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‘I’m going to live my life for me’: trans ageing, care, and older trans and gender non-conforming adults’ expectations of and concerns for later life

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Abstract

While research on the health and wellbeing of older lesbian, gay and bisexual adults is gradually expanding, research on older trans and gender non-conforming (TGNC) adults lags behind. Current scholarship about this group raises important questions about the intersection of ageing and gender identity for enhancing care and support for older TGNC adults and the lack of preparedness of health and social professionals for meeting these needs. In this paper, we examine the accounts of 22 TGNC individuals (50–74 years) on the topic of ageing and unpack their concerns for and expectations of later life. We present qualitative findings from a study of gender identity, ageing and care, based in Wales, United Kingdom. Data were generated from two-part interviews with each participant. Four key themes are identified: (a) facilitative factors for transitioning in mid- to later life; (b) growing older as a new lease of life; (c) growing older: regrets, delays and uncertainties; and (d) ambivalent expectations of social care services. We argue that growing older as TGNC can be experienced across a multitude of standpoints, ranging from a new lease of life to a time of regret and uncertainty. We critically discuss emergent notions of trans time, precarity and uncertainty running across participants’ accounts, and the implications for enhancing recognition of gender non-conformity and gender identity in social gerontology.

Keywords: trans; gender non-conforming; gender identity; ageing; older adults; social care

Introduction

In this paper we examine the ageing-related concerns and expectations of trans and gender non-conforming (TGNC)¹ individuals in mid- to later life (50+ years of age). In the United Kingdom (UK), knowledge generation about older TGNC people’s lives and communities has lagged behind recent scholarship on the

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intersections between gender, sexual identity and ageing (Almack and King, 2019). While it is difficult to estimate the number of TGNC people in the UK, Stonewall (2019) suggests that around 1 per cent of the population identifies as trans, including people identifying as non-binary, while the Government Equalities Office (2018a) suggests a lower estimation of 200,000–500,000. It is not known how many of this population are 50+ years of age and a lack of available population data contributes to the invisibility of older TGNC adults. A 2018 survey of 100,000+ lesbian, gay, bisexual (LGB) and TGNC respondents commissioned by the UK Government indicates that TGNC respondents (13% of the sample) report lower life-satisfaction scores than LGB respondents and the general population. Across the survey's sample, 6.9 per cent of respondents identified as non-binary, 3.5 per cent as trans women and 2.9 per cent as trans men (Government Equalities Office, 2018b). Only 6 per cent of the sample were 55+ years of age (age grouping in the survey), making it difficult to pull out findings specific to older TGNC adults.

Under the Equality Act 2010 in England and Wales, 'gender reassignment' is a protected characteristic and includes protecting individuals who are pre- and post-transitioning² from discriminatory treatment by service providers (arguably, this does not offer the same legal protection for people who identify outside the gender binary model of male–female, e.g. as non-binary). This is a pivotal time for TGNC citizens in the UK. In 2018, the UK Government initiated a consultation on proposed reforms to the Gender Recognition Act 2004, partly based on a 2016 report from the House of Commons Women and Equalities Committee. Proposed questions in the consultation included whether individuals should be granted the right to self-define their gender identity rather than having to prove this through the current medicalised measures embedded in the 2004 Act (Government Equalities Office, 2018c). For example, a current requirement is to have a documented mental health diagnosis of gender dysphoria (now reclassified as 'gender incongruence' under the World Health Organization (WHO) International Classification of Diseases (ICD)-11) (House of Commons Women and Equalities Committee, 2016). This proposal marks a positive shift towards a more individual-centred, self-determining process.

These policy efforts unfold during a time period when hate crime against TGNC individuals has increased by 32 per cent in England and Wales between 2016/17 and 2018/19; this represents crimes reported to the police (Home Office, 2018). Anecdotal accounts point to a parallel increase in negative media representation over the course of 2017, both in the UK and internationally (Barker, 2017), in which trans people and identities are frequently represented as 'monstrous' or 'dangerous' (Krutkowski *et al.*, 2019). The recent government consultation on proposed changes to the Gender Recognition Act 2004 evoked intensified media responses from trans-exclusionary groups and individuals voicing anxieties about the perceived violation of women-only spaces by cisgender men posing as trans women (Krutkowski *et al.*, 2019). Such arguments reiterate the negative discourse of 'dangerous' attached to trans adults' identities in the popular press.

The purpose of this paper is to examine the qualitative accounts of TGNC individuals 50+ years (N = 22) on the topic of ageing and growing older, and to unpack their expectations and expectations for later life. We present thematic findings from

a study of gender identity, ageing and care in later life, based in Wales, UK (2016–2019), which had a central focus on the provision of inclusive health and social care alongside a biographical focus on ageing as TGNC. A recent review of UK literature on LGBT health inequalities in later life points to the absence of evidence about the lives of older TGNC people in this body of work (Kneale *et al.*, 2021). The question guiding our discussion is: How do trans identities and life experiences shape older individuals' concerns about and expectations of ageing and later life? We argue that growing older as TGNC can be experienced across a multitude of standpoints: ranging from a new lease of life to a time of regret and uncertainty, dependent on each individuals' journey for those transitioning. We discuss TGNC individuals' concerns about getting older and, for individuals transitioning, we identify facilitating factors in mid- to later life. Underpinning our discussions are the notions of precarity in later life and trans time. We first outline the background literature to this enquiry and present the theoretical frames informing our analysis. We then provide details of our research design before presenting and discussing key themes identified in the interview data.

