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Research

Challenging cisgenderism in the ageing and aged care sector: Meeting the needs of older people of trans and/or non-binary experience

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Recent Australian legislative and policy changes can benefit people of trans and/or non-binary experience *(e.g. men assigned female with stereotypically 'female' bodies, women assigned male with stereotypically 'male' bodies, and people who identify as genderqueer, agender [having no gender], bi-gender [having two genders] or another gender option). These populations often experience* cisgenderism, *which previous research defined as 'the ideology that invalidates people's own understanding of their genders and bodies' [1–6]. Some documented forms of cisgenderism include pathologising (treating people's genders and bodies as disordered) and misgendering (disregarding people's own understanding and classifications of their genders and bodies) [1,2,7]. This system of classifying people's lived experiences of gender and body invalidation is called the* cisgenderism framework *[3,7]. Applying the cisgenderism framework in the ageing and aged care sector can enhance service providers' ability to meet the needs of older people of trans and/or non-binary experience.*

Legislative and policy developments

In recent years, legislative and policy changes have addressed the needs of older 'lesbian, gay, bisexual, transgender, and intersex ("LGBTI")' Australians. In 2012, the Commonwealth Government released National LGBTI Ageing and Aged Care Strategy (the Strategy) [8], the first federal strategy in the world focused on older 'LGBTI' populations. Older 'LGBTI people' were added to the 'special needs groups' whose needs must be considered in planning and allocation for Commonwealth-funded aged care placements under the *Allocation Principles* of the *Aged Care Act 1997* (the ACA) [9]. From 1 August 2013, the federal *Sex Discrimination Act 1984* (the SDA) has included sexual orientation, relationship status, gender identity and intersex status [10].

The 'gender identity' component of the SDA provides protection against gender-based discrimination beyond 'identity' [10], including mannerisms, behaviour, characteristics and history of having lived in another gender previously (e.g. a woman who was raised as a boy should be treated equally as a woman). The legislation also protects people whose clothing and/or behaviours are not stereotypically associated with their self-identified gender category.

The SDA protects people of non-binary experience – people who do not identify as either women or men. Many cultures have traditionally recognised more than two genders (e.g. fa'affafine in Samoa; Bissu, calalai and calabai in Bugis society on Sulawesi, Indonesia; sistergirls and brotherboys in Aboriginal/Indigenous and/or Torres Strait Islander communities; and Yimpininni in the Tiwi Islands). The SDA may provide an opportunity to redress ethnocentric erasure of people with these traditional genders. The SDA also prohibits faith-based discrimination in Commonwealth-funded aged care service provision.

The SDA applies to employment, education, accommodation and access to goods and services (e.g. restaurants, shops, transport, healthcare, etc.). It prohibits both *direct discrimination*, in which a person is treated differently in a similar or identical circumstance (e.g. 'no people of trans experience can fly on this airline'), and *indirect discrimination*, in which a policy or practice that is identical for all people has an unfair or disproportionate effect on a people with a protected characteristic (e.g. 'all passengers will be verified by cross-checking their listed sex against their physical appearance').

Despite these significant legislative reforms, professionals who may not be intentionally hostile or exclusionary may nevertheless engage in harmful actions. Even those with benevolent intentions may have accepted a system of thinking and acting – an *ideology* – that limits their ability to meet the needs of older people of trans and/or non-binary experience.

Understanding cisgenderism

Cisgenderism is defined in previous research as 'the ideology that invalidates people's own understanding of their genders and bodies' [2–4,6,7]. Cisgenderism is etymologically related to *cis-* and *trans-* terminology for contrasting atomic spatial positions in organic chemistry. The cisgenderism framework rejects the notion that all people can be classified into essential types of being such as 'cisgender' (i.e. non-transgender) people and 'transgender' people. This critique of the cisgender/transgender gender binary is integral to the cisgenderism framework. This framework acknowledges that the 'cisgender/transgender' gender binary can be as exclusionary as its 'woman/man' gender binary precursor. The 'cisgender/

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transgender' binary typically erases or miscategorises people with various intersex characteristics (i.e. people of any gender whose chromosomal, gonadal, hormonal and/or genital characteristics are not considered strictly 'female' or 'male' according to modern medical norms; many identify simply as women or men); people who identify as agender or non-gendered; people with non-binary genders such as genderqueer people; and people with culturally specific genders such as Aboriginal/Indigenous and/or Torres Strait Islander sistergirls and brotherboys. The cisgender/transgender binary also excludes people who live part but not all of their lives in the gender typically associated with their assigned sex classification.

