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Title
Session 310 Gay and Gray Vii: a Multidisciplinary Approach to Transgender Aging

Permalink
https://escholarship.org/uc/item/9930143r

Journal
American Journal of Geriatric Psychiatry, 25(3)

ISSN
1064-7481

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Publication Date
2017-03-01

DOI
10.1016/j.jagp.2017.01.052

Peer reviewed

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For *The American Journal of Geriatric Psychiatry* Word Count: 10,503

2017 American Association for Geriatric Psychiatry Annual Meeting

Gay and Gray Session: An Interdisciplinary Approach to Transgender Aging

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No research funding was received for research on which this article is based and no disclosures to report

BRIEF SUMMARY

Well-designed and well-powered research regarding the number, health disparities, resilience and optimal health care of older transgender individuals remains relatively sparse. This manuscript, like the 2017 American Association for Geriatric Psychiatry Annual Meeting session from which it was derived, aims to improve the health care of older transgender adults by providing a comprehensive summary of clinical information from the scientific literature relevant to the health and well-being of older transgender adults.

HIGHLIGHTS

1) This manuscript aims to provide a comprehensive review of the literature relevant to providing optimal mental health care to older trans adults.
2) Terms defined in this paper include: gender identity, gender expression, cisgender, transgender, non-binary gender, outing and transitioning.
3) Transgender older adults face greater risks of poor physical health, disability, anxiety, depression, victimization and stigma compared to non-transgender older adults.
4) Trans older adults have greater risks of and higher rates of smoking, excessive alcohol use, and risky sexual behavior compared to cis older adults.
5) The primary roles of a mental health professional assisting an older trans individual are: assessment, education, referral, treatment and advocacy.

ABSTRACT

With the overarching goals of improving the health care of older transgender individuals and of inspiring pertinent clinical research, a session at the 2017 American Association for Geriatric Psychiatry Annual Meeting focused on an interdisciplinary approach to transgender aging. The older the transgender adult, the more likely the individual grew up in an historical context when there was greater social stigma against their gender identity, even among mental health professionals. In order to provide optimal health care to transgender adults, mental health care providers should become familiar with the basic terminology presented in this manuscript. Transgender older adults face greater risks of poor physical health, disability, anxiety and depressive symptoms, victimization, and stigma, and higher rates of smoking, excessive alcohol use, and risky sexual behavior compared to non-transgender older adults. In spite of notable health disparities, some evidence points to resilience among transgender older adults. The mental health professional often serves as the first contact for a patient who is struggling with gender identity. The role of a mental health professional can be divided into five categories: 1) Assessment of gender dysphoria; 2) Psychoeducation of patients and family members about the diversity of gender identities and various options for alleviating gender dysphoria; 3) Referral to and collaboration with other health care professionals; 4) Treatment of coexisting mental health concerns; 5) Advocating for transgender patients and for the transgender community. Recently, the criteria for

medical and surgical transition have been simplified. End-of-life preparations are especially important for transgender individuals.

INTRODUCTION

Historically, the lesbian, gay, bisexual and transgender (LGBT) population in the U.S. has not been well-studied. As a result, even the number of individuals in the U.S. who identify as a member of a gender or sexual minority is still not especially well-understood .[1] The U.S. Census did not begin collecting data on same-sex households until 1990. Since then, the U.S. Census has continued to measure same-sex households and in 2010 added a measure of married versus unmarried households. Other than the U.S. Census, prior to 2000, information about LGBT adults came from a number of small research studies, all of which employed self-selected samples.[2]

Because national population-based surveys have only rarely asked respondents if they are transgender, data from two state surveys (California and Massachusetts) were used to estimate the size of the U.S. adult transgender population.[3] Based on data from these two states, it was estimated that 0.3% of the U.S. adult population, or approximately 700,000 adults, identify as transgender. Scientists at The Williams Institute at the University of California, Los Angeles, used somewhat more recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) to estimate the percentage of the U.S. adult transgender community to be 0.6% (approximately 1.4 million).[4] The best available estimates of the older (65-years-old or older) U.S. transgender population also come from The Williams Institute at the University of California, Los Angeles.[4] Overall, the U.S. older adult transgender population is estimated to be 217,050 which is 0.50% of the total number of older adults in the US. The states with the largest population of older transgender adults are CA (N=29,050), FL (N=19,350) and NY (N=12,850) and

the states with the smallest populations are ND (N=300), AK (N=250), and WY (N=200).[4]

Obtaining an accurate estimate of the size of the U.S. transgender community is considered a critical step in achieving a better understanding of transgender health including the extent to which members of the transgender community utilize various social services. Recently, efforts by government agencies to collect information about sexual minority status, including being transgender, were increasing. For example, the National Survey of the Older Americans Act (OAA) added questions about sexual orientation and transgender status in 2014.[5] In addition, the Centers for Medicare and Medicaid Services 2015 Equity Plan for Medicare beneficiaries encouraged the collection of information about sexual minority status.[6] Under the Trump-Pence Administration, however, the Department of Health and Human Services' proposed 2017 protocol eliminates the OAA survey's question about membership in a sexual or gender minority group. The explanation provided for this decision was that only a small percentage of older adults acknowledged being LGBT after questions about membership in a sexual or gender minority group were added to the survey.[7] This low rate of acknowledgment is consistent with other surveys which have asked older adults about membership in a sexual or gender minority and have found that, relative to middle-aged and younger adults, only a small percentage of older adults identify via survey questions as LGBT. The reasons for this are not yet well-understood but among the possible explanations are that this reflects intergenerational differences regarding the impropriety of disclosing this information and that older adults are more likely to fear adverse consequences from acknowledging sexual minority status.[8,9]

Although there are significant differences between and among, lesbian, gay, bisexual and transgender individuals, for a variety of reasons, including the shared experience of being members of sexual and/or gender minorities, these individuals are often viewed as one group. Perhaps the best example of this tradition is the widespread use of the term "LGBT." Reliable and clinically useful information about the LGBT community as a whole is relatively limited compared to other minority communities and, reliable and clinically useful information specifically about anyone one of the groups represented by the LGBT acronym is even more limited. If older age is included as a factor when searching the scientific literature about any of the gender and sexual minorities, then the observed quantity of information is even smaller. This is especially true regarding scientific information about older trans individuals. For example, the authors were unable to find data about the mean age at which trans individuals are requesting and/or obtaining gender affirming interventions or data regarding whether the mean age has changed over the past several decades.

With the overarching goals of improving the lives and health care of older members of the LGBT community and inspiring clinical research pertinent to this population, in 2010 the members of the American Association for Geriatric Psychiatry's (AAGP's) LGBT Interest Group prepared and delivered an inaugural scientific session titled "Gay and Gray: Addressing the Mental Healthcare Needs of Older Gay, Lesbian, Bisexual and Transgendered Individuals."[10] Each of the AAGP annual meetings since then has included a "Gay and Gray" scientific session. The intent of this paper is to provide the reader with a published version of the content of the 2017 AAGP Annual Meeting Gay and Gray session whose theme and title was "A Multidisciplinary Approach to Transgender Aging."[11] The session was composed

of three sections each of which involved different authors of this manuscript: 1) Important background information including definitions of key terms and a discussion of the evolution of the American Psychiatric Association's policy statements and DSM diagnoses related to transgender individuals throughout the years, as well as information about health disparities (BCY); 2) A summary of the optimal interdisciplinary approach to transgender care including the impacts of hormone therapy and gender-conformation surgery (KJ); and 3) A live interview of an older transgender female who is one of the authors of this manuscript (LAC) conducted by an author (DDS) using questions prepared by another author (JMA). LAC was given the interview questions several weeks ahead of the session and prepared for her interview by answering these questions in writing. Journal policy did not require LAC to sign a release of information form.

BACKGROUND INFORMATION

Terminology

In order to understand mental health issues among transgender older adults, geriatric mental health care providers should first be familiar with some basic terminology. In the current section of this manuscript, important and possibly new terms for the reader have been placed in italics when first used. *Sex* refers to one's biological status as male, female, or otherwise (e.g. *intersex*). Sex is assigned at birth and is associated with chromosomes, internal anatomy, and external anatomy.[1] In contrast, *gender* represents socially constructed attributes, roles, behaviors, and activities a given society considers appropriate for boys and men, girls and women, and everything in between.[1]

Other important terms include *gender identity* and *gender expression*. Rather than socially constructed roles, gender identity refers to an individual's sense of

being a man, a woman, or something else.[1] Gender expression is the way a person communicates one's gender to others and can involve behaviors, clothing, hairstyle, voice, and other personal characteristics.[1] *Cisgender*, or "*cis*," indicates that sex and gender identity are both the same, whereas *transgender*, or *"trans,"* indicates that sex is incongruent with gender identity.[1] For example, a *trans-man* is a transgender person assigned female sex at birth but whose gender identity is that of a man; a *trans-woman* is a transgender person assigned male *sex* at birth but whose gender identity is that of a woman.[1]

For a variety of reasons, gender expression does not always align with gender identity. Current vernacular associates the term "trans" only with gender identity and not necessarily with gender expression, which reflects the possibility that a person may have an awareness that the sex assigned at birth and the person's sense of the correct gender identity do not match but has elected to keep this awareness private and so continues to maintain the gender expression of the sex assigned at birth. For example, a person assigned the sex of male at birth may inwardly identify as female but, due to social concerns, outwardly choose to express the sex which was assigned at birth. Caitlyn Jenner is a very well-known example of someone who lived for most of her adult life expressing a gender contrary to her gender identity. Entertainers who cross-dress (informally known as *Drag Kings* or *Drag Queens*) provide another example of individuals whose gender expression may not necessarily match with their gender identity. A woman who makes a living as a performer who appears to be a man, a Drag King, is purposely choosing while at work to present the gender expression of a man, but may have no question about having the gender identity of a woman. In other words, a Drag King may be cisgender, as in this example, or transgender.