Background literature

In 2009, Persson (2009: 633) concluded that 'transgender elders are both underserved and understudied'. Since this time there has been a small growth in research on TGNC ageing (Fabbre and Siverskog, 2019). Old age is a reported concern for both younger and older TGNC adults. From a UK survey of TGNC adults, 65 per cent of respondents had experienced worries about 'growing old alone' (McNeil *et al.*, 2012). However, research on TGNC lives has tended to focus more on younger gender-diverse people's experiences of puberty and early adulthood (Waling *et al.*, *in press*), while research on TGNC adults has primarily focused on interactions with clinical and medical settings (Toze, 2018).

TGNC individuals have unique and diverse health-care needs, with inequalities encountered when accessing health and social care services across the lifecourse replicated in later life (Mitchell and Howarth, 2009; Whitehead, 2017). Limited epidemiological data available on TGNC adults show that as a minority group they are affected substantially by adverse health outcomes (Reisner *et al.*, 2016). A survey of 2,560 LGB (and trans) adults (50+ years) in the United States of America (USA) found that older TGNC adults were at higher risk of poor physical health, disability, depressive symptomatology and perceived stress compared with cisgender peers (*i.e.* individuals whose gender identity is similar to the sex assigned to them at birth) (Fredriksen-Goldsen *et al.*, 2013). Negative health outcomes for TGNC individuals are multifactorial, resulting from social and economic marginalisation and discrimination, including within health-care systems and settings (United Nations, 2011). Available research on the health-care needs of older TGNC adults remains sparse, and attention to mental health (Bailey *et al.*, 2019) and social care provision (Waling *et al.*, *in press*) is even more limited. Too often the needs of older people from this group have been conflated with those of older LGB adults across research samples (Witten, 2014a; Waling *et al.*, *in press*). This can lead to a form of 'coercive queering' where TGNC individuals are assumed to be LGB and sexual and gender identities are conflated (Ansara, 2015).

A repeatedly reported concern for TGNC adults centres around access to inclusive health care, and anxieties about mistreatment in these institutional settings. A small number of studies have identified multiple barriers to accessing general health care based on gender normative provision, such as being located in inappropriate wards, not having adequate bathroom access and improper pronoun use by staff (Whittle *et al.*, 2007; Rachlin *et al.*, 2008; Shires and Jaffee, 2015; Porter *et al.*, 2016). Indeed, one of the few studies of older TGNC adults' experience of health-care services found that some participants reported not receiving the care needed, as they did not fit into a binary gender model (Siverskog, 2014). Previous care contexts and experiences affect current perceptions of care, particularly if the individual has encountered transphobic attitudes from care providers (Siverskog, 2014). The receipt of conversion therapy is one poignant example of how TGNC individuals' trust and confidence in helping professionals can be severely eroded by earlier life experiences of unethical practice and intervention (Turban *et al.*, 2019). From the UK LGBT Survey (Government Equalities Office, 2018b), TGNC respondents aged 65+ were more likely to have experienced or been offered conversion therapy (20%) compared to younger age groups, and numbers increased (28%) for TGNC individuals from 'Black/African/Caribbean/Black British' backgrounds.

Concerns about accessing care services in later life also spill over to social care provision. Within long-term care environments, older TGNC adults report concerns about being 'outed' by others or hindered from exercising everyday choices over dress and presentation (Hudson, 2011). It is highly likely the situation will be exacerbated if the older adult has dementia. TGNC adults' fears about dementia in later life encompass not only the loss of self, but the loss of one's gendered self that individuals have fought for recognition across their lifetime, and increasing reliance on care workers to provide intimate, physical care (Page *et al.*, 2016; Witten, 2016). Gender identification and expression may shift continually for TGNC adults; from a trans-affirmative fluid approach, care and support staff need to be attuned to and affirming of this (Hunter *et al.*, 2016; Baril and Silverman, *in press*). The views and demands of biological family members may also conflict with how a TGNC person with dementia wishes to present and express their gender identity (Barrett *et al.*, 2015; Baril and Silverman, *in press*). In relation to end-of-life care, Witten (2014b) argues that older TGNC people experience a triple set of challenges on the basis of ageism, the stigma attached to trans identities, and the impact of living with a chronic condition or terminal illness.

TGNC adults across qualitative studies have expressed concerns about anticipated discrimination in long-term care environments, a lack of trans competent care and fears that their gender identity would not be acknowledged by care staff (Siverskog, 2014; Jones and Willis, 2016). The delivery of personal care, such as bathing, toileting and dressing, can evoke anxieties over how social care staff might respond to bodies that do not fit with gendered expectations or where individuals may have visible surgical scars (Jones and Willis, 2016). Concerns about compromised quality of care and the lack of dignity in service provision have triggered some older Australian women identifying as TGNC to consider alternative options for 'ageing in the home', such as planning home adaptations and considering euthanasia as a viable future option. Such strategies are considered more tenable

than the prospect of encountering discriminatory treatment in long-term care environments (Waling *et al.*, [in press](#)).

As noted above, discussions on TGNC ageing are frequently linked to medical provision and an overwhelming amount of available research is centred on clinical or care settings (Toze, 2018). Toze contends that social gerontology has yet to grapple with wider understandings of ageing for older TGNC people. A broader understanding of ageing within diverse trans communities across different social settings is needed and in parallel a deeper appreciation of the local and contextual factors that shape experiences of ageing amongst different TGNC groups (Toze, 2018). In this paper, we focus on less-recognised aspects of ageing for TGNC individuals beyond medical and clinical settings.