Unlike 'transphobia', which emphasises individual hostility and negative attitudes, the cisgenderism framework incorporates both unintentional and well-intentioned practices. Cisgenderism often functions at systemic and structural levels: even when individuals might reject some aspects of cisgenderist ideology, they may live and work within broader structural contexts that perpetuate and manufacture cisgenderism. The following five excerpts illustrate common experiences of cisgenderism shared with me during national consultations I conducted as Manager of Research and Policy at the National LGBTI Health Alliance. Pseudonyms and compositing have been used to preserve respondents' privacy.

Experiences of cisgenderism

1. Pathologising [1,5]: Characterising a person's gender(s) or non-gender as disordered or problematic;

   David was constantly trying to undermine Linda's wishes about her gender and trying to make the GP think Linda just had mental problems instead of accepting her as a woman.

2. Misgendering [1,5]: Characterising a person's gender(s) or non-gender in a way that is inconsistent with their own understanding of their gender:

   David would call Linda by her old male name and say 'he' and 'dad'. Staff found this confusing. They started slipping up as well.

Staff may attempt to rationalise about and justify their misgendering behaviour:

> *I spoke with a group of staff caring for a transgender woman. She had become aggressive with some of the staff. Some of them saw this behaviour as being because 'she is a man,' rather than her response to her frustration & dependency.*

3. Marginalising [2–4]: Excluding or imposing saliency on dimensions of a person's gender(s) or non-gender such as their history, experience, identity, expression and/or characteristics; treating their gender(s) or non-gender as strange or 'fringe'.

> *My partner said, 'excuse me. They are actually not a woman or a man, just Alex.' The aged care worker looked at me like I had two heads. The service had lots of social activities that were only for women or just for men. 'There isn't a category for you,' she said.*

One informant discussed how saliency is imposed on people of trans experience:

> *A difficulty is that many transgender people want to quietly live their lives as the man or woman they are, & don't want to be visible or identified as transgender. How to address this: training, education, public conversations, sensitive media portrayal.*

4. Coercive queering [2,3,5,6]: Imposing an 'LGBTI' or 'queer' label onto women and men of trans experience who live as and identify as heterosexual; assuming that people of trans experience have identical needs and experiences to people in same-gender relationships.

   They had gay-friendly posters on the wall, but nothing that spoke to me and to my experiences as a heterosexual trans woman.

Even people of trans and/or non-binary experience who are also lesbian, gay, bisexual or queer have distinct needs and experiences that are obscured by coercive queering [11]. Numerous respondents shared experiences of having been misgendered in nominally 'LGBTI' environments. Several discussed educational gaps that can result from 'the alphabet soup approach' [5] to awareness training, such as tacking a token 'T' to the end of lesbian, gay, bisexual, and queer sexuality themes like 'coming out' without equitable coverage of concerns central to people of trans and/or non-binary experience such as gender affirmation.

5. Objectifying biological language [2,3,6]: Using language that describes another person in terms of their assumed physical characteristics, where another person would typically be described by their gender.

   I was very embarrassed when one care worker found out and started referring to me as 'a female-to-male' or 'FTM'; I am just a man, I don't consider myself female.

Impact of cisgenderism

Experiences of cisgenderism throughout the lifespan can affect people's views about ageing. In a subset of 276 English-speaking lesbian women of trans experience from an international survey of ageing and end-of-life experiences, participants' top fears were becoming unable to care for themselves, becoming dependent on others, becoming confused or experiencing dementia-associated symptoms, and becoming sick or experiencing disability labels and/or impairment [11]. Participants expressed concern about how to defend themselves from mistreatment by medical profession-

als and aged care staff and whether their personal care, grooming and hormone needs would be met in residential care settings. Several respondents expressed fears that failure by aged care staff to meet their grooming needs would result in social isolation. One respondent described dementia as 'my worst fear' [11]. Another worried about 'being broke, no place to live and all alone and, as a consequence as usual being denied assistance . . .' [11]. Some worried about being abandoned by their children and former colleagues if they expressed their own understanding of their gender after years of hiding. These narratives challenge the assumption that gender affirmation is only for younger people.

