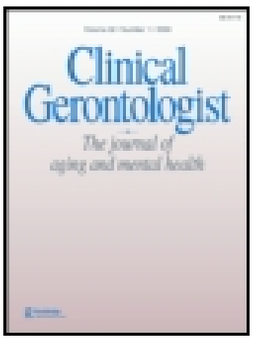

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Providing Competent and Affirming Services for Transgender and Gender Nonconforming Older Adults

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ABSTRACT

Despite the growing visibility and acceptance of transgender and gender nonconforming (TGNC) individuals, TGNC older adults experience many barriers in accessing competent and affirming health and social services due to anti-TGNC prejudice, discrimination, and lack of competent healthcare training on the part of healthcare workers. Clinical gerontologists and geriatricians will likely encounter TGNC adults in their practice given population aging and greater numbers of TGNC people who are living in their affirmed gender identities. The American Psychological Association recently published its Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, which document the unique needs of TGNC individuals and outlines approaches for competent and affirming service provision (APA, 2015). We interpret these Guidelines using a gerontological lens to elucidate specific issues faced by the TGNC older adult along with the practice and policy implications for this population.

KEYWORDS

discrimination; gender identity; health disparities; LGBT

Introduction

Transgender and gender nonconforming (TGNC) people are those whose gender identity is not aligned with their sex assigned at birth (e.g., female, male), or societal expectations for binary gender identities (e.g., woman, man) or expression (e.g., feminine, masculine; American Psychological Association [APA], 2015). There has been increased interest in the aging concerns of TGNC[1] people (Witten, 2003, 2014). However, little attention has been paid to how providers may work more effectively with TGNC people in later life. The issues experienced by TGNC older adults are often conflated with lesbian, gay, and bisexual (LGB) concerns, yet sexual orientation and gender identity are distinct, albeit inter-related characteristics (Witten, 2015a). Although there are several professional documents that

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guide mental health practice with TGNC people (e.g., World Professional Association for Transgender Health [WPATH] *Standards of Care* and American Counseling Association *Competencies for Counseling with Transgender Clients, 2010*), there is little specific guidance about how to work most effectively with members of this population who are growing older.

The literature on the older TGNC population describes numerous societal barriers to healthy aging, such as difficulty accessing TGNC-affirming healthcare, employment, and financial resources, as well as experiences of hate crimes, interpersonal violence, sexual assault, and anti-TGNC prejudice when accessing caregiving supports (Fredriksen-Goldsen et al., 2014; Witten, 2015a). The aging of the Baby Boom generation, along with increased visibility of TGNC persons, means that providers will likely encounter these older adults in their practices. The APA Task Force on Gender Identity and Gender Variance completed a survey in 2009 and found that only 30% of psychologists and graduate students understood the complex issues facing TGNC people (APA, 2009). As a result, the Task Force recommended creating guidelines to ensure that no harm would be done when working with TGNC people. Hence, the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA, 2015) were developed to assist psychologists "…in the provision of culturally competent, developmentally appropriate, and trans-affirmative psychological practice with TGNC people" (APA, 2015, p. 2). This 55-page document offers 16 guidelines that are meant to be an introductory and aspirational resource on practice, not treatment.

Scope

In this article we draw and expand on *Guideline 9*, which states "psychologists strive to understand both the particular challenges that TGNC elders experience and the resilience they can develop" (APA, 2015, p. 19). The intended scope of this paper is not to provide an exhaustive review of transgender literature, but rather to provide a context from which clinicians from all disciplines, not only psychology, can apply the APA (2015) *Guidelines* to provide competent and affirming services to older TGNC adults. We begin with an overview of the characteristics of the older TGNC population, followed by a discussion of life course perspectives that can help us better understand resilience in this group, followed by a review of policy and practice implications to better serve this population. A glossary of terms appears at the end of the article along with an appendix of online resources.

Who are TGNC Older Adults?

There is greater diversity than ever before among the general population of older adults. Larger proportions of older adults openly identify themselves as a gender and/or sexual minorities. However, it is difficult to know the true size of the TGNC population (Meier & Labuski, 2013). A defining characteristic of this population is that TGNC older adults have experienced inequity throughout their life course, with many coming of age during a time of significant transgender discrimination and stigma, which has contributed to the invisibility of this population (Services and Advocacy for GLBT Elders [SAGE] & National Center for Transgender Equality [NCTE], 2012). It is difficult to determine the accurate size of the TGNC population due to the lack of proper gender identity questions in population-based surveys as well as the challenges of self-report; TGNC individuals are less likely than their cisgender sexual minority counterparts to disclose their gender identities (Fredriksen-Goldsen et al., 2014).

Current estimates of the number of individuals in the TGNC population may be significantly understated (Witten, 2003, 2014; Witten & Eyler, 2012). Based upon the 2010 U.S. Census, the population of TGNC adults aged 65 years and older in the United States is estimated to be between 1.2 million and 2.8 million (Witten, 2015a). The TGNC older adult population is expected to grow and diversify as younger TGNC individuals emerge and age with their own gender-identity labels and experiences. The aging of the Baby Boom generation may also bring increased numbers of later-life transitioning individuals into the TGNC older adult population (Witten, 2015b).

Transphobia and Discrimination

Numerous factors contribute to the distinct lived experiences of TGNC older adults, including socioeconomic and educational status, race/ethnicity, gender identity disclosure, and nonconformity of appearance, to cite a few. As a group, TGNC adults experience marginalization and disparities including double the rates of violence and abuse compared to the general population, increased risk of anti-trans prejudice in accessing services like housing, employment, and healthcare, as well as disproportionate rates of HIV infection (Baral et al., 2013; Grant et al., 2011; Witten & Eyler, 2012).

Data from a study of 6,450 TGNC individuals aged 18 to 89 from all 50 states revealed staggering disparities (Grant et al., 2011). Key findings were that 78% of participants experienced discrimination or mistreatment in the work place with 47% being fired, not hired, or not promoted because they were TGNC. To mitigate potential discrimination, 71% hid their gender identity and 57% delayed their gender transition. Having a TGNC identity was related to housing instability; 19% had been homeless, 29% were turned

away from homeless shelters, and 22% were sexually assaulted by residents or homeless shelter staff. TGNC people of color experience the greatest amount of anti-trans discrimination. Grant and colleagues (2011) concluded that structural racism (i.e., the macro, institutional, and social systems that create and reinforce racial and ethnic inequities; Powell, 2008) was a major contributor to TGNC mental and physical health risk factors.

A national survey of 2,546 LGBT adults aged 50 years and older found that TGNC older adults reported significantly higher rates of lifetime victimization (11 incidents vs. 6) when compared to their cisgender sexual minority counterparts (Fredriksen-Goldsen et al., 2014). The majority of TGNC older adults reported experiencing verbal insults (76%) and threats of physical violence (54%). Lifetime victimization was found to mediate the association between gender identity and health outcomes; the indirect effect of victimization was associated with lower levels of physical health and higher levels of disability, perceived stress, and depression when compared to those who were not victimized.

