

Residential and Community Care of Transgender People



Residential and Community Care of Transgender People

By

Samantha Johnson BA/BSc (Honours) Health and Social Care, Cert HSC, Cert Managing Care.

Consultants

Helen Jones (Beaumont Society, Executive Secretary)
Amanda Stevens MA.

Academic Consultant

James Barrett. Bsc Msc MRCPsych (Consultant Psychiatrist, Charing Cross Hospital, London).

Proofreading

The author would also like to thank Jenny at [FXG](#)

Glossary

Cross-dressing: Dressing, dresses: wearing the clothes usually worn by the (birth) opposite sex.

Pre-op transsexual: a person before surgery.

Post-op transsexual: a person who has had surgery (sex-change).

Real Life Experience: period of time living as the opposite sex (new gender role) prior to surgery. Managed by a mental health care professional. Requires new (legal) last or last name and must either undertake full or part-time employment; function as a student ; function in a community-based volunteer activity or undertake some combination of the above activities.

Transvestite (Pseudo): a person who leads a normal male or female life. May get a kick from dressing. Not truly TV.

Transvestite (Fetishistic.): lives as their own birth sex. Dresses periodically or part time. Dresses under own clothes.

Transvestite - True: dresses constantly or often as possible. May live and be accepted as a woman (in the case of a male).

Transsexual- Non –Surgical: dresses as often as possible with insufficient relief of gender discomfort. May live as a man or as a woman. Often identifies as a 'transgenderist'. Asexual or autoerotic, may be bisexual.

True Transsexual - Moderate Intensity: feminine trapped in male body. Lives and works as a woman (in the case of male to female and as a man in the case of female to male) if possible. Insufficient relief from dressing. May have been married and have children.

True Transsexual - High Intensity: feminine. Total 'psycho-sexual inversion. Usually lives and works as a woman. No relief from dressing. Gender discomfort intense. Surgery requested and usually attained. May have been married and have children.

Transgender: any of the above.

(Above based on the Harry Benjamin Sex Orientation Scale)

No part of this document may be published without the writer's permission.

Introduction

In recent years there has been an increased media interest in transgender people. Hardly a day goes by without there being a mention of a transgender person - usually as the buff of humour. The media more often than not focus on salacious stories which feature 'drag artist(e)s' or over caricatured transgender people who tend to be young, fit, funny and outrageous and/or slant their newspaper copy to humiliate them. They sell papers and 'make good television'. Although there have been some sensitive portrayals of transgender people, many still find the idea of a man behaving as a woman or a woman undergoing surgery to emulate the opposite birth sex rather disturbing. Despite the media's often 'circus-like' negative portrayal of transgender people, many transgender people are quite 'normal', and can be passed on the street without being noticed.

If one thinks of a member of ones own family one-day coming to them to explain they are transgender

(or discovering quite by accident that they're living with a transgender person), could be terribly shocking and confusing for them.

If this 'discovery' coincided with the transgender person suffering a stroke for example (e.g. finding a trunk of feminine clothes in the loft) the carer could be presented with many unanswered questions and have little support to call on.

Transgender people exist in a rather 'grey area' of society. What exactly makes someone transgender is open to question, theories exist from having the hypothalamus (hormone and control area of the brain) of the 'wrong' gender, to social reasons. There is increasing evidence that autopsies have shown that part of the brain called the BST (which can only be examined after death) is the size of a female's BST in male to female transsexuals (Gender Clinic, Free University Hospital Amsterdam). This would indicate that being transgender could be an 'intersex' condition. 'One theory is that physical changes in the brain prior to birth cause parts of the brain to develop in a pattern opposite to that of the physical gender. 'It has been found, for example, that significant proportions of male transsexuals have abnormally low levels of HY antigen, (HY antigen mediates the masculinizing effects of the Y chromosome in men' (Stuart, 1999).

What is common is that many transgender people state that the 'gender dysphoria' (gender confusion) begins relatively early in life (around five to six-years-old). Once the individual understands the social hostility to their condition it can remain hidden for decades, even from the closest family members and often a chance occurrence brings it out into the open. This relates closely with the Gay experience of 'coming out' of the closet, and the fear and upset it can cause. However, this association with the Gay community does not recognise transgender people as an independent group that has often very differing needs and problems.