Key theoretical frames and concepts

Our approach to this topic area is informed by critical and discursive approaches to gender and ageing. Writing from a feminist position, Calasanti (2004) argues that a critical perspective on gender and ageing focuses on gender as a social force that ‘shape[s] both social organisations and identities’ and generates inequalities that are sustained into later life and embedded in social processes and everyday relationships. There is a danger that relying on this perspective alone perpetuates a binary understanding of gender, hence a discursive, post-structural approach is also needed. Judith Butler (1990, 1993) brought attention to the alignment of binary categories across the axes of sex/gender/sexuality that reiterate heterosexuality as a naturalised and socially desirable state. Butler (1993) argued that, as normative categories, sex and gender can only exist through available discourse, making problematic the notion of ‘sex’ from which gender identities are assigned to specific bodies. This opens up a wider recognition of masculinities and femininities that can be embodied in different ways regardless of ‘biological sex’ assigned at birth (Halberstam, 2005; Hines, 2007a). TGNC lives and identities trouble the normative, dichotomous linkages between sex (male, female), gender (man, woman) and sexuality (heterosexual/homosexual) and the definition of these binary categories as universal and oppositional (Worthen, 2016). According to Worthen (2016), this configuration represents a ‘hetero-cis-normative understanding’ of social relationships and many trans individuals do not fit within this confining social mould. Gender normative frameworks frequently underpin social and welfare provision (Hines, 2007b) as well as the delivery of health-care services (Arthur, 2015).

A critical approach to trans ageing is acutely important when TGNC identities and bodies are primarily understood through biomedical discourse. TGNC adults are not unaccustomed to being perceived as ‘diseased’ and ‘disabled’ because of the biomedical connotations attached to the historical pathologisation of gender non-conformity (Witten, 2014b). This intersects with wider critique in social gerontology of the biomedicalisation of ageing in which ageing is constructed as a primarily medical problem and understood through clinical criteria and diagnoses (*see* Estes and Binney, 1989; Kaufman *et al.*, 2004). Pearce (2018) observes that through a biomedical lens being trans is predominantly framed as a medical condition with clinical expectations and requirements imposed on how TGNC individuals should transition and adopt gender normative behaviours and expressions. This follows

Stone's (1991) earlier critique of gender dysphoria as a diagnostic label, and the medical responses to this that construct gender ambiguity and questioning as a 'correctable problem'.

Gender dysphoria is defined under the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) as 'a person's dysphoria with the biologically determined gender and the intense desire to be relieved from the characteristics determining it' (Apeiranthitou *et al.*, 2019: 73). The WHO's ICD-11 has recently redefined gender-related health as a 'condition related to sexual health' rather than a mental disorder. The new term, 'gender incongruence', refers to 'a marked and persistent incongruence between an individual's experienced gender and the assigned sex' (WHO, 2018). Arguably, redefining gender dysphoria through new diagnostic criteria is counter-productive to efforts to depathologise gender identity (Davy and Toze, 2018).

Older TGNC individuals may have experienced a lifetime of cisgendered assumptions and expressions that has a cumulative impact on their levels of confidence in helping professionals and services. Ansara (2012) defines cisgenderism as a dominant ideology in which individuals who self-define their gender are categorised as a homogenous group and perceived to be as inferior or lacking validity in comparison to those whose sex assigned at birth matches their gender identity. This ideology can be expressed on an individual level (*e.g.* through misgendering or naming someone by their incorrect gender identity or name); structural level (*e.g.* imposing requirements that trans individuals must meet in order for their gender identity to be recognised); and institutional level (where public servants and medical professionals are granted authority to confirm the legitimacy of an individual's gender identity) (Ansara, 2012).

An equally pertinent concept to the current study is the notion of 'trans temporalities' (or *trans time*) – the life experiences of TGNC individuals that do not fit within chronological and heteronormative notions of linear progression across the lifecourse (Pearce, 2019: 64). The notion of temporalities in plural denotes the subjective experience of time and echoes Halberstam's (2005) earlier discussion of 'queer time' and the non-linear progression of queer subjectivities located outside heteronormative life markers, such as marriage and parenthood. Trans years may not be linked to chronological years but instead be associated with pivotal life markers, such as first presenting to others with a self-selected name. Pearce (2018, 2019) argues that TGNC people's lives are marked by anticipation and uncertainty – orientation towards an often-uncertain future while the present is experienced as transitional.

Within social gerontology, there is limited understanding of how notions of 'successful' and 'positive' ageing apply to TGNC individuals in later life (or indeed whether these debated concepts should be cast aside; *see* Fabbre, 2015), and how current knowledge of the lifecourse may limit recognition of TGNC experiences of old age outside normative or chronological markers of time and progression (Fabbre and Siverskog, 2019). These concerns overlap with other critiques of successful ageing, in particular the imposition of social and cultural norms on 'ageing well' and the lack of recognition of the impact of structural and social inequalities that impede healthy living in later life (Katz and Calasanti, 2015). Fabbre (2015) argues that the prevailing discourse of successful ageing does not easily align

with TGNC lives. Success in later life may be marked by other pivotal moments such as self-acceptance or connections forged with TGNC individuals or groups where there is a shared affinity.

One other concept relevant to our discussion is the notion of precarity in later life that is currently the subject of discussion and debate in social gerontology (Grenier and Phillipson, 2018; Gilleard and Higgs, 2020). The notion of precarity brings attention to the inequalities and sources of exclusion and marginality older people increasingly experience in ageing societies, stemming from wider trends of growing economic and social inequality (Grenier *et al.*, *in press*). Gilleard and Higgs (2020) note that ‘the longer we live the more evident life’s inequities become’. This concept has been applied through a sociological lens to economic and social problems that intersect with older age, including unstable employment, financial insecurity, social exclusion, disability, frailty and dementia (Grenier *et al.*, 2017, *in press*). Financial precarity and socio-economic insecurity are disproportionality experienced by TGNC individuals across the lifecourse. Analysis of US survey data indicates that self-identifying TGNC individuals report lower education levels in comparison to cisgender individuals while in comparison to cisgender men TGNC individuals ‘report significantly lower employment rates, lower household incomes, higher rates of poverty’ (Carpenter *et al.*, 2020: 594). From the UK LGBT Survey (Government Equalities Office, 2018b), TGNC respondents were more likely to earn less than £20,000 a year (60%) in comparison to 45 per cent of cisgender respondents. A further 10 per cent indicated that they did not know their income, which arguably suggests levels of low income may be higher. Less attention has been given to the intersection between gender identity and experiences of financial and social insecurity in later life.