The Impact of Discrimination on Psychosocial Domains

Social support is a contributing factor in mental health outcomes among older adults in general (Adams et al., 2015), including LGB and TGNC individuals (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2015; Porter, Ronneberg, & Witten, 2013). Family support is considered a protective factor and increases the likelihood of positive well-being among TGNC people (Grant et al., 2011). However, TGNC older adults report lower levels of social support compared to their cisgender sexual minority counterparts, despite being more likely to have children, larger social networks, and to cohabitate (Fredriksen-Goldsen et al., 2014). "Coming out" and transitioning as a TGNC older adult can be isolating without the support from family or friends. However, families are not always supportive; 57% of TGNC respondents in Grant et al.'s (2011) study experienced rejection from family. Similar to sexual minorities, TGNC adults may form families of choice, that is, non-kin networks that function as biological family (Giammattei & Green, 2012; Hughes & Kentlyn, 2011). However, TGNC older adults report a lesser sense of belonging to the LGBT community (Fredriksen-Goldsen et al., 2011). Without these critical social resources, older TGNC adults are at increased risk for poor mental health outcomes (Fredriksen-Goldsen et al., 2014; Yates, Tuppett, & Masten, 2004).

Experiences of discrimination and victimization, along with reduced social support, increase the risk for depression and suicidal ideation (Clements-Nolle, Marx, & Katz, 2006). TGNC adults are more likely to experience depression compared to cisgender adults (approximately 50% vs. 17%, respectively; Budge, Adelson, & Howard, 2013). Further, older TGNC adults

have significantly higher levels of depressive symptoms compared with older cisgender sexual minority adults (Fredriksen-Goldsen et al., 2014). Grant and colleagues (2011) found that 41% of TGNC individuals had attempted suicide compared to only 1.4% of the general population. The proportion who had attempted suicide increased with additive stressors such as for those who lost a job due to bias (55%), were bullied in school (51%), and experienced physical or sexual assault (51% and 64%, respectively). Among transgender veterans, suicide-related behavior was found to be 20 times the rate for non-transgender veterans (Blosnich et al., 2013).

Life Course Perspectives on TGNC Aging

When working with older adults, it is necessary to consider their entire lifespan and developmental trajectories (Moody, 2006). The broad nature of life course perspective allows for multiple applications in various fields such as psychology, biology, and sociology (Settersten, 2006). When refined, a life course perspective is able to provide a comprehensive understanding of social, historical, and cultural factors that shape the lives of older adults individually as well as collectively (Elder, 1994; Settersten, 2006). Major cultural and societal transformations occurred when the current generation of TGNC older adults were coming of age, including the Civil Rights Movement, Feminism, the Vietnam War, and the Sexual Revolution, that served to upend the prevailing mores concerning individual expression, including sexuality and gender norms.

The *Guidelines* (APA, 2015) recognize the unique historical context that has shaped the experience of TGNC older adults, particularly around transitioning. Transitioning for TGNC people is not uniform and there is considerable variability in the degree to which TGNC individuals transition. Those who transitioned prior to the 1990's were encouraged to conform to a heteronormative, cisgender social ideal, and were urged to begin a new life by leaving the comforts of home and those who loved them (Kimmel, Rose, & David, 2006). In response to this hostile environment, many kept their gender identities hidden for decades, waiting to transition in later life (SAGE & NCTE, 2012).

The phenomenon of transitioning is closely related to individual developmental processes, such as psychosocial development. One of the focal psychosocial issues articulated by Erik Erikson in his eight-stage theory concerned the tension between identity development and role confusion (Erikson, Erikson, & Kivnik, 1994). Per Erikson, the psychosocial balance around identity, in this case gender identity, impacts all of the other psychosocial domains, such as one's capacity for intimacy, autonomy, and sense of integrity. Having to defer the expression of one's gender identity very likely had a profound psychosocial impact on the development of the current

generation of older TGNC adults given the historical pressures noted by Kimmel and colleagues (2006). However, on the positive side, Erikson posits that a positive psychosocial rebalancing around identity and other psychosocial domains, is possible at any age, and such realignments can provide the basis for better psychological functioning, and increased resilience to the challenges of later life (Erikson et al., 1994).

TGNC Aging and Resilience

Despite a life course overwhelmed by historical discrimination, violence, and mental health disparities, many TGNC older adults report they are aging well (Porter et al., 2013), which is indicative of a successful balance of psychosocial identity issues from an Eriksonian perspective (Erikson et al., 1994). Resilience is defined as the ability to bounce back from a perturbation in the life course trajectory (Bonanno, Westphal, & Mancini, 2011; Luthar, Cicchetti, & Becker, 2000; Smith, Tooley, Christopher, & Kay, 2010). There is a growing literature that documents resilience within the TGNC population (Bariola et al., 2015; Breslow et al., 2015; Nuttbrock et al., 2014; Testa, Habarth, Peta, Balsam, & Bockting, 2015). However, little work has focused on resilience in TGNC older adults (McFadden, Frankowski, & Witten, 2013; Van Wagenen, Driskell, & Bradford, 2013; Witten, 2014). Overall, resilience in TGNC older adults has been associated with taking care of their health, being involved in community activities (i.e., volunteering), spending time with families (however defined), maintaining a transcendent connectivity with those around them, focusing on being the best person possible, being involved with various religious/faith/spiritual activities, and personal development. These correlates of resilience highlight potential resources and adaptational processes that could be leveraged in working with the older TGNC client to foster more positive clinical outcomes.

Implications & Policy Recommendations

TGNC older adults are adversely affected by the lack of policies addressing trans discrimination and marginalization and face myriad barriers when trying to access services. Some of these barriers are at the institutional or macro-level, thus necessitating systemic change and others are at the provider level. We will examine institutional barriers facing TGNC older adults when accessing clinical and social services, before turning to specific recommendations for service providers. However, it should be noted that providers may play a critical role in addressing these barriers and promote systematic change in order to create more safe and inclusive spaces for TGNC older adults in the institutions and settings where they practice.

Restroom Access

TGNC people of all ages often have difficulty finding safe, accessible, gender-inclusive restrooms and are often victims of violence when they are perceived to be in the "wrong" restroom (Herman, 2013; Transgender Law Center, 2005). This can be an even greater challenge for TGNC older adults who may feel more vulnerable in gender-segregated restrooms, such as those with limited mobility or those who rely on caregivers for activities of daily living with a different gender identity than themselves (SAGE & NCTE, 2012). The issue of accessible restrooms may be especially salient for those in institutionalized settings.

Restrooms are a hot-button topic when jurisdictions are considering human rights legislation (Moyer, 2015). There have been some changes in the ways in which restrooms are labeled, more recently the use of "all gender" or "family restrooms," as opposed to restrooms labeled on a gender binary (i.e., women or men). Arguments in opposition to such legislation include concern for letting "men, sex offenders and/or violent criminals" in a women's restroom. Slowly, states are putting policies in place that validate the need of TGNC people to access safe restrooms. For example, the District of Columbia is enforcing a law that requires single-stall restrooms to be "all gender" (Office of Human Rights, n.d.). Although legislation ensuring safe and accessible restrooms for TGNC people has been passed, a number of jurisdictions haven taken the opposite tack. For example, in March 2016, North Carolina signed into law a bill that requires a person to use a public restroom that is consistent with the sex on their birth certificate (NCTE, 2016). It has been reported that 76% of TGNC people have not changed the sex on their birth certificate, putting them at greater risk of prosecution for violating these restroom statutes, and subjecting them to inter-personal violence (Herman, 2013; Transgender Law Center, 2005).

