Person-centered, Trauma-informed Care of **Transgender Older Adults**

FORGE

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National Resource Center on LGBTQ+ Aging

FORGE reduces the impact of trauma on trans/non-binary survivors and communities by empowering service providers, advocating for systems reform, and connecting survivors to healing possibilities. FORGE strives to create a world where ALL voices, people and bodies are valued, respected, honored, and celebrated; where every individual feels safe, supported, respected, and empowered. forge-forward.org

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National Resource Center on LGBTQ+ Aging

The National Resource Center on LGBTQ+ Aging is the country's first and only technical assistance resource center aimed at improving the quality of services and supports offered to lesbian, gay, bisexual and/or transgender older adults. Established in 2010 through a federal grant from the U.S. Department of Health and Human Services, the National Resource Center on LGBTQ+ Aging provides training, technical assistance and educational resources to aging providers, LGBTQ+ organizations and LGBTQ+ older adults. The center is led by SAGE, in collaboration with leading aging and LGBTQ+ organizations from around the country. lgbtagingcenter.org

For 40-plus years, SAGE has worked tirelessly on behalf of LGBTQ+ older people. Building off the momentum of the Stonewall uprising and the emerging LGBTQ+ civil rights movement, a group of activists came together to ensure that LGBTQ+ older people could age with respect and dignity. SAGE formed a network of support for LGBTQ+ elders that's still going and growing today. SAGE is more than just an organization. It's a movement of loving, caring activists dedicated to providing advocacy, services, and support to older members of the LGBTQ+ community. LGBTQ+ elders fought—and still fight—for our rights. And we will never stop fighting for theirs. sageusa.org

Photos by Jess T. Dugan

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Introduction

More than two and a half years after the onset of COVID-19, we are all more aware of our collective fragility—and resilience. Mental health problems have soared. People are hungry for connection yet at the same time feel less capable of interacting in ways that are kind and caring. Now is an excellent time to review the concepts of person-centered and trauma-informed care.

Despite how often the concepts of person-centered and/or trauma-informed care have been discussed, practical advice on implementing them is lacking. Even less common is advice on implementing these care concepts in the context of a population with unique cultural needs. This guide aims to explain the why and how of providing person-centered and trauma-informed care to transgender older adults in practical language. The concepts shared in this guide are useful for anyone working in health and aging services where a focus on individualized support is optimal for overall health and well-being.

TRANSGENDER OLDER ADULTS

A Generational View

Transgender and nonbinary ("trans") individuals are people whose gender identity does not match the sex they were assigned at birth. Although trans people use a myriad—and changing—set of identity labels, they all share some of the same circumstances.

Trans people have lived in every era and every culture. In fact, some cultures have recognized roles for trans people. In some of those cultures, trans people were revered and seen as having special powers. However, Western culture has not recognized such roles.

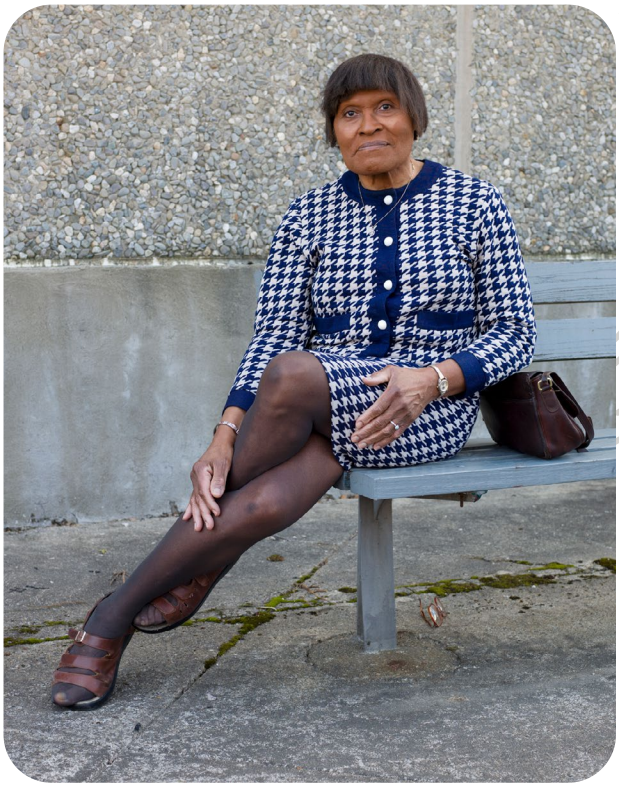
Most people learn their culture from their parents. That is not the case for trans people. Nearly all trans people have parents who do not identify as transgender and do not know how to teach their children "how to be trans." In fact, until recently, most parents who were aware of their children's budding transgender identity tried their best to get their children to conform to the sex they were assigned at birth. That has had two primary consequences: trans people typically carry a heavy burden of past trauma tied to their gender identity, and trans people have to learn "how to be trans" as adults, from other trans people.

We'll start with the second consequence first.

People who are trans elders fall into one of three "generations." Generation One transitioned from living as the sex they were assigned at birth to another gender between the 1960s and 1990s. The World Psychological Association for Transgender Health (WPATH)—formerly known as the Harry Benjamin International Gender Dysphoria Association—was formed in 1979 and began issuing transition guidelines. Almost no information was available to the public before these guidelines; at best, someone might have been able to track down some clinical literature on trans people. As a result, this generation of what would become today's trans older adults managed to live with their gender feelings, died by suicide, or invented their own unique way to live in the world. Oftentimes they didn't know anyone else who was trans, and they may never have connected with the trans community.

Generation Two transitioned between the 1990s to the 2010s. During this time, the internet changed everything for trans people. Suddenly people could sit in their own home or a library cubicle and privately start asking questions that led them to discover words like transsexual and the fact that people can, and have, "changed their sex" (to use the phrasing of the time). Every iteration of formats for talking to people online—bulletin boards, listservs, LiveJournal, etc.—had trans-focused groups. This information seeking and sharing took another leap forward with the launch of Google in 1996.

During this time period, trans people also started to organize. In-person support groups sprang up in many places: Boston, D.C., San Francisco, and Milwaukee, among other cities. There had been national conferences aimed primarily toward trans women, but 1995 saw the first one aimed at trans men. There were nationally distributed



Kendrah, 72, Boston, 2015

transgender magazines during this period, if you were lucky enough to find them.

Finally having a name for themselves and a little bit of a roadmap for what to do next, many adults began transitioning. Others chose not to transition, often because they were afraid of the transphobia that also became more obvious at this time and/or because they had well-established families and careers and didn't want to upset or risk those.

Generation Three—where we are now—started around 2010. This generation has been greatly influenced by YouTube, which since 2005 has allowed individuals to upload how-to videos about the stages of transitioning as well as tricks of the trade like makeup tips and how to make homemade packers. Learning "how to be trans" was no longer limited to individuals in cities—anyone could learn from the privacy and security of their own desk.

At the same time, broader culture in the U.S. became increasingly aware of trans

people. Media began to feature trans actors, for the first time introducing individual transgender people to the general public. Colleges started offering courses and then majors in trans studies. In addition to hundreds of books by and for trans people, we now have academic journals focused on trans topics. Google has cataloged more than two *billion* websites that use the word transgender. We have even seen the opening of health clinics that specialize in caring for trans people.