Sexual orientation is the nature of romantic or sexual attraction toward others.[1] Lesbian, gay, and bisexual are examples of sexual orientations. Sexual orientation is separate from gender identity or gender expression, meaning that an individual may identify as any sexual orientation while having either cisgender or transgender identity.[1] A number of synonymous terms may be used to describe adults who are transgender. These terms include: *transgender-identified individuals*, *trans-identified individuals*, *transgender-identified adults* and *trans-identified adults.*

Recently, a number of additional terms have been receiving increasing media attention, in part, due to states like Oregon and California passing laws that allow for a third option regarding the sex recorded on government documents like birth certificates and driver's licenses. *Binary gender* refers a classification system which recognizes only two genders: male or female. For millennia, however, a number of cultures have recognized more than two genders. The term *non-binary* (NB) is used to describe individuals who do not identify with either being a man or a woman.[12] A non-binary person is not necessarily the same as a transgender or an intersex person.[12] Synonyms for NB include *androgynous, gender nonconforming, gender variant, pangender, gender fluid*, and *genderqueer* (GQ) which, in some contexts, can be simplified to just "*queer*." A "Q" is now often added to LGBT, LGBTQ, in order to acknowledge individuals who, for whatever reason, do not fit into the binary gender classification system. Except for this paragraph, the authors have not added "Q" to the abbreviation LGBT because it is a term that few older adults have adopted. There are also individuals who identify with no gender whatsoever and identify with the terms *gender neutral, agender, or nongendered.*[12, 13]

A pictorial summary of this terminology (known as the "Genderbread Person") can be found online. [14] The American Psychological Association has also published handouts which further discuss this terminology.[15,16] Table 1 provides a list of the terms and their definitions.

Intersectionality is a concept developed in the 1980s by Kimberele Crenshaw to describe situations when discrimination occurs not as the result of a person belonging to one group at-risk for discrimination but due to the combined effect of belonging to more than one at-risk group. [17] There are many personal characteristics that may predispose to discrimination such as age, gender, race, ethnicity, faith community, sexual orientation or gender identity and these characteristics may exert an additive effect in terms of the risk and extent of potential discrimination. The situation that inspired Crenshaw's development of the term intersectionality was her awareness that black women who brought legal action against employers for discrimination had been unsuccessful because the accused employers had provided evidence that no discrimination was occurring against women employees and no discrimination was occurring against Black employees. In these cases, however, the evidence which refuted the discrimination was regarding white women and black men but not black women. Crenshaw expressed the opinion that this one-dimensional approach to assessing potential discrimination fails to identify consistently and/or quantify accurately experiences of discrimination. For example, an older adult is at risk of discrimination based on age. A person who is transgender is at-risk of discrimination due to being transgender. Intersectionality acknowledges that an older transgender person may experience more frequent discrimination or more intense discrimination due to being both older and transgender. The potential for discrimination may be even greater if a person is

older, transgender and also identifies as African-American, has a disability or limited financial resources. Research in the area of health disparities highlights the role of intersectionality in the lives of transgender individuals and will be the subject of further discussion later in this manuscript.

Scientific research has provided an abundance of evidence which demonstrates that human behavior, beliefs and attitudes are shaped by cognitive processes occurring outside of conscious awareness.[18] This phenomenon has been termed *unconscious bias* (UB) and is gaining increasing attention in parallel with the increasingly diverse demographics of many countries including the U.S.[19] Members of the trans community are vulnerable to both conscious bias and UB. The impact of both types of bias on the care of members of the trans community will be addressed in a later section of this paper.

Pronouns and Titles

In the English language, the pronouns we use to refer to others carry a gendered connotation. “He,” “him,” “she,” and “her” are examples of gendered pronouns. Titles, such as Mr. or Ms., also carry a gendered connotation. This can be problematic for some transgender and gender nonconforming individuals who do not identify with a binary gender construct. Hence, some refer to themselves with gender-neutral pronouns and/or titles. Using the word “they” in a singular context is one way of accomplishing this. Other singular gender-neutral pronouns include the nominative “zhe” (pronounced “zee”, to replace he/she) and objective “hir” (pronounced “here”, to replace him/her). Gender neutral titles include Mx. (pronounced “mix”) and Misc (pronounced “misk”).[20] “It” is almost never used and is often considered insulting.

When someone uses the incorrect pronoun to refer to someone, they *misgender* that person. Some misgender others intentionally as a form of discrimination or harassment. This can happen to anyone—including those who are cisgender, however, it can be particularly damaging to those who are transgender. [21] It is important, therefore, to clarify a person's preferred pronouns by asking, "What are your preferred pronouns?" or "What pronouns do you use to describe yourself?" instead of relying solely on appearance or what the medical record may indicate.

Coming Out

Coming out or "*coming out of the closet*" is a defining developmental process for all people who identify as lesbian, gay, bisexual, or transgender (LGBT). [1] Coming out is a process in which one becomes aware of his or her own sexual orientation or gender identity and then openly declares it to others. [1] It is important for geriatric mental healthcare providers to recognize that coming out is a process, and so a patient may be "out" in some contexts and not others. [15, 16] For example, one may dress and behave in accordance with one's gender identity on the weekend or with friends but not at work or when visiting family.

Ideally, but not invariably, a person who is considering coming out in a particular setting first discerns the level of safety (e.g. the level of social stigma) in the environment before choosing to come out.[1] Coming out to others for the first time may occur at any age, even older adulthood, and some individuals, based on personal discernments of safety, decide never to come out at all. [1] Safety concerns may be heightened near the end of life when older LGBT adults encounter new caregivers, new medical providers, or new living circumstances, such as a long-term care community, compelling some to go "back in the closet." [21,22,23] Except in

the oldest old, lower disclosure of gender identity due to social stigma is associated with poorer mental health.[24,25] Little is known about the number of geriatric transgender individuals who are out; however, in the transgender population overall, only 32% reported being out to all their non-LGBT friends and 22% reported being out to all immediate and extended family members.[26] Nonetheless, coming out in a particular setting is a personal decision, and health care providers should avoid *outing* others, which means disclosing someone's sexual orientation or gender identity without the consent of the individual.[1] In order to avoid outing a patient, the clinician should ask the individual who is trans specific questions like "Is it OK for me to record your gender identity in your medical record?" and "Are there individuals to whom I should not reveal that you are trans?"

Transitioning

The term *transitioning* refers to the process by which an individual alters one's gender expression, or other characteristics such as external anatomy, to more closely reflect one's gender identity.[16] Transitioning is closely related to a discernment of safety and the process of coming out.[16] Transgender Standards of Care (SOC) developed by the World Professional Association for Transgender Health (WPATH)[27] and the University of California, San Francisco, Center of Excellence for Transgender Health recommend transitioning for those who desire it.[28]

The process of transitioning may include a number of gender-affirming treatments and procedures, including cross-sex hormone therapy, surgery, facial hair removal, interventions for the modification of speech and communication, and behavioral adaptations such as genital tucking/packing or chest binding.[28] All are deemed appropriate and medically necessary by WPATH.[27] Some research has found improvements in depression, anxiety, distress, and psychological functioning

with provision of gender-affirming treatments.[29-32] Seventy percent of transgender adults 65 years of age or older, however, report waiting until after retirement to transition because apprehension about job discrimination and concerns about financial stability.[33] More information on the relevance of this knowledge for geriatric mental health care providers is included below.

