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Loree Cook-Daniels & michael munson

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Sexual Violence, Elder Abuse, and Sexuality of Transgender Adults, Age 50+: Results of Three Surveys

LOREE COOK-DANIELS and michael munson
Transgender Aging Network, Glendale, Wisconsin, United States

Relatively little is known about the lives of transgender people once they are through their gender transition. Even less is known about transgender elders, either those who transitioned many decades ago and now have grown older or those who are transitioning in mid- or later-life. This article reports on the findings of three online surveys of transgender adults age 50 years and older on three topics: sexual violence, elder abuse, and sexuality. Sexual violence and elder abuse had been experienced by a strong majority of those surveyed. The sexuality survey demonstrated clearly that there is a vast range of diversity in transgender people's sexual lives and that the majority of midlife and older transgender people believed their gender identity influenced their sexuality.

KEYWORDS *Transgender adults, sexual violence, elder abuse, sexuality, online surveys*

INTRODUCTION

Relatively little is known about the lives of transgender people once they are through their gender transition. Even less is known about transgender elders, either those who transitioned many decades ago and now have grown older or those who are transitioning in mid- or later-life. Because of its unique transgender aging program, For Ourselves Reworking Gender Expression (FORGE)—a 16-year-old, national transgender social service, education, and

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Address correspondence to Loree Cook-Daniels, Transgender Aging Network, 6990 N. Rockledge Avenue, Glendale, WI 53209. E-mail: LoreeCD@aol.com

advocacy organization based in Milwaukee, Wisconsin—consistently attracts a relatively high percentage of older respondents in its national surveys on transgender issues. In this article, we report on responses we have received on three issues—sexual violence, elder abuse, and sexuality—from transgender people who were 50 years old or older.

Violence in the Lives of Transgender People

The problem of violence and crime against the transgender community is so acute that a national collaboration of transgender health experts charged with setting the top health priorities for the transgender community decided that violence and murder prevention was the top health priority (Xavier et al., 2004).¹ Not even one national, federally funded study collects any kind of data on transgender people, and there has been only one statewide, state-funded survey (Xavier et al., 2007). That survey asked only about crimes that had happened since the respondents were 13. Findings were that 27% of respondents had been forced to engage in unwanted sexual activity, and 40% had been physically attacked.² It may be interesting to look at these figures in combination with those from a Minnesota study which found that 23% of its transgender participants had experienced sexual abuse as a child and 38% had experienced childhood physical abuse (Bockting, Robinson, Forberg, & Scheltema, 2005).

Other studies have been privately funded surveys with varying methodologies and questions. One found that 47% of transgender individuals had been assaulted during their lifetime with 16% being assaulted the year before the (1997) survey. In that year, the National Crime Victimization Study found 8.2% of Americans were assaulted, meaning transgender people were nearly twice as likely as their cisgender peers to be attacked (Kenagy, 2005). A Washington, DC, survey found 43% of transgender people had been the victim of violence or crime (Xavier, Bobbin, Singer, & Budd, 2005). Other surveys have found even higher rates: the percentage of transgender people reporting they'd been forced to have sex were 68% and 55% in San Francisco and 53.8% in Philadelphia (Kenagy, 2005). Other surveys' respondents saying they were physically abused or experienced violence in their home included 47% in Los Angeles, and 56.3% and 51.3% in Philadelphia (Kenagy, 2005). These figures are many times larger than those for the general public. For instance, lifetime sexual assault victimization rates for the general public are reported as 17% for women and 3% for men (Anonymous, 2008).³

SEXUAL VIOLENCE

In 2003, FORGE realized that approximately half of those who regularly attended our Milwaukee social support meetings had revealed that they were survivors of sexual violence. Around the same time, a FORGE member

was repeatedly sexually assaulted, and reported major difficulties accessing services and being treated with respect by sexual assault services and law enforcement officials. To find out if these experiences were widespread or Milwaukee anomalies, FORGE undertook a lengthy (54 questions) national survey that received responses from 302 transgender people and Significant Others, Friends, Family, and Allies (SOFFAs). Of those respondents, 53, or 18%, were age 50 and older.

METHOD

All three of the surveys reported here were conducted online via Survey Monkey.com. Participants were recruited largely through announcements and solicitations on listservs geared toward transgender individuals and/or SOFFAs., including ElderTG (a peer support listserv for transgender persons age 50 and up) and the listserv that FORGE's Transgender Aging Network maintains for researchers, service providers, advocates, and others interested in transgender aging issues.

FORGE defines *transgender* in the broadest possible way, ranging from post-operative people who no longer see themselves as “trans” to “butch” women and “feminine” men (who *also* may not self-define as trans!). We typically hear from a good mix of those on the female-to-male (FTM) gender vector and those on the male-to-female (MTF) vector.

FORGE surveys also encourage SOFFA participation. We believe SOFFAs are often as affected by transphobia and a gender transition as are transgender people, and that attending to SOFFA needs and issues will ultimately benefit the transgender people with whom they are involved. We have also realized from many years of handling information and technical assistance requests that, oftentimes, a transgender person will not reach out on his or her own behalf and that it is actually often the partner or parent who does the research, makes the connections, and tells the stories.

Because of the vast diversity of genders transgender people claim (along with many transgender people's refusal to categorize their gender as anything other than male or female), FORGE asks a series of gender-related questions (sex assigned at birth, current gender identity, and current gender role) and assigns respondents to “MTF,” “FTM,” “cisgender⁴ male,” or “cisgender female” categories after comparing the answers on these three questions.

Each of the surveys conducted will be presented and described separately. Findings from each survey are also presented separately while a discussion will summarize and integrate the findings from all three surveys.

DEMOGRAPHICS

The vast majority of our older respondents (89%) were in their fifties; six (11%) were in their sixties. We had no respondents older than 64. In this

survey, our age 50+ respondents were overwhelmingly MTF: 88%. Only one (2%) was FTM. Three were cisgender male and two cisgender female; we believe all the cisgender respondents were partners of a transgender person.

RESULTS

FORGE surveys allow respondents to check multiple sexual orientation boxes. Of the 70 responses, the largest category was heterosexuals, at 24%. Twenty percent marked lesbian, 19% bisexual, 9% celibate, 7% pansexual, and 6% queer. Eleven marked “other” and gave write-in answers that included “questioning” and multiple versions of “woman desiring a man.” None of the older respondents marked *gay male* (compared to nearly 7% of the overall sample), and many fewer marked *queer*, which, at 33.6%, was the largest category for the whole sample.

Most respondents were white (84%), with 6% marking multiracial and one each marking or volunteering Pacific Islander, Jewish, human, unknown, and “no.” Geographic spread was remarkably even, with roughly equal numbers indicating they lived in the Midwest, on the East Coast, on the West Coast, or in the South. Six lived in other countries. Eighty-one percent had health insurance, 13% did not, and 6% marked “other,” noting they had veterans’ benefits or lived in the United Kingdom and were covered by that country’s universal health care system.

Unlike many other transgender studies, our income responses showed a remarkable diversity: 19% had annual incomes under \$20,000; 19% had incomes between \$20,000 and \$35,000; 17% were between \$35,001 and \$50,000; 13% were between \$51,001 and \$75,000; 23% were between \$75,001 and \$100,000; and 8% had incomes of over \$100,000. More than one-third (36%) said they had physical or mental health disabilities. We asked what kind of disabilities they had. Arthritis, diabetes, back injuries, and vision impairments or blindness were mentioned by two or more people. Half of the write-in responses were mental or emotional conditions, including five with major depression, bipolar depression, or Type II Bipolar; two with post-traumatic stress disorder (PTSD); two with anxiety; and one that replied “stress out easily.” One person gave four mental health diagnoses, along with chemical dependency and gender dysphoria.

Sexual Violence Experiences

Only 44 of the older sample responded to the direct question “Have you experienced unwanted sexual touch?” Almost two-thirds (64%) of those respondents said yes, 23% said no. Eleven percent marked that they were unsure or didn’t remember if they had experienced unwanted sexual touch,

and one marked “other.” Only 36 answered the question asking if they were a direct or primary survivor, secondary survivor, both, or neither. Forty-two percent were direct survivors, followed by 25% marking they were both a direct survivor and the partner, parent, family member, or friend to another direct survivor. Eight percent were secondary survivors, and 25% marked “other,” usually noting it was “none of the above” or that the respondent doesn’t “consider myself a survivor.”