Between 1990 and 2010, when awareness of trans people was booming, many adults decided they still did not want to do anything about their gender identity because the risks were too high. Many people changed their minds as they grew older. Often what has pushed this group into transitioning later in life is a significant event such as the death of parents (meaning they no longer have to face their parents' reaction) or adult children leaving home (meaning they will be less affected). Divorce may take a hostile spouse out of the picture. Retirement can spark a transition because the retiree no longer has to deal with informing coworkers or facing job discrimination. Often the catalyst of a serious medical crisis like a heart attack or cancer; suddenly the survivor might think they are facing their last chance to live their life authentically.

A History of Trauma

No matter when an older trans person began to question their sex assigned at birth, they have faced trauma. Western civilization not only hasn't had a role for trans people, but it has a long history of active hostility toward those who want to cross or blend genders. Children who express trans feelings have ironically been abused by parents wishing to spare their children from discrimination and prejudice by forcing them to conform to the sex they were assigned at birth. Youth have been sent to horrific conversion therapy programs or even institutionalized. Others have been ejected from homes and forced to make their way on the streets. Adults have lost spouses, children, work, and more when they transition. In fact, the Caring and Aging with Pride longitudinal study in 2013 found that its transgender older adult participants reported experiencing an average of 11 incidents of discrimination and victimization during their life, compared to an average of 6 for cisgender lesbian, gay, or bisexual (LGB) older adult participants. In other words, trans older adults experience a trauma rate nearly twice as high as their lesbian, gay, and bisexual peers (another highly traumatized population.)

It is imperative to recognize that providing trauma-informed care does not require knowing what specific trauma(s) your client has experienced. However, for those who are interested, we have included a more detailed discussion of the types of traumas trans people may experience in Appendix B.

Trans veterans are worth calling particular attention to. People who are transgender older adults today are far more likely to be military veterans (41%)[1] than the general public (~1%),[2] lesbian, gay or bisexual older adults (24.4%),[3] or the transgender population as a whole (20%).[4] Military veterans of course have a higher risk of experiencing combat-based traumas, but transgender military veterans seem to run a special risk: one study has found that transgender veterans are nearly twice (23% to 12%) as likely to have experienced sexual assault in the military as their cisgender peers.[5] Additionally, veterans specialists advise service providers to ask people if they "ever served in the military," as some who would say yes to that question don't see themselves as "veterans." If you do discover someone is a military sexual assault survivor, there are specialized services available to them even if they are not connected with a Veterans Administration facility. You can learn more at https://www.mentalhealth.va.gov/msthome/index.asp.

Person-centered, Trauma-informed Care of Transgender Older Adults

PERSON-CENTERED CARE (PCC)

Although the detailed history of both person-centered care (PCC) and trauma-informed care is unclear, it appears that person-centered care came first. It grew out of nursing homes and assisted living communities (long-term care, or LTC). Like so many other practices, the definition of PCC differs from source to source. The Alzheimer's Association Greater Missouri Chapter defines PCC as:

> *Person-centered care is a focus on elders' emotional needs and care preferences, consistent with their lifestyle. The emphasis is on relationships in the care (Social Model), rather than the task-centered approaches that focus on physical health of elders (Medical Model).*

The Chapter says PCC's core values are choice, dignity, respect, and self-determination. An essential part of PCC is also considering "the person's relationships and the impact that other people, practices, physical care, and the environment may have on the individual."

The *New England Journal of Medicine* adds to this definition in its article, "What is Patient-Centered Care?", noting that

> *...in patient-centered care, an individual's specific health needs and desired health outcomes are the driving force behind all health care decisions and quality measurements. Patients are partners with their health care providers, and providers treat patients not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective.... Patient- and family-centered care encourages the active collaboration and **shared decision-making** between patients, families, and providers to design and manage a **customized** and comprehensive plan. (emphasis in the original)*

TRAUMA-INFORMED CARE (TIC)

Trauma-informed care (TIC) has a different primary focus, but meshes quite well with PCC. One handbook on TIC begins:

> *[B]eing trauma-informed is a process of infusing an entire organization or system with a guiding set of principles that reorders the environment to promote safety, empowerment, and healing for both patients and staff.*[6]

Let's begin at the end: "*for both patients and staff.*" A critical underpinning of TIC is recognizing that those caring for others bring their own trauma history with them into the workplace. They can also be re-traumatized or experience vicarious or secondary trauma by being exposed to their clients' trauma stories. It isn't enough to recognize and appropriately work with clients' traumas; the same care has to be taken with staff. That means organizations likely have to change from top to bottom to implement practices that promote safety, empowerment and healing for all employees. This, however, is beyond the scope of this publication. The Substance Abuse and Mental Health Services Administration (SAMHSA) National Center for Trauma-Informed Care is a good place to start for those interested in learning more (https://www.traumainformedcare.chcs.org/resource/samhsas-national-center-for-trauma-informed-care/).

Blending the PCC and TIC systems gives us an approach to care that:

- Creates safety
- Is based on shared decision-making / Empowers older adults
- Promotes healing
- Addresses clients' emotional as well as physical needs
- Provides care in line with clients' care preferences

We will address general and trans-specific aspects of each of these values in the rest of the guide.

CREATING A SENSE OF SAFETY

Person-centered care may lead professionals to forgo safety in order to respect an older adult's right to make decisions for themselves. Many in the elder care field believe that older adults should have the right to take risks. When it comes to trauma-informed care, however, building safety is critical. There are many definitions of trauma, but fear or terror is a component of nearly all of them. The brain of a traumatized person is not the same as before they experienced the trauma, particularly if they develop post-traumatic stress disorder (PTSD). There's a part of everyone's brain that constantly scans for danger and that will when activated, instantly prepare the body to fight, flee, freeze, or fawn (try to placate the danger). The brain becomes consumed by the threat of danger, so the thinking part of the brain goes offline, taking the person's problem-solving abilities with it.

People who have been traumatized—especially if they have many experiences of traumatization—become even more sensitive to signs of threat. While everyone's brain is always on threat-detection duty, these people may consciously always be on guard. This armoring is self-protective, but it can make accepting care and building relationships much harder. This is why the first goal of TIC is to ensure clients feel safe.

How is this done? The following portions of this guide will discuss best practices you can implement as you offer person-centered and trauma-informed care. To start:

Introduce yourself.

"My name is Dawn Doe. I will be your nurse today. I use she/her/hers pronouns."

People receiving services should always know who is in the room with them and what they are there for. Offering your own pronouns sets the example you want.

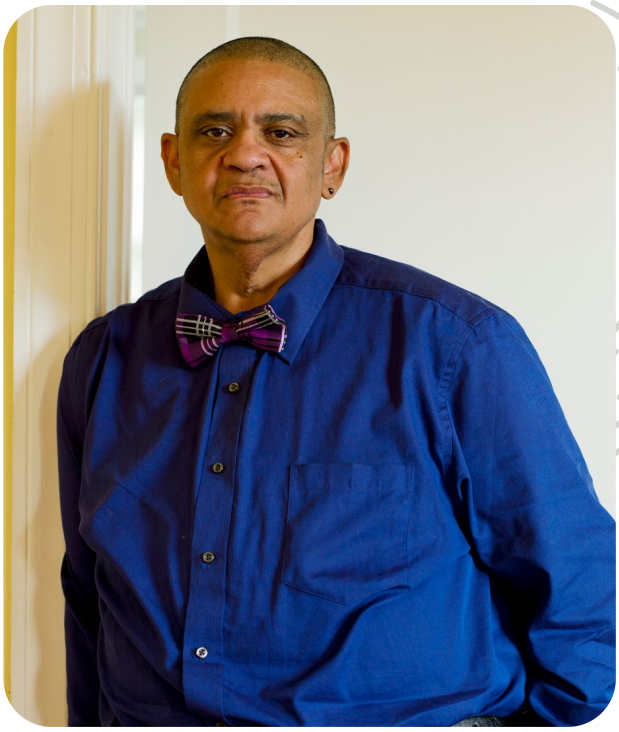
Ask the person to introduce themselves.