Social Services and Identity Documents

There may be very personal reasons why TGNC older adults will not change the gender marker on their birth certificate or other identity documents, including the financial cost. TGNC older adults have poorer financial well-being than younger TGNC people (Hartzell, Frazer, Wertz, & Davis, 2009), which may predispose a greater reliance on social services (SAGE & NCTE, 2012). Some TGNC older adults may have concerns about gender identity disclosure when applying for Social Security or veterans' benefits (Hartzell et al., 2009). Identity documents are also frequently required to gain entrance into retirement communities and other types of senior housing. Thus, it is important that TGNC individuals have identification that matches the gender in which they present themselves (Campbell & Arkles, 2017). The process for

changing identity documents varies depending on the jurisdiction where a person lives (state policies can be found at http://www.transequality.org/documents). In some cases, there may be an expectation that a TGNC person has completed a medical transition, including genital surgery, prior to changing identity documents. However, this may cause difficulty for the TGNC person if, for example, their insurance company expects a social transition before genital surgery is authorized, putting the TGNC individual in an unnecessary and untenable bind.

Health providers may be called upon to write letters of support or even testify in court on behalf of their clients for such surgery to be authorized. The Veteran's Health Administration (VHA) 2011 directive mandates that transgender veterans receive support letters for legal name and gender change on identity documents within and outside the VHA (Department of Veterans Affairs, 2013). The current version of the WPATH Standards of Care provides guidance for writing letters of support (Coleman et al., 2012), and extends letter writing privileges to master's level mental health practitioners for the first time. In addition, there is guidance on the number of letters required for letters of support for hormone treatment (1 letter of referral) and gender-affirming surgery (1 letter of referral for top surgery and 2 letters of referral for bottom surgery). The WPATH Standards of Care are intended to be flexible in their application, as there are diverse needs of TGNC clients. For instance, there is not a required length of counseling set for referral to hormone treatment. Counseling itself is no longer a requirement to access medical services, but rather recommended to support TGNC clients in accessing the services they need, and to assist them as they explore and learn about their gender identity.

Access to Care

Health disparities among TGNC older adults are compounded by the barriers encountered when trying to access health care. Compared to cisgender sexual minority older adults, TGNC older adults were significantly more likely to report financial barriers around service access (Fredriksen-Goldsen et al., 2014). These economic disparities contributed to lower rates of health insurance or insurance that did not include coverage for appropriate medical treatment.

It is not clear how the Affordable Care Act (ACA) will affect this situation. Although the ACA does not allow for healthcare discrimination, gender affirming surgery is not mandated coverage under ACA although the current administration is taking steps to increase access (Leonard, 2015). The VHA has created policies to assist in gender-affirming medical care and has taken strides to provide education about transgender care (Johnson, Shipherd, & Walton, 2016). Although the VHA provides gender-affirming hormone

therapy, it currently does not provide access to gender-affirming surgeries (Department of Veterans Affairs, 2013). In addition, access to gender-affirming care varies greatly among VHA hospital locations. For example, while some locations offer access to additional services such as culturally competent psychotherapy, gender affirming voice and communication therapy, and post-surgical care, these services may not be uniformly available across all VHA facilities.

While more recent policies have increased health care access for TGNC individuals in some sectors, access to competent TGNC health care is still a concern for many (dickey, Budge, Katz-Wise, & Garza, 2016). Half of TGNC individuals reported they had to teach their health care provider about transgender care (Grant et al., 2011). This is not surprising when one-third of medical schools in the United States and Canada surveyed require no clinical hours on LGBT health curricula (Obedin-Maliver et al., 2011). For schools that did provide LGBT health curricula, 60 minutes was the average amount of time spent on the topic. Of the 132 medical schools that participated, only 30% teach about gender transition and 35% teach about gender-affirming surgery. Of note, the VHA piloted a national program to increase provider education on transgender health via teleconsultation. Although only 40% of participants completed the evaluation, two-in-five reported that they felt greater confidence to treat TGNC veterans upon completion of the 14-session course (Kauth et al., 2015).

Once an older TGNC individual has found a medical provider and has the means to afford such care, the use of gendered language in health care settings can be a further barrier (Hagen & Galupo, 2014). For example, the use of binary-gender language on health care intake forms (e.g., male or female) or in discussion with the healthcare provider can result in feelings of invisibility and isolation (Hagen & Galupo, 2014). Moreover, not referring to the patient by their gender-affirming name and/or pronoun due to a failure to ask the patient, or a refusal to use the patient-requested words, is discriminatory health care (Nadal, Skolnik, & Wong, 2012).

As a result of past healthcare discrimination, TGNC older adults may choose not to disclose their gender identity to providers resulting in inappropriate care (APA, 2015; Fredriksen-Goldsen et al., 2014; Hagen & Galupo, 2014). One-quarter of TGNC adults report discrimination or denial of equal treatment by a physician or hospital and one-fifth reported being refused medical care because of their TGNC identity (Grant et al., 2011). Among TGNC adults aged 50 and older, 40% reported being denied or provided inferior health care as a result of disclosing their gender identity (Fredriksen-Goldsen et al., 2014). Compared to older cisgender sexual minority adults, TGNC older adults were significantly more likely to report fear as a barrier to accessing health services (Fredriksen-Goldsen et al., 2014).

Long-Term Care

The continuum of long-term care programs (LTC) includes aging in place, independent living communities, in-home care, adult day care, assisted living, skilled nursing, and hospice care (White & Gendron, 2016). Issues of TGNC safety in LTC facilities may include physical or psychological abuse, denial of personal care, being "outed," and being prevented from dressing according to one's gender identity (National Academy on an Aging Society & SAGE, 2011; SAGE & NCTE, 2012).

TGNC older adults, regardless of the degree of gender transitioning, are at risk for abuse, mistreatment, or violence in institutionalized settings, especially those needing assistance with activities of daily living such as showering, dressing, and toileting (National Senior Citizens Law Center, 2011). At present there are no federal policies to guide LTC facilities on how to appropriately house a TGNC older adult; unmarried residents are typically separated by sex into double occupancy rooms and nursing homes are not required to allow consenting adults to share rooms (Cornelison & Doll, 2013). There are no policies for making an official determination of a TGNC older adult's gender, or established criteria for placing a TGNC nursing home resident in a same-sex shared bedroom. LTC private rooms are not covered by Medicare or Medicaid and require a higher out-of-pocket cost (Center for Medicare and Medicaid Services, n.d.a, n.d.b). Although not specific to LTC or older adults, the VHA directive (Department of Veterans Affairs, 2013) includes a provision that rooms for TGNC veterans are assigned based upon self-identified gender without regard to physical presentation or surgical history.