Historical Context

The experience of members of the LGBT community varies considerably based upon the age of the cohort being studied. The older the members of the cohort of LGBT adults, the more likely that these individuals grew up in an historical context when there was greater social stigma against their sexual orientation and/or gender identity, even among mental health professionals.[34.35] In the initial editions of the Diagnostic and Statistical Manual of Mental Disorders, DSM-I and DSM-II, homosexuality was listed as a “sociopathic personality disorder” or “sexual deviation.”[34] The oldest old LGBT age cohort was told that gay and lesbian sexual orientations were mental disorders or even criminal acts.[35] Following the 1969 Stonewall Riots, however, demonstrations at the American Psychiatric Association (APA) annual meetings, and the testimony of Dr. H. Anonymous at the 1972 APA annual meeting, homosexuality was removed from DSM-II-Rev in 1973.[34]

In contrast to the progress that was occurring regarding the understanding of homosexuality as a variation of normal human behavior, the APA contributed to the belief that simply being transgender was a type of pathology by actually adding diagnoses relating to transgender identity to DSM-III-R in 1987.[35] Transsexualism, however, was removed from DSM-IV in 1994. Gender identity disorder and transvestic fetishism were removed from DSM-5 in 2013 and replaced by the

diagnosis of *gender dysphoria*.[35] Although still controversial because of the stigma associated with being assigned a psychiatric diagnosis, including gender dysphoria in the DSM provides transgender individuals with a diagnosis that facilitates insurance-funded optimal transgender-related health care.[35]

The historical context in which one grew up and developed a sense of one's sexual orientation and/or gender identity impacts how the process of coming out proceeds, as well as lifetime mental health.[1] The effects of growing up at a time when one's sexual orientation and/or gender identity was assigned a pathological label can be seen in survey results today. The process of coming out more frequently improves self-reported mental health in younger cohorts; however, among the oldest LGBT adults, coming out more often leads to worse mental health.[25,26] In addition, reports of both lifetime victimization and internalized stigma are higher among the oldest cohort of LGBT older adults (age 80 years and older) compared to younger cohorts (age 50-79 years).[20] When treating older LGBT patients, therefore, it important for geriatric mental health care providers to consider the possibility that the person's date of birth impacted various aspects of their physical, psychological and social development due to differences in the prevailing medical understanding of these personal characteristics and the associated societal attitudes and opinions about LGBT individuals.

Health Disparities and Resilience

Transgender older adults face greater risks of poor physical health, disability, anxiety and depressive symptoms, victimization, and stigma, and higher rates of smoking, excessive alcohol use, and risky sexual behavior compared to non-transgender older adults.[36] In spite of these numerous health disparities, until the

last few years, research focused on this high-need population has been quite sparse.

In 2011, a study of 2,560 LGBT individuals age 50 years and older, *Caring and Aging with Pride*, marked the first large scale survey of older adults which included transgender individuals in addition to lesbian, gay, and bisexual individuals.[20] The transgender older adults in this survey had a significantly higher risk of poor physical health, disability, depressive symptoms, and perceived stress compared to non-transgender participants.[36] Lifetime history of suicidal ideation was 71% among transgender participants.[20] Rates of victimization and stigma explained the highest proportion of the total effect of gender identity on health outcomes.[37]

In 2014, the same research team responsible for *Caring and Aging with Pride* completed the first pass of the first longitudinal survey of LGBT older adults in the U.S., the *National Health, Aging, and Sexuality/Gender Study (NHAS)*, which included 183 transgender individuals out of 2,450 total LGBT participants; most results are pending.[38] The need for improved health care for members of the transgender community are highlighted by the findings of the *National Transgender Discrimination Survey* (NTDS) released by the National Center for Transgender Equality (NCTE) and the National LGBTQ Task Force.[39] The NTDS includes data from surveys and interviews with 6,456 participants. This was followed by the *2015 U.S. Transgender Survey* (USTS)[26] The 2015 USTS represents the largest survey examining the experiences of transgender people in the United States and included 27,715 respondents from all fifty states, the District of Columbia, American Samoa, Guam, Puerto Rico, and U.S. military bases overseas. The 2015 USTS was an anonymous online survey of transgender individuals who were 18 years or older and was conducted in the summer of 2015 by the NCTE. Of the respondents, 803 are

over the age of 65; however, results of this survey stratified by age are very limited in scope.[27] Because the data were collected via online surveys, the survey may have missed many who are in the geriatric population, are non-white, or have lower incomes. In the near future, as the data from the studies above are more completely analyzed and as other studies of this population are undertaken, research uncovering modifiable factors for public policy and individual interventions to improve health disparities among transgender older adults should become available.

Key findings of the USTS shed light on some of the reasons trans adults experience suboptimal health care: 1) 25% of respondents acknowledged a problem in the past year with their insurance related to being transgender, such as being denied coverage for care related to gender transition or being denied coverage for routine care because they were transgender; 2) 55% of those who sought coverage for transition-related surgery in the past year were denied; 3) 25% of those who sought coverage for hormones in the past year were denied; 3) 33% of those who saw a health care provider in the past year reported having at least one negative experience related to being transgender; 4) Negative experiences included being refused treatment, verbally harassed, or physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care; 5) 31% of respondents reported not being out to any of their health care providers; 6) In the past year, 23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person; and 7) 33% did not see a doctor when needed because they could not afford it.

With the exception of some individual states and institutions, historically, few policies or laws have been created to protect the rights of transgender individuals in

employment and public accommodations including health care settings. Although there are community organizations, such as SAGE,[40] which are committed to redressing discrimination against older LGBT people, including those who are transgender, this means little to no legal recourse may be available for transgender individuals who have experienced discrimination. Whether or not legal remedies for discrimination exist, health systems, residential care communities and insurance plans may have patient or resident experience officers or ombudsman available to help address instances of discrimination or mistreatment.

The USTS found that 1.4% of the trans adults in the survey were living with HIV which is almost five times the rate in the U.S. population (0.3%). HIV rates were higher among transgender women (3.4%), especially transgender women of color. Nearly one in five (19%) Black transgender women were living with HIV. The rates of HIV in trans American Indian and trans Latina women were 4.6% and 4.4%, respectively. Research has demonstrated that the older the age of HIV seroconversion and the older the person with HIV, the more difficult treatment of individuals living with HIV becomes. Evidence from the Strategies for Management of Antiretroviral Therapy (SMART) trial and other observational studies suggest that HIV infection and anti-retroviral therapy influence morbidity and mortality through effects on inflammation, treatment-related toxicity, interactions with other chronic viral infections and co-morbid diseases typically associated with increasing age.[41] HIV-infected persons may exhibit an excess burden of co-morbid conditions as well as the pre-mature onset of a number of clinical symptoms and syndromes that are associated with aging, including polypharmacy and declines in physical and cognitive reserves.[41] While AIDS-defining illness are becoming increasingly rare in individuals whose viral loads have been suppressed by ART, the list of HIV-

associated, Non-AIDS (HANA) conditions is growing. This list includes cardiovascular disease, cancers, osteoporosis, liver disease, renal disease and neurocognitive decline.[41] This makes proper screening for HIV and careful education about HIV risk reduction especially important when working with older trans individuals. Given that the most common risk factor for dementia onset is increasing age and given the elevated rate of HIV-infection in trans individuals, an older trans adult should be screened for HIV seroconversion and an older trans individual, whether or not living with HIV, should have regular cognitive screening evaluations to assess for emerging dementia.

In spite of notable health disparities, some evidence from Caring and Aging with Pride points to resilience among transgender older adults. Ninety percent of LGBT older adult participants reported involvement in some type of leisure activity and feelings of belonging in their communities and 80% engaged in moderate physical activity at least once per week.[42] In addition, many reported involvement in spiritual activities and services, with rates higher among transgender than non-transgender participants.[42] Each of these factors was associated with more positive self-rated health and greater quality of life.[42] Yet the adverse influence of discrimination on quality of life was still greatest for the oldest LGBT participants.[33]

X

AN INTERDISCIPLINARY APPROACH TO TRANSGENDER CARE

Overview of the Role of the Geriatric Mental Health Professional

The mental health professional often serves as the first contact for a patient who is struggling with gender identity.[42] Patients may disclose this during their first session or reveal this over years of treatment. Either way, having a mental health professional who is knowledgeable and sensitive to the diversity of gender identities

and transgender experiences is essential.[21] Given the data reported above from the USTS, there is a significant probability that a trans patient, presenting for an appointment with a health care provider, may have a history of past negative experiences involving the health care system. In order to decrease the likelihood of a negative experience, if a clinician is not comfortable providing care to a trans patient, then the clinician has an obligation to help the patient establish care with someone who is comfortable providing care. In addition, during the initial assessment, asking about the quality of any previous experiences with health care providers, especially previous interactions during which the individual being transgender was acknowledged, often reveals important information and may also help establish rapport.

Some clinicians with noble intentions may have still have UB about trans patients. Although there is no established method to detect UB regarding trans individuals, a clinician's UB is likely to be just as problematic for the trans patient as conscious bias.[19] To address UB, Teal et al.[19] recommend adapting and using a published intercultural competency model developed by Bennet .[44] This model identifies and defines six stages of intercultural competency and provides examples of behaviors that are characteristic of each stage. The six stages are: denial, defense, minimization, acceptance, adaptation and integration. If the clinician is uncertain about the presence of UB and/or the impact that either conscious bias or UB may be having on the experience of the patient, requesting feedback from the patient may quickly provide helpful guidance.