Transgender people for the most part remain 'underground' in their activities, some meeting in private or at social meetings of like-minded individuals. Information on the care needs of transgender people are difficult to come by. The impetus has been on the medical, psychological and surgical approach (biomedical model) to the condition rather than social care. This is one of the reasons that the subject of transgender people in care settings needs to be researched further. Access to the transgender subculture is complicated and confidentiality is of particular concern. Despite the common myth that transgender people are 'camp' extroverts, the reality is that transgender people are often quite 'ordinary' and can hold responsible jobs throughout society. Rather than being nightclub entertainers, they are just as likely to be academics, professionals or business people.

When people react with hostility to the condition, transgender people appear baffled and sometimes wonder what all the fuss is about, 'we are people like everyone else, what on earth do they think we are going to do to them!' They comment. Comedian Eddie Izzard makes an interesting point when he was trying to come to terms with being transvestite and just how confusing it can be:

"I remember when I was 21 this one friend of mine saying - chit chat, chat chat - 'have you ever worn women's clothes?' And I remember my mind going, that's the one question that's right at the heart of the problem, and my voice going, 'Ahh...ggh...ay...hyuh...uhh...no. No! NO!"Oh.'It's going all the way in and alarm bells are going off - AWOOP AWOOP! Dive dive dive. All right, man the decks! Batten down the hatches!. I had to lie down in a dark room to think about being TV and how to get on top the situation." (Eddie Izzard, 1998)

Eminent psychologists such as Jung (1875-1961) have found that change during the life course is 'normal', obviously being transgender could be seen as more extreme, but as the following quote points out radical change should not be seen as peculiar:

'We cannot live the afternoon of life according to the programme of life's morning, for what in the morning was true will at evening be a lie' (Jung, 1972, p.396).

It is difficult for daytime 'chat shows' to educate society as to the needs of transgender people, and academic literature can be dull and difficult to understand. However, the author has tried to make this booklet a reference guide that is user friendly and easy to digest.

Sex Change

[Click here!](#)

The terms gender reassignment surgery (GRS), sex-change, sex reassignment surgery (SRS) are all more or less the same. The term sex reassignment surgery is becoming more popular as it relates more to the surgical procedure than to the gender, which many transgender people believe is set at birth. To the best of our knowledge there have always been Gay people, and there have no-doubt always been transgender people - especially transvestites. There are various references throughout history which refer to people with transgender traits which are beyond the scope of this booklet, suffice it to say, being transgender is nothing new, nor is successful SRS. Dr Magnus Hirschfield (who was one of the early specialists who used categories to determine the many different types of transgender people) quotes a case not much different of that today where, in 1921 he treated a pre-op transsexual (then classed as an 'extreme transvestist') that led to successful sex reassignment surgery in 1930 (quoted in Haire, 1934).

[Click here for the whole article of the 1921 case...](#)

The following questions seem to be the ones most people want to ask, but are often too embarrassed to do so:

'What is involved in gender/sex reassignment surgery for a male to female transsexual?'

'Vaginoplasty', the erectile tissue of the penis is removed and the penile skin is used to fashion a vagina, the testicles are removed and the scrotal skin is used for the labia. The urethra is shortened and a skilled surgeon can create a clitoris from the nerve-endings at the base of the penis.

Does a post-operative (female to male) transsexual man have a penis?

It is far more difficult to create a penis than to remove one, so although it is possible to construct a penis (*phalloplasty*), it is often refused by the patient. Hormone replacement therapy (HRT) such as testosterone enlarges the clitoris. HRT also deepens the voice and causes beard growth, this coupled with a total hysterectomy and breast removal (*bilateral mastectomy*) produces final results that are for

many quite satisfactory and very convincing. However, female to male transgender people are commonly dissatisfied with size and often use padding (in underwear sometimes referred to as a 'soft-packer') for cosmetic effect.

'Can transgender people get married?'