Research design

The setting for our study is Wales,³ a devolved nation in the UK, and the majority of participants were Welsh residents at the time of interviews. Our study adopted a cross-sectional, mixed-methods design with interviews of TGNC-identifying individuals and a survey of health and social care professionals running concurrently. Here we focus on findings generated from interviews with 22 individuals 50+ years of age. This age parameter was adopted in keeping with the Welsh Government’s Strategy for Older People (2021–2023) which encompasses adults 50+ years of age. Ethical approval was granted by the College of Human and Health Sciences Research Ethics Committee at Swansea University. We applied purposive sampling to recruit interviewees by circulating calls for potential participants through a range of groups and services on- and off-line. These included TGNC peer groups, online support forums (*e.g.* closed Facebook groups) and organisation-led networks (*e.g.* Stonewall Cymru and Age Cymru). Some peer support groups in the West of England were also included as some members of these groups lived near the Welsh border. Potential participants received a Participant Information Sheet and informed consent was obtained before interviews. Participants took part in two separate interviews, and all were audio-recorded with consent. All interviewees were debriefed post-interview. Each interview ran for 1.5–2 hours in duration and mostly took place in interviewees’ homes at their invitation or in nearby settings

that were private. Twenty-two adults participated in a total of 43 interviews (one person did not participate in a second, follow-up interview).

Approach to interviewing

The first interview collected interviewees' life-stories as a narrative using a graphic timeline to capture the pivotal events and experiences as they occurred across the life-course and maintaining a broader focus on significant experiences, relationships and changes over time. The second interview was semi-structured and followed a schedule that had been reviewed by our Critical Reference Group (of which half the 12 members were TGNC-identifying). Questions included experiences of and expectations for health and social care services, thoughts on growing older, and what three things the interviewee would change relating to current health and social care delivery.

We adopted a triologue model of interviewing whereby members of the TGNC community were actively involved in the interview process as co-interviewers. The rationale for this was twofold. First, the interaction with another TGNC community member in the interview process would help to create a safe environment in which participants felt comfortable to disclose and discuss highly personal and sometimes emotionally charged life experiences. Second, this approach was part of a wider strategy for building collaborative working with TGNC-identifying community members into all stages of the study. We sought to promote active involvement in the fieldwork, and other phases, for the epistemic purpose of 'knowledge-making with trans individuals' rather than 'on trans individuals' (Humphrey *et al.*, 2019: 176). Four peer-interviewers who identified as TGNC were recruited, and the research officer (a cis-woman) and the peer-interviewers received training from a (TGNC-identifying) British Association for Counselling and Psychotherapy-accredited counsellor. All interviews were undertaken by the research officer together with a peer-interviewer, where the peer-interviewer took the lead. Where appropriate, the research officer would ask clarifying or probing questions to open up dialogue where there appeared to be shared, but unstated, understanding between peer-interviewer and interviewee.

Approach to data analysis

Four team members, including a peer-interviewer, carried out an initial coding exercise on a small number of randomly selected transcripts (six) to identify manifest themes. These initial themes were then collated together to create a framework matrix organised around 13 thematic categories with sub-themes under each. Using the framework approach prominent in health research (Gale *et al.*, 2013), interview data were chartered across the framework with 'other' categories created to capture extraneous data that do not fit prescribed categories. Categories were then coded selectively and summarised with two members of the research team checking that summaries adhered closely to chartered data. Throughout coding, we were attentive to the social discourses participants drew on to frame and situate their gender identity and the ways in which a male–female binary restricted their sense of self and relationships to others. From the summaries, themes and sub-themes were identified. NVivo analysis software was used to organise and collate the framework.

About the participants

Participants ranged in age from 50 to 74 years, ten of whom were between 50 and 59 and 12 who were 60 or older. Our sample reflects a younger to third age cohort and as such does not capture the perspectives of participants aged 75+ years. All participants were of White-British background, except for two people born outside the UK (both White). Ten people resided in a rural area (town, village or hamlet/isolated dwelling) and the others (12) resided in urban areas. Participants described their gender identity using a variety of terms, including transsexual; woman with a trans history; transgender woman; transgender; gender fluid/queer and sometimes just woman or man. Nineteen participants were actively seeking to, or had previously sought to, transition medically as well as socially (15 women and four men). In addition, two individuals described themselves as (male) cross-dressers and one individual as gender fluid. Although we did not specifically seek details of socio-economic status, we estimate that nine participants were experiencing some degree of precarious financial circumstances based on their reliance on either low-paid employment (*e.g.* part-time employment as a care worker) or state pension only.

Findings

Four themes speak directly to the question, ‘How do TGNC identities and life experiences shape older individuals’ concerns about and expectations of ageing and later life?’ These are: (a) facilitative factors for transitioning in mid- to later life; (b) growing older: a new lease of life; (c) growing older: regrets, delays and uncertainties; and (d) ambivalent expectations of social care services in later life. Names below are pseudonyms selected by participants.

Theme 1: Facilitative factors for transitioning in mid- to later life

For most participants, gender transitioning was associated with a journey of undergoing social and medical changes (medical transitions encompass hormone therapy treatments and gender-affirming surgeries, such as vaginoplasty and breast implants for trans women and phalloplasty and mastectomy for trans men; *see* Vincent, 2018). The majority were on this journey at different stages – from having recently commenced hormone treatment and waiting on referrals to UK-based gender identity clinics through to having received final surgery in the preceding 12 months. Two participants had transitioned at earlier life-points – one person through a private clinic overseas (an arguably faster process) and another having commenced this journey in the 1970s.