"What name and pronouns would you like me to use for you?"

This question is not trans-specific. Its phrasing acknowledges that any individual might go by different names in different settings, or have a preference for how they're addressed (Mrs. Kane vs. Clara). Make sure you record the name and pronouns you're given, and make sure that they are recorded in a prominent place on the client's paperwork if they're not already there. Then *always use this name and the appropriate pronouns!*

Paying careful attention to the client's name and pronouns is critical: gender identity, name, and pronouns are significant to almost everyone. Even though some of us take them for granted, a trans person may have had to fight long and hard to claim theirs. By consistently using them, you tell the trans client that you respect who they are.

Make sure you never slip-up, even when you are outside the person's hearing, and use an incorrect pronoun or name for them. Why? Because someone else may overhear and begin to question how much *they* can trust you. Slip-ups can also "out" a person (make others realize someone is trans), which



Charley, 53, Charlottesville, 2014

may endanger them and even be a violation of privacy protection laws.

If you do slip up, apologize once, say you'll try to do better, and move on. Long explanations or apologies prolong everyone's discomfort and distract from the care the person needs and wants.

Ensure all staff—especially those who first greet people who come through the door—are also trained on the importance of using the correct names and pronouns. It does no good to have a trans-savvy therapist or caseworker if the potential client walks back out the front door as soon as the front desk greets them.

Make sure other staff introduce themselves (name and role, at minimum) when they enter the room.

Limit those entering a room to people with a specific purpose.

The more people are present, the harder it is for the client to track who is there and why they are there. That kind of tracking

can be critical to a trauma survivor. One or more of their traumas may have taken place in a chaotic situation, and you don't want to inadvertently re-create for them a feeling of being out of control.

Some agencies have a wall with staff pictures clearly labeled with the person's name and role (and pronouns!). This practice can also help trauma survivors feel safer.

Know and tell why.

In many workplaces, we just do what we've been told to do, or what's always been done. This isn't good enough in trauma-informed care. If you don't already know, investigate why a question is asked or why a procedure is done, including what the results are used for. Then, before you ask the client a question or do something to them, tell them why the question or procedure is useful.

For example:

> *We would like to check if you qualify for any public benefits you're not getting. To do that, I need to know what your personal and household incomes are.*
>
> *This is an organ inventory. Since many people have had organs removed at some point, inventorying your remaining organs helps us track the kinds of medical monitoring you might need. (See Appendix C for an example.)*

One of the most frightening parts of seeing a health care provider or accessing a new service is that clients don't know what will happen to them in these settings. Narrating what you are doing and why you are doing it helps a person develop trust that you won't surprise or harm them.

An organ inventory is a good way to get necessary medical information from trans (and other) clients. The World Professional Association for Transgender Health (WPATH)[7] suggests the inventory should ask about the presence of: penis; testes; prostate; breasts; vagina; cervix; uterus; and ovaries.

Don't surprise your client!

Try to always warn the older adult before something changes: "I'm going to go to my office for a moment. When I come back, it'll be time for your medications."

People lose control in a trauma. Not only may it "come out of nowhere," but its victim doesn't know and can't control what will happen next. The more predictable an environment is, the more many trauma survivors prefer it.

If something takes much more time than expected, explain what's going on. Note how this hospital patient links a delay to feelings of safety:

> *As for the documentation in checking me in, it took them several hours to check me into my room. But I was okay with that because they told me what was going on and that ten other patients had come in at the same time, which I totally understood. When you're in a situation like that the communication is what soothes you. Not knowing scares you more.*[8]

Be dependable.

Do not make promises if you may not be able to keep them. When you do make promises, make sure you follow through.

Trauma shatters trust, making many survivors feel like anyone might be dangerous. Creating trauma-informed care means doing your best to not only always be kind, but also reliable. Trust is built over time, as the client

begins to realize they can count on you to do what you say you will do.

Whenever possible, early in your relationship with a new client, create a reason to separate the older adult from their companion(s), if they brought any.

Ideally, explain the separation with something like this: "We're required to ask a couple questions in private; we will bring you [companion] back in just a couple of minutes."

Companions can be extremely helpful to both the older adult and service providers. They can help soothe or reassure the older adult, distract the person if needed, or help entertain them during boring wait times. They can be a bridge between the client and caregiver, conveying information and seeking and passing on explanations and instructions. They can be a reassuring "piece of home" for someone in an unfamiliar place.

They can also be abusers. A significant proportion of coupled trans people or trans older adults with an adult child experience intimate partner violence or elder abuse. So, ask a couple of screening questions in private. One tool asks how often their partner or companion:

1. Physically hurts you?
2. Insults or talks down to you?
3. Threatens you with harm?
4. Screams or curses at you?
5. (optional) Forces you to do sexual acts that you are not comfortable with?

Others would ask even more questions:

6. Is anyone controlling your funds without your permission?
7. Does anyone prevent you from seeing your doctor or friends?
8. Does anyone try to keep you from leaving your home for any reason?
9. Does your caregiver ever threaten to leave you alone?
10. Are you always given food when you need or want it?

Also ask if the person is comfortable having their companion with them all the time, or if there are times when the client would like some privacy. On rare occasions, a trans older adult will not be out to their companion and would welcome extra privacy efforts if disrobing is needed.

Be a stickler about privacy measures.

Even with changing policies and practices, trans older adults have seldom altered all of their primary and secondary sex characteristics, meaning they are automatically outed as trans when they are disrobed. (It's important to acknowledge that not every trans person wants these medical interventions.) Being outed as trans is not only dangerous (it may expose the person to discrimination or even abuse by others), but often highly disturbing. If the person's trauma(s) involved being sexually victimized or if they experienced a hate crime, exposure can also trigger powerful trauma memories. Keep light blankets handy, as they can be used to quickly cover someone up.

All facilities that may involve a client disrobing have strict privacy procedures. These are there for good reasons, and they are *critical* for trans older adults. Make sure all staff are doubly careful to use them with trans clients. This includes, of course, knocking before entering open doors or going through doorways.

Give choices about seating and doors.

As important as privacy is, try to ask if the client would like the door to a room closed

or left slightly open. If a closed door is a trauma trigger for a client, you may need to compromise privacy a little (consider using a drape or blanket if the person needs more covering). Whenever possible, use rooms with multiple seating options—including at least one that faces the door—and let the older adult choose where to sit first.

Train staff not to express surprise.

Some service providers believe that all staff should be told when they have a trans client. This is not true. Being trans or having a trans history is medical information covered by HIPAA. You may empower a trans client by asking them if they want other staff to know and, if they do, whether they would prefer to tell them themselves or have you do it. However, many trans people are (understandably) protective of this information.

Trans people may also not share with service providers that they are trans or have a trans history. This may be on purpose or a simple oversight. One trans cultural competency trainer tells audiences that he's deathly allergic to a common but frequently hidden ingredient in medications and salves. In a medical emergency, he's far more concerned with getting that information across than "warning" providers what they'll see when he's unclothed.