This is a mute point, at this time (2000) the birth certificate continues to show the birth sex - although in other countries it is allowed to be changed for post-operative transsexuals. Transsexuals can get married, e.g. a transsexual man is legally entitled to marry a birth male and a transsexual female can marry a birth female.

***Since this was written the **Gender Recognition Act 2004** now enables transpeople who meet the necessary criteria to now marry in their 'acquired gender'.

See: Gender Recognition Act in our [Library](#) or [click here](#)

Electrolysis

Male to female transsexuals can need to have electrolysis (hair removal) particularly beard removal. Carers may need to be made aware of this and whether the care recipient has already begun an electrolysis programme which may need to take place at another location (e.g. Beauty salon, hospital or clinic). There are now some technicians which offer home electrolysis in the private sector. For transgender people who are unable to attend, afford or obtain electrolysis, carers should pay particular attention to shaving and skin moisturising. Few things can be more distressing than a male to female transgender person who is unable to shave properly or take appropriate skin care.

Labels

'...Individuals become 'mentally ill' not simply on the basis of their behaviour but because they now have a particular label attached to them. If others apply the label it is less likely to stick if it is not supported by a psychiatrist's opinion. Psychiatrists are also able to

decide on the label to be given to describe a particular disease entity'(Bond, Briggs and Coleman, 1993). *Psychiatry's labeling of people who find they cannot 'fit in' with sexual stereotypes as suffering from a 'disorder is a case in point'* (Stewart, 1999).

This is partly the reason why transvestites don't seek mental healthcare, they are often fine and function perfectly well without the psychiatrist intervening. To quote Eddie Izzard again, when he went to see his doctor concerning a cough:

" I went to see the doctor wearing make-up:

' I've got a cough.'

- ' You've got a what?'
- ' I've got a cough.'
- ' You're a transvestite?'
- ' No, I've got a cough. I am a transvestite, but I got a cough.'
- ' Well, I'd better sort the transvestite thing out. Have to refer
you for that.'
- ' No that's not the problem. Just the cough, thanks."(Izzard, 1998)

This is a good example of transgender person who doesn't necessarily wish to involve the medical profession. Many older transgender people have suffered 'aversion therapy' when they were young, and attempted to seek help, ' *It didn't work though!*' They comment.

Numerous transgender people have a preferred label and so generalising is best avoided, the term 'transgender' is almost a universally acceptable term which encompasses all that exist in this 'grey area'.

Terms like:

Gender bender; he-she; ladyboy; she-male; tranny and so on are often used to describe transgender people in the media. These terms are for the most part derogatory. In recent years there has been a trend in 'reclaiming' negative labels. Black people have reclaimed the word 'nigger', Gay people have reclaimed the word 'queer' and transgender people often use negative labels within their community. Nonetheless, all these labels if used outside their peer group can be frowned upon.

'The way we speak about people with disabilities says a great deal about how we value - or devalue - people and how serious we are about working with them as partners in planning and developing services. A lifetime of being labeled has made labels a major issue.' (Whittaker, 1990).

How many transgender people are there?

Statistics are difficult to come by due to the previously mentioned 'underground' culture, with risks of breeches in confidentiality leading to financial or family ruin - even blackmail! So there is obviously a reluctance for transgender people to 'come out' - unfortunately this only adds to problems of acceptance in society. The majority of transgender people are unlikely to ever seek counselling from a mental health care professional.

Transvestites are commonly believed to exist in far greater numbers than is commonly believed. Male to female transvestites could risk social isolation and female to male transvestites who have adopted

male traits, e.g. trousers; short hair; no make-up; 'butch' persona; trainers; sweatshirts and the like are perfectly acceptable in western society as are 'tomboys', but what of 'tomgirls'?! - as a parent which would you find easier to accept? It is particularly difficult to estimate numbers – are they female to male transvestites, or women comfortably dressed? Statistics are bound to be biased toward male to female transvestites. 'Cross-dressing' is still carried out for comic effect from pantomime to drag. It is still relatively unacceptable for a male to wear women's clothes in public and in the workplace. This not only over-stigmatizes male to female transvestites, it seriously under-estimates the numbers of female to male transvestites.