The multifaceted role of a mental health professional can be divided into five categories:

(1) Assessment of gender dysphoria

(2) Psychoeducation of patients and family members about the diversity of gender identities and various options for alleviating gender dysphoria

(3) Referral to other professionals and collaboration with these professionals in an interdisciplinary manner

(4) Treatment of coexisting mental health concerns including referral to a qualified psychotherapist if psychotherapy is indicated and the mental health professional is not able to provide psychotherapy

(5) Advocating for transgender patients and for the transgender community as a whole[21, 45]

Definitions of the Role of the Geriatric Mental Health Professional

(1) **Assessment:** Geriatric mental health providers can assess the person's experiences with gender identity and look for signs of gender dysphoria. There is no standard screening or assessment tool for diagnosing gender dysphoria, and assessment protocols vary among providers and clinics. The existence of a gender dysphoria diagnosis is a very sensitive issue, which should be carefully discussed with the patient. Gender dysphoria was added to the DSM-5 in place of Gender Identity Disorder in order to place more emphasis on the psychological distress associated with having a gender identity that does not match one's sex while hoping to avoid labeling all transgender individuals as ill simply because of the incongruence between their sex and gender identities.[46] A diagnosis of gender dysphoria, however, can also be perceived as pathologizing their identity. At the beginning, it may be helpful to explain the framework for the assessment and reassure the patient that the overall goal is to achieve the best possible outcome. Explain

to the patient that the evaluative process is not an attempt to disrupt their transition or dissuade them from transitioning. The process is designed to ensure the patient is appropriately prepared for the process. As noted above, given the possibility that the patient may have had negative past experiences while seeking health care, asking about the quality of any previous experiences with health care providers is one way to convey caring and commitment to providing unbiased assistance.

In a comprehensive assessment, the clinician should explore the person's history of gender dysphoric feelings and how they have attempted to address these feelings (e.g. choosing a name or experimenting with different forms of gender expression). The clinician should rule out other conditions that may cause or mimic gender dysphoria, such as body dysmorphic disorder, dissociative experiences, trauma related diagnoses (i.e., PTSD, borderline personality disorder), substance use, or psychotic disorders.[45] The clinician should also screen for mental health concerns that may interfere with a positive outcome of surgical or medical transition—including co-occuring substance use problems such as tobacco use disorder.[21] Those with untreated mental illness are at greater risk of poor outcomes after surgical transition.[47] Taking a good medical history that includes a sexual history is important to screen for potential medical and social complications associated with transitioning. The assessment should also explore the availability of psychosocial support as this will also impact the success of transitioning. For example, prior to gender-affirming surgery, the patient should have stable housing, strong social support, access to transportation, and adequate financial means to get the patient through the post-operative

recovery period.[48] Some may obtain psychological testing or laboratory testing (such as a urine toxicology screen) to acquire more comprehensive data. Some clinical settings require (or strongly recommend) at least a few months of psychotherapy. Given the health disparities previously described, the initial assessment also provides an opportunity for general health promotion which may not be provided by the patient's primary care provider. Helpful tools to guide the clinician include with this assessment include the WPATH Standards of Care.[45]

(2) **Psychoeducation:** Scientific understanding of gender identity and gender expression is increasing and may be outpacing the understanding of these issues among members of the general public. As a result, providing education to the patient and the patient's important social supports is a very important task of mental health care providers. Even if the mental health provider does not feel able to provide ongoing mental health care, some knowledge of these issues is critical in order to avoid adding to the psychological trauma that trans individuals are likely already to have experienced. At this very critical and potentially vulnerable moment for the patient, the provision of basic information about the diversity of gender identities and the recognition that the binary gender classification system is both antiquated and inaccurate may be very helpful. The provider should be able to educate patients on the diversity of gender identities and the various options to alleviate gender dysphoria. This may include discussing basic terminology that can be used to describe transgender experiences and exploring non-binary gender.[41] In addition, it is very important to nurture a sense of hope for the patient and the members of their support network. A

trans individual needs to be informed emphatically that simply being trans or NB is not a form of illness; however, it does increase the risk of mental health problems, at least in part, related to a spectrum of potentially toxic life experiences from being repeatedly misunderstood to being a victim of various forms of abuse. Table 2 provides a list of potentially helpful written and online resources including a “Field Guide” created by The Joint Commission with support from the California Endowment and titled Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community.[49] In addition to chapters whose themes include the provision of care, treatment and services and patient, family and community engagement, this 92-page monograph includes a glossary of important terms as well as four appendices one of which provides a checklist to help achieve effective communication and cultural competence for members of the LGBT community. [49]

(3) Referral: Unless this has not already been done, the geriatric mental health provider will likely need to refer to a number of different care partners and subsequenlty engage with them in caring for the older trans patient. In the course of providing care for an older transgender person some of the most common care partners include health care providers from other fields, attorneys, vocal coaches, estheticians and others.[34] A detailed discussion of these additional professionals from other fields is included in the forthcoming section titled, “Other Important Care Partners.” The NTDS found that 40% of transgender adults 55-64 years-old and 54% of those older than 65 served in the military.[39] This is important to remember when considering where to refer an older trans individual for health care.

To prescribe gender-affirming hormones or conduct gender-affirming surgeries, medical and surgical providers may require a referral letter (evaluation) written by a mental health professional. [41] These letters provide documentation the person has gender dysphoria and is able to provide informed consent for medical and/or surgical treatment.[50,51] The letter can also state whether the person is an appropriate candidate to be evaluated for surgery and list any potential concerns that may need to be addressed prior to the operation (such as addressing past trauma or substance use issues). If the person has significant barriers or problems that render them an inappropriate surgical candidate, the letter should indicate this and also provide a treatment plan to address these concerns. Table 3 lists the important components of this evaluation.

(4) Psychotherapy and Treatment: In addition to helping the patient through the transition process, the mental health professional's role also includes diagnosing and treating, depending on the clinician's license, co-occurring psychiatric and/or medical concerns such as mood disorders, neurocognitive disorders, or psychological and psychiatric sequelae of trauma. Psychotherapy is not a requirement for medical or surgical transition. The geriatric mental health professional is likely to be the best-qualified professional to identify and treat the mental health impacts of stigma and minority stress, and to facilitate a coming out process.[43, 45] As noted above, the mental health provider can also play an integral role in educating family members and other members of the patient's support system.

(5) Advocacy: Because transgender and gender nonconforming individuals encounter discrimination, violence, and trauma from numerous sources, mental health professionals can play a vital role in education and advocacy.[45] Educating

yourself and your colleagues on the health and wellness needs of transgender individuals is perhaps one of the most important forms of advocacy. This may include reading articles or books on transgender health, or attending trainings. Table 4 includes a list of conferences that usually include an educational component for health care providers. Most offer CME credit. Clinicians should help educate and train ancillary staff, such as nurses, medical assistants, scheduling staff, and security staff in the hospital setting, clinic setting, and at extended care facilities that care for geriatric patients. These trainings should include topics such as using appropriate language, important transgender health issues, non-discrimination policies, and identifying and dealing with any UB. Table 2 lists resources that can be helpful in facilitating these training experiences. Advocacy could also include consulting with other professionals, institutions (including hospitals, nursing homes, short-term rehabilitation centers, etc.), and community organizations. In addition, advocacy may involve working with other providers or with insurance companies to help the patient obtain gender-conforming interventions. Lastly, advocacy may include helping the patient take the steps needed to ensure that, when the time comes, the patient’s wishes are respected at the end of life.

Other Important Care Partners

(1) Primary Medical Care Provider: As it would be for anyone, establishing a trusting professional relationship with a primary care clinician such as an internist, geriatrician, family medicine physician, physician assistant or nurse practitioner is highly recommended. In addition, the services of an endocrinologist may be helpful. The role of these providers includes initiating and/or maintaining hormone therapy. The primary care provider is also responsible for maintaining the patient’s physical health during the transitioning process, which may include tracking

laboratory values or managing medical comorbidities.[45] Some clinicians rely on the assistance of a mental health professional prior to starting cross-hormone therapy, while others do not. This also varies based on the individual needs of the patient. Not all transgender people want hormone therapy; however, it is considered a medically necessary intervention for many.[45] Neither WPATH nor the Endocrine Society guidelines list advanced age as a contraindication to starting hormone therapy. They do suggest, however, assessing the patient for risk factors (i.e. smoking, risk of stroke), medical monitoring (cardiovascular risk, osteoporosis risk), and regular cancer screening.[52] Little is known about the long-term effects of cross hormone therapy and most of the transgender medicine research focuses mainly on younger, healthier people. There are also no guidelines on whether to continue, decrease, or discontinue hormone therapy once a transgender person reaches late middle age. In addition to having a higher number of medical comorbidities, transgender older adults may have transition goals that differ from that of younger adults. For example, older adults have already completed menses and are likely not to worry about fertility preservation during the transition process. Older adults also have lower testosterone and estrogen levels at baseline, which will impact the dosage of hormones needed for transition.[53]

(2) Surgeon: Not all transgender people want surgery, but many do.[43] As noted above, surgeries that assist with transition are called gender-affirming surgery or gender-confirmation surgery because it affirms that person's already existing gender identity. This term is used instead of "sex-change operation" which invalidates the idea that the patient has had a gender identity all along.