Approximately one-third (37%) of the victims had only one assault in their history. A quarter marked they had been assaulted “several times” and another quarter marked “many times.” Six percent each couldn’t remember how many assaults they had experienced or marked “other.”

We asked how old they were when they experienced unwanted sexual touch. Fifty-eight percent had at least one assault before the age of 19, and 42% had been assaulted somewhere between the ages of 19 and 60 (no one reported an assault after age 60). Reported age spans were as follow: (1) 0–12 years old, 27%; (2) 13–15 years old, 22%; (3) 16–18 years old, 9%; (4) 19–21 years old, 9%; (5) 22–40 years old, 14%; and (6) 41–60 years old, 18%.

PERPETRATOR CHARACTERISTICS

The vast majority of sexual assault survivors (66%) knew the person(s) who abused or assaulted them; 27% did not know the perpetrator(s). Family members made up 24% of the assailants; 8% were intimate partners and 6% were dates. “Someone else you knew” was the largest category of perpetrator, at 26%. Twenty percent were “strangers.” One person each reported being assaulted by a police officer and a health care professional. Locations of the assaults were mostly public settings (26%), the victim’s childhood home (21%), or the victim’s adulthood home (14%). It may be notable that three assaults took place in the workplace and two in a health care or social service setting.

Survivors were asked to note how many different people had assaulted them, and what their genders were. Due to the way this question was asked, we cannot distinguish how many people were assaulted by more than one person at a time (e.g., gang rape) from how many had different perpetrators at different times. The genders of 80 perpetrators were reported. Eighty-one percent of the perpetrators were male, 16% were female, and 2% were transgender. Seven of the victims had had four or more male perpetrators; four victims had had two female perpetrators. Overall, of the 40 survivors reporting their perpetrators’ gender, 22% had had at least one female perpetrator.

ROLE OF GENDER

Survivors were asked what gender they were perceived to be when the assault(s) happened. Roughly equal numbers were perceived as being male

or female at the time of the assault: 32% were perceived as male, and 34% as female; these figures vary significantly from the larger sample, in which 73% said they were perceived as female at the time of the assault(s). Fourteen percent said they were visibly transgender at the time, and 7% said they were androgynous. A total of 13% said they didn't know how they were perceived or gave an "other" answer.

The majority of respondents (55%) said they felt "the abuser's perception of your gender/gender presentation/gender expression was a contributing factor in the abuse/assault(s)." Nineteen percent said gender wasn't a factor, and the balance didn't remember, were unsure, or answered "other." One write-in response was, "My uncle wasn't picky. My ex abused me because I wasn't enough of a man for her (her words)."

REPORTING AND POST-ASSAULT SERVICES

More than half of the survivors told no one about the assault(s) around the time they happened. Interestingly, the number who reported they tried to tell someone is roughly equal to the number who succeeded in telling someone: 13% for the former and 16% for the latter. Thirteen percent were unsure or didn't remember if they reported the assault(s). Only 16% of the assaults were reported to the police; 75% were not; the rest were unsure or gave an "other" answer.

A small percentage of victims needed medical attention for physical injuries or for evidence collection: three (9% of the 35 who answered this question) received medical attention (two from an emergency room or hospital), and three were treated at home. Most received this medical care within a day of the assault, with a year elapsing before one person got care. Most of the 28 who answered the question said they had no physical scars, long-term medical conditions, or disabilities as a result of the assault, but four (14%) said they had physical scarring, and one had a long-term medical condition as a result of the assault(s). One respondent was "unsure" if he or she should answer "yes" to the question. Two write-in answers were mental and psychological scars. Only one respondent said he or she was unsure or didn't remember if he or she had received "medical services against your will"; in the overall survey results, four people (2.5%) had received medical services against their will, including psychiatric institutionalization.

The few who were seen by a service provider ($n = 12$) generally said service providers did not know they were transgender (due in part, perhaps, to the number of child sexual assault cases), but of the four whose service provider knew they were transgender, only one thought services were negatively impacted by the knowledge. One person said services were actually positively impacted by the service provider knowing they were transgender. In comparison, two people said their race influenced the services they received, and one said health care coverage was an influence.

One striking finding, which may be related mostly or solely to the child sexual abuse incidents, is that survivors often waited years before accessing professional emotional support services. Two survivors received such care within a week to 6 months after the assault(s), but one didn't receive care until 5 years later, one 10 years later, and five more than 10 years later. The largest category of the type of care received was one-on-one therapy, with nine people accessing that modality. The next largest categories were largely self-help or peer support: reading self-help books/articles (five people), Internet Web sites (four), and group therapy, social support groups, Internet chat rooms, and partners being utilized by three people each. It may be important to note that when it came to therapists people saw for transgender issues, they may not have brought up the sexual assault(s); this was true for one of the older respondents, and several of the younger ones.

Several of the comments respondents wrote about professional emotional support services illustrate the range of responses the older survivors had:

My therapist is a gender specialist, and because 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. So now the therapist and I are starting to deal with it.

[There is] nothing [that could be done to improve services]. The damage was already done.

Often I was ignored by psych services because I was deemed to "not be psychiatrically ill, only transsexual," and therefore didn't need support. This attitude was used to justify providing NO support.

Some therapists were remarkably insensitive to the emotional trauma of sexual assault.

BARRIERS TO SERVICE

In an open-ended question, respondents were asked, "If you knew of services you wanted to access—but didn't—what stopped you?" Many respondents answered, including two that simply said "Shame." Other responses referred to both internal and external barriers, some of them related to being transgender:

[I was] afraid of issues coming to surface and having to deal with them.

My ex[-wife] had me convinced she could turn everyone against me and take my kids and eventually grandkids away from me, and that no one would want to deal with a queer (of whatever stripe I was) like me. Turns out she was wrong; my older daughter and son-in-law are a wonderful, daily joy, and sounding board in my life, for example.

For rape ... I was considered a male at the time; no one would have believed I was raped by a female.

Help did not exist in the 1950s, and I was too young to understand anyway. No one ever asked if I needed to talk to anyone. Maybe everyone figured that a police interrogation was therapy.

Women's Center in [New Zealand] does not allow transsexuals in their offices because they are men and "we have women who have problems with men coming here for help." [Service name withheld, a Christian program aimed at helping LG's] insisted that I attend a men's group, despite knowing of my rape history and my discomfort with men, and despite my appearance as a woman being sufficiently close that most people don't recognize that I was once male when meeting me. In the end I stopped attending their meetings because of the rigid attitude and total unwillingness to see me as a normal person and my inability to feel OK in the men's meetings (most of the men didn't even know why a woman was attending their group, until one of the leaders leaked my personal information to the group and I felt that I had to explain my situation).

I have been encouraged by many [to get care] ... but I can't do it ... because of fear. ... The people that did this are all still alive ... and as long as they are still alive, I can't go public with what happened. [This respondent explained in other answers that the perpetrators are believed to have killed two other family members; police listed one death a suicide, and the other person has been missing for five years.]

On the other hand, there were some heartening stories:

In another hospital, I was asked by the Head of the Psych unit, a rather large woman, "What was wrong with being a woman?" and she wouldn't let me out of supervision until I agreed to go back onto hormone therapy (this was when I was trying to turn myself back into a man, and having suicide episodes). She also asked me, "What was wrong with being happy?"

My younger daughter made me see it was not just for me that I should leave [my abusive wife] (which I still considered selfish and taboo though I left the church way back at about age 9), but that she was suffering as

well from the situation. This also made it okay to others (my in-laws and older daughter and family) that we were leaving.

INTIMATE RELATIONSHIPS

One of FORGE's working hypotheses is that intimate relationships are more affected by one or both members' sexual assault history than is usually acknowledged. To test this hypothesis, we asked people about the relationship, if any, between their sexual assault history and their intimate relationship(s). Nineteen percent said they weren't in an intimate relationship, 6% said their partner was the abuser, and 21% gave an "other" answer. Of the remaining responses, 36% said there had been no effect; 28% said the relationship was "stressed" by the assault(s)/abuse, and 13% said the trauma had been part of why the relationship ended. On the other hand, 8% said they supported each other through difficult times, and 4% said their relationship was "stronger because of these experience(s)."⁵ Some of the respondents elaborated on their answers, including these:

I am the partner [now] but was not at the relevant times; my partner has extreme difficulty with anxieties as a consequence of the abuses. . . .