Fourteen participants had commenced transitioning via medical treatments and surgery in mid- to late life, typically during their forties, fifties and sixties. There were no specific, singular life events that triggered this process. Alternatively, participants referred to a multitude of factors coalescing at definitive life-points, typically in their forties and fifties, that facilitated their decision to seek medical support. All had commenced socially transitioning at earlier life-points, *e.g.* by dressing part-time as themselves, often without the awareness of significant others, or by making small changes to their physical appearance, *e.g.* the removal of body hair for trans women.

Many individuals described living as TGNC in secrecy in young adulthood (during their teens, twenties and early thirties) and not disclosing their TGNC identity to others to avoid negative repercussions, and not feeling adequately equipped and confident to 'come out' as TGNC during earlier lifestages. This was partly compounded by the lack of information about TGNC lives prior to the arrival of the internet in the 1990s. Accessing the internet heralded the emergence of online communities of TGNC individuals who were geographically dispersed (Whittle *et al.*, 2007).

Several participants reflected on the lack of information and language available to describe and understand TGNC identities when they were in their twenties and thirties:

[In my early twenties] I did try at various times to look at my sexuality, um, because there wasn't a clear understanding of, of transgender or anything. I didn't even know transgender existed. Um, the closest I could get was, you know, whether I was a transvestite cross-dresser you know, or whether I was homosexual. (Skogsra, 57)

Likewise, other participants related how others around them, such as adolescent peers, identified (and targeted) them as gay or lesbian because their behaviour and presentation in childhood and early adulthood did not conform with gendered expectations of being male/female.

Before the availability of the internet, participants often looked to the popular press media and texts that featured stories about prolific individuals and celebrities identifying publicly as trans. These sources were important texts in triggering thinking about their own gender identity: 'It was about '84, '85 that I found Jan Morris' autobiography [Welsh historian and writer, trans woman] in the library ... and there were enough paragraphs in there to confirm in my mind that that's really who I was' (Alice, 63). Claire (67) described her first encounters with the word 'transvestite' when she was 18 years of age – a term that does not reflect her gender identity but resonated with her at that time:

I'd gone into a tobacconist shop for cigarettes and they had the girly magazines on the side. And there was one ... and it was called something like, 'Transvestite'. And it was obviously a man dressed in women's clothes ... it was a bit bizarre, but I thought to myself that person and myself have something in common.

Media representation of TGNC lives and issues often reflected transphobic and homophobic messages about the censure of gender non-conformity:

[At 16–17 years] I thought, you know, I was a pervert, and this wasn't done ... It was coming, well it came from the media. You were associated at that time with um, homosexuality, you were associated with being a pervert, and that was the media as well as the people I mixed with at school. (Elaine, 63)

For all 14 participants who were seeking to transition medically in mid- to later life, this had been a long-term decision. Changes to the prioritising of other family

members' welfare were frequently cited as key turning points for participants in their forties and fifties. This included pivotal events such as separation from spouses, experiencing bereavement through the death of a family member or adult children no longer needing parental care. The eldest participant, Clueless (74), described the heteronormative pressures to marry when she was in early adulthood: 'We had to. You had to get married and have kids. That's what you did.' Divorce from her spouse, along with increased contact with local trans groups and networks, had been important drivers in making her decision to move forward her plans to transition. Louise (58) discussed how her changing relationships with her adult children preceded her living as herself full-time:

...the relationship with my children deteriorated not because of anything I'd done, just did, it faded over so many years, but then I decided, I'm getting old, better late than never, I'm going to live my life for me ... I'll say it as it is, sod everyone. I'm going to do what makes me feel right.

Keeping paid employment, and avoiding disruptions to income, was cited by several participants as another key priority that inhibited them from living full-time as themselves, particularly if they were income providers for other family members.

Once 'out' as TGNC, numerous participants discovered supportive allies amongst family members, including spouses, adult children and siblings, who helped validate their gender identity and related decision-making about transitioning. This sometimes included close, supportive friends who encouraged participants to seek out medical support. While supportive responses from health-care practitioners had been highly variable, a small group of participants pointed to supportive professionals such as general practitioners (GPs) or counsellors who had been key players in their decision-making to live full-time as themselves. Antonia (63) had accessed numerous counsellors over her lifetime but it was her most recent counsellor who had been the most supportive:

...this was about 18 months ago ... she [counsellor] was very good actually, and that's what made me make the decision, I think, finally, to do something about it. It just did it, it was just in a natural thing to do and ... I wanted to do that, and I feel happy about that.

Consequently, Antonia had recently decided to access some medical treatments but not undergo genital reconstruction surgery:

I probably wouldn't go the full McCoy because it's too invasive at this stage of my life. Maybe if I was younger and stronger and I felt able and strong enough, I might have done that.

In this comment, Antonia perceives herself as too old to proceed with this form of surgery, and like other participants, conveyed some regret in not having sought medical treatments in younger adulthood. She described her recent decision to access hormone treatment in later life as 'walking out into the snow' but equally considered herself 'more lucky' than others.

Theme 2: Growing older: a new lease of life

Participants ranged in age from 50 to 74 and as such differed greatly in terms of lifestages such as their transition journey (for those transitioning), family circumstances and employment status. Consequently, whether people have had discussions with others about growing older or planned for the future depends on the confluence of these factors. Many of the participants were not concerned about growing older and had not given it much consideration, preferring to focus on living in the moment and taking ‘each week as it comes’:

Not yet, because I still feel 21 up here, even though I’m 54 (laughter). I do feel fit, I feel comfortable in my life, so. I’ll worry about that later when my back starts going, and I’ve got a walking stick or something. But no, I’ve never really thought about what’s going to happen when I’m older. Especially um, because I’ve only been transitioning as well for the last two or three years anyway. (Rebecca, 53)

Rebecca’s comments convey a number of different temporalities as she refers to her chronological age of 54, her subjective age as ‘feeling 21’ and the number of years she has been transitioning as another important marker of time. Her comments disrupt a linear understanding of chronological time. Similarly, Skogsra discussed her experiences of ‘going through puberty’ at 50 years of age: ‘We go through puberty aged, in my case, you know, 50, and you’re channelling a 13-year-old girl (laughs)’ (Skogsra, 57). She described herself as reliving life in her twenties, associated with her recent journey of transitioning.