Discovering someone has a trans history by seeing them unclothed can surprise staff. We heard of one sexual assault nurse examiner who berated a newly assaulted person for not telling her ahead of time that she was trans. This is neither person-centered nor trauma-informed care! How do we keep it from happening? Through intentional training and frequent reminders that when people disrobe, they often reveal something surprising such as a shocking scar, an ostomy bag, or a risqué tattoo. Seeing a body part you weren't expecting (or not seeing a part you were expecting) is something that should be, well, expected.

Make sure bathrooms are safe and accessible.

A "safe" bathroom to a trans person typically means one in which no one questions their right to be there. One easy way to do this is to mark all single-stall bathrooms as "all-gender bathrooms." If your facility has multi-stall bathrooms, you may want to post a sign such as, "Gender diversity is welcomed here. All are welcome to use the restroom that best fits their identity." If there's a gender-neutral restroom elsewhere, the sign can also note where it is.

If your facility's bathrooms are multi-stall, you can also offer to accompany a reluctant client to the door and wait to accompany them back.

If your facility has gender-specific bathrooms, explain where both the men's and women's bathrooms are whenever someone asks for directions. If someone asks why you do that ("can't you see I'm a woman?"), you can say you always do that in case people are asking for someone else.

Touch as much as permitted.

Touch can be very healing but it can also be extremely traumatizing to someone who experienced physical and/or sexual abuse. Make sure you always ask for permission before you touch someone.

Is it okay if I help you change into your night clothes before bed?

I know this is difficult news. May I give you a hug?

Asking them again even after they've repeatedly given you permission simply

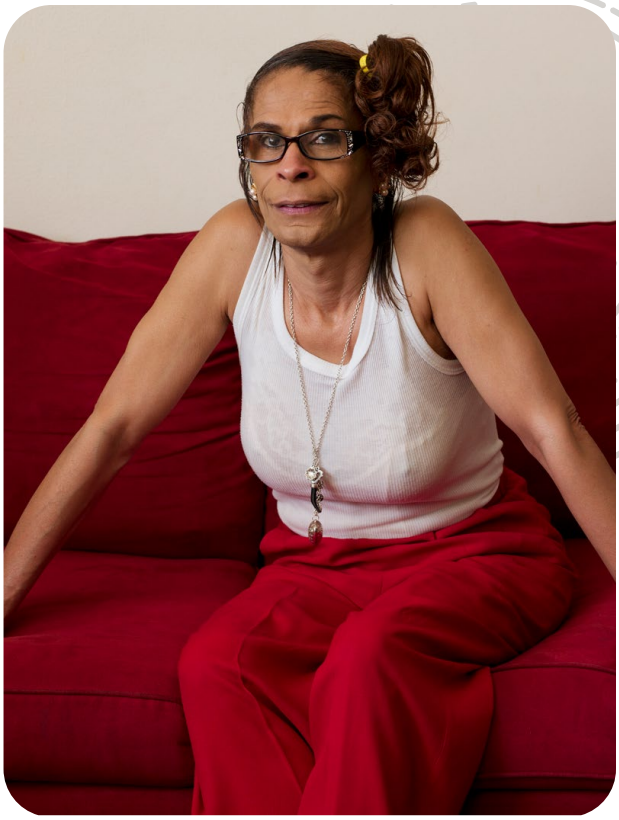
reminds them that they always remain in control and you will always treat them with respect and safety.

Be aware of triggers.

It is now common to see trigger or content warnings on pictures and posts. These are helpful to some trauma survivors, but are entirely useless to others. An innocuous item such as a half-full glass of water left on a table may be a trigger if that's what signaled to a survivor that an abusive aunt was present.

While not all triggers can be predicted, some common experiences can create trauma triggers for trans older adults. For example, individuals who were institutionalized against their will may fear health care providers and other authority figures. If that institutionalization involved restraints, even bed guardrails could be triggering. Because so many trans people have had bad experiences with law enforcement officers, uniformed security guards can be triggering. Therapists can also be triggering due to the (now fading) practice of requiring trans people to get a therapist (or two) to write a letter to access hormones or surgery. Not only does this practice disempower people by stripping away their ability to choose their own medical care, but some therapists have exploited this practice to blackmail clients into sex or other unwanted practices. If the person was institutionalized or abused by a therapist, medical records and notetaking by professionals may be another trigger. Helping the client access those medical records (if possible) may help. Empower clients by helping them read/understand what's in those records, and ask for corrections if needed.

Trans older adults who are immigrants or asylees may well have come from countries where they were persecuted.



Tyra, 64, Milwaukee, WI, 2015

This persecution may have included torture, sexual assault, detention or jail, by officials as well as others. They may have lost loved ones to these ordeals. Again, you do not need to know exactly what they experienced; you need to simply pay careful attention to how they are reacting now.

You may realize someone has been triggered by a sudden change in their behavior. You don't need them to confirm they're triggered or tell you what the trigger was. Use your own body and emotions to model calmness and safety for the person. You may want to ask, "Did something just happen?" Note they may or may not be able to tell you. If they can tell you, you can ask if they want to talk about it. Again, your job is not to fix, but to listen and be present with someone who is experiencing pain. Once the person has righted themselves, you can both talk about making changes that will minimize the chances of that particular trigger being repeated.

EMPOWERING CLIENTS

Trauma occurs when something bad or undesirable happens that the victim seems unable to stop or avoid. This creates a sense of powerlessness that is a hallmark of having been traumatized. If you couldn't stop whatever happened, what else might occur? How else can you be harmed? Who else might betray you? The sense of the world being dangerous and unpredictable may become all-encompassing.

Therefore, it needs to be a top and omnipresent goal to empower the people you work with whenever possible.

Combine "know and tell why" with permission-asking.

For example:

> *We use an intake form as a way of quickly getting to know something about you so that we can better serve you. Would you be willing to fill it out?*

When there are many steps to be done, explain and ask permission before every step. This may feel tiresome, but it can be very reassuring to a trauma survivor, knowing that you will stop whenever they want you to. A client can always say, "You don't need to ask me that every time!" In such a case, you empower them by stopping your permission-asking for the time being.

Whenever possible, offer the client choices.

These choices can be minor—"would you like the paste that smells like lemons or grapes?"—or bigger—"Let's sit here and do a pros-and-cons list for both assisted living places you're considering." Choices help a person feel like they have control over what happens to them, which can be very therapeutic for a trauma survivor.

Identify and reinforce the older adult's coping strategies.

We all have developed coping strategies, even if we can't think of any in a moment of crisis. Some agencies ask clients to fill out coping strategies worksheets (which you can find examples of for free through an internet search). The older adult may need help or encouragement to fill out such a sheet, but once it is done, it's a resource both you and the client can use if the client becomes upset.

Ensure clients have access to information they can understand.

To have shared decision-making, clients need to understand the choices and their pros and cons. Conveying this information requires flexibility because people learn in different ways. For example, some of us learn best by reading while others absorb more from the spoken word. You can ask your client for their preference, or make sure they are given information in multiple ways. When written material is provided, make sure the reading level is not too advanced. Many people—trans and non-trans—have relatively limited literacy levels. Information provided must be in the language the person is most fluent in. (Need health information in a language other than English? Check out: https://medlineplus.gov/languages/languages.html)

If you use materials for "LGBTQ+" audiences, make sure they are actually inclusive of trans people and examples. When LGBTQ+ materials only talk about same-sex couples or report on studies that excluded trans people, it sends trans people the message that they aren't truly understood, that you don't know there are

differences between trans and cisgender lesbian, gay, bisexual, and queer people.