Lacking protective policies and fearing discrimination and abuse, some TGNC older adults may recloset (i.e., hide their gender identity), reverse their gender transitions (i.e., return to a gender expression more closely in line with sex assigned at birth; Ippolito & Witten, 2014), or have euthanasia/suicide plans to avoid entering LTC (Witten, 2014). These TGNC older adults may fear mistreatment, discrimination, or violence from staff and residents who are unaware of their gender identities (Bockting & Coleman, 2007). This is one of the reasons why some TGNC older adults have entered LTC facilities without acknowledging their transgender experience (Maddux, 2011). These issues may be especially relevant for those who have not accessed gender-affirming surgical interventions. Sadly, these people may then be forced to live out the last years of their life in a body that may not be consistent with their internal gender identity.

According to the ACA, it is illegal for health organizations to discriminate against TGNC people in the provision of care (NCTE, 2015). The ACA includes prohibitions related to refusal to treat, refusal to provide access to appropriate gendered facilities (e.g., restrooms), harassment from facility

staff, and isolation or deprivation. LTC residents of Medicare/Medicaid accepting nursing homes are protected under the Nursing Home Reform Act (NHRA) which asserts that all residents have the right to dignified and respectful treatment, as well as the right to choose their clothing, which is particularly salient for TGNC older adults (NCTE, 2015). Additionally, the Fair Housing Act (FHA) applies to residential care facilities and prohibits discrimination based upon gender identity. Moreover, nursing home ombudsperson programs are available across the U.S. to provide free mediation between a resident and the facility for issues related to mistreatment, care, or other complaints (Department of Health and Human Services, Administration on Aging, 2015).

In addition to discrimination, long-term care providers may lack knowledge or experience in working with TGNC older adults (White & Gendron, 2016). The need for training medical providers has been well-documented (see previous section, Access to Care; Obedin-Maliver et al., 2011). Although it might seem that care for TGNC older adults as they age would be no different than a cisgender older adult, TGNC older adults may have unique geriatric medical needs (Grant et al., 2011; SAGE & NCTE, 2012). For example, TGNC older adults using hormone therapy concurrent with medications for age-related conditions may require closer screening for drug interactions, contraindications, and polypharmacy (Witten & Eyler, 2015). In some cases, hormone therapy will be clinically contraindicated given other medical conditions (Witten & Eyler, 2015), and providers can support older TGNC adults in navigating their reactions to this situation. Some TGNC older adults may not find it difficult to discontinue hormone therapy if they have achieved their goals regarding masculinization or feminization and do not have concerns regarding bone health. Others, however, especially those who have started their medical transitions later in life and those who are requesting hormone therapy at a later stage in life, may have many feelings of disappointment and grief.

End-of-Life Concerns

End-of-life concerns include legal issues, such as writing advanced directives and living wills, power of attorney and health care proxies, visitation rights in health care facilities, as well as wills and estate planning (Ippolito & Witten, 2014). TGNC older adults are less likely to have these documents in place when compared to their cisgender sexual minority counterparts (Fredriksen-Goldsen et al., 2014). Providers are encouraged to discuss these documents and policies with TGNC older adults and extend assistance or referrals to support the individual in securing or completing these documents.

TGNC older adults nearing the end of life may have specific anxieties about being misgendered after death. There are few protections to ensure

that they will be posthumously recognized in their affirmed gender because TGNC people have little control over the disposition of their bodies (Ippolito & Witten, 2014). Misgendering becomes a significant problem if the TGNC person has not provided advanced directives or had not completed genital surgeries. Misinformation on death certificates can serve to negate a TGNC person's gender identity posthumously, which is at odds with the goal of TGNC inclusion in our society. The challenge, from a policy perspective, is the lack of consistent rules governing how a person's gender is recorded by a coroner or medical examiner. At present in the United States, only California has a statute that requires that, "…the official responsible for completing a transgender person's death certificate to do so in a manner that reflects the person's gender identity" (Transgender Law Center, n.d., 4th para.). A more widespread adoption of this type of policy is critical for TGNC people of all ages who desire to be treated respectfully after death.

Provider Recommendations

Providers should be attentive to and respectful of the boundaries of disclosure that may exist for TGNC older adults. Having come of age in a time of TGNC discrimination and non-acceptance, these older clients may be guarded when asked to about their life or gender histories. Providers are encouraged to be mindful of the questions they ask of TGNC older adults and whether they are relevant to the presenting concern or clinical encounter. For example, it is inappropriate for primary care doctors to ask older TGNC clients to relay their entire gender or sexual histories when the presenting concern is a sinus infection.

During an intake session with a TGNC older adult, adequate time and attention should be taken to not only thoroughly assess each client's needs, but to pay special attention to generational and cohort concerns and previous experiences with health and mental health care. An attitude of cultural humility and an accepting, nonjudgmental stance on the part of the provider may aid in developing rapport. It is important to respect self-identification and to follow each client's lead regarding the language used to describe themselves, including name and pronouns. When working with TGNC older adults, it is important to screen for depression, loneliness, and suicidal risk (Fredriksen-Goldsen et al., 2011; SAGE & NCTE, 2012). Providers may play an essential role in helping TGNC older adults to cope with and heal from acts of abuse and discrimination that are commonly experienced by this population (Redman, 2011).

It is important to maintain awareness about the ways in which access to gender-affirming health care has changed over time and how this has affected TGNC older adults at various stages of their lives. For example, prerequisites for hormone therapy or surgical interventions were much more stringent in

the past. The Medicare ban on TGNC health care was lifted in 2014; thus, many TGNC older adults now have access to these services for the first time (National Center for Transgender Equality, n.d.). The VHA (Department of Veterans Affairs, 2013) provides transgender healthcare including mental health care, hormone therapy, and preoperative evaluations; however sex reassignment surgery is not currently provided nor funded which is a major limitation of the policy.

Providers may aid clients in navigating the wide range of emotions that may arise, including excitement, shock, fear, disbelief, and grief of not being able to fulfil their transition needs at an earlier age. Though many TGNC older adults with Medicare may meet the current requirements for surgery, at this time there is still a dearth of physicians who provide gender-affirming surgery and accept Medicare (Green, 2014). Dementia and cognitive impairment may be a concern for TGNC older adults (Witten, 2014), thus providers must pay attention to the ability of an older TGNC individual to provide informed consent for gender-affirming medical treatment as recommended by the WPATH standards of care (Coleman et al., 2012). Providers are encouraged to take time to explore clients' knowledge of the risks and benefits of gender-affirming services, as well as expectations for how these services may affect their lives.

In the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA, 2015), the importance of providers exploring and validating intersectionality as a foundation for working with TGNC people is emphasized. The concept of intersectionality posits that, "…the crossing of multiple forms of oppression with regard to gender, race/ethnicity, class, sexuality, etc., produces distinct sets of perspectives and consequences among individuals" (Stirratt, Meyer, Ouellette, & Gara, 2008, p. 90). The experience of societal discrimination, anti-TGNC prejudice, and disparities can be multiplicative for TGNC older adults of color (Grant et al., 2011; Van Sluytman & Torres, 2014). Therefore, assessing the intersection of gender identity with other cultural identities is an important component of intake assessment and ongoing treatment.