For some participants, life post-treatment and surgery brought a sense of new life and a desire to live life to the full. Reaching 50 years of age marked a new lease of life for Richard on a number of levels, including medical transitioning as a trans man and returning to education:

I’ve had no qualifications, and um, even though when I tried, you know, when I came to my fifties and I decided I was going to transition and nothing was going to change my mind, and I was going to do that on my own, and then I thought, yes, and then I’ll do a degree. (Richard, 63)

The sense that life should be enjoyed while people are healthy and able to do so is echoed by Suzanne – for her, life was an adventure, but later life brought with it the potential to foreclose this:

[T]o me life’s still, still completely an adventure. Um, I know at some stage it’ll stop being an adventure and start becoming quite tedious, and, certainly, I would hope to be able to exit with dignity, if that means something. (Suzanne, 65)

Suzanne’s final comment conveys her wishes to access euthanasia services if she lost mental capacity to make her own decisions.

The inclination to live in the moment means that many of the participants did not often discuss growing older with other people. Moreover, whether people have thought about their health in later life is influenced by how fit and healthy they feel currently. Most of the participants self-reported as physically well and did not have

pressing health concerns. However, several of the participants expressed concerns over the increased health risks of taking hormones in older age and the perception that hormone levels are not well monitored by GPs and health-care services. This was a particular worry for Gabriella (56), with a family history of heart problems:

I'm aware of the fact that the medication I'm on, with oestrogen ... which I now have to have for the rest of my life, having had gender reassignment surgery ... puts me into a higher risk bracket as well.

Theme 3: Growing older: regrets, delays and uncertainties

Where people are in their transition journey can impact on an individual's subjective understanding of ageing. When reflecting on their current age and life circumstances, some participants conveyed regret and sadness for missed opportunities earlier in their lives. Although Barbara did not dwell on getting older, she expressed sadness that she will be 70 years by the time she completes her medical transition:

You see yourself sort of ageing and you think, you know, where will I be in ten years' time? I don't fear, um, the ageing process, I just feel a bit sad that I'm nearly 70 before, I will probably be 70 by the time I actually finish this process. (Barbara, 69)

When reflecting on her current chronological age, Barbara conveyed a sense of 'running out of time' and having limited years left to live as Barbara. For the majority of the 14 participants who were currently transitioning through medical means, their lives were marked by heightened periods of uncertainty regarding when they would have completed their journey. Structural factors in the health-care system that exacerbated feelings of uncertainty included: extended and often unexplained delays for referrals to gender identity clinics and consultants; being totally reliant on local GPs and mental health professionals for referrals to specialist clinical services to take place (and then having to follow up that referrals had taken place); and, once referred to specialist services having to experience repeatedly cancelled or delayed appointments or extended periods of non-communication. These are some of the institutional problems recently identified by the Royal College of Physicians (2019) as needing improvement in UK gender identity services.

Growing older almost inevitably leads to reflection on how one's life has been lived. Several participants wished they had socially and medically transitioned sooner, describing 'missed opportunities' at earlier life-points:

I've got friends similar to myself that, feel as though our life has been wasted, you know, where could we have been um, using the energy and the strength to, to get where we are, where could we have been if we hadn't had to use that energy. Just to survive. (James, 63)

Waiting until later in life to transition had caused some participants to frame their lives as having been 'wasted' in the struggle to live with conflicting identities and responsibilities. Antonia (68) was at the very early stages of transitioning and

had commenced hormone treatment 18 months before the interviews. She conveyed her concerns about not being able to complete her journey as a trans woman:

...you know, how long have I got, and if I don't do this now, if I don't be ... happy now, well I never will be. I'll just go, I'll just bury it and just disappear and ... nobody will know ... I won't have come into flower, will I, I would have just been...

Antonia describes her everyday life as 'only existing' and 'not living, really', equating her gender identity and physical body as somehow incomplete. She also observed that this would have been a much easier journey as a younger person without the welfare and happiness of significant others, such as a spouse and children, to prioritise.

While there were variations in participants' financial stability and socio-economic status, the majority of participants did not raise concerns about financial security in older age. There were those who were home-owners with pensions in place and had either always planned for the future or felt that they did not need to. Several participants who were not financially stable expressed concerns about having a place to live and enough money to survive now and in future years. This also impacted on how much they could invest in medical treatments. Elaine (63) was working part-time as a cleaner and described herself as 'skint':

...I'm jealous of people with money who can go and get a boob job, or go and pay for it all privately, and I am very jealous of all that, they have no problems paying for electrolysis, they have no problems paying for facial feminisation surgery, they have no problems getting a boob job, they can pay privately for the op, and I wish, I wish I'd have been normal, and had a proper career and saved enough money for my senior years, so I could do all that. But I haven't.

One of Elaine's main concerns was 'having somewhere stable to live' as well as progressing with her medical transition; limited financial resources required her to continually juggle both priorities.