There is thought to be around 65,000 people in the UK who are likely to be transgender and 'out' to some degree. This may not sound a lot, but it must be remembered that this does not take into account what was mentioned previously (in terms of the difficulties in obtaining statistics) or the fact that many transgender people move to larger and more tolerant population centres - London, Manchester, Brighton and so on. This can seriously increase the concentration of transgender people and their need for flexible and understanding residential and community care. The problems in relation to 'geographical mobility' are addressed in the next section.

COMMUNITY CARE

The four statements which follow demonstrate what is fundamental to community care:

" Most caring is undertaken by kin".

(Abrams, Abrams, Humphrey & Snaith, 1989)

" In practice, community care is overwhelmingly care by kin, and especially female kin, not the community "

(Walker, 1982)

" Families friends, neighbours and other local people provide the majority of care [...] this is as it should be. "

(The Griffiths Report, 1988, p.5)

" These networks have long been recognised by governments as irreplaceable and the principle source of support and care in old age." (DHSS, 1981, p.37)

From this we can glean community care is for the most part carried out by the **social circle** that exists around the care receiver.

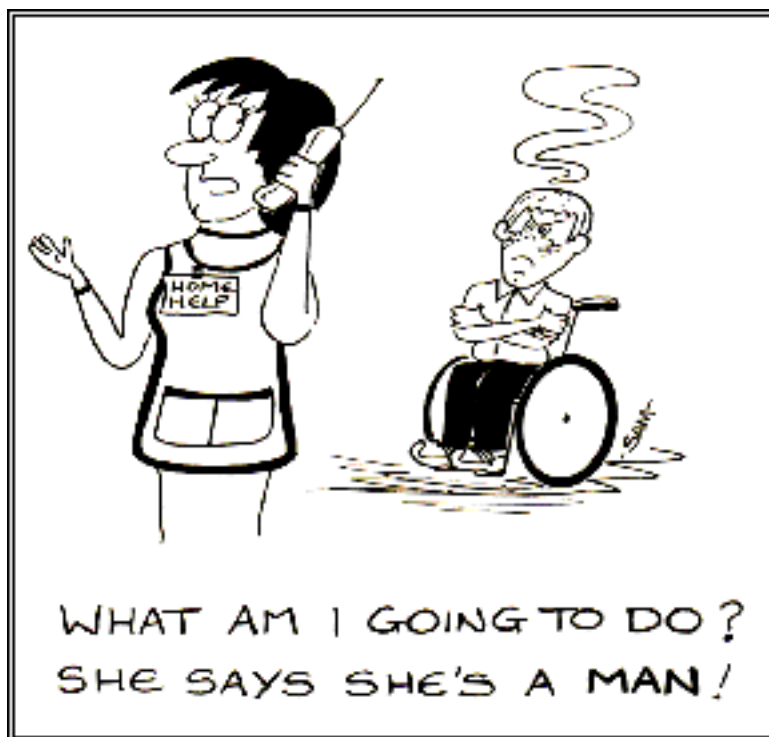
Due to prejudice; stereotyping and discrimination (which are still institutionally based for many issues) transgender people can become easily isolated. These issues could be a cause of Society's stigmatisation of gender dysphoria, and this is a major factor causing the collapse of many families that have a transgendered dimension. Not only are transgender people at risk of relationship and marriage

breakdowns, but they also risk losing their relationships with parents, children and extended families.

Geographical mobility is also a key player in the loss of community ties that may have taken a lifetime to create. Often, after a person changes gender roles they move away from their area in which their roots exist or were formed.

The communities that in many cases would take on the caring are often not only no longer interested in the individual, but also have little association with them. This is the main problem with community care. Unlike most family units, transgender people can have little or no support to call on, and often use statutory; voluntary and private caring services; who in turn may themselves have *prejudiced views about the transgender client.

Care is something that is often taken for granted. Illness and disability can occur without warning through accident or old age, and the opportunity to arrange and inform local caring services about their 'lifestyle' or past as a male or female may not be possible. If the client in need of care; is unable to wash; dress or manage basic care requirements, and informal carers are unavailable; outside care agencies are often brought in to take on the bulk of the caring - residential care will be addressed later.