Another study described a 94-year-old woman of trans experience named Jamie, who had been living as a woman since she was 80 and had moderate cognitive impairment [12]. She was referred for psychiatric services by staff at her long-term residential care facility after she expressed confusion regarding 'whether she was male or female'. Staff sought guidance regarding which pronouns to use and whether Jamie's clothing and haircut should be 'feminine or masculine'. Whereas Jamie's daughter dismissed her gender as a 'façade', Jamie's GP documented her history as a prominent woman in her local transgender society. The contested nature of Jamie's gender after years of public life as a woman highlights the validity of fears about ageing and cognitive impairment. Researchers have barely begun to address these questions.

Misgendering and denial of hormones are themes regularly reported to the Research & Policy Team at the National LGBTI Health Alliance on ageing-related concerns. The following previously unpublished narratives from our ongoing national consultations illustrate the practical impact of cisgenderism in aged care, as Mila, a residential aged care worker, reported:

> *I wasn't sure what to do, when the GP told us to stop Linda's hormones. There was no medical reason, but her son David was constantly trying to undermine Linda's wishes about her gender and trying to make the GP think Linda just had mental problems instead of accepting her as a woman. Linda's son David would visit and often try to get care staff to dress Linda in men's clothing, even though Linda had lived as a woman for thirty years. David would call Linda by her old male name and say 'he' and 'dad'. Staff found this confusing. They started slipping up as well.*

Respondents have reported concerns about how aged care staff would respond to their personal care needs. Andrew, a 75-year-old man of trans experience, discussed the barriers he encountered:

> *It was embarrassing trying to talk to residential aged care staff about the personal care I needed. I was having trouble with urinary incontinence, but kept hiding it because I was afraid that staff at the home care place where I was living would discover that I hadn't always lived as a man. I needed this kept secret so that I could just be me and not have my past get in the way of people understanding who I am. I was very embarrassed when one care worked found out and started referring to me as 'a female-to-male' or 'FTM'; I am just a man, I don't consider myself female. I needed more privacy than the other residents, but there was no system in place to give me what I needed.*

People of non-binary experience often feel alienated and isolated in aged care environments. Alex, a 68-year-old genderqueer elder, explained:

> *My grandson was bringing me to see an aged care service provider for the first time. During the appointment, I saw the worker check 'female' for gender on the intake screen. My partner said, 'excuse me. They are actually not a woman or a man, just Alex.' The aged care worker looked at me like I had two heads. The service had lots of social activities that were only for women or just for men. 'There isn't a category for you,' she said.*

These narratives depict common experiences in Australian ageing and aged care contexts.

Reducing cisgenderism in aged care services

Some aged care service providers conceptualise 'fairness' as providing identical treatment to everyone. Treating everyone identically often fails to meet the population-specific needs of older people of trans and/or non-binary experience. International research findings match Australian anecdotal evidence that the experiences and needs of older people of trans and/or non-binary experience are unique.

As this paper has explored, meeting the needs of older people of trans and/or non-binary experience often requires us to work differently to address specific privacy, personal care and social support needs. We can create a privacy policy for people who have previously received services in another gender. We can discontinue definitions of 'family' that privilege biological relatives and devalue non-biological kin. We can develop protocols to protect people from biological relatives who disrespect their gender.

We can promote inclusive practice by changing databases to provide non-binary and non-gendered options, to integrate multiple options for people who live in more than one gender and to recognise women and men of trans experience in their self-identified binary gender. We can ensure that people who change their *administrative gender marker* (i.e. the field on a form or identity document that determines someone's gender for administrative purposes, typically based on assigned 'sex' labels such as 'F' or 'M') can retain privacy regarding their previous administrative gender marker while they continue to access care associated with any physical characteristics. We can display visual materials that welcome people of trans and/or non-binary experience instead of relying on gay-focused or generic 'LGBTI' posters. Policy manuals and

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training can include specific scripts for respectful personal care interactions with people of trans and/or non-binary experience. Making these kinds of structural, policy and practice changes to reduce cisgenderism can improve health outcomes and meet service providers' legislative and policy obligations.