Theme 4: Ambivalent expectations of social care services in later life

Participants expressed many of the same concerns about needing to access social care services or long-term care provision as might be expected from the general population. This included concerns about a perceived loss of independence, dignity and respect as older people in care settings (Hill *et al.*, 2007). Specific to TGNC identities, participants held concerns about being treated with dignity and respect in long-term care settings in relation to maintaining personal appearance. Women participants mentioned the importance of being appropriately dressed and the high dependency of service users on care staff to maintain body/facial hair and wig maintenance, where their mental capacity may be declining or fluctuating:

It's much more difficult for an elderly transgender woman to maintain dignity in a social care context, than it is a cisgendered woman ... there won't be any, any, provision probably for looking after a transgender woman's appearance, in the same way that a cisgender woman can. (Suzanne, 65)

As someone who identified as a cross-dresser, Dolly expressed concerns about living with dementia and the difficulty of conveying a non-transitioning status to care workers:

If someone goes into a home, at some point in the future, and they start to suffer from dementia ... there wouldn't necessarily be anything in place for me, because I don't identify in a medical way, therefore, if I suddenly started expressing a preference to do certain things or to present myself in a certain way, are the care workers going to say, 'It's just part of the dementia'? (Dolly, 54)

Dolly described being 'a non-transitioning person' as a grey area where care workers and services are unsure how to categorise and respond to one's needs and wellbeing: 'If you take yourself out of one bucket, you put yourself in the other one, they know how to deal with you. Society's not very good at dealing with grey areas.'

A further concern was the importance of being correctly gendered by care home staff and the fear of being outed as TGNC to staff and other residents. Alongside this were worries about how other residents may respond to TGNC individuals in long-term care settings and the potential for transphobic responses. However, the opinion that social care for trans people would be different from that of cisgendered people was not universally held. This may reflect some participants' hopes that by the time they require access to social care services, staff attitudes and practices will have shifted progressively in keeping with current legislative requirements.

Discussion

In this paper, we have explored how TGNC adults experience and anticipate ageing and, connected to this, their concerns and anxieties for receiving long-term care services. There are a number of illuminating findings that extend current understanding of the intersection between ageing and gender identity in mid- to later life, which will have local and international relevance. Based on the findings, we contend that TGNC adults experience a form of trans precarity in later life, marked by uncertainty for the future *versus* an imagined future of living full-time as one's self. We first discuss the notion of trans time before returning to the notion of precarity.

Several participants' comments resonate with discussions about the importance of recognising 'trans time' as non-linear in which TGNC individuals experience multiple ages in both past and present time periods (Fabbre, 2015; Pearce, 2019). This hinges on a range of life factors including their current experiences of transitioning. Their accounts disrupt a normative, linear model of life progression in which older age can bring with it experiences of 'youthfulness' or younger age and be experienced as a new lease of life or way of being in the world. Their subjective understanding of ageing differs from heteronormative or gender-normative accounts of time and may include a return to adolescence or young adulthood in later life in association with important life markers such as the receipt of hormones or other medical treatments. Counter to this narrative of 'new life', other participants' stories are marked by regret for missed opportunities in earlier life and a

sense of running out of time – time is a lost entity that is experienced as rapidly diminishing because some individuals experience high levels of uncertainty about gaining access and support for medical treatment or have prioritised the welfare of others over their own transition journey.

Another notable finding is the theme of uncertainty that runs through participants' accounts – uncertainty about their present and futures lives with no tangible sense of how long their journey of transitioning will continue or what the endpoint will look like beyond their imagined future. Similar to participants in Fabbre's (2015) US-based study, reflecting on past life experiences heightened awareness of sadness and regret for TGNC adults in our study. Uncertainty about the future also generated financial and material insecurity for a small number of participants – other markers of precarity in later life (Gilleard and Higgs, 2020).

These different forms of uncertainty do not inhibit the exercise of agency, evident in participants' determination to move forward in their journey of transitioning and in the majority of cases with supportive allies around them. This is a highly empowering position to reach, particularly after several decades of prioritising the welfare of others over their own wellbeing. Pearce (2019: 202) notes that the social and physical transitions that TGNC individuals undertake is a journey of 'defining themselves and constructing their future'. Participants' accounts in our study convey a similar unfolding journey as mid- to later life provides a time of new possibilities to prioritise their wellbeing and identity, and construct their own future. The rapid expansion of information about TGNC lives and identities available through the internet in parallel with other social advances such as increased recognition of civil rights and legal equality, opens up a greater range of possibilities and subjectivities for TGNC individuals, locally and globally – sources and insights that were not available to them during adolescence and early adulthood. Older TGNC individuals in other nations will have experienced similar rapid increases in online information and access to virtual communities.

A further important finding is participants' lack of planning for later life beyond their own transition journey (for those transitioning). In many ways, this is no different from disparities noted amongst other groups of older people in the UK, where variable levels of attention are given to future considerations such as advance care planning (Samsi and Manthorpe, 2011; Musa *et al.*, 2015) or other forms of future planning (Hill *et al.*, 2007). Trans respondents (50+ years) in de Vries *et al.*'s (2019) Canadian study similarly gave greater weight to current life concerns such as having sufficient material and financial resources over planning for end-of-life care, again highlighting the precarity attached to some older TGNC individuals' everyday lives locally and in other Global North nations.

Participants in our study were cognisant of the potential challenges they may encounter if at some future point they experienced declines or fluctuations in their mental capacity, and they became reliant on social care services for ongoing care and support. The prospect of the latter was accompanied by anxieties about transphobic treatment or impersonalised care where an individual's specific care needs (including physical, bodily care) would not be met. This builds on concerns noted in international literature regarding TGNC adults' dependency on service providers in later life for the receipt of dementia care and long-term support (Siverskog, 2014; Hunter *et al.*, 2016; Page *et al.*, 2016; Witten, 2016; Waling

et al., in press). It also chimes with recognition that precarious living in later life is often triggered by the onset of receiving care; precarity is heightened for those reliant on public services to meet their needs (Grenier *et al.*, in press). While many older adults anticipate a degree of vulnerability as their dependency on others increases, we would argue that for TGNC adults this vulnerability is heightened by anxieties about exclusion, mistreatment and isolation specific to their gendered selves – this represents a form of trans precarity. Not knowing if helping professionals are going to provide the care and support sought or how they are going to respond to individuals' bodies who do not meet their expectations brings a new layer of precarity to TGNC lives in older age. This has implications for TGNC citizens' engagement (or lack of) with care services.