Surgeons who specialize in transgender care are usually board certified in plastic surgery, but many are also trained in urology or OB/GYN. WPATH

recommends at least one referral letter from a mental health provider for chest/breast surgery (also referred to as "*top surgery*") and two letters for genital surgery (sometimes referred to as "bottom surgery"). Some surgeons follow different guidelines and have their own specific requirements.[21] Very little is known about surgical transition in geriatric populations. The literature is limited to a few case reports and news articles—including a 2014 article about an 81-year-old transwoman who successfully got gender-confirmation surgery at the age of 81.[54] Table 5 lists and defines gender affirming surgeries.

(3) Voice and Communication Therapist or Coach: According to the NTDS, those who start transitioning after the age of 55 are predominately transwomen. One common concern in this population is gaining the ability to speak in a feminine tone of voice.[39] There are a variety of professionals who may be qualified to assist with issues related to helping the individual's voice match with gender identity. These professionals include vocal coaches, speech-language pathologists, speech therapists, speech-voice clinicians, singing teachers, and/or movement experts. [39, 41] They assist with adjusting tone or pitch. The coach may also emphasize teaching gender-specific differences in intonation, feminine or masculine inflection, or speech patterns. The overall goal is to help the patient adapt their voice or communication in a way that is safe and authentic.

(4) Lawyer and/or Legal Consultant: In addition to medical and surgical transition, many transgender people desire to legally change their name and the sex listed on numerous government documents, which include their driver's license, birth certificate, passport, and/or social security paperwork. This process varies from state to state and often requires documentation from a health professional.

The process is also financially burdensome for many. In the USTS, only 30% of respondents have completed the legal name change process. This drops to 1%, however, among those over the age of 65. Among those respondents who have not changed their legal name, 35% report not doing so because they cannot afford it. Because the cost may be prohibitive, some clinics that specialize in transgender health also include a lawyer to assist in this process. The lawyer can also assist with concerns about immigration status, travel, health insurance, end-of-life documentation, discrimination, and/or criminal issues. The Transgender Law Center's website (Table 2) keeps an updated list of legal clinics by state.

(5) Hair Stylist or Barber: The first visit to a hair stylist at the beginning of a transition period can be anxiety provoking.[43] Depending on location, there may be hair stylists who advertise themselves to be sensitive to transgender issues and can provide a safe space for those exploring their own personal style.

(**6) Personal Trainer**: Hormones redistribute fat stores and often cause weight gain. A personal trainer can assist with keeping the patient at a healthy weight and with helping the patient learn more about developing a body shape/type that is more congruent with their gender identity.[43] For example, a transgender woman may want to learn weight training exercises that encourage physical health but do not create excessive muscle bulk in the upper arms and shoulders.

(7) Electrologist and/or Laser Treatment Provider: For trans-feminine people, estrogen therapy does not stop facial hair growth. Many rely on medical treatments to minimize hair growth. Furthermore, many genital surgeries require electrolysis of the genital regions (e.g. the scrotum) for several months.[21]

(8) Beauty Consultant/Esthetician and/or Fashion Consultant: Some may seek the advice of a beauty or fashion consultant to help develop a gender expression and sense of style that is comfortable and allows them to “pass” (i.e. be perceived by others as expressing the correct gender identity) more easily.[43] Many consultants provide a safe space for the person to experiment with different clothing styles, practice applying makeup, and practice with feminine/masculine mannerisms. Some attend transgender-oriented “finishing schools,” which help trans-feminine people pick out clothes, find flattering clothing/hair, and learn how to act more feminine.[55]

Gatekeeping

Historically, the requirements for hormones and surgery were generally quite restrictive but have become less so over the years. For example, the fifth version of the WPATH Standards of Care (1998) required transgender patients to obtain at least three months of psychotherapy therapy to “qualify” for hormone therapy.[56] It also required that the trans individual live at least 12 months in the desired gender expression prior to obtaining surgery (previously and problematically called “real life tests”) in addition to psychotherapy, if required by the mental health professional. These requirements have contributed to the impression that health care professionals are “gatekeepers,” whose purpose is to keep transgender individuals from transitioning with requirements that can be perceived as cumbersome and discriminatory. This impression can negatively impact the therapeutic relationship between the patient and the provider.[50] Patients may feel forced to falsely convey a “textbook” story of gender transition in order to access necessary care, or they may avoid medical and/or mental healthcare altogether. [21]

The most recent version of the Standards of Care (2011) has no such requirements for hormones or top surgery; however, they do continue to require 12 months of living in a gender role congruent with gender identity prior to bottom surgery. [45] The criteria for medical and surgical transition are still evolving and are likely to involve fewer hurdles in the future. As mentioned above, it is important, however, to keep this historical dynamic in mind when interacting with transgender patients, for it can be a source tension or initial mistrust.[48]

End of Life Considerations

The important preparations recommended for trans individuals are no different than those for cis individuals. In order to ensure that a person's wishes are followed, especially regarding end-of-life care, it is important for transgender individuals to prepare in advance by creating key legal documents such as a will and a power of attorney. Without these properly prepared and executed documents it is possible for unsupportive family members to take charge of the various decisions including decisions about medical care or funeral arrangements. Without these protections the individual's pronouns, name, and physical appearance may be incorrectly identified or represented including the appearance of the deceased at a viewing, wake or funeral service. Health care planning documents can be written to ensure a respectful decision-maker is given all the authority necessary to have the individual's gender identity and expression maintained.[57] Documents such as an *advance directive, living will, or deposition of bodily human remains* (DBHR) can include a section directing providers to respect the patient's gender identity and expression.[57] Figure 1 contains sample language which can be included in such documents.

THE VOICE OF AN OLDER TRANS INDIVIDUAL

With the assistance of a staff member at the Resource Center (the name for the gay and lesbian community center) in Dallas, one of the authors (DDS) was connected to an older transwoman (LAC). As part of the scientific session, LAC agreed to be interviewed by one of the authors (DDS) during the session. Another author (JMA) prepared questions which were emailed to LAC several weeks before the session. In order to prepare for her interview, LAC prepared written answers to each of the questions. During the session, the questions which were posed were generally, but not completely, the same questions in the same order as appears below. In a similar fashion, the answers provided by Lilith during the session were very similar but not 100% identical to the answers below. Because LAC provided written answers and her interview was one-third of the session, the faculty members for the session believed that she should be included as an author of this manuscript. LAC accepted this invitation.

1. What is your name? What are your preferred personal pronouns?
    a. Lilith Ann Calbridge
    b. She/her
2. When and where were your born?
    a. October 15, 1948 in Morristown, NJ
3. What name were you given at birth? What sex was assigned to you on your birth certificate?
    a. Robert Calbridge, Jr.
    b. Male

4. When did you start to become aware that the way you viewed yourself, and the way you felt about yourself, did not match with the sex you were assigned at birth?
    a. At age ten. The family was residing in Japan at the time. I expressed myself by surreptitiously borrowing some of my younger sisters clothing (with a bit of stretch in them).
5. What were some of the critical moments in your transition? How did you express your gender? How did the people in your family react? Friends or schoolmates?
    a. Most critical was with the advent of a pervasive internet. I had found a discussion group of like-minded people and their actions spurred me on to being more aggressive in my expression and daring to go out in public.
    b. Prior to the internet I sometimes just tried wearing articles of clothing under my daily wear, however, that was psychologically uncomfortable. Just before deciding I could and should transition, I mostly got out my expression at support meetings. After the decision I spent my weekends and holidays out as Lilith which is essentially what I did after public transition.
    c. By the time I'd decided to go ahead with transition the only member of my immediate family left alive was (and is) my younger sister. She took it well and felt it necessary to let me know that while I was at college my mother had told her that she had discovered that I cross dressed. My sister eventually told me that she had grown more comfortable with my transition but would never be completely

comfortable. Today I think she's more comfortable with it than she thought she'd ever be.

d. I have a step-family mostly located in San Antonio. Due to their religious beliefs, they were very questioning about my having dealt with a minister. In that I'm not a religious person myself it didn't matter much. Although I used to feel close to them I haven't seen any of them in at least 15 years due to dropped communications. The exception is my step-niece who currently lives in Austin with her family. She's the one with a liberal outlook and says she teaches her two children to take the same view. She was always supportive of me before and after transition. Although I haven't seen her in years we still communicate on Facebook.

6. When did you complete your transition?
    a. There are some differences of opinion as to when transition begins and ends. For me I felt that transition ended when I went fulltime with a name and gender change on my driver's license due to a court order just before 9/11/2001. Physically the transition ended with my gender confirming surgery in Bangkok on December 2, 2003. Age 55.
7. Have you taken hormones? For how long? How did they affect you?
    a. Yes
    b. Since 1997, approximately
    c. Emotionally I was hit pretty hard early on, mostly notable during movies with emotionally charge themes. At other times it was when I would despair that I'd ever be able to successfully transition.