Providers can affirmatively work with TGNC older adults of color by establishing strong rapport and a collaborative working alliance that acknowledges the power differentials between the practitioner and the client (Chang & Singh, 2016). For instance, a white cisgender practitioner working with a TGNC person of color can explore what it is like for the client to work with the provider, while explicitly sharing that the practitioner has a TGNC-affirming and minority-affirming approach to practice. Providers can also conduct a safety assessment that is intersectional in nature (APA, 2015). So for example, when working with a TGNC older adult of color in hospice care, the practitioner can specifically explore how TGNC-affirming and minority-affirming the hospice environment is for the client and their family. Providers

working with TGNC adults of color should have a strong referral list that is affirming and culturally responsive to the concerns and needs of TGNC adults of color (Chang & Singh, 2016). An affirming, culturally sensitive approach also requires that providers actively explore and challenge their own biases and assumptions. For example, when working with an African American TGNC older adult, it is important to consider not only racial background, TGNC identity, and age/generational cohort, but also the impacts of racism, anti-trans bias, ageism, and associated minority stress (Hendricks & Testa, 2012).

Providers should be aware of any culturally specific language (e.g., names, pronouns, cultural practices) that TGNC adults of color may use. For instance, an African American TGNC person may use the term "masculine of center" rather than transgender to describe their gender identity (Brown Boi Project, 2011). Attention to trauma and resilience due to the myriad influences of racism and anti-TGNC prejudice on TGNC mental health is also essential. Because racism and classism are intricately linked, providers should also carefully assess the financial resources that clients have in order to help them access the best quality and most effective medical treatments they may need (Grant et al., 2011).

An interdisciplinary approach to working with TGNC older adults, such as geriatric or coordinated care models, may involve a collaboration among all providers (i.e., primary care physicians, endocrinologists, geriatricians, pharmacologists, other health care specialists) as well as family, friends, and significant others. In general, providers can work with all TGNC older adults to identify sources of strength and resilience (Singh, Hays, & Watson, 2011). As TGNC people who are affirmed in their gender identity have better mental health (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013), it can be helpful to identify and strengthen the client's social support network. While some clients will be connected to other TGNC people, others may not be as comfortable around other TGNC people. Providers may also find it helpful to reference Lev's (2004) Family Emergence States Model in exploring the effects of TGNC identity and disclosure on the TGNC client and their social support system.

A Case Study

Joanne is a 68-year-old African-American transgender woman who is seeking psychotherapy and would also like to explore options for bottom surgery. She reports that she started socially transitioning in her 20s and started hormone therapy in her 30s. She was interested in vaginoplasty, but at one of the university gender clinics where she sought help, the surgeons were unwilling to assess and refer women of color at that time. She feels scared to start the process of even talking about surgery as an option because she does not want to get her hopes up again. Additionally, because she is over 65 years old and

has Medicare as her primary coverage, she is unsure if there are even surgeons who accept this insurance. Joanne's husband is incredibly supportive and willing to be by her side regardless of what she decides.

Joanne meets with Dr. Stevens, a psychologist, for a first appointment. Dr. Stevens makes sure to validate Joanne's experience encountering barriers to care, including those based on gender, race, and the predominant views in medical and mental health care at the time when she first started medically transitioning. She helps Joanne to identify how surgery might affect her life, as well as any specific concerns or questions she may have. She acknowledges how hard it must be to start this process again after so many years. Dr. Stevens supports Joanne in identifying her strengths and sources of resilience, including ways that she has coped over many years with dysphoria, anti-trans bias, and racism. Joanne feels affirmed for the first time by a health professional, and this allows her to feel more comfortable bringing her full self to the therapy process. As an advocate, Dr. Stevens not only supports Joanne as an individual, but she consults with other gender specialists about how to navigate insurance-related barriers and stay up-to-date about changes in Medicare and surgical options so that she may be able to inform and support other clients.

Conclusion

Given the diversity within TGNC communities with regard to gender identity, race/ethnicity, socioeconomic position, as well as life course experiences of transitioning to one's gender identity, stigma, discrimination and violence, a nuanced approach to practice is warranted in order to best serve older TGNC adults. The physical and behavioral health challenges facing older TGNC adults are numerous and included disproportionate rates of HIV infection, complications of hormone treatment particularly when obtained through illicit channels, and high rates of mental health problems, including substance use and suicidality. Despite these challenges and a society and culture that continue to struggle to accept those who do not identify as cisgender, TGNC individuals have demonstrated remarkable resilience in the face of adversity which provides an important personal resource that can be leveraged in clinical settings.

For providers working with older TGNC adults, there are a number of ways to be welcoming and inclusive of these individuals in clinical practice. Insuring one has had the proper training to offer culturally competent and humble services is a first step. In addition, creating a safe space for TGNC clients can involve active marketing to this community including explicit mention that TGNC individuals are welcome in one's practice setting, having TGNC office staff, having TGNC-affirming materials in the waiting room or on the web site, insuring that all gender restrooms are convenient and available on-site,

addressing TGNC clients by affirming names and pronouns, and avoiding hetero- and cisgender-normative assumptions and language when interacting with these clients. In this way, clinicians can make a significant contribution to the full integration and acceptance of older TGNC individuals in our society by providing needed and affirming health services that have the potential to improve the quality of life for these clients as they age.

Glossary

The below definitions are terms used in this paper. For a more complete list of terms that related to transgender health, please see APA, 2015.

Anti-Trans Prejudice (Transphobia): Prejudicial attitudes that may result in the devaluing, dislike, and hatred of people whose gender identity and/or gender expression do not conform to their sex assigned at birth. Anti-trans prejudice may lead to discriminatory behaviors in such areas as employment and public accommodations, and may lead to harassment and violence. When TGNC people hold these negative attitudes about themselves and their gender identity, it is called internalized transphobia (a construct analogous to internalized homophobia).

Cisgender: An adjective used to describe a person whose gender identity and gender expression align with sex assigned at birth; a person who is not TGNC.

Cultural Humility: the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the person (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 2)

Gender Affirming Surgery (Sex Reassignment Surgery or Gender Reassignment Surgery): Surgery to change primary and/or secondary sex characteristics to better align a person's physical appearance with their gender identity. Gender affirming surgery can be an important part of medically necessary treatment to alleviate gender dysphoria and may include mastectomy, hysterectomy, metoidioplasty, phalloplasty, breast augmentation, orchiectomy, vaginoplasty, facial feminization surgery, and/or other surgical procedures.

Gender Binary: The classification of gender into two discrete categories of boy/man and girl/woman.

Gender Expression: The presentation of an individual, including physical appearance, clothing choice and accessories, and behaviors that express aspects of gender identity or role. Gender expression may or may not conform to a person's gender identity.

Gender Identity: A person's deeply-felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics. Since gender identity is internal, a person's gender identity is not necessarily visible to others. "Affirmed gender identity" refers to a person's gender identity after coming out as TGNC or undergoing a social and/or medical transition process.

Hormone Therapy (Gender Affirming Hormone Therapy, Hormone Replacement Therapy): The use of hormones to masculinize or feminize a person's body to better align that person's physical characteristics with their gender identity. People wishing to feminize their body receive anti-androgens and/or estrogens; people wishing to masculinize their body receive testosterone. Hormone therapy may be an important part of medically necessary treatment to alleviate gender dysphoria.