I can't hold a relationship.

It happened—I got over it.

My marriage was destroyed because of the effects on me, including acting out.

[I was] rejected by my mother.

Other long-term ramifications came out in responses to the two final questions: "What kind of services would you find useful?" and "Is there anything else you would like to share?"

I think I need help—still having flashbacks. [The respondent gave identical answer to both questions.]

[I could use] social support and therapy to help me develop the missing social skills that are a consequence of my childhood abuse and my years and years of cognitive dissociation. . . .

To talk with others who have been through severe physical and sexual abuse. . . .

Until you felt you could trust someone with the knowledge of being tg [transgender], you just wouldn't talk to anyone.

I did not think I would have a nervous breakdown. I shattered like glass ... the emotions suddenly overwhelmed me ... and I became dysfunctional.

I understand that my gender dysphoria arises from the childhood abuse. I had researched this area fairly carefully, and if useful, I have literature suggesting abuse as a possible cause of gender dysphoria.

My life got really, really small, slowly over 30 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. I love my life, my family, my new friends and still, still don't hate my ex[-wife]—but I don't think she had a right to treat me the way she did and worse, the way I used to, any more.

Transgender Elder Abuse

In 2007, FORGE's Transgender Aging Network conducted a survey designed primarily to identify stories of abuse of transgender elders. With this goal in mind, both transgender elders themselves and other people who knew of transgender elders were invited to participate. Unfortunately, the rest of the survey instrument did not adequately account for the two types of respondents, confusing respondents, and making analysis difficult. Therefore, many respondents gave up on the survey midway through.

In addition to demographics, the survey covered three primary topics: (1) We encouraged respondents to give as many details as they'd like about incidents of abuse of transgender elders. (2) We also asked about respondents' personal experiences with the major types of elder abuse (as defined by most states' laws), plus two types of discrimination that are frequently experienced by transgender people: health care and housing discrimination. (Employment discrimination was not included because it was thought that the majority of respondents would either be retired or might find it difficult to tell whether job discrimination was due to age or to transgender status.) (3) A third section of the survey assessed the extent to which respondents worried about various types of elder abuse happening to them.

DEMOGRAPHICS

Although 56 people responded to the survey, only 30 gave their age. Four were under 50, and 20 were between the ages of 50 and 60. Four were in

their sixties, and one was 70 years old. We did not have enough data to determine the gender (vector) of 26 respondents; of the remainder, 23 were MTF, 6 were FTM, and 2 were cisgender female.

Of the 29 respondents who gave their race, 79% were white and 10% each were multi-racial and African American. Twenty-nine respondents also answered whether they had physical or mental health disabilities or challenges; 34% said yes and 65% said no. The same respondents also reported their sexual orientation: 31% were heterosexual, and 28% lesbian. Twenty-four percent were celibate or asexual. Fourteen percent said they were bisexual, and 7% each claimed pansexual and other. Only one said he was a gay male, and no one claimed the term *queer*. Income was again widely distributed, with 21% each reporting incomes of \$10,000 to \$25,000 and \$26,000 to \$40,000. Eighteen percent each reported incomes of \$41,000 to \$55,000 and more than \$70,000. Seven percent had incomes under \$10,000, and 14% had incomes between \$56,000 and \$70,000.

PERSONAL EXPERIENCE WITH ELDER ABUSE

Up to 56 respondents answered questions about their personal experiences with various types of abuse. Some abuse categories went unexplained, including “physical abuse, assault, or violence,” “sexual abuse, assault, or violence,” “emotional/psychological abuse,” and “health care discrimination.” Elder abuse terms that are not common in general conversations were explained as follows:

1. neglect of physical needs (such as help with medication, going to the store, using the restroom, getting to the doctor, etc.);
2. self-neglect (this usually occurs when someone is too ill or depressed to take care of their own basic needs, such as food, cleanliness, and safety);
3. financial exploitation (when someone has taken advantage of an elder for monetary gain); and
4. abandonment (when someone with physical needs is left alone without care by their designated caregiver).

Housing discrimination was given elder-specific examples: particularly senior housing, nursing homes, etc.

The vast majority of respondents had never personally experienced any of these types of abuse, with one glaring exception: 64.8% of respondents said they had experienced emotional or psychological abuse more than once, with only 29.6% saying they had never experienced it. Health care discrimination was also relatively common, with 30.9% saying it had happened to them more than once and 10.9% saying they had had one such experience. Sexual assault was particularly low compared to other surveys that have

shown that up to one-half of transgender people have experienced sexual assault. In this survey, of the 55 people who answered the question, only 7 said they had been sexually assaulted more than one time.

A major surprise was the number of people who said they had self-neglected more than once: 27.3%. Self-neglect is usually only thought of in terms of very frail elders. Perhaps adding depressed to the definition prompted people to apply this category to themselves (surveys of transgender people have found extremely high rates of depression).⁶

FEARS OF ELDER ABUSE

The last section of the survey asked how much respondents feared various types of elder abuse would happen to them. Fears were rated on a 5-point Likert scale, with 1 being “not at all,” 3 being “I think about it often,” and 5 being “I am extremely afraid this will happen to me”; “2” and “4” were left undefined on the survey form.

Since many respondents quit the survey midway through, only 27 to 29 people answered these questions. Most people said they were not very worried about being abused. Most worried “not at all” about neglect, financial exploitation, and abandonment happening to them. “2” was the answer most chosen for all the other types of abuse and discrimination: physical abuse, sexual abuse, emotional abuse, self-neglect, health care discrimination, and housing discrimination. However, six people said they were “extremely afraid” of being emotionally abused or being the victim of health care discrimination, and five each were “extremely afraid” of financial exploitation and abandonment. Indeed, at least two people were “extremely afraid” of being the victim of every type of abuse.

Respondents were also asked an open-ended question: “Have you changed any aspect of your life to lessen your fear of being abused? If so, please describe.” Thirteen people discussed their strategies. Some of them were dramatic:

I have decided not to have any life-extending surgery because of past mistreatment by nurses at [the Veterans Administration hospital].

I prostitute myself at age 55 because even though I’m a [post-operative transsexual] and passable [as a woman], no one passes 100% of the time. NO ONE. Job discrimination is bad because you’re stuck with fellow employees 8 hours a day, 40 hours a week. That much harassment is bad for one’s mental health.

I am presently living alone to eliminate in-home abuse. However, that increases my medical risk and also eats up all the money needed for medication and medical care. It’s a lose-lose situation as of this moment.

... A is a transgender 35 year old who is a service provider who has borne witness to incidents of violence and abuse for elders: "I'm scared to death about my own future. There is Alzheimer's in my family, and I know there's a good chance it's going to claim me as well. What will happen to me once I can no longer advocate for myself? Will they call me 'she'? Will they make fun of my body right in front of me, knowing I won't really understand? Without a significant other, and without children I fear I'll be left in a nursing home somewhere where no one actually cares about me as a human being. At 35, I've already written a living will. In Ontario it's called a Power of Attorney for Personal Care. And honestly? I have more or less decided that I just won't let myself get to that point where I can't take care of myself. I'd rather take matters into my own hands and self-euthanize (that's a nice way to say it, don't you think?) while I am mentally cognizant and physically capable of it. Should the time come when I need to take my own life in order to avoid these horrific experiences, I will."

ELDER ABUSE STORIES

The middle section of the survey instrument included space to write three stories of elder abuse. Respondents were also asked a short series of questions about each story. For the most part, these questions were demographic, although one assessed the extent to which the reporter thought anti-transgender prejudice played a part in the incident. The motive question-answer categories were: none (the abuser didn't know and/or care that the victim was transgender); unknown; possibly played a role; anti-transgender prejudice motivated the incident; and other.

Forty stories of elder abuse were reported. Most of the respondents told of their own experiences. Since respondents were mostly in their fifties, almost all of the stories ended up not being about elder abuse, due simply to the fact that the victim was too young to be covered by elder abuse laws. Indeed, only one of the 40 stories might have been classified as elder abuse, although even it might have been ruled out in some states due to the nature of the relationship between victim and perpetrator:

An elder transgender woman of limited finances agreed to let a young, questioning transgender person stay at her small apartment while the person struggled to get their life together. But quite quickly it became clear that the younger person was taking advantage and financially exploiting this elder transgender woman for her generosity. Eventually, after being there three months without contributing to rent, food, phone, or cable, she stole the woman's bank card, credit cards, and some of her ID, leaving this woman in a horrible state.