Encourage questions.

Many people are deferential to experts. Others don't want to bother people. Some don't want to admit they don't understand something. Take every opportunity to remind the clients you work with that you are there to answer their questions and that you care that they understand what is happening to them. If the client will be in your setting for a while, ask your manager to create small notepads labeled "Things to Ask About" that you can give the person to help them remember what to ask.

Set up and communicate multiple ways to get problems or complaints addressed.

If the person you're working with is distressed, they're not going to stay calm, cool, and collected. Clients should be invited to use multiple ways of resolving things. For example:

> *You can always ask me to look into something if it doesn't feel right to you, or Director Smith has an open door policy about resolving things on the spot—simply go to the door just to the left of the entrance.*

The Cleveland Clinic uses the acronym "heart" to help staff remember the proper way of handling complaints:

Hear the story
Empathize
Apologize
Respond to the problem
Thank them.

You may not be able to solve every complaint or problem, but using the "heart" technique helps to ensure clients that they are being heard and appreciated.

PROMOTING HEALING

Don't ask or expect a client to share the details of their trauma with you.

Providing trauma-informed care does *not* mean the person has to share information about the trauma(s) they've experienced. Many trauma survivors don't want to revisit those awful memories, and staff risk being traumatized themselves just from hearing the stories.

> *Is there anything in your history that makes seeing a practitioner or having a physical examination difficult?*

A question like that, edited to fit the situation, can be very helpful. Even if a person is not a trauma survivor, perhaps they have a joint problem that will make it difficult to get on an exam table, or maybe they can simply say something like, "I can't stand the sight of blood." Some survivors will take the opportunity to share what happened to them. In such cases:

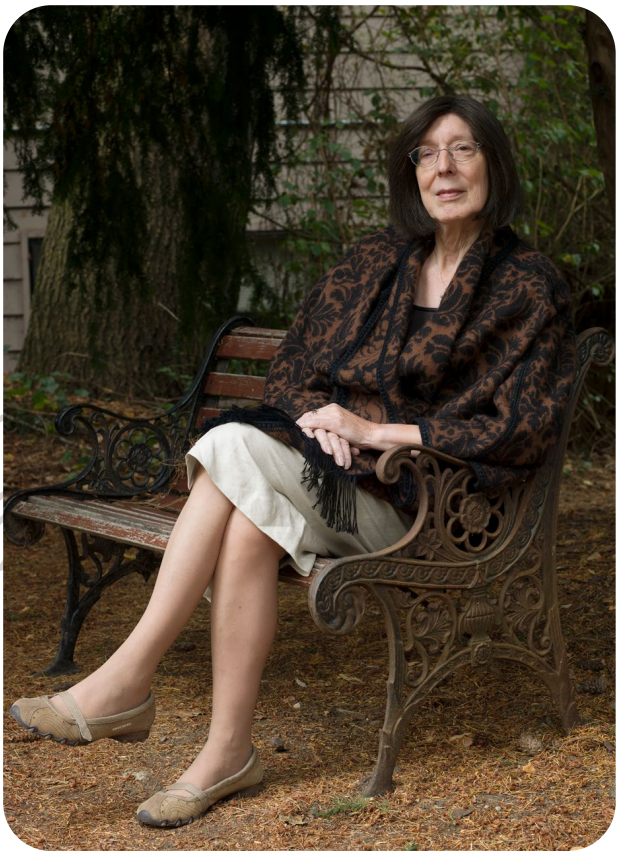
Witnessing is what is important.

Many people feel like they don't know what to say when someone shares something awful. The good news is you don't need to say anything. Although it's normal to want to "make it all better," survivors know better than anyone that what has happened cannot be undone. What you can do now —the healing you can provide—is to make

sure that the survivor isn't alone in their experience this time. Listen closely and with empathy. If appropriate and the person consents, hold their hand or touch their leg or shoulder to provide physical reassurance of safety and acceptance. "I'm so sorry that happened to you" is all you need to say. If you were doing something when the trauma story started, stop and give the person your full attention.

Provide a "safe, stable and nurturing relationship."

People who have survived trauma have experienced at least one event and sometimes an entire childhood or relationship where the person or people around them were *not* safe, stable, and nurturing. But research shows that both children and adults need this kind of relationship to be healthy. It doesn't matter who you are in someone's life; if you can provide them a safe, stable, and nurturing relationship, you are doing healing work. It teaches survivors that they are individuals worthy of respect, care, and safety, all critical antidotes to trauma.



Amy, 77, Seattle, 2016

If desired, help clients find trauma-informed, trans-friendly resources.

Providing trauma-informed care does not mean you need to become a trauma therapist. This guide is about giving care sensitive to the needs of trauma survivors. Helping survivors address the wounds and distortions that trauma causes are well beyond our (and your) scope. You can, however, try to assist an older trauma survivor who wants to address their trauma directly by helping them find good resources.

Unfortunately, there aren't a lot of them. Ask around to see if any local therapists are known to be trans-savvy and good with trauma. If there's a local trans group, they may be able to identify someone.

FORGE has several resources that may be helpful. Although all are focused on sexual victimization, each guide contains multiple chapters that pertain to all kinds of trauma, including the aftermaths of trauma; options for healing; techniques for coping with strong emotions; techniques, exercises and concepts for healing; and an annotated bibliography.

Transgender Sexual Violence Survivors: A Self Help Guide to Healing and Understanding

A Guide for Partners and Loved Ones of Transgender Sexual Violence Survivors

A Guide for Facilitators of Transgender Community Groups: Supporting Sexual Violence Survivors

The guide for partners and friends includes content for those who are also sexual victimization survivors and self-help

advice. If part of your job is to run groups, you may want to look at the facilitator's guide.

Help survivors regulate their emotions.

Some traumas happen so early in life that children miss out on important developmental stages, including how to identify and manage their emotions. Other survivors may have acquired those basic skills but be unable to access them under stress due to the changes trauma has made in their brain and worldview.

In these situations, bodies can do the "talking." Just as the people around a distressed person can also become distressed, a calm person can help calm others. That is your job. Remain as calm and in control as you can. Breathe evenly and deeply. You may be able to invite the older adult to match your breathing, slowing it little by little.

Consider distracting someone in distress.

Our brains and brain chemistry are remarkably efficient—and quick. Neurotransmitters are chemicals in the brain released in response to a stimulus. (Most of us are familiar with neurotransmitters like adrenaline.) These transmitters are how neurons—nerve cells in the brain—communicate with each other. For people living with trauma, the powerful impact of neurotransmitters can render us paralyzed or cause extreme agitation or distress.

In general, neurotransmitters will clear the synapse in less than 90 seconds if the neuron is not re-stimulated. This means that the intense emotions will stop if we can prevent the neurons/neurotransmitters from re-firing. When someone is distressed, helpers can try to shift their attention for just two minutes: move them into another room, have them help you make tea, walk in place (taking 90 steps), draw a sketch, listen to music, or watch a few short videos. This technique won't work with everyone or every time, but if you remember this 90 second fact, you may be able to help someone shift out of a bad place.

Help those who are dissociating.