Sex (Sex assigned at birth): Sex is typically assigned at birth (or before during ultrasound) based on the appearance of external genitalia. When the external genitalia are ambiguous other indicators (e.g., internal genitalia, chromosomal and hormonal sex) are considered to assign a sex with the aim of assigning a sex that is most likely to be congruent with the child's gender identity (MacLaughlin & Donahoe, 2004). For most people, gender identity is congruent with sex assigned at birth (see cisgender); for TGNC individuals, gender identity differs in varying degrees from sex assigned at birth.

Sexual Minority: a person whose sexual identity differs from heterosexual, such as people who identify as gay, lesbian, or bisexual (LGB).

Sexual Orientation: A component of identity that includes a person's sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction. A person may be attracted to men, women, both, neither, or to people who are genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others.

Structural Racism: the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups (Powell, 2008).

Transgender Nonconforming (TGNC): An adjective used as an umbrella term to describe people whose gender expression or gender identity differs from gender norms associated with their assigned birth sex. Subpopulations of the TGNC community can develop specialized language to represent their experience and culture, such as the term "masculine of center" that is used in communities of color to describe one TGNC identity (Brown Boi Project,

2011). While the term "transgender" is commonly accepted, not all TGNC people self-identify as transgender.

Trans: Common short-hand for the terms transgender, transsexual, and/or gender nonconforming. While the term "trans" is commonly accepted, not all transsexual or gender nonconforming people identify as trans.

Transition: A process some TGNC people progress through when they shift toward a gender role that differs from the one associated with their sex assigned at birth. The length, scope, and process of transition are unique to each person's life situation. For many people, this involves developing a gender role and expression that is more aligned with their gender identity. A transition typically occurs over a period of time; TGNC people may proceed through a social transition (e.g., changes in gender expression, gender role, name, pronoun, and gender marker) and/or a medical transition (e.g., hormone therapy, surgery, and/or other interventions).

Note

1. Please refer to the glossary at the end of this article for a description of terms. The authors use transgender and gender nonconforming (TGNC) to be as inclusive as possible, recognizing that not all TGNC people identify by this term.

References

Adams, T. R., Rabin, L. A., Da Silva, V. G., Katz, M. J., Fogel, J., & Lipton, R. B. (2015). Social support buffers the impact of depressive symptoms on life satisfaction in old age. *Clinical Gerontologist*, (just-accepted). http://dx.doi.org/10.1080/07317115.2015.1073823

American Counseling Association (2010). *Competencies for counseling with transgender clients*. Retrieved from http://www.counseling.org/Resources/Competencies/ALGBTIC_Competencies.pdf

American Psychological Association. (2009). *Report of the task force on gender identity and gender variance*. Washington, DC: Author.

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, *70*(9), 832–864. http://dx.doi.org/10.1037/a0039906

Baral, S. D., Poteat, T., Strömdahl, S., Wirtz, A. L., Guadamuz, T. E., & Beyrer, C. (2013). Worldwide burden of HIV in transgender women: A systematic review and meta-analysis. *The Lancet Infectious Diseases*, *13*(3), 214–222. http://dx.doi.org/10.1016/S1473-3099(12)70315-8

Bariola, E., Lyons, A., Leonard, W., Pitts, M., Badcock, P., & Couch, M. (2015). Demographic and psychosocial factors associated with psychological distress and resilience among transgender individuals. *American Journal of Public Health*, *105*(10), 2108–2116. doi:10.2105/AJPH.2015.302763

Blosnich, J., Brown, G. R., Shipherd, J. C., Kauth, M., Piegari, R., & Bossarte, R. (2013). Prevalence of gender identity disorder and suicide risk among transgender veterans

utilizing veterans health administration care. *American Journal of Public Health*, *103*(10), e27–e32. http://dx.doi.org/10.2105/AJPH.2013.301507

Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming-out process. In R. Ettner, S. Monstrey, & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185-208). New York: Haworth.

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the U.S. transgender population. *American Journal of Public Health*, *103*, 943–951. doi:10.2105/AJPH.2013.301241

Bonanno, G. A., Westphal, M., & Mancini, A. D. (2011). Resilience to loss and potential trauma. *Annual Review of Clinical Psychology*, *7*, 511–535. doi:10.1146/annurev-clinpsy-032210-104526

Breslow, A. S., Brewster, M. E., Velez, B. L., Wong, S., Geiger, E., & Soderstrom, B. (2015). Resilience and collective action: Exploring buffers against minority stress for transgender individuals. *Psychology of Sexual Orientation and Gender Diversity*, *2*(3), 253–265. doi:10.1037/sgd0000117

Brown Boi Project. (2011). *Freeing ourselves: A guide to health and self love for brown bois*. Retrieved from https://brownboiproject.nationbuilder.com/health_guide

Budge, S. L., Adelson, J. L., & Howard, K. A. (2013). Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology*, *81*(3), 545. http://dx.doi.org/10.1037/a0031774

Campbell, L. F., & Arkles, G. (2017). Ethical and legal concerns for mental health professional. In A. A. Singh, & l. m. dickey (Eds.), *Handbook of trans-affirmative counseling and psychological practice*. Washington, DC: American Psychological Association.

Center for Medicare and Medicaid Services (n.d.a). *Your medicare coverage, skilled nursing facility care*. Retrieved from https://www.medicare.gov/coverage/skilled-nursing-facility-care.html

Center for Medicare and Medicaid Services (n.d.b). *Nursing Facilities*. Retrieved from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/institutional-care/nursing-facilities-nf.html

Center, T. L. (n.d.). *CA governor signs respect after death act*. Retrieved from http://transgenderlawcenter.org/archives/11140

Chang, S., & Singh, A. A. (2016). Affirming psychological practice with transgender and gender nonconforming people. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 140–147. doi:10.1037/sgd0000153

Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons. *Journal of Homosexuality*, *51*(3), 53–69. doi:10.1300/J082v51n03_04

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people, 7th version. *International Journal of Transgenderism*, *13*, 165–232. doi:10.1080/15532739.2011.700873

Cornelison, L. J., & Doll, G. M. (2013). Management of sexual expression in long-term care: Ombudsmen's perspectives. *The Gerontologist*, *53*(5), 780–789. http://dx.doi.org/10.1093/geront/gns162

Department of Health and Human Services, Administration on Aging (2015). *Long-term care ombudsman Program* (OAA, Title VII, Chapter 2, Sections 711/712). Retrieved from http://www.aoa.gov/AoA_programs/Elder_Rights/Ombudsman/index.aspx

Department of Veterans Affairs (VA). (2013). *Providing health care for transgender and intersex veterans (VHA Directive 2013–003)*. Retrieved from http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2863

dickey, l. m., Budge, S. L., Katz-Wise, S. L., & Garza, M. V. (2016). Health disparities in the transgender community: Exploring differences in insurance coverage. *Psychology of Sexual Orientation and Gender Diversity*, Apr 18. http://dx.doi.org/10.1037/sgd0000169.