Another case involved an elderly nursing home resident, although it is not clear if state officials would judge her treatment abusive:

A cross-dresser had to enter into a nursing home and was basically told, “You can’t do that here.” She said she felt she’d been threatened—“Don’t do it, or you’ll be kicked out.”

Interestingly, even if the victims had met the age/ability prerequisites of their state’s elder abuse law, only 5 of the 40 stories would likely have been classified as abuse. In addition to the financial abuse case discussed above, two respondents were physically abused by a spouse, one was physically abused and financially exploited by an adult son, and one was repetitively emotionally abused by a spouse.

The remaining 35 stories could be divided into the following categories: street violence or harassment by strangers; acquaintance abuse or exploitation; family or close friend abandonment; services discrimination; family abuse and exploitation that would probably not rise to the level necessary to be deemed abuse under existing laws; problems with bathrooms and other sex-segregated facilities; and other.

The largest category was street violence or stranger harassment, with nine stories. Here are two typical ones:

There is a group of teens in my neighborhood that will call out HESHE HESHE as I walk by. A younger child walked over to my daughter and me, and one of them came running up saying, “Stay away from her, she’ll rape you.”

I live in a very conservative area—rural Wyoming—where I was raised. I am constantly subjected to covert, and sometimes, overt ridicule, and live with the constant awareness of the potential for violence.

The next largest category of stories was acquaintance abuse or exploitation:

I am currently working with a transgender victim who was assaulted and threatened at the church she has belonged to for more than 35 years. She was told, “I will beat you like the man you are,” and as the perpetrator was saying this, he was hitting her and telling her to leave the church.

A transgender person was living in a trailer with her wife. The neighbors saw the [gender] transition and started to call and harass the couple, saying they would “kick your freak ass” if they didn’t move out.

There were four health care discrimination stories and two examples of housing discrimination. A typical health care discrimination story is this one:

One Navy doctor refused me care when a suture site related to my sex reassignment surgery became infected.

Although abandonment in the elder abuse field typically refers to leaving a care-dependent person without a caregiver, it seems an appropriate label for the third largest group of stories, which documented the loss of key family members or friends:

I am [a male-to-female post-operative transsexual] and aged 52. I have a 14-year-old daughter who just said to me one day, "My father died." I have had no contact in years.

My son and daughter-in-law will not let me see my grandson. They think I will do something to him. I don't even know him now. It breaks my heart not to see him.

My closest friend of over 30 years finally said, "I just can't handle this." No contact in years.

My ex-wife was very supportive in the beginning but when physical changes started taking place there was anger. She moved away when I went for surgery. Never seen her or my daughter again.

An example of a family abuse story is this one:

My wife cannot accept the fact that I'm transgender. I got attacked for lying about who I was, told I'm a sinner, asked what others would think, got the silent treatment. This went on for months. Right now if I don't present myself as female at home things are better between us.

A uniquely transgender category of stories were problems with bathrooms or sex-segregated services:

A very conservatively dressed transwoman 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.

The remaining four stories included two about police harassment or rudeness and a case in which prior employers are giving unwarranted poor job references.

MOTIVE ATTRIBUTION

Unfortunately, the survey instrument asked only one question about possible motives for the elder abuse: whether the reporter thought the abuse was motivated by anti-transgender bias. Thus, respondents were not asked to evaluate whether and how age played a role in the victimization. Nevertheless, it is interesting to note that issues of age did not enter into any of the stories. Even the story of the exploited trans elder said nothing about her age beyond answering a direct question about how old the victim was (in this case, mid-sixties). The reporter added a comment to his note about motive:

It [anti-transgender bias] definitely played a role. Just because the transgressor was transgender themselves, they still knew that this transwoman would be reluctant to call police and open herself up to that trauma.

Reporters did categorize the vast majority (77%) of their stories as being motivated by anti-transgender prejudice. There were nine exceptions. A transwoman who was abused by her female-to-male husband and then exploited by another transgender friend left the motive questions blank, and three reports of street violence or harassment were marked motive unknown or possibly transgender related. Three stories of housing and health care discrimination were marked unknown or “possibly” motivated by anti-transgender bias. The transperson whose wife called her a sinner was unsure if anti-transgender bias motivated the name-calling.

Sexuality of Transgender Elders

DEMOGRAPHICS

In 2007–2008, 829 transgender people and/or their intimate partners responded to a 41-question FORGE survey about transgender sexuality. Of the respondents, 272 (33%) indicated they were 50 years of age or older. Seventy-two percent were in their fifties; 24% were in their sixties; and 4% were 70 or older (the oldest was 79).

Unfortunately, only a third of the older respondents answered enough of the gender identity questions for us to categorize them as MTF (50%), FTM (32%), cisgender female (11%), or cisgender male (6%).

FORGE surveys sometimes sacrifice analytic simplicity in favor of using multiple terms that respondents may feel more accurately describe them and their lives. That was the case in the question about current partner status, where both committed relationship(s) and long-term relationship(s) were categories, and respondents could mark multiple categories. We collected

378 check marks from our 272 older respondents, who said they had the following partnership statuses:

1. [in] committed relationship(s), 20%;
2. [in] long-term relationship(s), 16%;
3. legally married, 14%;
4. single and looking to date, 13%;
5. single and happy about not being partnered, 9%;
6. celibate, 9%;
7. other, 7%;
8. dating, 5%; and
9. casual or anonymous interactions, 5%.

As with the sexual violence and elder abuse survey results, our older sexuality respondents had more varied incomes than some previous, city-based surveys of transgender people have shown. Eighty people answered the income question. Six percent of respondents had incomes under \$10,000; 25% had incomes between \$10,000 and \$25,000; 14% made between \$26,000 and \$40,000; 12% brought in between \$41,000 and \$55,000; 19% had incomes between \$56,000 and \$70,000; and 24% had incomes in excess of \$70,000.

Race was predominately white/European/Welsh/Irish-American, with 76% of those answering the race question giving one of those answers. Of the remainder, multiracial was the largest category ($n = 5$), followed by Native American ($n = 4$), Jewish ($n = 3$), and black ($n = 2$). Other responses included Gay, Human, N/A, Pagan, Rather not say, and Sure. Just over a third (36%) said they had a physical or mental health disability or challenge.

SEXUAL ORIENTATION

Several survey questions explored sexual orientation issues. The simplest one asked people to check off a category for themselves. There were 116 answers to this question.⁷ The largest category was bisexual, with 23% of those responding. Other responses, in order of popularity, were heterosexual (17%); lesbian (15%); queer (12%); pansexual/omnisexual and celibate/asexual (9% each); gay male (8%); and questioning (7%). As with the sexual violence survey, the older respondents' sexual orientation labels varied considerably from those of younger respondents: 45% of all respondents said they identified as queer (versus 12% of the older respondents). The celibate/asexual category also differed significantly: only 4.6% of all respondents marked this, nearly half the rate of the older respondents.

A later section asked whether the respondent's and/or their partner's sexual orientation had changed over time. More than half (54%) of the responses indicated their or their sexual partner's sexual orientation had

changed, 41% said it had not changed, and 6% said they didn't know. The primary reasons why respondents believed their or their partner's orientation had changed were "becoming more comfortable in body" ($n = 32$); "finally discovered my/hir true orientation" ($n = 30$); because of hormones ($n = 26$); due to "curiosity about other gender's body/sexuality" ($n = 20$); "erotic attractions expanded as I/sie adjusted to partner's gender" ($n = 19$); "changed sexual orientation label to honor/acknowledge partner's gender" ($n = 12$); and "politically wanted/needed to be seen as . . ." ($n = 9$).

One respondent articulated a theory circulating in the FTM community—that some FTMs are so identified as queer or GLBT that they may become attracted to gay men post-transition in order to maintain such an identity:

I honestly feel that a lot of guys go through the same invisibility issue [that I went through as a femme with my first partner who transitioned] as they transition (especially if they were dyke identified) and really need that acceptance. So they become gay. The other reasons can be because many of their partners don't see them the way they want to be seen and they are tired of explaining things. So they become gay. Might seem rude, but it's my observation.