At times, we all dissociate, which means feeling disconnected from our thoughts, feelings, memories, and surroundings. Daydreaming is a pleasant version of dissociation. Other common examples of dissociation are when someone driving a car realizes they can't remember the last few miles, or a reader realizes their eyes have "read" a page but they have absolutely no idea what was on it. Dissociation can also happen when someone feels threatened or fearful. It's often quite easy to tell when someone's dissociated: they appear "gone" from their body. This can happen even when the observer (and, sometimes, the person themselves) has no idea what they are reacting to.

There are a couple of easy techniques to help someone who is dissociating to "come back to the room."

You can say something like:

> *Look around the room, and tell me three things that are red. Now, three things that are blue. Now, tell me three sounds you hear. Now, three textures you can see or feel. Now, if it feels safe, look into my eyes and notice what you see there.*

Alternatively, you can ask the person to focus on what they are feeling in their body. If the body overall is not a safe space or the request is overwhelming, ask them to focus

on the sensations of a particular small part of the body, such as the hands or the bottom of the feet. You can also ask the person to focus on different parts of the body and their sensations and/or on how the sensations change over time. Gradually direct the person's focus until they can look in your eyes and the two of you can connect.

Identify what they have to live for.

Sometimes part of trauma recovery is finding or remembering a reason to live. "What really matters to you?" is a good question. So is, "What do you need to be healthy for?" If the older adult can give you an answer, remember it and bring it up later as a motivator.

ADDRESSING CLIENTS' EMOTIONAL AND PHYSICAL NEEDS

Agencies are typically structured to address their clients' physical *or* their emotional needs, but seldom both. Person-centered care reminds us that we can't separate clients' needs that way. People seeking services like therapy still need to eat; those requesting medical care still need attention to their emotions. Since much of this guide addresses trans older adults' emotional needs, we will just take a moment here to remind providers who focus on emotional needs to consider their clients' physical needs. If a person doesn't have a roof over their heads, that will have a major effect on their well-being; be prepared to help them locate assistance with housing. Hunger and thirst affect how people feel; blood glucose levels can contribute to a client's emotional stability or instability. Nearly every culture from the beginning of time has offered food and/or drink as a sign of welcome and acceptance. Ensure you have something available to offer.

Monitor media fed to clients.

We have all grown more sophisticated recently in how media can be used and abused. At the same time, we've become able to totally tune out when there's constant media on in the background, so you'll need to consciously assess your environment.

Remember the news adage, "if it bleeds, it leads?" Most of the time, having news channels on is not a good choice when you're trying to provide trauma-informed care; there is a high probability something in the broadcast will trigger trauma survivors. Talk shows can also be problematic if hosts or guests argue, air highly partisan opinions or even just regularly talk over each other, which may be challenging for those who grew up in embattled or chaotic environments. Trans clients of all ages will be distressed by coverage of anti-trans legislative efforts or protests. Try to pick soothing music or inoffensive nature shows instead.

Practice harm reduction.

Many behavioral health risks most familiar to people are actually outgrowths of trauma. People often drink alcohol, use drugs, overeat, have high-risk sex, smoke cigarettes, etc. to help themselves handle difficult emotions. Those emotions may relate to identifiable trauma, but many stem from earliest childhood. If a child experiences neglect, abuse, or household dysfunction, they will miss out on the natural development of social and emotional regulation skills. These deficits make life harder, leading to additional issues such as delinquency and

driving while intoxicated. You can learn much more about this cycle by reading about the Adverse Childhood Experiences (ACEs) study at https://www.cdc.gov/violenceprevention/aces/index.html.

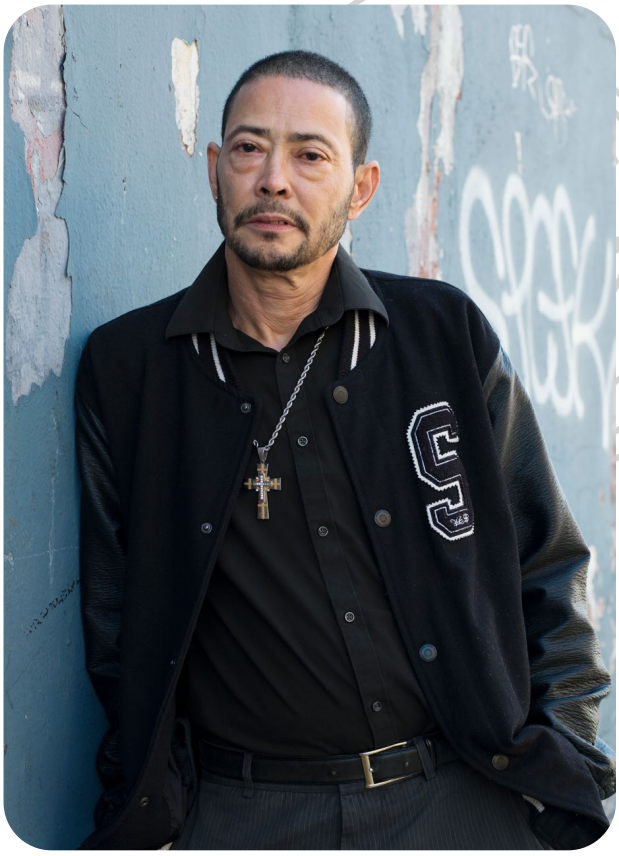
Harm reduction takes into account that many trauma survivors are using coping strategies or methods which also threaten their health. Harm reduction acknowledges that these coping strategies are helping the trauma survivor live. In harm reduction, the goal is not to end the health-threatening coping strategy, but instead to either find a healthy alternative or find a less harmful way of engaging in the coping strategy. An example is needle exchanges for those who use intravenous drugs; people are still using drugs, but they are at less risk of catching serious diseases from shared needles.

Educate the older adult about trauma—how it happens and what happens afterward.

This helps trauma survivors believe their behavior makes sense and can be brought under control.

Many trauma survivors never get effective help in understanding and overcoming what happened to them. This may be because the survivor is "keeping the secret" (especially common with children abused by adults) or feels being victimized is something shameful. Even if the survivor sought help, they may not have gotten good help (or any help at all). Trauma survivors could behave in ways brought on by trauma that occurred decades ago. It may never occur to them that some behavior that seems "just part of me" had a traumatic origin. Explaining how those linkages happen—and that many post-trauma behaviors are designed to be self-protective but have also outlived their usefulness—can be healing as well as empowering.

There are many good books and websites that can help you and the survivor understand more (including all of FORGE's guides listed above), and we will not try to cover them all. However, below are some common concerns trans and/or older survivors may struggle with that you can help them sort out.



Sukie, 59, New York, 2016

It's not black and white.

When people talk about trauma or crime, they generally speak in black and white terms: victims are here and perpetrators are over there. In reality, people are far too complex for such simple dichotomies. Family members can be loving as well as abusive. Abuse survivors often harm others. People who harm come in every gender, culture, age, religion, and political stripe; the same is true of people who are victimized. This information may help a survivor stuck in a belief like, "she couldn't have done that to me; she was such a good mother."

Trans-specific power and control tactics.

