting things done.

Trans-lesbian concerns around aging and its consequences are quite similar to those of the overall transgender TMLS population (Witten & Eyler, 2012; Witten, 2014). However, there are some differences when compared to natal female lesbians. Natal lesbians expressed concerns around “potential loss of physical ability, loss of independence, lack of money to survive until old age and potential loss of mental faculties” (p. 137). While both groups mention loss of mental faculties/dementia, for trans-persons dementia will have a potentially profound influence on how they are cared for (Witten & Whittle, 2004). Disconnects between the body presentation and the gender self-perception can become problematic when a trans-identified elder develops dementia and begins to self-refer with the past body-sex identity rather than that of the current identity. Nystrom and Jones (2012) report that priorities in the natal female lesbian population are “maintaining good health, independent functioning, connectedness with friends and family, and staying in own home for as long as possible” (p. 135). For trans-lesbians, self-actualization was also very important factor along with those mentioned by natal lesbians.

As with many other studies, I find that the willingness of community members to interact with healthcare workers and caregivers is decreased due
to fears of disconnect between the perceived gender identity and the actual physical body state, and how this disconnect would affect their healthcare and caregiving treatment as they aged (Lev & Sennot, 2012):

I am mostly concerned when it comes my time to go, that because I have not had all my surgeries that I will be looked at as a freak at the end of my life. Right now I have had just top surgery and have no intention of getting bottom surgery, so when I die, and they get me ready for cremation my secret will be out and I may once again be looked at a freak or a weirdo, and that would be horrible, to live your life as a man, and have everyone around you accept me as a man, then at the end have the secret let out of the bag and everyone call me a freak again, I may be around to hear those words again, but it would be still terrible knowing that people know my secret after all the years living in secret.

The fear of how they would be treated revealed a sub-component of the trans-lesbian respondent population that was either pondering suicide/self-euthanasia or had already put plans into place: “I’d personally rather commit suicide than go into the elderly care “I can afford” due to the exceptionally poor quality of it & the extremely high incidences of sexual/physical/mental abuse that happens there.”

Nevertheless, not all aspects of trans-aging were seen with doom and gloom. Many of the trans-lesbian TMLS participants responded with positive comments about hope and living a good life. It appeared that they had developed wisdom about life and resiliency. Only recently has there been any research on the development of resilience in the face of the negative life challenges in the trans-community and its elders (Witten, 2013 reviews the few studies in this area).

**STUDY LIMITATIONS**

The respondent population represents individuals with Internet access and who are primarily Caucasian, educated, financially middle-class or better, and therefore could be said to represent a “best of the worst case” scenario. I do not know how many members of the target population were missed using this survey approach. Additionally, the respondents are principally from Western biomedically oriented countries and, as such, the survey did not capture as much of the richness of the multicultural, multinational populations as I had hoped. While the respondent population is geographically diverse, it is still a sample of opportunity and not a rigorous sample based on a deeper understanding of gender self-perception and gender presentation within the known global community. As Witten and Eyler (2012) point out, an unknown subset of the trans-identified population no longer identifies
as trans once surgery has been attained. Thus, I likely missed all of these individuals. Finally, despite the large sample size, this survey still represents a cross-sectional snapshot at one time point.

CONCLUSIONS

This article represents the first research to explore the potential intersection of lesbian sexual identity × aging × transgender self-perception around the topic of older adults' fears, perceptions, and preparations concerning later-life and EOL challenges. Study results demonstrated that the trans-lesbian respondent population is comprised of a complex collection of sub-populations whose membership intersects with many different sociodemographic variables. This makes understanding the dynamics of the trans-identified population a non-trivial challenge.

The endemic negativity against and fear of healthcare providers, coupled with fears around the normative consequences of aging (physical weakness, decreased mental capacity, inability to take care of oneself, etc.) prevent many trans-lesbian individuals from seeking the healthcare that they need as they grow older in their physical bodies. For healthcare providers, this research emphasizes the need for training in the complexities of transgender medicine and healthcare as this worldwide population will continue to grow and will continue to have aging-related needs and challenges.

For social workers, these results speak of the need for enhanced social justice on behalf of this complex population (Markman, 2011). Trans-cultural competency training needs to be a priority. Disturbingly, I found that a small fraction of the respondents disclosed that they were thinking of “euthanasia” because they could not face the potential negatives of growing old as members of the transgender-identified community. Social workers who work with the elder trans-identified population should be aware of the “planned suicide” construct and be trained to address it. Our results suggest the importance of creating safe places for trans-identified elders to live out the rest of their lives without fear. For caregivers in assisted living homes and nursing homes I emphasize the need for culturally sensitive ways of interacting with the large variety of potential trans-identities and concomitant sexualities.

Given the religious diversity of this population (Porter, Oala, & Witten, 2013), it is important for nursing homes or other institutions that typically provide religious programming for their clients to include a similar program for individuals who are atheist or non-affiliated with any religion where their beliefs or lack thereof could be explored and discussed with others (Levy & Lo, 2013). It may be that one’s level of social support, found among members sharing similar beliefs, is what leads to successful aging and to exiting this life with grace (Witten, 2009). Training programs cultivating awareness must be made available to faith-based service organizations to provide a more
profound understanding of the unique needs of the trans-lesbian population, its friends, families and allies. Finally, aging service providers must develop inclusive respectful policies and protocols to address the bio-psycho-social-spiritual needs of this unique and diverse population. This is particularly true for social workers who work in this community (Gwyther et al., 2005).

The observed lack of later-life and EOL legal protections and EOL document preparation suggests that facilities and individuals that serve trans-identified individuals, especially for those in mid to later life, need to raise the discussion about legal preparations for the challenges of growing old as a member of the trans-lesbian identified community. This is particularly true for natal female trans-lesbians. Questions around legal and ethical will preparation, financial and medical power of attorney, burial/cremation choices, funereal desires, caretaking needs, long-term care insurance, and many other legal requirements must be addressed. A number of trans-lesbian respondents stated that they either “did not know how” to even go about getting such things while others stated “thank you for bringing this up. I had not thought about how important these items are.” End-of-life providers, as well as institutions such as nursing homes and community-based supports, are encouraged to discuss EOL planning with transgender older adults and their families.

For those interested in feminist theory, queer theory, and the inclusion of trans-identities in the lesbian dialogue, this article speaks of the significant complexities of the intersection of aging, gender self-perception and presentation and lesbian sexual identity. How the lesbian community interacts with and seeks to integrate the trans-lesbian population can have future implications for long-term quality of life and quality of care for all lesbians, trans-identified or otherwise. I have seen that many trans-lesbians are isolated, have nobody to care for them and are living alone. They are concerned about the quality of care that they will receive at the hands of the eldercare system. Inclusive intersession by the global lesbian community, on behalf of this newly emerging trans-lesbian community can benefit all members of the lesbian community not just the trans-lesbian population.

Despite the rampant negatives, a percentage of both the natal lesbian (Nystrom & Jones, 2012, p. 150) and the trans-lesbian population still felt that they had aged successfully and that they had developed a resiliency to the challenges of life (Witten, 2013). Identifying mechanisms by which these members have developed their resiliency can further aid members of this community as well as all communities in general.

REFERENCES


CONTRIBUTOR

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