8. What is your sexual orientation? Did transitioning impact your sexual orientation in any way? On the topic of sexual orientation I can give you some of my thoughts and observations on the matter but it doesn't amount to a study on the subject. Perhaps my response may be best viewed as the starting point of a discussion with regards to the combinations. Bear in mind that I can't speak from the female-to-male perspective. Although I've been in direct contact with a fair number of female to male transgender individuals (FTMs) I've never heard a one of them speak of their orientation. Most of the male-to-female transgender individuals (MTFs) I've personally known have retained the sexual orientation they had prior to their transition. Many have remained with the spouses they had at the time of transition though a few have ended the relationship without having changed their orientation. It was simply that the spouse couldn't deal with the new situation and wanted to move on. Other MTFs, and I'm thinking a lesser percentage, do switch their orientation. I fall under this heading but I'll get into a bit more detail later. Back in the early days of the internet I was a member of a couple of discussion groups online. There was a lot of talk regarding "validation." This meant that the trans woman (in these cases) felt the need to have a man for a companion in order to make her feel more like she was being accepted as a woman. Whether this is a true orientation or just a necessary set dressing for one's self-perception I don't know.

    I've known a couple of trans women who grew up in the gay community. One of them realized later in life that it was the woman in her that made her attracted to men. The other knew she was transgender from an early age and was a heterosexual woman but didn't feel that she could

publicly transition until it became more feasible. But her female feelings had her drawn to males as her relationship.

I've known several trans people who have relationships with other trans people, either of the oppositely identified gender or the same identified gender. This may blur the line somewhat in that some trans people, in my observations, don't completely lose the characteristics of the gender they were assigned at birth and were raised as.

As for myself, it's complicated. Prior to transition I was attracted to women. Leading up to and following transition I consciously thought about how I'd seek a relationship. I first considered that even lesbians wouldn't be attracted to a transwoman. Later this turned out not to be the case, as I've seen a number of relationships between trans women and lesbians. I, myself, have had two lesbians who apparently were attracted to me but my (lack of) ego didn't let me realize it at the time. I also considered a relationship with another trans person but I found that too many of us have our own agendas and hang-ups that don't lend well to solid partnerships. Eventually, I came to the feeling that I'd rather be with a male. It wasn't a matter of validation, per se, as it was just a feeling that it was a better fit. From time to time I still have a kneejerk reaction to an attractive woman but I have no desire to form a relationship. Mind you, prior to transition I didn't have a very successful dating experience because of low self-esteem issues. That improved somewhat after transition. It probably went hand in hand with feeling more comfortable in my own skin. But I never got over my lack of initiative when it came to romantic entanglements. Most of the transwomen I know who

weren't already involved or who were socially active prior to transition remained the same way following transition.

9. Where have you lived as an adult? What kind of job(s) have you held? Has being transgender had an impact on your ability to find employment? To live with financial security? To obtain health insurance?
    a. I've primarily lived in the Dallas area since I was four years old until present.
    b. Jobs
        i. Fish cutter at Alfie's Fish and Chips
        ii. Courier work and auditing for an apartment management company
        iii. Shipping and receiving/order desk/computer manager at a machinists' tools supply company
        iv. Senior email administrator at Dallas County Community College District (DCCCD) where I transitioned
    c. Incidentally—None of this had any relationship to my bachelor's degree in Physics.
    d. I transitioned about half-way through my employment at DCCCD and have not needed any other employment since. I approached HR prior to transition to ask what the policy was for someone transitioning in the organization. Although there was no policy in place, I was advised that "District isn't like that." I was free to transition as long as I made my intentions as to when known to management.
    e. Retirement has been handled as a part of my employment as was my health insurance. I'm now receiving retirement payments along with

Social Security (at a greatly reduced rate due to my having worked for a quasi-governmental agency that didn't pay into SS).

10. Have you ever experienced anxiety or depression? Have you ever thought about suicide?
    a. Shortly into my transition I had gotten depressed although I didn't recognize it until my PCP asked me if I was. At that point I broke out crying because it suddenly hit me. I believe that it was mainly due to my fear that my job was at risk based on the behavior of some of my superiors. I was put on an anti-depressant but took myself off of it when I realized I wasn't worried about anything, including keeping my job.
    b. Suicide never entered my mind immediately before or into my transition. Only when I was out of a job for sixteen months and had had my engagement cancelled.
11. Did you ever seek mental health care from a psychotherapist or a psychiatrist, or both? What kind of care did you receive?
    a. A therapist in the area whose specialty was gender and sexual identity issues.
    b. Initially I think I did maybe three sessions with her, mostly to get over my fear of going out publicly as Lilith. Eventually I joined in her every-other-week group session with a couple of individual sessions sprinkled in. Talking things out helped a lot but I wasn't crazy about doing affirmations. It felt too much like brainwashing to me.
12. If you needed psychiatric care today, how would you go about finding a provider?

   a. Probably go to one of the local support groups to find who they'd recommend.

13. What would be the most important things that you would want your provider to know about you?
    a. I'm both shy and an introvert. Although I can socialize in large crowds I'm not very willing to approach new people and would rather they approach me. I believe this affects my ability to function to the maximum but I wouldn't want to change it and the person I am at my core.
14. Would you be willing to answer questions about your gender identity on intake forms at your provider's office? How could office staff make you feel welcome?
    a. Yes. I've done that in the past when it's been on a form for surgery. I'm prone to be outright with medical providers if I feel it's necessary. I've been in a couple of situations, however, both where my gender identity was and wasn't stressed ahead of time, when I did receive some annoying responses. Some interesting ones also.
    b. Mostly use of proper pronouns. But also keeping the personal questions down regarding physical modifications unless they're relevant to the treatment being discussed.
15. What advice can you give to the people in this audience to help them understand the needs of transgender individuals who seek their help?
    a. Most simply encouragement and recognition that they're a functioning member of society. A sense of self-worth and normality.

b. Developing a plan for their transition or, if already transitioned, how best to deal with the people around them.

SUMMARY

Whether considered together or viewed individually, clinical research about the mental health of members of the sexual and gender minorities has only recently been a subject of well-designed and well-powered research efforts. If one is interested in older members of sexual or gender minorities, the availability of reliable scientific findings to guide their mental health care becomes is even more limited. Over the past several decades, the combined efforts of members of the scientific community and advocates for sexual and gender minority members have yielded some helpful scientific and clinical information. This information has, in turn, begun to influence societal attitudes and, in a few cases, has inspired legislative efforts to help improve the lives of members of the trans community.

This manuscript and the scientific session on which it was based represent attempts to disseminate emerging research findings and clinical information about both the LGBT community as a whole and, more specifically, the older members of the trans community, with the hope that this will lead to these individuals receiving more sensitive and helpful mental health care. This manuscript lists and defines many of the terms which are a prerequisite for proving members of the gender and sexual minorities with optimal mental health care. In addition to presenting helpful vocabulary such as coming out and transitioning, the authors have highlighted research which demonstrates that older members of the sexual and gender minorities are, themselves, a diverse group. Some of this diversity has been found to relate to the span of history through which each person has lived.

Transgender older adults face greater risks of poor physical health, disability, anxiety and depressive symptoms, victimization, and stigma, and higher rates of smoking, excessive alcohol use, and risky sexual behavior compared to non-transgender older adult.[26] In spite of notable health disparities, some evidence from *Caring and Aging with Pride* points to resilience among transgender older adults.[42]

The primary tasks of a mental health clinician working with an older transgender adult are to: 1) assess gender dysphoria; 2) provide education for patients and family members about the diversity of gender identities and various options of alleviating gender dysphoria; 3) refer to other professionals and collaborate with these professionals in an interdisciplinary manner; 4) diagnose and treat any possible coexisting mental health concerns and to refer to a qualified psychotherapist if psychotherapy is indicated and the mental health professional is not able to provide psychotherapy; and 5) advocate for transgender patients and for the transgender community as a whole.

The session on which this manuscript is based was fortunate to include an older trans woman who was willing to share with poignant honesty her life journey. Her courage and the gratitude of those who attended the session was acknowledged at the end of her interview with a standing ovation. For a large number of those who attended, meeting LAC represented a first opportunity to meet and learn from an older trans individual. Though not formally assessed, written feedback from those who attended indicated that LAC's contribution to the session was both highly instructive and heartwarming. As stated at the beginning of this manuscript, the authors hope that both this manuscript and the session on which it is based will help, even if in a small way, increase the likelihood that older

members of the trans community receive the highest quality of mental health care possible and, perhaps, will also inspire ongoing research in this area.