***The 1999 Disability Rights Commission Act** has brought about the **Disability Rights Commission**, the Commissioners (the majority of which are themselves disabled) have new legally enforceable powers and can investigate issues of discrimination on the grounds of disability (e.g. someone with mobility problems being refused a hotel room or someone with learning difficulties being refused access to a pub), furthermore they offer a conciliation service. The subject of transgender 'rights' are still at this juncture (2000) poor, although some moves have been made to introduce transsexual employment legislation which could be beneficial to paid carers who are transgender in need of specific employment protection.

INFORMAL CARE

" What began as helping out can become a life sentence."

(Pitkeathley, 1989)

When caring takes place, and partners, friends or relatives supply support and the transgender person's care needs. The subject of being transgender (which may of remained hidden from unsuspecting friends and neighbours) could be exposed by caring services. Statutory services do have confidentiality policies and are accountable if they break them, as do those professions who are accountable to a professional body; doctors, nurses etc.. It would be worth finding out in this regard if the potential caring agency employees have or understand the issue of confidentiality, and whether they have signed a contract of employment in which breeches of confidentiality can receive disciplinary action.

'Anyone who works in the NHS or in a local authority social services or social work department will know that they can be rather 'leaky' so far as confidentiality is concerned [...] many people who work their simply do discuss patients or clients with their spouses and friends, even if they do so without identifying them' (Feldbaum and Dick ,1997).

'The civil law gives people who believe their confidentiality has been breached the opportunity to sue for damages - but only if they can demonstrate that 'tangible harm' has come to them a consequence' (Gomm, 1998).

If this were to occur it could cause a conflict between informal carer and care recipient in that, 'being outed' could just be the 'last straw' on top of everything else! Support therefore should be available to the carer, as should respite care by someone

supportive and understanding of transgender issues.

Relationships can quickly become abusive if the carer feels trapped by their situation. If the relationship was in difficulties before the transgender person needed care, this extra unwelcome predicament can only serve to intensify the situation. An atmosphere based on obligation, duty and guilt can lead to the slippery slope that could cause abuse of not only the care receiver, but the carer too.

For these reasons informal carers should have:

Support - From one of the many local self help groups, telephone or Internet, and by informed, understanding and supportive caring services. Or by contacting one of the carers' associations, (e.g. Carers National Association). Many offer citizen advocates who can help with a number of issues.

Information - Contacting one of the national transgender support services e.g. Press for Change, Gires, Beaumont Society, FTM Network, Mermaids, Women of the Beaumont Society (WOBS) and Gender Trust. *Or by contacting support groups related to the disability concerned or care required.

Respite Care - Through the carer's and client's own circle of support, local social services departments, or from organisations associated with the disability or care needs.

Income to cover the cost of caring - by contacting the Citizens' Advice Bureau, DSS, local council and organisations associated with the disability concerned where day care; transport; grants; health-aids and lunch clubs can sometimes help with household expenses.

****Recognition** of their contribution and their own needs as individuals in their own right. This not only applies to any caring services but also to the care receiver, who can often take their carer's hard work for granted! Consulted and Involved during the preparation of the care plan.

- *The author has compiled a Resources Guide. [It is available here!](#)

- ** The implementation of the 1995 Carers' (Recognition and Services) Act entitles the carer to an assessment of needs providing they care for over 20 hours per week on a regular basis.

Young Carers (under 18-years-old)

In the case of a crises which involves young carers **social services** must be consulted, as extra help could be available so the young carer concerned may (as much as possible) continue unaffected (studies etc.). Fears of involving social services due to there being a 'transgender element' to the situation, fears of a young person being taken into care for example, are for the most part ungrounded. If at all possible social services would make every effort to work for the person's best interests and attempt to keep the family together.