The signs of intimate partner violence are not always obvious, especially to the person who may be subjected to them. Here is one trans older person talking about their experience of intimate partner violence:

> *My life got really, really small, slowly over thirty years, and it took me more than a year to get to where I was comfortable with myself, and six more months before I dealt with any of the abuse—only in the last month has most of the dealing with the abuse happened.*[9]

A good, inclusive article on the signs of intimate partner violence and how an observer can help can be accessed at https://www.webmd.com/mental-health/mental-domestic-abuse-signs. FORGE has a list of trans-specific power and control tactics (which can also be used by a trans person against a cisgender partner) available at https://forge-forward.org/wp-content/uploads/2020/08/power-control-tactics-categories_FINAL.pdf. If the older person needs help thinking about how to stay safe, check out FORGE's safety planning tool here: https://forge-forward.org/wp-content/uploads/2020/08/safety-planning-tool.pdf.

Trauma can re-emerge later in life.

Older trauma survivors may be surprised to find their trauma becoming more salient. Many trauma survivors successfully suppress their memories and/or trauma symptoms for many years through substance use, overwork, devotion to childrearing, or other diversions. Some types of trauma—especially sexual assault trauma—seem prone to being held at bay for long periods of time. In a sexual violence survey FORGE conducted, it was not unusual for transgender sexual violence survivors to wait ten or more years before seeking emotional help to cope with their sexual assault(s).[10]

Even elders who feel they have already "dealt with" or are long past previous abuse(s) may be surprised when a health crisis, life change (such as retirement or moving into a long-term care community), or death of a loved one suddenly causes the trauma to re-emerge and produce painful symptoms. One woman, a survivor of both childhood sexual abuse and several types of abuse perpetrated over decades by her ex-wife, told FORGE:

> *I have good coping skills and attitude, and at the same time was able to stow/compartmentalize both abuse situations away from my conscious awareness. It didn't come up seriously until I started volunteering for a group for "stopping abuse in the lesbian, bisexual women's and transgendered communities"—the training I went through kicked it ALL loose. The sexual abuse was only a part of what was going on, with physical and emotional, and financial abuse as well.*[11]

Trauma survivors often feel profoundly alone and damaged. When you can reassure them that their feelings are completely justified and understandable, you are providing healing care.

PROVIDING CARE IN LINE WITH CLIENTS' PREFERENCES

Many organizations talk about cultures and how they can provide services in a culturally competent way. This is very good, but it can also be very limiting.

Avoid Master Status thinking.

The term "master status" was first used by Everett Hughes in the 1940s to describe the tendency of observers to believe that one label or demographic category is "more significant than any other aspect of [the observed person's] background, behavior, or performance." In 1954, Gordon Allport described master status as the "label of primary potency" in *The Nature of Prejudice*. Hughes and Allport are describing the tendency to define a person by one aspect of their identity, rather than as just a part of the whole. Examples include referring to someone primarily by the color of their skin, (a black person), their ability (person in a wheelchair), or religion (a Muslim person), rather than seeing these characteristics as being only one part of who they are. When applied to transgender people, master status assumes that everything about a transgender person must be related to their gender.

When you think about providing care in line with clients' preferences, be very careful to ***ask***, not assume, what those preferences are.

Remember the "Terms Paradox."

When it comes to language about trans people, the terms paradox suggests that terms are simultaneously extremely important and useless. They are important because using the terms a person uses for themselves —starting with their name and pronoun and continuing with things such as their identity labels—demonstrates respect. At the same time, identity terms tell you almost nothing. Language about the trans experience changes rapidly. Definitions can change with time, and the acceptability of terms can also change. Do not assume that you know anything about the trans person's journey or decisions solely from their identity label. If you absolutely need to know something about a trans person's transition or medical decisions, you will need to ask directly.

Repeat clients' language.

As we discussed early in the guide, trans people "learn to be trans"—including the language they should use—from other trans people, usually when they first transition. Many older adults do not regularly update their language. Some older trans people have sadly found out that younger people view their language as incorrect or offensive. It's critical to remember that it is never appropriate to correct the label a trans person uses for themselves. One service provider was deeply upset when their client used the pronoun "it" when referring to their childhood. Try hard not to "correct" your client. They likely have good reasons for using the language they're using, and they certainly do not need you to tell them who they are.

This also goes for body part names. If the care you give involves talking about or touching body parts, be aware that trans people may use alternative or created names for their body parts, especially those that are commonly associated with one binary sex or the other. For example, a person may refer to their "chest" when to you, they are "breasts." You can learn to smoothly ask people what they call a given body part with some practice. When they answer, *use their term*. Trans people have often been told they aren't

"really" who they say they are. Using the same term your client uses tells them you respect them and their "owner's rights."

Be careful about curiosity.

While asking in many situations is important, you must be careful what you ask about. Many people who aren't trans themselves are naturally curious about trans people. Many cisgender adults today have never met a trans person, and asking questions is a time-honored way of getting to know someone. However, this does *not* mean you should ask a trans person to teach you about being trans. You are a professional. Remember "know and tell why": if you can't explain to a client how the information you are asking them will improve their care ("because I'm curious" doesn't cut it), don't ask. Google and YouTube are available to you if you want to learn more on your own.

Conclusion

Many trauma survivors were alone when they were traumatized. Others were made to feel alone when they sought help because people did not believe them, blamed them, or simply didn't know what to do. Even decades later, you can help heal this wound by simply providing services in a person-centered, trauma-informed way. You are in a position where you can help older adults feel safe, cared for, and cared about. You can see and address the entirety of them, in all their complexity and with their myriad needs. Doing so is healing work—for you and for them.

Appendices

APPENDIX A: PERSON-CENTERED, TRAUMA-INFORMED CARE OF TRANSGENDER OLDER ADULTS: KEY POINTS TO REMEMBER

CREATE SAFETY

- Introduce yourself and your pronouns
- Ask the person to introduce themselves and their pronouns
- Make sure other staff introduce themselves
- Know and tell why you are asking each question
- Don't surprise your client
- Be dependable
- Check in about any companion(s)
- Be a stickler about privacy measures
- Give choices about seating and doors
- Make sure bathrooms are safe and accessible
- Touch as much as permitted
- Be aware of triggers

EMPOWER CLIENTS

- Combine "know and tell why" with permission-asking
- Offer choices
- Identify and reinforce client's coping strategies
- Ensure clients have access to information they can understand
- Encourage questions
- Communicate multiple ways to get problems or complaints addressed

PROMOTE HEALING

- Ask about barriers or concerns
- Witnessing is important
- Provide a "safe, stable and nurturing relationship"
- Help clients find trauma-informed, trans-friendly resources
- Help survivors regulate their emotions
- Consider distracting someone in distress
- Help those who are dissociating
- Identify what client has to live for
- Monitor clients' media
- Practice harm reduction
- Educate the client about trauma and its effects
  - It's not black and white
  - Trans-specific power and control tactics
  - Re-emergence of trauma in later life
- Avoid "Master Status" thinking
- Remember the "Terms Paradox"
- Repeat clients' language
- Be careful about curiosity

APPENDIX B:
TRAUMAS EXPERIENCED BY TRANS OLDER ADULTS

Discrepancies in the amount of trauma trans people experience begin, amazingly enough, in childhood. A 2021 study[12] found that trans adolescents were more likely to report childhood psychological abuse, physical abuse, and sexual abuse than were cisgender peers.

Trans students are four times as likely as their cisgender peers to feel unsafe in school. This is for good reasons, given that they're more likely to experience bullying in school and online: 65% report being verbally harassed, 25% have been physically harassed, and 12% have been physically assaulted.[13]

Trans adolescents and adults are more likely than even their lesbian, gay, and bisexual (LGB) peers to experience intimate partner violence, sexual assault, or domestic violence (10% of people who have come out as trans to their immediate family report a relative was violent in response). For example, trans people report lifetime sexual assault rates of around 50%, far higher than most other groups'.