INFLUENCE OF TRANSNESS ON SEXUALITY

A major goal of the survey was to determine if and how people thought their sexuality was related to their (or their partner's) (trans)gender identity. This question is a politically sticky one as much of the general public confuses or conflates gender with sexual orientation, and many transgender educators and advocates are very careful to distinguish the two as independent variables. Interestingly, some of our respondents may be less than perfectly clear on the distinctions, as well. For instance:

Once I admitted to my transexuality, I then was able to come to terms with my extremely strong sexual urges to men.

I am not comfortable as a male but I have all the male parts. I have adjusted to the fact that I am a transsexual male to female who has sex with men and because I feel like a woman I feel it is only natural to have sex with men only.

Most of those who answered the question "To what extent do you think your sexuality has been influenced by being transgender or being the partner of a trans person?" felt that their (or their partner's) gender had had some influence on their sexuality in that 48% said it had "somewhat shaped" their sexuality and 22% said it had "completely" shaped their sexuality. Only 29%

said that their or their partner's transgender identity had had "no effect" on their sexuality.

Trans people's write-in responses addressed sexual orientation as well as other aspects of sexuality:

Once I came out as FTM, suddenly I was attracted to everyone.

Before T[estosterone], I couldn't see myself being with a man sexually in the context of being female. Once I began to see myself as physically masculinized, the context changed.

Transitioning has helped me with the acceptance of my sexuality as well.

Through the changes to my body, I have experienced a change in my sexuality. It's not only the comfort that I now have with my more masculine body, it's also the growth of what I call my penis, which now allows me to enjoy oral sex performed on me.

I've had [sexual reassignment surgery] and my sexuality changed from one based on sensuality to an emotions-based one.

Had I not transitioned I probably would have claimed the label of bisexual, but in transitioning I discovered that there is far more out there than just male and female, man and woman, not to mention coming to the realization that I, myself, am neither man nor woman but simply human.

Coming out as transgender left me very confused on my sexuality. I had a hard time understanding what my gender meant for my sexual partners.

Before I admitted to myself that I was transgender, I was almost convinced I was asexual because the thought of sex was disgusting, even though I found myself attracted to people.

Through transition (from male to female) and the introduction of estrogen into my body chemistry my orientation has changed to more of a bisexual orientation whereas in the past I was strictly attracted to women.

Being on T[estosterone] has raised my sex drive and made me sexually attracted to women again (I haven't been for the past few years). The way I think of women now is more like how I feel about men—very genitally focused and somewhat detached.

I'm MTF. I had an orchiectomy more than a year ago, and I have very little interest in sex and don't miss it, really. I'm 59 years old, and my wife is 67 and being celibate is a relief for her. I am very relieved to not be driven by sex anymore!

I am not physically capable of any sexual activity I would really want to do. I am a eunuch. I have no desire to display that particular deformity to another human being. All attempts to work around it have thus far been miserable humiliating failures.

Prior to transition I didn't really experience sexual attraction at all.

I always desired men though in my early years; I didn't act on it as society said it was wrong. Now I can be myself.

Partners' responses also revealed struggles and newfound joys:

I had no idea how much change there would be for me (non-transgender) and how difficult it would be to find what works for us [sexually] over the long term.

It's hard to be yourself. You're used to being with women, and when your S[ignificant] O[ther] becomes a man, you feel guilty for still liking sex with him when his body is still female. How do you act?

Before my partner transitioned to male, I identified completely as a lesbian. Now that he is a man, my attraction has transitioned as well and I no longer feel connected to the lesbian identity and feel more comfortable identifying as straight.

I went from closed-minded lesbian to queer high femme. Both queer in sexuality and gender. It was a struggle to let go of the need for visibility at first, but it was also very freeing as I no longer limit myself.

I was femme and queer identified before I began to seriously date transmen, but my experience dating FTM(s) has created new particularities of my desire and identification.

SEXUAL ACTIVITIES

A second major goal of the survey was to develop better information about the sexual practices and sexual activity and body parts language used by transgender people and their partners, in order to produce transgender-specific safer sex educational materials. Some of the data cannot be reported here because we have not yet been able to break down the analyses to make better sense of the responses. (For instance, we asked if the transperson's vagina was penetrated during sexual activities. This question will only be marginally useful in regard to FTMs—most of whom have vaginas—since the survey did not ask sufficient questions to determine how many of the MTF

respondents had surgically constructed vaginas.) The responses reported here will therefore only include gender- or body-part-neutral questions.

Most of the respondents did engage in oral sex on the transgender person: 57% engaged in this practice, and 43% did not. A significant minority (37%) engaged in anal penetration of the transgender person, while 63% said they did not. The question about whether the transgender person had their nipples sucked or played with also needs more gender vector analysis to provide more meaning to the results: 62% of respondents did engage in this activity, while 38% did not.

OFF-LIMITS ACTIVITIES AND BODY PARTS

Respondents were asked, "If any of the above activities are off limits, can you say which and comment on why?" Seventy-nine people gave narrative answers. Many were simple dislikes (especially around anal play) or a statement that nothing was off limits, and others addressed global issues such as, "We have [had] no sexual relationship for the last three years." Some answers reflected a particular transgender "take" on the issue, and/or biological factors:

Vaginal penetration is painful and something a man does not want done to him.

Under absolutely no circumstances would I ever consider any form of vaginal contact, let alone penetration. More power to those who like it, but I can't stand the idea.

It is off limits to play with transperson's boobs because he does not enjoy admitting that he has them.

In general the nipple play and the penetration of vagina are off limits because it is feminizing.

For me all are off limits (I am the transpartner). I feel that I will not be completely comfortable with any sexual activity until I have been on T[estosterone] for awhile and had at least chest surgery.

As an FTM, I do not allow or want my partner to penetrate me vaginally. While it is something that I have enjoyed in the past, since starting T[estosterone], I find it uncomfortable and painful.

Past trauma played a role for some:

There are activities that are off limits with others for me because of past sexual abuse. It is rare I want to be or enjoy being penetrated with something other than fingers/a hand.

My MTF partner was sexually abused as a child and is uncomfortable with anal penetration or play.

Finger fucking front hole [is] too likely to set off double whammy [of] gender dysphoria and PTSD.

Religious beliefs governed some respondents' sexuality:

I am a born again Christian. God gives me the power not to do anything that causes me to act as a transgender person. My faith is on Jesus Christ.

All sexual activities are off limits. Prior to transitioning I believed I was a heterosexual male. Now I am a lesbian, and I am having conflicts with my walk with Christ and homosexuality.

Respondents were asked, "Are there parts of your/your partner's trans-body⁸ that are off limits or no-touch zones?" Seventy-six people said there were no off-limits body parts. For those that did have off-limit parts, the largest categories were anus/asshole (36 respondents), vagina/front hole (24 respondents), chest/breasts (12 respondents), clit/cock (9 respondents), and nipples (6 respondents).⁹

LANGUAGE

Some couples with at least one transgender member re-christen body parts with names that better match the transgender partner's internal gender. Thus, an FTM's breasts may become his chest or pecs, or a MTF's genitals may be referred to as her pubic area. FTMs and their partners seemed a bit more creative than our MTF respondents; nearly all of the more creative terms refer to FTMs' body parts, including the following: bonus hole, T-hole, manhole, man pussy, and boycunt (for vagina or vulva); dicklet or trannycock (for enlarged clitoris); and man boobs or chesticles (for breasts).

CLOTHING DURING SEX

One way some preoperative or non-operative transgender people cope with body dysphoria during sexual activity is to wear some clothing and/or (for FTMs) to wear a dildo or prosthesis. Of the 163 responses to a question on these topics, 59% said that typically they are naked when they engage

in sexual activity. Of those who do wear clothing, most wear either a shirt ($n = 23$), a dildo/prosthesis ($n = 22$), or underwear/pants ($n = 18$). Three people reported wearing a chest binder during sex.

NEGOTIATION

In line with FORGE's interest in developing trans-specific safer-sex educational materials, we asked several questions about sexual negotiation and safer sex. Our first question was vague: "What role/s does negotiation play in your relationship(s)?" Excluding the 25 people who answered "not applicable," there were 119 responses.¹⁰ Nineteen percent said they negotiated around safer sex. Nearly as many (18% each) said they initiated negotiation, and "I have no clue what you are referring to." Fourteen percent each "do whatever my partner wants," and "negotiate for BDSM (Bondage, Discipline, Sado-Masochism) play." Nine percent let their partner initiate negotiation, and 6% didn't negotiate.