Table 1. List of Key Terms and Definitions

Term	Definition
Binary Gender	Refers to a classification system which recognizes only two genders: male or female
Cisgender (or "cis")	indicates that sex and gender identity are both the same
Coming Out	A process in which one becomes aware of his or her own sexual orientation or gender identity and then openly declares it to others
Drag King/Queen	Entertainers who cross-dress for the purposes of entertainment
Gender	Represents socially constructed attributes, roles, behaviors, and activities a given society considers appropriate for boys and men, girls and women, and everything in between
Gender Identity	Refers to an individual’s sense of being a man, a woman, or something else
Gender Dysphoria	A DSM-5 diagnosis that refers to those who are experiencing psychological distress due to the incongruence between their gender identity and assigned sex at birth
Gender Expression	The way a person communicates one’s gender to others and can involve behaviors, clothing, hairstyle, voice, and other personal characteristics
Gender Neutral	individuals who identify with no gender whatsoever (also known as agender, or nongendered)
Intersectionality	Describes situations when discrimination occurs not as the result of a person belonging one group at-risk for discrimination but due to the combined effect of belonging to more than one at-risk group
Misgender	When someone uses the incorrect pronoun to refer to someone; this can be done accidentally or intentionally as a form of discrimination or harassment
Non-Binary (NB)	Describes individuals who do not identify with either being a man or a woman (also known as androgynous, gender nonconforming, gender variant, pangender, gender fluid, and genderqueer)
Sex	Refers to one’s biological status as male, female, or otherwise (e.g. intersex)
Sex assigned at birth	Refers to the sex assigned at birth (also known as natal sex)
Sexual Orientation	The nature of romantic or sexual attraction toward others
Transition or Transitioning	Refers to the process by which an individual alters one’s gender expression, or other characteristics such as external anatomy, to more closely reflect one’s gender identity

Transgender (or "trans")	Indicates that sex is incongruent with gender identity
transman	Transgender person assigned female sex at birth but whose gender identity is that of a man (also known as FTM or man)
transwoman	A transgender person assigned male sex at birth but whose gender identity is that of a woman (also known as MTF or woman)

Table 2. Transgender Web-Based and Print Resources

Web Resources:

- American Society on Aging (asaging.org)
- E-courses via *The Center for Affiliated Learning* (hrc.org/hei/hei-training-on-the-cal)
- Endocrine Society: Endocrine Treatment of Transsexual Persons, Clinical Practice Guidelines (https://www.endocrine.org/advocacy/priorities-and-positions/transgender-health)
- *Transgender Aging Network* Listserv (forge-forward.org)
- The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide LGBTFieldGuide.pdf (http://www.jointcommission.org/lgbt/)
- *The Transgender Law Center* (*https://transgenderlawcenter.org)*
- Learning Modules via *National LGBT Health Education Center* (lgbthealtheducation.org)
- Vancouver Coastal Health' Transgender Health Information Program: a resource hub that provides information to anyone in BC with a transgender health question. (http://transhealth.vch.ca/)
- Webinars via The National Resource Center on LGBT Aging (lgbtagingcenter.org)

Print Resources:

- Erickson-Schroth, L. (2014). Trans bodies, trans selves: a resource for the transgender community. Oxford: Oxford Univ. Press. (http://transbodies.com/)
- Improving the Lives of LGBT Older Adults. LGBT Movement Advancement Project (MAP) & Services for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE). (2010). (https://www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf)
- Still Out, Still Aging: The MetLife Study of Lesbian, Gay, Bisexual and Transgender Baby Boomers. American Society on Aging, MetLife Mature Market Institute. (2010). (https://www.metlife.com/assets/cao/mmi/publications/studies/2010/mmi-still-out-still-aging.pdf)
- The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults. Fredriksen-Goldsen, K.; Kim, H.; Emlet, C.; Muraco, A.; Erosheva, E.; Hoy-Ellis, C.; Goldsen, J.; Petry, H. A Collaborative report with 11 LGBT aging organizations. (2012). (http://age-pride.org/wordpress/wp-content/uploads/2012/10/Full-report10-25-12.pdf)
- The Report of the 2015 US Transgender Survey. (http://www.ustranssurvey.org/)
- Transgender Emergence: Understanding Diverse Gender Identities and Expressions. Lev, A. (2006). (http://www.choicesconsulting.com/assets/pro_writing/transgender[1].pdf)
- WPATH (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Minneapolis, MN: World Professional Association for Transgender Health.
- Yarns, B. C., Abrams, J. M., Meeks, T. W., & Sewell, D. D. (2016). The Mental Health of Older LGBT Adults. Curr Psychiatry Rep, 18(6), 60.

doi:10.1007/s11920-016-0697-y

Table 3. Essential Components of a Mental Health Letter Which May Be Requested Prior to Gender Affirming Surgical Interventions

1. Identifying characteristics
2. Any diagnoses (psychiatric and/or medical)
3. Duration and type of counseling
4. A statement providing the rationale for medical/surgical intervention
5. A statement indicating that there are no mental health issues which preclude the person from providing informed consent
6. A statement that the referring health professional is available for coordination of care

Table 4. Annual or Biennial Transgender Health-Oriented Conferences that Frequently Offer Training and Networking for Healthcare Professionals

- Philadelphia Annual Transgender Health Conference
- Gay and Lesbian Medical Association Conference
- Fenway Health's Annual Transgender Health Conference
- LGBT Health Workforce Conference
- Gender Odyssey Conference-- Professional Track
- Black Trans Advocacy Conference
- Keystone Conference
- World Professional Association for Transgender Health (WPATH) Biennial Symposium
- WPATH Global Education Initiative Trainings: Foundations and Advanced Courses

- US Professional Association for Transgender Health (USPATH) Conference
- European Association for Transgender Health (EPATH) Conference
- Canadian Professional Association for Transgender Health (CPATH) Conference

Table 5. Gender Affirming Surgeries and Their Definitions

Surgery	**Definition**
Reconstructive chest surgery	Removal of breast tissue (mastectomy) followed by surgically constructing a male chest contour.
Breast augmentation	Implantation of breast prostheses to create a more feminine appearance.
Vaginoplasty (often with labioplasty and cliteroplasty)	Inversion of penile skin tissue that would lead to the creation of a neovagina.
Orchiectomy	Removal of the testicles and scrotal sac.
Metoidioplasty	Reconstruction of clitoral tissue (often enlarged) into a penis.
Phalloplasty	The construction of phallus from grafted tissue from other sites.
Scrotoplasty	The construction of a scrotal sac, which would often include testicular prostheses.
Hysterectomy and salpingo-oopherectomy	Removal of uterus, ovaries, and fallopian tubes.
Facial feminization surgery (FFS)	Numerous surgeries that assist in body feminization, which may include a facial bone reduction, face-lift, rhinoplasty, and/or blepharoplasty (rejuvenation of the eyelid).
Reduction thyroid chrondroplasty	Reduction of Adam’s Apple (also known as a tracheal shave).
Voice modification surgery	Surgical adjustment of the vocal cords (to create a higher pitch).

Figure 1. Sample Language for an Advance Directive

Maintenance of Cisgender Expression

During any period of treatment, if I am unable to personally maintain my [place here the individual's correct gender identity e.g. female or male] appearance, I direct my physician and all medical personnel involved in my care to do so.

Respectful Use of Preferred Names and Pronouncs

During any period of treatment, I direct my physician and all medical personnel to refer to me by the name of [place the individual's preferred name here] irrespective of whetehr I have obtained a court-ordered name change, changed my gender marker on any identification document or undergone any transition-related treatment.

During any period of treatment, I direct my physician and all medical personnel to use the [insert the patient's preferred prnoun here] to use the [insert the preferred pronoun here] pronoun in referecne to me, my chart, my treatment,etc irrespective of whetehr I have obtained a court-ordered name change, changed my dender marker on any identification document or undergone any transition-relted medical treatments.

Sample text from a Disposition of Bodily Human Remains (DBHR) document:

During any memorial service or preparation thereof, I direct all coroners, funeral home employees, healthcare workers, and participants to refer to me by the name of __________________, and to use the __________________ pronoun, and to maintain my __________________ appearance.

References

1. Yarns BC, Abrams JM, Meeks TW, et al: The Mental Health of Older LGBT Adults. *Curr Psychiatry Rep* 2016; *18*(6), 60. doi:10.1007/s11920-016-0697-y

2. Fredriksen-Goldsen KI, Muraco A: Aging and sexual orientation; a 25-year review of the literature. Research on Aging 2010; 32(3):372-413

3. Gates, GJ: How Many people are lesbian, gay, bisexual and transgender? Los Angeles, CA: The Williams Institute http://wiliamsinstitute.law.ucla.edu/wp-content/uploads.Gates-How-Many-People-LGBT-Apr-2011.pdf

4. Flores A , Herman J, Gates G, et al: How many adults identify as transgender in the United States? Los Angeles: The Williams Institute. 2016. Available at: http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf

5. Sign S, Durson LE, Tax A: The Trump Administration is rolling back data collection on LGBT older adults. Washington, DC: Center for American Progress, 2017. Available at www.americanprogress.org/issues/lgbt/news/2017/03/20/42863/trump-aministration-rolling-back-data-collection-lgbt-older-adults Accessed November 27, 2017.

6. Cahill SR, Makadon HJ: If they Don’t Count US, We Don’t Count: Trump Administration Rolls Back Sexual Orientation and Gender Identity Data Collection. LGBT Health, 2017; 4(3), p 13

7. O'Hara ME: Trump Administration Removes LGBTQ Questions From Elderly Survey. NBC Out, 2017. Available at: www.nbcnews.com/feature/nbc-out/trump-administratin-removes-lgbtq-questions-elderly-survey-n735741 Accessed November 27,2017.