Elder Jr, G. H. (1994). Time, human agency, and social change: Perspectives on the life course. *Social psychology quarterly*, *57*(1), 4–15.

Erikson, E. H., Erikson, J. M., & Kivnick, H. Q. (1994). *Vital involvement in old age*. New York, NY: WW Norton & Company.

Fredriksen-Goldsen, K. I., Cook-Daniels, L., Kim, H. J., Erosheva, E. A., Emlet, C. A., Hoy-Ellis, C. P., & Muraco, A. (2014). Physical and mental health of transgender older adults: An at-risk and underserved population. *The Gerontologist*, *54*(3), 488-500. doi:10.1093/geront/gnt021

Fredriksen-Goldsen, K. I., Kim, H., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., & Petry, H. (2011). *The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults*. Retrieved from http://caringandaging.org/wordpress/wp-content/uploads/2011/05/Full-Report-FINAL-11-16-11.pdf

Fredriksen-Goldsen, K. I., Kim, H.-J., Shiu, C., Goldsen, J., & Emlet, C. A. (2015). Successful aging among LGBT older adults: Physical and mental health-related quality of life by age group. *The Gerontologist*, *55*(1), 154–168. http://dx.doi.org/10.1093/geront/gnu081

Giammattei, S., & Green, R. (2012). LGBTQ couple and family therapy. In J. J. Bigner, & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 1–22). New York: Routledge.

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Kiesling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*. Washington, DC: National Center for Transgender Equality & National Gay and Lesbian Task Force. Retrieved from http://endtransdiscrimination.org/PDFs/NTDS_Report.pdf

Green, J. (2014). Transsexual surgery may be covered by medicare. *LGBT Health*, *1*(4), 256–258. http://dx.doi.org/10.1089/lgbt.2014.0076

Hagen, D. B., & Galupo, M. P. (2014). Trans* individuals' experiences of gendered language with health care providers: Recommendations for practitioners. *International Journal of Transgenderism*, *15*(1), 16–34. http://dx.doi.org/10.1080/15532739.2014.890560

Hartzell, E., Frazer, M. S., Wertz, K., & Davis, M. (2009). *The state of transgender California: Results from the 2008 California transgender economic health survey*. San Francisco: Transgender Law Center. Retrieved from http://transgenderlawcenter.org/?s=state±of±california

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice*, *43*, 460-467. doi:10.1037/a0029597

Herman, J. L. (2013). Gendered restrooms and minority stress: The public regulation of gender and its impact on transgender people's lives. *Journal of Public Management and Social Policy*, *19*(1), 65-80.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr, & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366. http://dx.doi.org/10.1037/a0032595

Hughes, M., & Kentlyn, S. (2011). Older LGBT people's care networks and communities of practice: A brief note. *International Social Work*, *54*(3), 436–444. doi:10.1177/0020872810396254

Ippolito, J., & Witten, T. M. (2014). Aging. In L. Erickson-Schroth (Ed.), *Trans bodies, trans selves: A resource for the transgender community* (pp. 476–497). New York: Oxford University Press.

Johnson, L., Shipherd, J. C., & Walton, H. (2016). The psychologist's role in transgender-specific care with U.S. veterans. *Psychological Services*, *13*(1), 69–76. http://dx.doi.org/10.1037/ser0000030

Kauth, M. R., Shipherd, J. C., Lindsay, J. A., Kirsh, S., Knapp, H., & Matza, L. (2015). Teleconsultation and training of VHA providers on transgender care: Implementation of a multisite hub system. *Telemedicine and E-Health*, *21*(12), 1012–1018. http://dx.doi.org/10.1089/tmj.2015.0010

Kimmel, D. C., Rose, T., & David, S. (2006). *Lesbian, gay, bisexual, and transgender aging: Research and clinical perspectives*. New York: Columbia University.

Leonard, K. (2015, September 3). Obama defends health rights for transgender Americans. *U.S. News & World Report*. Retrieved from http://www.usnews.com/news/articles/2015/09/03/obamacare-expands-rights-for-transgender-patients

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York: Haworth Clinical Practice.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, *71*(3), 543–562. http://dx.doi.org/10.1111/1467-8624.00164

MacLaughlin, D. T., & Donahoe, P. K. (2004). Sex determination and differentiation. *New England Journal of Medicine*, *350*(4), 367–378. http://dx.doi.org/10.1056/NEJMra022784

Maddux, S., Producer & Director. (2011). *Gen silent [Motion Picture]*. Boston, MA, USA: Interrobang Productions.

McFadden, S. H., Frankowski, S., & Witten, T. M. (2013). Resilience and multiple stigmatized identities: Older transgender/Intersex identified persons reflect on aging. In J. Sinnott (Ed.), *Positive psychology and aging* (pp. 247–268). New York: Springer Publishing Company. http://dx.doi.org/10.1007/978-1-4614-7282-7_16

Meier, S. C., & Labuski, C. M. (2013). The demographics of the transgender population. In A. K. Baumle (Ed.), *International handbook on the demography of sexuality* (pp. 289–327). New York: Springer.

Moody, H. R. (2006). *Aging: Concepts and controversies (5th ed.)*. Thousand Oaks, CA: Sage Publishing Co.

Moyer, J. W. (2015, November 4). Why Houston's gay rights ordinance failed: Fear of men in women's bathrooms. *Washington Post*. Retrieved from https://www.washingtonpost.com/news/morning-mix/wp/2015/11/03/why-houstons-gay-rights-ordinance-failed-bathrooms/

Nadal, K. L., Skolnik, A., & Wong, Y. (2012). Interpersonal and systemic microaggressions toward transgender people: Implications for counseling. *Journal of LGBT Issues in Counseling*, *6*, 55-82. doi:10.1080/15538605.2012.648583

National Academy on an Aging Society (GSA), & SAGE. (2011). Integrating lesbian, gay, bisexual, and transgender older adults into aging policy and practice. *Public Policy & Aging Report*, *21*(3), 1–36. Retrieved from http://www.sageusa.org/uploads/PPAR%20Summer20111.pdf

National Center for Transgender Equality (2015). *Know your rights: Healthcare*. Retrieved from http://www.transequality.org/know-your-rights/healthcare

National Center for Transgender Equality. (2016). *North Carolina's shocking anti-trans bill means we are fighting harder*. Retrieved from http://www.transequality.org/blog/north-carolina-s-shocking-anti-trans-bill-means-we-re-fighting-harder

National Center for Transgender Equality (n.d.). *Medicare and transgender people*. Retrieved from http://transequality.org/PDFs/MedicareAndTransPeople.pdf

National Senior Citizens Law Center. (2011). *LGBT older adults in long-term care facilities: stories from the field*. Washington, DC: National Senior Citizens Law Center.