A number of respondents addressed safer sex in their comments, usually discussing how they and their partner had been tested and were monogamous and/or got re-tested regularly. Some, however, had different stories to tell:

Mostly I do what my partner wants (he is the man, I am the woman).

I only negotiate for BDSM play in the beginning to find someone who will allow me to serve and submit myself to them. I negotiate safer sex opposite maybe what I should but actually I want a man to cum in me and not use condoms as I feel a great need and desire for the seed of a man, I guess much like a woman desiring to get pregnant. Once I have a partner, I do whatever pleases him.

I am a sex slave to my male partners, doing whatever they want to please them.

When we asked the somewhat more specific question, "What role does safer sex play in your life?" we got 100 responses. A plurality (33%) practice safer sex in all sexual interactions. Twenty-five percent said the question wasn't applicable because they were celibate or not currently in a relationship. Nineteen percent said they were "fluid bonded" with one or more of their partners.¹¹ Thirteen percent said they practiced safer sex with some partners and not with others, while 10% admitted they didn't practice safer sex at all. Some of the comments, however, seemed to indicate respondents had a different definition of safer sex than experts may have:

We do practice safe sex and sometimes not. I have had only two male sexual partners.

My current partner is my only partner and never more than one man at a time.

I'm sterile and my spouse also is.

i only practice safe sex if my partner tells me to and most want bareback sex so i do as i am told. i love to receive a man's fluid (cum) into me on every occasion accepting his acknowledgement that he is disease free.

LIBIDO

Respondents were asked whether being transgender affected their (or their partner's) libido. Of the 186 answers we received, 57% said it had increased their libido, 22% said it had decreased their libido, and 20% said it had had no effect.¹² Specific reasons why respondents thought they or their transgender partner's libido increased included the following: use of hormones ($n = 36$); increased comfort with their body ($n = 22$); and having less shame about their body ($n = 14$). Reasons why respondents thought they or their transgender partner's libido had decreased included use of hormones ($n = 14$); unwillingness to expose their body to another ($n = 6$); and disappointment or shame about their body ($n = 5$).

Of those saying hormone use increased their libido, half indicated they were FTM and two said they were MTF. There were 4 partners (vector of transgender partners unknown) and 12 respondents whose gender vector could not be determined from their survey responses. Of those saying hormone use decreased their libido, 71% were MTFs. One was FTM, and three were partners or of unknown gender vector.

Some of the comments to the libido question included the following:

We both feel more sexy now that we have transitioned. When I started hormones I just plain couldn't get enough. My partner's libido always goes up shortly after he has his testosterone shot.

We are both in menopause. All these answers are historical <weak smile>.

My sex drive is decreased since transitioning to female, probably due to different emphasis in sexual behaviors on my part as female and maybe due to anti-depressants and estrogen.

Her libido decreased once she began taking estrogen and after [sexual reassignment surgery]. Now that I'm on testosterone, my libido is high most of the time.

My cisgender partner's libido has diminished due in part to menopause but prior to that, it was because she had shut it down prior to my getting surgery because I had denied her sex back when I had a lot of shame and lack of comfort in my own body. Now that I'm in a very good place about my sexuality and physical state, she is having a hard time thinking of herself as a sexual being again. I feel very badly about this and take much of the responsibility for where we currently find ourselves.

I don't feel the need for sex as often as before due to hormonal and mental changes. Sex is far more intense and gratifying than before. I experience multiple full body orgasms but it is harder to reach a climax.

I attribute decrease to lack of testosterone and related hormones due to orchiectomy. I'm taking estrogen and I haven't much in the way of a libido. My wife hasn't had much of a libido for several years.

DATING AND DISCLOSURE

A perennial question on many transgender listservs is, "When do I tell a prospective romantic partner that I'm transgender?" We got 124 responses to this question.¹³ Thirty-seven said it was "not applicable" and 21 gave narrative responses. Of the remaining 66 responses, the smallest percentages were at the extremes: 4% never told their partners they were transgender, and 3% told only when they were in bed. Most (41%) said they discussed it "only at the point when we might become sexually involved." Twenty percent told on the first date, and 32% wouldn't set up a date until they had come out to the person. Some of the narrative responses included the following:

When he asks, "What's THAT?"

If I don't think the relationship is leading toward marriage, I might not disclose.

I let the guy get to know my personality, then if there is anything there in the relationship I let him know my condition.

I have casual sex with men at an adult bookstore once in a while and don't reveal I'm transgender and for the most part hide that I have a female body.

After the third date I inform my date of my gender identity history.

Accidentally by mentioning reading Conservative Transsexuals messages!

Excluding not applicable answers, 79 people answered the question “Has discussing gender identity and/or transgender status/history with a partner altered the course of the relationship?” Forty percent said it didn’t change anything. Thirty-three percent said yes, “the other person was ‘offended’ or no longer interested in the relationship,” and 27% said it “increased the attraction/passion/interest.” Some of the narrative responses included the following:

Some are offended and some are accepting. I have found that most women are initially accepting until later into the relationship they discover you were serious, and they can not convert you.

So far it has not made a single bit of difference. A few years ago I was dating a singles pastor at a conservative church. When I told him, I thought the relationship would end. He asked a lot of questions but in the end it had no effect on our relationship.

Men don’t like transgender, women don’t like transgender; therefore [I] can’t be sexually active.

I’ve had several relationships and been in several periods of dating since [sexual reassignment surgery]. There have been no issues about my history if the person has gotten to know me . . . the two times it appears to have altered the course was for women that thought being assigned female at birth determined one’s current status.

I am a transgender magnet! I have had multiple experiences where I purposely dated a butch female who then came out as transgender during the course of our relationship. It was wonderful each time, but hilarious that I could not date a woman if I tried. I swear that I did not pressure anyone to transition!

Coming out has resulted in being dumped, 100% of the time.

[I] avoid relationships because I don’t want to have to get into a situation where I have to reveal my medical history and feel compromised.

BDSM.¹⁴

One hundred and five people responded to the question “What is your relationship to/involvement with BDSM?” Forty-five percent said it was “not my style,” and 20% were open to exploration. Twenty-two percent said they “like a bit of BDSM in my sex life,” while 7% said BDSM was a “significant”

part of their sexuality. Five people said they “live 24/7 in a BDSM life/relationship.” We had 118 responses to the question “If BDSM is or has been part of your life, how has it influenced you and/or your relationship to gender?”¹⁵ Fifty people said the question wasn’t applicable to them, and 20 said BDSM has had no effect on them one way or the other. Up to 11 said BDSM had influenced their relationship to gender.¹⁶ Those who said BDSM had influenced their relationship to gender could mark any or all of several options, all of which began, “Yes, it has influenced my relationship to gender. Through BDSM I’ve ...

... found that the BDSM community welcomes gender expression.”	<i>n</i> = 11
... become more sex positive.”	<i>n</i> = 7
... explored gender through Daddy/boy or other roles.”	<i>n</i> = 5
... learned to accept my body.”	<i>n</i> = 5
... found that BDSM enforced gender roles.”	<i>n</i> = 5
... been challenged by ‘only’ and/or gendered play spaces.”	<i>n</i> = 5

One comment particularly stuck out:

Through BDSM i have learned to appreciate my extremely passive and nurturing personality, my desire to please and how good i feel when i satisfy a man sexually to the max. It is why i feel like i am a feminine woman in need of a man to care for, to take care of, and to please ... just like the girl that married dear old dad.

TOYS AND TOOLS

Many respondents use sex toys or tools; only 28 said they didn’t use any. The toys or tools that were most used were dildos (*n* = 61); strap-ons (*n* = 44); BDSM toys of any type (*n* = 33); buttplugs (*n* = 32); and a binder or clothes to cover chest (*n* = 10). No one said they used a sponge or other device to conceal/trap vaginal fluid, but nine wrote in that they used vibrators. Other common write-in responses included nipple clamps or suction. For those who use toys or tools, we asked if “getting it ready/in place is a shared erotic experience between me and my partner(s)” or “getting it ready/in place is done alone and in private.” Sixty-seven people answered this question, with 72% saying it was a shared experience and 28% saying it was done separately and in private.