8. Gates GJ: Demographics and LGBT health. J of Health and soc. Behav. 2013; 54(1):72-4

9. Fredriksen-Goldsen KI, Kim H: Count me in: response to sexual orientation measures among older adults. Res Aging. 2014; Published on-line roa.sagepub.com

10. Sewell DD, Stowell KR, Poveda RA, et al: Gay and Gray: Addressing the mental health care needs of older gay, lesbian, bisexual and transgendered individuals. Am J Geriatr Psych 2014; 18:3S, Supplement 1, S34-S35

11. Yarns B, Abrams J, Johnson K, et al: Gay and Gray VII: A multidisciplinary approach to transgender aging. Am J Geriatr Psych 2017; 25:3S, Supplement 1, S23

12. Dea, Shannon: Beyond the Binary: Thinking About Sex and Gender. Peterborough, ON, CA: Broadview Press, 2016

13. American Psychological Association: Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. American Psychologist 2015; 70(9), 832-864. doi.org/10.1037/a0039906.

14. Killermann, S: The Genderbread Person 2016.

15. A. P. A.: Answers to your questions about sexual orientation and homosexuality. 2008. Available at: www.apa.org/topics/lgbt/orientation

16. A. P. A.: Answers to your questions about transgender people, gender identity, and gender expression. 2011. Available at: **www.apa.org/topics/lgbt/transgender**

17. Crenshaw K: Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. The University of Chicago Legal Forum 1989; 140:139-67

18. Burgess DJ, Fu SS, van Ryn M: Why do providers contribute to disparities and what can be done about it? J Gen Intern Med 2004; 19(11):1154-9

19. Teal CR, Gill AC, Green AR, et al: Helping medical learners recognize and manage unconscious bias toward certain patient groups. Medical Education 2012; 46:80-8

20. Erickson-Schroth, L: Trans bodies, trans selves: a resource for the transgender community. Oxford: Oxford Univ. Press, 2014

21. Floyd FJ, Bakeman, R: Coming-out across the life course: Implications of age and historical context. Archives of sexual behavior 2006; 35(3), 287-296

22. Brotman S, Ryan B, Collins S, et al: Coming out to care: caregivers of gay and lesbian seniors in Canada. Gerontologist 2007; 47(4), 490-503

23. Stein G L, Beckerman NL, Sherman, PA : Lesbian and gay elders and long-term care: identifying the unique psychosocial perspectives and challenges. J Gerontol Soc Work 2010; *53*(5), 421-435. doi:10.1080/01634372.2010.496478

24. Bockting WO, Miner MH, Swinburne R, et al: Stigma, mental health, and resilience in an online sample of the US transgender population. Am J Public Health 2013; 103(5), 943-951

25. Hoy-Ellis, CP, Fredriksen-Goldsen, K I: Depression Among Transgender Older Adults: General and Minority Stress. Am J Community Psychol 2017; 59(3-4), 295-305 doi:10.1002/ajcp.12138

26. James James SE, Herman JL, Rankin S, et al: The report of the 2015 US transgender survey. Washington, DC: National Center for Transgender Equality, 2016

27. W. P. A. f. T. H.: Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. 2017

28. UCSF, C. o. E. f. T. H.: Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, 2017

29. Colton Meier SL, Fitzgerald, KM, Pardo ST, et al: The effects of hormonal gender affirmation treatment on mental health in female-to-male transsexuals. Journal of Gay & Lesbian Mental Health 2011*; 15*(3), 281-299

30. Gómez-Gil E, Zubiaurre-Elorza L, Esteva, I, et al: Hormone-treated transsexuals report less social distress, anxiety and depression. Psychoneuroendocrinology 2012*; 37*(5), 662-670

31. Newfield E, Hart S, Dibble S, et al: Female-to-male transgender quality of life. Quality of Life Research 2006*; 15*(9), 1447-1457

32. White HJM, Reisner SL: A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. Transgender Health 2016*; 1*(1), 21-31

33. Carroll, L. 2017; Therapeutic Issues with Transgender Elders. Psychiatr Clin North Am 2016*; 40*(1), 127-140. doi:10.1016/j.psc.2016.10.004

34. Drescher J: Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual. Archives of Sexual Behavior 2010; 39(2), 427-460

35. Drescher J: Queer diagnoses revisited: The past and future of homosexuality and gender diagnoses in DSM and ICD. International Review of Psychiatry 2015; 27(5), 386-395. doi:10.3109/09540261.2015.1053847

36. Fredriksen-Goldsen KI, Cook-Daniels L, Kim H-J, et al: Physical and mental health of transgender older adults: An at-risk and underserved population. The Gerontologist 2013; 54(3), 488-500

37. Fredriksen-Goldsen KI, Kim HJ, Shiu C, et al: Successful Aging Among LGBT Older Adults: Physical and Mental Health-Related Quality of Life by Age Group. Gerontologist 2015; 55(1), 154-168. doi:10.1093/geront/gnu081

38. Fredriksen-Goldsen KI, Kim H. J: The Science of Conducting Research With LGBT Older Adults- An Introduction to Aging with Pride: National Health, Aging, and Sexuality/Gender Study (NHAS). Gerontologist 2017; 57(suppl 1), S1-s14 doi:10.1093/geront/gnw212

39. Grant JM, Mottet L, Tanis JE, et al: Injustice at every turn: A report of the National Transgender Discrimination Survey. National Center for Transgender Equality, 2011

40. Choi SK, Meyer IH: LGBT aging: A review of research findings, needs, and policy implications. Los Angeles: The Williams Institute, 2016

41. High KP, Brennan-Ing M, Clifford DB, et al: HIV and aging: state of knowledge and areas of critical need for reserch. A report to the NIH office of AIDS Research by the HIV and Aging Workding GroupJ Acquir Immune Defic Syndr 2012; 60 (suppl 1): S1-18

42. Fredriksen-Goldsen KI: Despite disparities, most LGBT elders are aging well. Aging Today 2014; 35(3)

43. Boedecker AL : The transgender guidebook: keys to a successful transition. New Hampshire: Bodecker, 2011

44. Bennet MJ: A developmental approach to training for intercultural sensitivity. Int J Intercult Relat 1986; 10(2):179-96

45. WPATH: Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Minneapolis, MN: World Professional Association for Transgender Health, 2011

46. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association, 2013

47. Byne W, Bradley SJ, Coleman E, et al: Report of the American Psychiatric Association task force on treatment of gender identity disorder. Archives of Sexual Behavior 2012, *41*(4), 759-796

48. Graham J: Guidelines for psychosocial assessments for sexual reassignment surgery or gender affirmation surgery: comprehensive assessments and psychoeducation. November 30, 2013. Retrieved December 08, 2017, from https://www.sfdph.org/dph/files/THS/TransgenderHealthServices_MH%20Guidelines.pdf)

49. The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide. Oak Brook, IL, Oct. 2011. LGBTFieldGuide.pdf

50. Budge: Psychotherapists as Gatekeepers: An Evidence-Based Case Study Highlighting the Role and Process of Letter Writing for Transgender Clients. Psychotherapy 2014; 52(3); 287–297

51. Rachlin K: How to write a letter for hormones or surgery. In Trans Bodies Trans Selves New York, NY: Oxford University Press, 2014; p. 299

52. Hembree WC, Cohen-Kettenis P, Waal HA, et al: Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline. The Journal of Clinical Endocrinology & Metabolism 2009; 94(9), 3132-3154 doi:10.1210/jc.2009-0345

53. Mahan RJ, Bailey TA, Bibb TJ, et al : Drug therapy for Gender Transitions and Health Screenings in Transgender Older Adults. J of Am Geriatr Soc 2016; 64 (12):2554-2559. doi:10.1111/jgs.14350

54. Duffy N: 81-year-old woman becomes oldest person to have gender reassignment surgery. October 13 2014. Retrieved December 13, 2017.

Available at: http://www.pinknews.co.uk/2014/10/13/81-year-old-woman-becomes-oldest-person-to-have-gender-reassignment-surgery/

55. Stern C: They deserve to feel beautiful. Meet the stylist-turned-'femme coach' who teaches transgender women how to look, dress, and act like ladies. May 1, 2015. Retrieved July 31, 2017. Availiable at: http://www.dailymail.co.uk/femail/article-3064263/They-deserve-feel-beautiful- Meet-stylist-turned-femme-coach-teaches-transgender-women-look-dress-act-like-ladies.html

56. WPATH, Levine SB, Brown G , Coleman E, et al: THE STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS. IJT 2,2, 1998. Availiable at: http://www.symposion.com/ijt/ijtc0405.htm

57. National Center on LGBT Aging, Whitman-Walker Health: Creating End-of-Life Documents for Trans Individuals: An Advocate’s Guide 2014. Availiable at: . https://www.whitman-walker.org/wp-content/uploads/2015/02/End-of-Life-PlanningArticle.pdf

Acknowledgments: The authors wish to thank Johnny Humphrey, a staff member at the Resource Center, the LGBT Community Center in Dallas, TX, for his assistance in connecting DDS with Lilith Calbridge. The authors also wish to thank the Editor-in-Chief of this journal for his invitation to publish a manuscript based on the AAGP annual meeting session which the authors prepared and presented in Dallas, TX on March 26, 2017.