RESIDENTIAL CARE

" The role of stereotypes is to make fast, firm and separate what is in reality fluid and changing". (Dyer, 1979)

Residential care applies to anyone of any age in a care home or supervised environment. However, in this instance it has been biased towards older people in need of residential care services. In the first section I spoke of isolation and lack of support which can occur when a transgender person changes gender roles. When a client decides or is advised to seek a residential care home numerous fresh obstacles can result.

If a transgender person has lived most of their life dressed in clothes usually attributed to the (birth) opposite gender, but have not, or did not wish to have complete reassignment surgery (sex-change), the home which is chosen may not wish to risk upsetting the families of the residents (for whom they are equally responsible for) by accepting a transgender person as a resident, *'even one eccentric resident could be deemed too much'* (Garland, 1991). Although Garland in this case was talking in terms of mental frailty it could and no-doubt does apply often to transgender people in refusal to be

accepted by some residential care providers.

Attitudes are constantly changing as more people become informed, but it is better to:

Inform, advise and support...

any residential and community care services, and know where appropriate services can be found. Rather than have to research and while so doing suffer possible discrimination at a time when the client is too frail or unwell to deal with it.

It is for this reason that concerned local people are advised to contact the local Registered Residential Care Association and Social Services Department, to see if their locality has made provision for transgender people.

In recent years practitioners have used 'reminiscence' as a therapeutic tool. The introduction of the Help the Aged tape/ slide programme 'Recall' offered care workers and community staff a new medium - and has since become a popular activity in the care of older people. Not everyone benefits from these methods.

Care workers should discuss with transgender people the subject of the reminiscence/ life review, and if it is likely to be in a group environment. Many transgender people have 'switched off' part of their life through choice (just as refugees; criminals and others have done) and so may find recalling it abusive. Subject matter such as recalling the traditional role of being a wife and mother and the issues of family, are subjects often raised in conversation. This could have taken place for a transgender person, but in a past 'gender role'. The uninitiated approaching this in group discussion could find they face problems. Not only for the group who may find transsexuality (for example) confusing, but also for the 'enabler' concerned. The importance of the transgender resident having access to outside self-help is crucial, and if requested it should be offered.

'..The importance of the presence of a Confident' (Coleman, 1993).

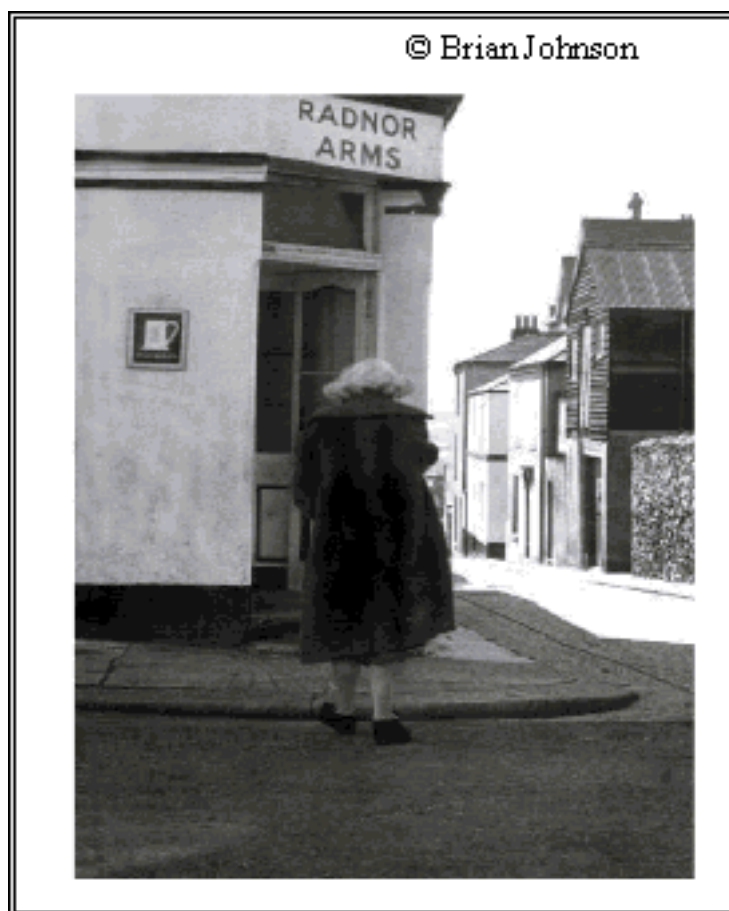
Transgender people are very diverse in their needs, isolation within the care home is likely to exacerbate and precipitate depression. Care workers are unlikely to be able to relate to many of the issues which the transgender person raises, so contacts/helplines should be available at all times. A confident(e) is important for the majority of older people. Research carried out by Murphey discovered *'those elderly people who reported a lack of confiding relationships were most vulnerable to depression when they encountered poor health and adverse life events'* (Murphey, 1982).