Nuttbrock, L., Bockting, W., Rosenblum, A., Hwahng, S., Mason, M., Macri, M., & Becker, J. (2014). Gender abuse and major depression among transgender women: A prospective

study of vulnerability and resilience. *Amer Journal Public Health*, *104*, 2191–2198. doi:10.2105/AJPH.2013.301545

Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., Brenman, S., & Lunn, M. R. (2011). Lesbian, gay, bisexual, and transgender: Related content in undergraduate medical education. *JAMA*, *306*, 971–977. doi:10.1001/jama.2011.1255

Office of Human Rights (n.d.). *Safe bathrooms DC*. Retrieved from http://ohr.dc.gov/page/safe-bathrooms-dc

Porter, K. E., Ronneberg, C. R., & Witten, T. M. (2013). Religious affiliation and successful aging among transgender older adults: Findings from the Trans MetLife Survey. *Journal of Religion, Spirituality & Aging*, *25*(2), 112–138. http://dx.doi.org/10.1080/15528030.2012.739988

Powell, J. A. (2008). Structural racism: Building upon the insights of john calmore. *North Carolina Law Review*, *86*, 791–816.

Redman, D. (2011). Fear, discrimination and abuse: Transgender elders and the perils of long-term care. *Aging Today*, *XXXII*(2), 1–2.

Services and Advocacy for GLBT Elders (SAGE) & National Center for Transgender Equality (NCTE). (2012). *Improving the lives of transgender older adults*. New York: Authors. Retrieved from http://transequality.org/Resources/TransAgingPolicyReportFull.pdf

Settersten, J. R. (2006). Aging and the life course. In R. H. Binstock, & L. K. George (Ed.), *Handbook of aging and the social sciences* (pp. 3–19). Burlington, MA: Academic Press.

Singh, A. A., Hays, D. G., & Watson, L. (2011). Strategies in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling and Development*, *89*, 20-27. doi:10.1002/j.1556-6678.2011.tb00057.x

Smith, B. W., Tooley, E. M., Christopher, P. J., & Kay, V. S. (2010). Resilience as the ability to bounce back from stress: A neglected personal resource? *Journal of Positive Psychology*, *5*(3), 166–176. doi:10.1080/17439760.2010.482186

Stirratt, M. J., Meyer, I. H., Ouellette, S. C., & Gara, M. A. (2008). Measuring identity multiplicity and intersectionality: Hierarchical classes analysis (HICLAS) of sexual, racial, and gender identities. *Self and Identity*, *7*(1), 89–111. http://dx.doi.org/10.1080/15298860701252203

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Diversity*, *3*(1), 65–77. doi:10.1037/sgd0000081

Transgender Law Center. (2005). *Peeing in peace: A resource guide for transgender activists and allies*. San Francisco: Author. Retrieved from http://transgenderlawcenter.org/issues/public- accomodations/peeing-in-peace [sic]

Van Sluytman, L. G., & Torres, D. (2014). Hidden or uninvited? A content analysis of elder LGBT of color gerontology. *Journal of Gerontological Social Work*, *57*(2–4), 130–160. doi:10.1080/01634372.2013.877551

Van Wagenen, A., Driskell, J., & Bradford, J. (2013). "I'm still raring to go": Successful aging among lesbian, gay, bisexual and transgender older adults. *J. Aging Studies*, *27*(1), 14. doi:10.1016/j.jaging.2012.09.001

White, J. T., & Gendron, T. L. (2016). LGBT elders in nursing homes, long-term care facilities, and residential communities. In D. A. Harley, & P. B. Teaster. (Eds.), *Handbook of LGBT Elders: An interdisciplinary approach to principles, practices, and policies*. New York: Springer. http://dx.doi.org/10.1007/978-3-319-03623-6_21

Witten, T. M. (2003). Transgender aging: An emerging population and an emerging need. *Review Sexologies*, *XII*(4), 15–20.

Witten, T. M. (2014). End of life, chronic illness and trans-identities. *Journal of Social Work in End-Of-Life & Palliative Care*, *10*(1), 34–58. doi:10.1080/15524256.2013.877864

Witten, T. M. (2015a). When my past returns: Loss of self and personhood – dementia and the trans-person. In S. Westwood, & E. Price (Eds.), *Lesbian, gay, bisexual and trans* individuals living with dementia: Theoretical, practical and rights-based perspectives*. New York: Routledge Press.

Witten, T. M. (2015b). Elder transgender lesbians: Exploring the intersection of age, lesbian sexual identity, and transgender identity. *Journal of Lesbian Studies*, *19*(1), 73–89. doi:10.1080/10894160.2015.959876

Witten, T. M., & Eyler, A. E. (Eds.). (2012). *Lesbian, gay, bisexual, and transgender aging: Challenges in research, practice, and policy*. Baltimore, MD: Johns Hopkins University Press.

Witten, T. M., & Eyler, A. E. (2015). Care of aging transgender and gender non-conforming patients. In R. Ettner, S. Monstrey, & A. E. Eyler (Eds.), *Principles of transgender medicine and surgery*. New York: Routledge Press.

Yates, T. M., Tuppett, M., & Masten, A. S. (2004). Fostering the future: Resilience theory and the practice of positive psychology. In P. A. Linley, & S. Joseph (Eds), *Positive psychology in practice* (pp. 521–539). Hoboken, NJ: Wiley. http://dx.doi.org/10.1002/9780470939338.ch32

Appendix: Online Resources

Aging/Elders

FORGE Trans Aging https://forge-forward.org/aging/
National Resource Center on LGBT Aging http://www.lgbtagingcenter.org/
SAGE'S Transgender Page: http://www.sageusa.org/issues/transgender.cfm

Providers-Standards & Guidelines

APA Guidelines: https://www.apa.org/practice/guidelines/transgender.pdf
Competencies for Counseling Transgender Clients
http://www.counseling.org/Resources/Competencies/ALGBTIC_Competencies.pdf
Endocrine Society- https://www.endocrine.org
Lesbian, Gay, Bisexual And Transgender (LGBT) Veteran Care
http://www.patientcare.va.gov/Lesbian_Gay_Bisexual_and_Transgender_LGBT_Veteran_Care.asp
Providing Health Care For Transgender And Intersex Veterans: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2863
TRANSLINE: An Online Transgender Medical Consultation Service For Health Care Providers http://project-health.org/transline/
World Professional Association for Transgender Health [WPATH] Standards of Care: http://www.wpath.org/

Reports

A Report of the National Transgender Discrimination Survey http://endtransdiscrimination.org/PDFs/NTDS_Report.pdf
A Report of the Task Force on Gender Identity and Gender Variance
www.apa.org/pi/lgbc/transgender/2008TaskForceReport.html

Improving The Lives Of Transgender Older Adults: Full Report http://www.transequality.org/issues/resources/improving-lives-transgender-older-adults-full-report
The Aging and Health Report: Disparities And Resilience Among Lesbian, Gay, Bisexual, And Transgender Older Adults
http://caringandaging.org/wordpress/wp-content/uploads/2011/05/Full-Report-FINAL-11-16-11.pdf

Rights, Policies, & Document Issues

HRC Resources: Transgender http://www.hrc.org/resources/topic/transgender
Id Document Policy By State: http://www.transequality.org/documents
Lambda Legal http://www.lambdalegal.org/issues/transgender-rights
Lambda Legal Transgender Seniors
http://www.lambdalegal.org/know-your-rights/transgender/trans-seniors-faq
National Center for Transgender Equality http://www.transequality.org/
Transgender Law Center http://transgenderlawcenter.org

Miscellaneous

Soul Force: http://www.soulforce.org