Beyond 'aged care'

Beyond aged care, healthy ageing involves multiple dimensions of life such as spirituality, social activities and community engagement. Older people of trans and/or non-binary experience often have personal assets such as experiential wisdom, interpersonal relationships and structural health efficacy (i.e. the ability to overcome structural barriers and navigate health systems strategically to achieve desired aims) to enable them to lead fulfilling, meaningful and contributing lives even when they encounter systemic inequities [13,14,15].

Gender affirmation (the consensual processes through which people express their own understanding of their gender[s] or non-gender) [1,3,5–7] can be a major aspect of healthy ageing. There are at least three main ways that older people might seek to affirm their own understanding of their gender: socially, medically and administratively. Gender affirmation is distinct from 'coming out' about sexuality. Older people might need support to decide where and how to express aspects of their gender(s) or non-gender; assistance with decisions about identity document changes; advocacy to obtain hormones and surgical procedures [6,7]; and/or logistical help to obtain a packer (penile prosthesis), chest binder, or gaff (bulge-concealing underwear used to achieve a typically 'female' crotch appearance). Elders with arthritis or limited manual dexterity might need assistance with vaginal dilation following vaginoplasty (surgery to construct a vagina). Although research with people over 70 who have taken hormone replacement therapy for gender affirmation is currently limited, such elders might need medical assistance to achieve and maintain physiological hormone levels appropriate to their age and overall health. Some might need vocal coaching. Others might need spiritual guidance from representatives of their faith tradition or spiritual community [13] or advice about how to discuss their gender experience and needs with their loved ones [14]. Some might need legal assistance with estate planning to ensure their genders are respected at end of life. Some people might have concerns about gender-based elder and sexual violence [15]. People's needs and experiences will vary widely; there is neither a sole pathway to gender affirmation nor a consistent definition of so-called 'full transition'. We can respect and validate someone's own understanding of their gender as 'real', regardless of their voice, physical appearance, prior medical intervention, or identity documents. Several resources can enable care providers to acquire awareness, knowledge and skills in healthcare communication [16], clinical care provision [17,18], electronic medical recordkeeping [19] and caring for people of non-binary experience [20,21].

Coming of age

Chronological age may not be a useful criterion for evaluating and understanding the cognitions, needs and experiences of people of trans and/or non-binary experience. Maggie, a residential aged care provider, described her experience with Nancy, a 79-year-old woman of trans experience:

> *Nancy dressed very inappropriately when I first met her. The staff used to think it was funny when she walked out in a bikini with half her genitals falling out the bottom of her bikini pants. They thought it was funny to watch her get around like that. When I took over the place I fired the lot of them and helped Nancy to feminise herself. We were teaching her how to be feminine and she blossomed.* [22]

Although similar behaviours are often pathologised as evidence of cognitive decline, this assessment of Maggie's behaviour would overlook Maggie's description of Nancy as having 'blossomed' and Nancy's apparent success in acquiring new skills. These details suggest that Nancy's difficulty with her gender expression was related to coming of age rather than cognitive decline. By taking action to meet Nancy's needs, Maggie demonstrated her understanding that Nancy had not been taught the same skills other women typically learn during adolescence. Some women in Nancy's situation have described their first time coming of age in a gender that feels right as 'a second puberty'. This process can be even more difficult for those without a stereotypical gender appearance [20]. Research has documented additional ageing challenges for people of trans and/or non-binary experience [23].

Conclusion

This article explores how applying the cisgenderism framework in ageing and aged care contexts can meet the practical needs of people of trans and/or non-binary experience. We can treat the needs of people of trans and/or non-binary experience as normal and legitimate, and provide individualised services. We can challenge forms of cisgenderism such as pathologising, misgendering, marginalising, coercive queering and objectifying biological language. We can learn from the wisdom of elders of trans and/or non-binary experience and integrate these insights into all aspects of our work.

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