VIOLENCE

Unfortunately, the survey’s violence question was mistakenly written too broadly to be of use in determining sexual violence rates: “Have you

experienced sexual violence or interpersonal violence in your life (such as childhood sexual abuse, rape, domestic violence, or other trauma)?" Nevertheless, the fact that this was billed as a sexuality survey instead of one on violence may bring the responses closer to a transgender violence prevalence rate than our other surveys. Of the 92 people who answered the question, 47% said they had experienced such violence, 47% said they had not, and 6% were unsure. Some of the comments were telling:

We both have . . . most of my partners have.

Until the age of 18 [I] fought nearly every day of my life.

Raped by nurse in mental hospital, age 13.

CONCLUDING REMARKS

FORGE often asks a "What else would you like to tell us?" question at the end of a long survey. At this point, respondents have had ample opportunity to write in various comments as well as to get a good sense of the issues we are interested in. Therefore, we pay special attention to how respondents sum up their thoughts on the issues. Here are approximately a third of those commenting on "How your sexuality interacts with a trans + history/identity."

Well, it has meant I'm a lifelong virgin.

Taking [testosterone] was responsible for a huge expansion of sexuality. I would have to call it a sexual explosion that really took me to the core of my sexual being. Whereas pre-T, I had been able to remain unaware of some of my sexual interests and proclivities, my 2nd puberty brought them into full focus.

Laughing . . . it doesn't. Transgender is an umbrella term that goes, and goes, and goes . . . on for ever, ever, ever, ever, ever, ever, ever. Who I am is not a medical condition. Does your root canal affect your sexuality and identity?

It's a lot harder than I expected to find what works well for both of us. The body dysmorphic transgender thing is really a barrier, as is partner's past history of unsuccessful sex . . . I wish it could just be over and done with, pouf, a new life now, with different roles and not the same old expectations, but that's not to be.

It's been very discouraging to be with two MtoFs who lost their sex drive when they transitioned and thereby ended up becoming not very active sexually.

It is really a challenge to stay sexually aroused by a transman, being a lesbian, but our relationship is so wonderful I am hoping that I will be able to continue to see past physical features to the love we share. It feels isolating. I don't know many lesbian partners who stay long-term after a butch announces he is a man, and who stay lesbian. . . .

I suspect that psychiatric treatment for transsexualism causes asexualism for many, as it may have done for me. I strongly believe that, for transsexual people, psychiatry does far more harm than good and should be eliminated ASAP.

I identify as a person predominately attracted to women, and my partner is a biologically assigned male living as a female. That raised so many questions for me and my orientation, and we have yet to have sexual experiences because I know it worries the both of us. We are afraid that both of us will be disappointed by the anatomy of the other.

I believe being transsexual significantly affected my sexuality . . . or lack of it!

Given that I've dated mostly heterosexual women, I think there is a level of feeling like I won't measure up to biological males. However, this is my own internalized transphobia, and I'm working with it. I've had partners who cannot enjoy my body, and that has contributed to my internalization of transphobia.

DISCUSSION

Prevalence of Violence

Two of the three surveys focused explicitly on transgender people's experiences with violence and abuse, and the third asked one question about it. As other researchers have found, these studies confirm that transgender people have experienced more than their fair share of such trauma, both as children and as adults. Some survivors felt their experiences had negatively impacted their relationships, their sexuality, and even how they generally conducted their lives. A few, however, felt their relationships had grown and strengthened as a result of facing the aftermath together.

It is clear from the data that some people first sought professional help in dealing with their sexual victimization as long as 10 years after the abuse took place that the ramifications of even childhood abuse are very long-lasting. Also, a growing body of evidence shows that traumas from childhood and early and mid-adulthood may re-emerge and produce painful symptoms in later life (Karner, 2008). Thus, it is crucial for those providing services to transgender people and SOFFAs to become familiar with the effects and

treatment of trauma and to provide education and support to those who may be unaware of the links between past trauma and current problems.

The elder abuse survey suggests that a large proportion of the family and friend interactions that transgender people label abuse would not fit any legal definition of the term. Abandonment, for instance, is keenly felt, and more than one person deemed skirmishes over public bathroom access as abuse. This finding deserves more in-depth research and analysis. Having observed a tendency among some transgender people to develop an isolating, angry victim mentality, FORGE social support group meetings are open to all regardless of gender identity. Discussion questions are worded to draw personal reflections from and highlight commonalities between cisgender and transgender attendees. For example, we will ask all participants to address an opening question such as, "Name one part of your body you like and one you don't." This approach suggests that body dysphoria is a ubiquitous human experience rather than a transgender experience that only other transgender people would understand.

Is the seeming inability to distinguish painful discriminatory acts (such as bathroom use challenges) from actual abuse part of a victim mentality or does it reflect a more benign but unmet need for more opportunities to metabolize these small-t traumas of transphobic or even run-of-the-mill, rudeness-based interactions? Is there a relationship between transgender people's strong response to such incidents and the transgender community's documented high rates of depression and violence? We need more research before we can begin to draw conclusions and suggest interventions.

Gender-Based Systems and Theories

An important finding of the sexual violence survey is that roughly the same number of survivors were perceived as male and female at the time of the assaults. These figures are massively different from mainstream statistics showing only 10% of rape victims are male (Anonymous, 2008). More research needs to be done to determine if perpetrators were detecting subtle femininity cues in the male victims, or if MTFs are more prone to admitting having been sexually abused than are cisgender men. We also found a higher percentage of female sexual violence perpetrators than many rape organizations admit.¹⁷

Both the prevalence of male and transgender sexual violence victims and the prevalence of female perpetrators pose real problems within our current (U.S.) sexual assault response system, which is set up largely for female victims with male perpetrators. Our sexual violence survey showed that many people chose not to report their assault(s) or seek services because they were perceived as male and/or had a female perpetrator. In addition, both in Milwaukee and elsewhere, many services are open only to women or, as

our New Zealand respondent documented, provide only gender-segregated services that may not be appropriate or comfortable for a transgender survivor. These service inequalities and assumptions must be addressed before we can truly say our victim services systems serve all victims.

Transphobia As a Motive for Violence

Seventy-seven percent of those who told of midlife and elder abuse and prejudice and 55% of the transgender sexual violence survivors believed that transphobia was at least part of their perpetrators' motive. Accurate or not, this perception makes survivors more vulnerable to emotional and psychological complications. The fact that a victim "... was selected because of race, skin color, ethnicity/national origin, sexual orientation, gender, religion or disability (the federal definition of a hate crime), can create greater-than-usual trauma: It is widely hypothesized that hate crimes or hate-motivated violence can inflict psychological damage far greater than other types of violence as a result of assaulting the victim's identity as well as his or her person or property" (Gay and Lesbian Medical Association, 2010, p. 390). The Gay and Lesbian Medical Association (2010) says, "... the psychological toll of violence based on sexual orientation [and gender identity] is significant. In fact, recovery from bias-based violence takes much longer than recovery from random violence. Trauma associated with hate crime victimization probably lasts longer than one year, perhaps as long as five years" (p. 390). Although it did not include transgender victims, a California study of lesbian, gay, and bisexual survivors of physical violence based on sexual orientation may be relevant (Gay and Lesbian Medical Association, 2010). This study found that survivors

... appeared to have higher levels of psychological distress. Bias crime assault survivors were more anxious and angry than others and experienced more symptoms of depression and post-traumatic stress disorder. They also displayed less willingness to believe in the general benevolence of people and rated their own risk for future victimization somewhat higher than did others. (p. 390)

The link violence and abuse survivors may make between their gender identity and their perpetrator's motives may complicate both exploration of their own gender (if they are in that stage) and their healing from the trauma. Indeed, the overall sexual violence study results make it very clear that many survivors did not tell their gender therapists (from whom they wanted a letter allowing them to obtain hormones and/or surgery) about their sexual violence history, and did not always tell their abuse service providers or therapists about their transgender status. This may make effective therapy

difficult, perhaps particularly if the client links his or her gender identity to prior victimization and/or carries a lot of shame about either or both gender identity and prior victimization. Thus, it is critical that all therapists and trauma or violence services professionals become transgender-savvy, and that therapists who work with transgender clients become trauma-informed.