It is also clear from research that depression can be linked with bereavement and individuals can recover far more quickly if they have the advantage of close friends.

The loss of a loved-one can lead to a change in the socio-economic status 'a reduced financial state led to reduced social participation resulting in greater loneliness and anxiety (Sidell, 1993). *'The negative impact sometimes attributed to widowhood derives not from widowhood status, but rather from socio-economic status'* (Harvey and Bahr, 1974, p. 106). If the residential care is being paid for or subsidised in part by the transgender person (e.g. sheltered housing), the loss of a partner can lead to

an unwelcome move (due to the loss in financial status) at a difficult time, the residential home who would house the transgender person must be aware of the possible lack of family members and the need for contacts from their social circle, '*clients often report satisfaction and relief at being able to talk to someone about their problems, even if the problem itself is not significantly changed*' (Kalus, 1994). This may be made more practical with the use of the **Internet**. Transgendered groups use the Internet widely, it offers anonymity to those who wish it and would negate any problems of postal material that could upset other residents (e.g. information on medical advancements in the field of transsexuality). If possible access to a PC and an e-mail facility (if 'surfing' is too expensive) would go a long way to supporting and achieving a better quality of life for transgender person who is unable to publicly socialise due to health or financial problems.

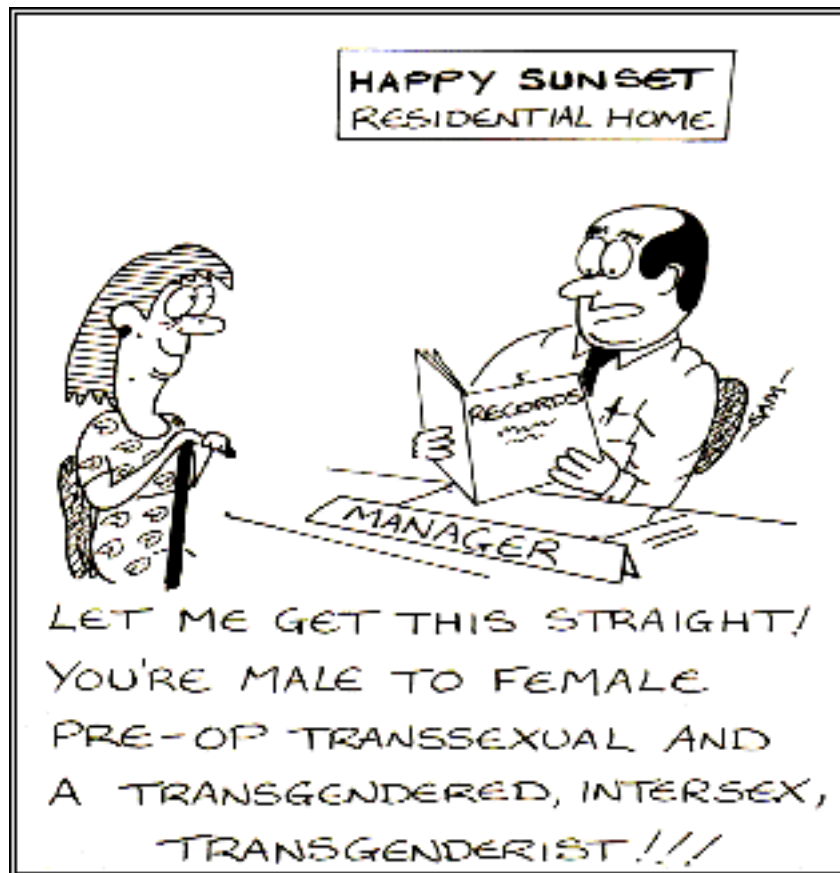
Transgender people often make good use of social activities (e.g. pubs, clubs and organised social weekends) and close friends invariably meet at such venues. These social activities play an important part in the lives of many transgender people, for most it is the only time they can 'be themselves'. For this to be removed suddenly or refused could be a wrench for a transgender person, not only has he/she lost their social life, but also their close 'confident(e)', which as Murphey points out can lead to depression. It is therefore crucial that transgender people have ample opportunity to (if at all possible) continue to meet their transgender and non-transgender friends and participate in transgender social activities.