Implications for informing practice

Our findings hold a number of implications for providers of care and support services for older adults, within the UK and internationally. Notwithstanding the more obvious demand for services to provide inclusive provision, there is the recognition that care professionals need to ensure that older TGNC adults have confidence in care and support services for older adults. This encompasses recognition of the ways in which the lifecourse of TGNC individuals holds different turning points and life markers in comparison to cisgender older adults. It also requires responding affirmingly to the successes (to use Fabbre's language) experienced by TGNC patients and service users in developing confidence to be and present as themselves across their lifetime while living in cisnormative social environments and balancing personal and familial responsibilities. Bringing certainty and affirmation to these interactions requires professional knowledge of TGNC identities and other social differences that intersect with gender identity, such as old age, along with the confidence to engage in life-affirming conversations and advocate for TGNC individuals in mid- to later life where appropriate. Locally, we are aware of current initiatives to increase professional education for physicians and GPs in England and Wales (*e.g.* the creation of online training modules on gender identity health care by the Royal College of Physicians, 2019). However, the training and education of social care workers on TGNC inclusion remains sorely unaddressed, and our findings suggest that this is an arena that provokes much anxiety and uncertainty amongst TGNC adults in mid- to later life.

Limitations to the study

Findings are generated from a non-representative sample and as such transferability to other national contexts where equality legislation and policy and health-care provision may differ is limited. Participants' accounts are from a position of racial privilege (White British in the main) and we estimate that over half the participants were economically secure, which is out of kilter with broader economic disparities identified amongst trans groups and communities, as noted earlier. The intersection between race, ethnicity and ageing amongst TGNC individuals is a neglected area of enquiry in gerontological literature (Van Sluytman and Torres, 2014), with larger national surveys of TGNC individuals (in the USA) indicating higher

reported levels of unemployment, police harassment and refusal of medical care among black and ethnic minority respondents in comparison to white TGNC respondents (Grant *et al.*, 2011). More attention is needed on the impact of structural and institutional racism on TGNC individuals from black and ethnic minority groups and how these experiences contribute to social exclusion in later life (Chang *et al.*, 2016). We were successful in recruiting a small number of men (four), however, reaching out to men identifying as TGNC proved challenging, despite connections with social groups and networks for trans men. This was often reflected in the membership of TGNC groups in Wales in which the majority of members were women. A partial explanation for this may be that men from this group are less likely to identify with TGNC identities in later life if these identities do not align with the embodiment of masculine subjectivities and presentation. The intersection of TGNC identities and masculinities in older age is an area for future research. There is a notable absence of individuals identifying as non-binary in our study; another area for research is the ageing experiences of non-binary and genderqueer individuals.

Concluding comments

TGNC identities and lives in old age represent new territory in social gerontological literature within the UK and internationally, and for health and social care providers signal new requirements to provide a level of care and support not widely recognised or sufficiently mandated. Through a qualitative lens we have explored critically how these unique identities and life experiences shape TGNC individuals' concerns and expectations about ageing and later life. As reports of hate crime and speech against TGNC citizens increases in the UK, this is a crucial time to examine and identify what dignity and respect means for TGNC individuals in later life. From a social gerontological perspective, it is also a pivotal point to expand public and professional understanding of how the lifecourse of TGNC older adults can diverge from other older people and generate different experiences of lifestages commonly associated with chronological time. Further exploration is needed into the lived experience of dementia for TGNC adults in mid- and later life.

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Notes

1 Trans is an umbrella term that encompasses a diverse spectrum of individuals whose gender identity differs from that assigned at birth. This includes individuals who have transitioned medically or socially from male to female or female to male, individuals who cross gender norms (cross-dressers/transvestites), and those whose gender identity does not fit within the confines of conventional binary gender categories, e.g. non-binary and genderqueer (Burns, 2018). We recognise inherent tensions in using this term as

first, many gender diverse individuals do not identify as ‘trans’ or instead identify as man or woman, and second, describing a diverse group of people under one unifying descriptor risks ‘reifying essentialist notions about “the trans person” as a fundamentally distinct class of being’ (Ansara and Hegarty, 2013: 160). We use the term ‘gender non-conforming’ (GNC) alongside trans to capture the identities and experiences of individuals who do not situate their gender identity within the cultural binary of man/woman; this is in line with other authors in this field (Glick *et al.*, 2019).

2 ‘Transitioning’ refers to the journey an individual undertakes in changing their presentation and expression to match their gender identity and involves social transitions (such as dressing and expressing oneself in ways that match their identity) and medical transitions (such as taking hormones and/or accessing surgical treatments) (Vincent, 2018). While the term transition suggests a beginning and an endpoint, for many TGNC individuals transitioning is a life-long journey involving daily routines and practices.

3 As a devolved nation the Welsh Government administers public health-care services for those registered with a GP surgery in Wales, which has resulted in different pathways for accessing gender identity clinics compared to services available in England or Scotland. In Wales, the old pathway was through an assessment conducted by a mental health service that assessed whether individuals were ‘gender dysphoric’. The local assessor acted as a gatekeeper to gender identity clinics in England. During our study’s lifecycle, National Health Service (NHS) Wales completed a review of the pathway and a New Welsh Gender Service commenced in September 2019, providing more medical treatments locally (*see* NHS Wales, 2019).

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