Income and Segmentation of the Community

Previous studies that have looked at the income of transgender people have found relatively low income levels, to the point where a statement like this is not unusual: “. . . low-income and homeless transgendered people, who together make up a majority of the transgendered population . . .” (Golann, 2008). A San Diego study found that 57% of transgender people made under \$20,000 a year and only 14% earned \$50,000 or more (Zians, 2006). A San Francisco study of African-American, Latina, and Asian/Pacific Islander transgender people found that only 26% earned more than \$24,000 a year (Keatley, n.d.). These figures contrast starkly to the findings of the three surveys reported here. In all three surveys we conducted, the majority of respondents made at least \$35,000 to \$41,000 annually.

These findings illustrate a critical but all-too-often-ignored point about research on the transgender community: there is no such thing. Many of the existing surveys have been conducted on transgender people who are sex industry workers, came to a sexually transmitted infections clinic, or were reached through peer networks. The obvious biases introduced by these methods of recruitment are not always included when the findings are cited by other sources, such as in the Keatley PowerPoint report just mentioned. In addition, some studies imply they are or are cited as research on the transgender population when, in reality, only those of one gender vector (usually MTF) were studied.

FORGE surveys, on the other hand, are generally answered by people who are Internet-savvy and involved in some sort of transgender advocacy or peer support network. The fact that we attract a higher percentage of older people may by itself make a significant difference. Judging from the participants of ElderTG, a peer support listserv sponsored by FORGE's Transgender Aging Network, many of the midlife and older transgender people who are active in Internet-based transgender networks transitioned later in life, often after successful careers in the gender they were assigned at birth. Their income may be very different from younger transgender people who had little opportunity to develop a career before facing transphobic job discrimination. It is, therefore, critical to those who are studying transgender issues and designing services or interventions for transgender people to examine critically the limitations of the research they are using, and to investigate how closely their own clients mirror the characteristics of those in the study or studies at hand.

Sexual Orientation

All three surveys confirmed that transgender persons' sexual orientations vary widely. Of particular importance to those who are designing programs or educational materials for transgender individuals is our finding that midlife and older transgender people are extremely unlikely to claim the queer identity, although younger transgender people often claimed that as their most preferred term.

The Importance of SOFFAs

FORGE tries to design all of its surveys so they can be answered not only by transgender people but also by the SOFFAs (Significant Others, Friends, Family, and Allies) of transgender people. As stated in the Method section earlier, we believe SOFFAs are often as affected by transphobia and a gender transition as are transgender people and that attending to SOFFA needs and issues will ultimately benefit the transgender people with whom they are involved. We have also realized from many years of handling information and technical assistance requests that oftentimes a transgender person will not reach out on his or her own behalf, and that it's actually the partner or parent who does the research, makes the connections, and tells the stories.

The older respondents in these three surveys supported our theories. Not only was it often a SOFFA who told the painful or wonderful story about their transgender loved one's experience, but they often told of their own journeys and struggles, as well. SOFFAs played starring roles in helping transgender people come to terms with their sexuality and their traumatic pasts and also played the villain in more than a few stories of abuse and rejection. We strongly advocate that service providers and health professionals begin paying more attention to transgender people's SOFFAs, including them in support groups and therapy and helping them articulate and work through their own struggles.

Self-Neglect

An astonishingly high number of midlife and older transgender respondents said they had had one or more bouts of disability so potent that they were unable to take care of their own basic needs like food, cleanliness, and safety. What systems exist to help middle-aged people—transgender or cisgender—who experience this sort of (presumably temporary) psychological or physical disability? This may be a particularly pressing question for those transgender people who have lost the usual family and friend support due to transphobia. Is this an area in which transgender advocacy and services groups should consider providing support services?

Sexuality

The sexuality survey demonstrated clearly that a vast range of diversity exists in transgender people's sexual lives, and that the majority of midlife and older transgender people believed their gender identity influenced their sexuality. Some reported being a virgin or celibate because of their struggles with their gender or their religion or because of others' rejection, but others have found compatible partners and crafted rich sexual lives. Body dysphoria certainly plays a role in many of these older transgender people's sexuality, but it was by no means universal. Our findings on BDSM indicate that this is an area that should be studied more in relationship to transgender people, since a number of people not only participated in the practices (sometimes living a 24/7 BDSM lifestyle), but felt it had had an impact on their gender identity.

Another significant finding is that a number of the cisgendered partners who answered the sexuality survey indicated that they had been partnered with two or more transgender individuals. Although these people are sometimes derogatorily called "tranny-chasers" and charged with being fetishists, their responses on this survey suggest a more complex picture involving a nuanced and respectful attraction to transgender individuals. This is another area where more research is warranted.

Safer-Sex Education

Safer-sex education that is specific to transgender people is obviously indicated; a significant proportion of these midlife and older transgender individuals seem unclear on some of the basics about how to protect themselves from sexually transmitted infections, including HIV, and many are not universally practicing risk reduction. Given that HIV is rampant among MTF populations—other studies have found MTF HIV+ rates ranging from 10% to 68% (Dean, Meyer, Robinson, et al., 2000; Kanegy, 2005; Kaufman, 2008; Xavier et. al., 2004; Xavier Honnold, & Bradford, 2007; Zians, 2006)—educating this population is critical. It has also been speculated that MTF constructed vaginas may be unusually susceptible to HIV transmission, a fact that is not well-known in the MTF community (Clements-Nolle, Marx, Guzman, & Katz, 2001; Kenagy & Hsieh, 2005). The Transgender Aging Network is particularly concerned about MTFs who transition in midlife. Frequently these MTFs have been in heterosexual marriages for several decades and may not have paid attention to safer-sex messages because they felt the messages pertained only to gay men and/or younger people who were actively dating. These midlife and older women may not have good sexual negotiation skills, and they may be unusually willing to engage in unsafe sex with men because they are prioritizing having their femininity confirmed through heterosexual intercourse.

Hormones and Libido

Hormones clearly influence libido: the vast majority of transgender people who experienced an increase in their libido were those on testosterone, and the vast majority of those who experienced a decrease were on estrogen. These data point to an area of inquiry that is vastly underutilized: people who transition from one gender to another as adults are a rich opportunity for exploring which gender differences are socialized and which are influenced by biology. For instance, anecdotal reports from the FTM community indicate that the use of testosterone sometimes shuts off much or all of a person's ability or tendency to cry. More study of these differences and dissemination of the results to the heterosexual community might help heterosexual couples better understand and cope with some conflicts, particularly if those conflicts are believed to be rooted in socialization or personality.

NOTES

1. This document was commissioned to complement the U.S. Department of Health and Human Services' *2010 Healthy People* blueprint for improving the nation's health.
2. Note that since the median age of respondents was just 28 for FTMs and 40 for MTFs, this lifetime prevalence rate is probably an underestimate.
3. We were unable to locate lifetime physical assault rates for the general public.
4. Non-transgender.
5. Respondents could mark more than one category.
6. For examples, see: Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health interventions. *American Journal of Public Health, 91*(6); Zians, J. (2006). The San Diego County Transgender Assessment Report. Family Health Centers of San Diego's Transgender Health Project, 31; and Bockting, W. O., Robinson, B. E., Forberg, J., & Scheltema, K. (2005). Evaluation of a sexual health approach to reducing HIV/STD risk in the transgender community. *AIDS Care, 17*(3), 296.
7. Respondents could mark multiple categories, so actual number of respondents may be fewer than 116.
8. At least one respondent objected to this term, which was coined in our attempt to make an understandable question that could be answered either by a trans person or a non-trans partner.
9. Respondents could list multiple body parts as off limits, so it is not possible to calculate percentages for these responses.
10. Respondents could check multiple answers on this question, so actual number of respondents may be lower than 119.
11. Several respondents indicated they did not know what fluid bonded meant. From their descriptions, many of them were in monogamous, fluid-bonded relationships.
12. Respondents could check multiple answers on this question, so actual number of respondents may be fewer than 186.
13. This question permitted multiple responses, so the number of respondents is probably fewer.
14. Bondage & discipline, sadism & masochism.
15. Respondents could check multiple answers on this question, so actual number of respondents may be lower than 118.
16. Respondents could check multiple answers on this question; we have not cross-walked the data to determine how many answered multiple times.
17. The Rape, Abuse & Incest National Network, for instance, gives no statistics on the percentage of perpetrators who are female and uses exclusively masculine pronouns when discussing rapists.

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