The workplace can be dangerous to trans people. The largest recent trans study (N=27,715) reported that 30% of respondents who had a job in the previous year had experienced being fired, denied a promotion, or some other form of workplace mistreatment because of their gender identity or expression. If their "workplace" is the underground economy (sex work, drug sales, and other currently criminalized work), exposure to violence and police misconduct is even higher. One in five (20%) trans people have participated in the underground economy at some point in their lives.

Routine experiences like going to the doctor or accessing services can also pose problems for trans individuals. Common trans health care experiences include: having to teach the health care provider about trans health in order to get appropriate care, putting up with unnecessary or inappropriate questions, being refused care (8% of those seeking care in the previous year were refused), being verbally attacked (6%), and even physical and sexual assault. While trying to access a public service in the past year, about a third of trans people who thought people knew they were trans reported a negative experience, including being verbally harassed (24%), being denied equal treatment or service (14%), and being physically attacked (2%).[14]

Trans people who interact with law enforcement also report high levels of violence or harassment. Of the 40% of trans people who had contact with police or law enforcement in the previous year, 57% said they were never or only sometimes treated respectfully; 58% reported some type of mistreatment.[15]

Statistics about hate crimes are hard to find, but we know the impact is outsized when it happens. "Hate crimes are a particularly painful type of event because they inflict not only the pain of the assault itself, but also the pain associated with the social disapproval of the victim's stigmatized social group. The added pain is associated with a symbolic message to the victim that he or she and his or her kind are devalued, debased, and dehumanized in society. Such types of experiences affect the victim's mental health because it damages his or her sense of justice and order."[16] Another researcher "delineates ways in which violence that is perceived to be related to one's gender identity or expression disproportionately increases distress, compared to violence motivated

by other reasons. Such violence leads to internalized transphobia, which can involve negative self-appraisal and rejection of this critical aspect of the person's sense of self, as well as expectations for future rejection and/or victimization. Experiences of violence related to one's gender, alongside these resultant sources of stress, may also lead to concealment of one's trans identity or expression."[17] Hate crimes are also uniquely likely to affect people who do not know the victim but share an identity with them.

Another way that trans people are traumatized by actions happening to others is through political debates. Someone does not need to be a trans adolescent or the parent of one to feel humiliated, shamed, and enraged about state-level fights over whether trans students can access health care or school sports teams. Similarly, when discussing whether or not trans people could serve in the military, it was loud and clear that the government was saying "we don't want you," even to trans people who may have never intended a military career.

Another category worth mentioning has been called by many names: little-t traumas, micro-aggressions, minority stress, and insidious traumas. They are described as "everyday experiences of disrespect and disparate treatment"[18] or "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups."[19] They are uniquely damaging because "stress related to stigma is not assessed solely by its intrinsic characteristics but also by its symbolic meaning within the social context: even a minor event or instance can have symbolic meaning and thus create pain and indignity beyond its seemingly low magnitude."[20]

One 67-year-old transgender woman reported about a visit to her primary physician:

> *I had not had a surgery of any kind. The only thing I had done was laser. So when I walked into the doctor's office… the receptionist started laughing at me. One had to excuse herself and go in the other room because she was laughing so hard.*[21]

One set of researchers identified twelve categories of trans-specific microaggressions. These include:

1. Use of transphobic and/or incorrectly gendered terminology
2. Assumption of universal transgender experience
3. Exoticization
4. Discomfort/disapproval of transgender experience
5. Endorsement of gender normative and binary culture or behaviors
6. Denial of the existence of transphobia
7. Assumption of sexual pathology/ abnormality
8. Physical threat or harassment
9. Denial of individual transphobia
10. Denial of bodily privacy
11. Familial microaggressions
12. Systemic and environmental microaggressions.[22]

A particularly potent trans-related set of little-t traumas revolve around public bathrooms and locker rooms. One observer noted, "…as a matter of tradition and policy, we have built minority stressors for transgender and gender non-conforming people into our very environment due to

our reliance on gender segregation in public facilities."[23] Multiple studies have found very high incidences of bathroom-based problems among transgender people. One reported that 70% of survey respondents had been denied access, were verbally harassed, or were physically assaulted in public restrooms; 18% had been denied access altogether, while 68% were verbally harassed and 9% were physically assaulted.[24] FORGE was told of one story involving a transgender elder:

> *A very conservatively dressed trans woman was eating, with two friends, a man and a woman, at a local pizza place. When she wanted to use the bathroom (a single-use bathroom), she was approached by one of the staff, who loudly told her that she could not use either the women's or the men's room. When her friends asked to see the manager, they were told to leave, which they did. There was no follow-up to the incident.*[25]

These problems can result in such a high level of fear that people limit their activities; a British study found that 38.8% of transgender individuals avoided public restrooms altogether.[26] In Virginia, 11% of transgender people reported that a lack of appropriate restroom facilities had prevented them from seeing a doctor or getting health care.[27] One researcher noted that bathroom-related stress had caused their transgender respondents to reorganize their schedules and change their eating and urinary habits in order to avoid restrooms altogether.[28] Another researcher concluded: "These experiences impacted respondents' education, employment, health, and participation in public life."[29]

Despite this overwhelming list of bad things that can happen to a trans person, it is critical to note that trauma is not confined to trans people. Most people experience traumas and learn to live with them. Some 45% of all children in the United States experience at least one trauma during their childhood, and trauma happens to adults on a regular basis. That is why a growing number of agencies are implementing trauma-informed care.

APPENDIX C:
ORGAN INVENTORY

Sample Anatomical Inventory

Breasts: ○ Present ○ Absent
- ○ Chest reconstruction
- ○ Bilateral mastectomy
- ○ Unilateral mastectomy, R
- ○ Unilateral mastectomy, L
- ○ Breast augmentation/implants

Uterus: ○ Present ○ Absent
- ○ Hysterectomy—cervix removed
- ○ Hysterectomy—cervix remains

Ovaries: ○ Present ○ Absent
- ○ Bilateral salpingo—oophorectomy
- ○ Unilateral salpingo—oophorectomy, R
- ○ Unilateral salpingo—oophorectomy, L

Cervix: ○ Present ○ Absent

Vagina: ○ Present ○ Absent
- ○ Colpocleisis—closure of the vagina
- ○ Vaginoplasty

Penis: ○ Present ○ Absent
- ○ Phalloplasty/penile implant
- ○ Metiodioplasty
- ○ Erectile device
- ○ Penectomy

Testes: ○ Present ○ Absent
- ○ Testicular implant(s)
- ○ Bilateral orchiectomy
- ○ Unilateral orchiectomy, R
- ○ Unilateral orchiectomy, L

Urethra: ○ Present ○ Absent
- ○ Urethral lengthening

Prostate: ○ Present ○ Absent
- ○ Prostatectomy

(adapted from Grasso, et al., 2021)

INTERNATIONAL ASSOCIATION OF Forensic Nurses

Taken from the National Protocol for Domestic Violence Medical Forensic Examinations. For the full Protocol, see https://www.safeta.org/page/protocoldocuments

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305 Seventh Avenue
15th Floor
New York, NY 10001
212.741.2247

sageusa.org
lgbtagingcenter.org
@sageusa