The importance of an active social life should not be overlooked!

Care workers should pay particular attention to the use of **pronouns**. Referring to a 'pre-op' male to female transsexual as 'Mr' or he, could be very distressing for the client - this would equally apply to addressing a female to male transgender person as 'Mrs' or she. Upon admittance, the transgender

person should be asked **how** they wish to be addressed.



Particular care should be taken not to generalise about the needs of transgender people. The assumption that there is a 'sexual element' to their condition is usually incorrect. Just as a black resident could risk abuse through appearance, so can a transgender person. 'Institutional transgenderism' (legal concerns in relation to birth certificates, etc.) and 'internalised transgenderism', such as offensive interpersonal action (for example, calling someone a sexual pervert or kinky) could be very offensive indeed:

"...Professionals used to dealing with extremes of human behaviour tend to over estimate the levels of problem behaviour and sometimes misinterpret what is perfectly normal."

(Dartington Social Research Unit, 1995)

Those residents who think that having a transgender person equates to having a 'child molester' in their midst should remember that evidence supports that 'child abusers' don't tend to conform to society's stereotypes, rather than being the 'bogeyman' who kidnaps, it is more likely to be a trusted, well respected and known family member or neighbour, and not a transgender person.

Patronising transgender people is also a risk, "I have lots of Gay friends!" Or, "You people..." It should also be remembered that a transgender person who 'presents' themselves as a male or female, should be treated 'normally'(!) as of 'that' gender.

In recent years more attention has been paid to the importance of sexuality in care settings. Often,

transgender people are confused with people who are gay and lesbian. Although it's true that transgender people can be gay or lesbian they can also be 'heterosexual'. In the case of transgender people sexuality and gender must be separated. Just as any woman can be straight or gay so can a transgender woman.

It is easy to paint a bleak and desperate image of transgender people. Transgender people could have fought (in one way or another) all their life for rights, justice and medical care. Rather than being 'passive' in old age they are more likely to be 'activists'. The common practice of changing gender roles later in life due to commitments such as family, business or financial, means there are many prosperous transgender people who have made ample financial provision for care in later life. There are also many childless career-driven professionals which have the 'pink-pound' to spend. For these reasons it would be beneficial for private/commercial care providers to take an interest in transgender care issues. As more people understand transgender issues, more transgender people are likely to 'come out', so problems are liable to arise if they were to present themselves to an unprepared care industry.

Hormone Replacement Therapy

'Many researchers report a high rate of osteoporosis if hormone replacement therapy isn't started soon after removal of premenopausal ovaries' (Aitken et al., 1973; Lindsay et al., 1976).

Most transgender people have hormone replacement therapy (HRT). For post-operative transsexuals HRT is essential. Female to male transsexuals take testosterone and male to female transgender people usually take oestradiol. This maintains hormone levels of that of the chosen gender.

Carers should pay particular attention to this medication as withdrawal could lead to osteoporosis. Removal of the ovaries in female to male transsexuals, greatly increases their chances of osteoporosis. A birth male has a larger bone density (age for age compared with birth females) and birth males can continue production of testicular hormones well into old age, this helps protect the body from osteoporosis. In the case of a transgender male, they have a birth female bone density, and assuming the individual has had surgery (sex-change) early in life, they have had their menopause much sooner than normal. The importance of HRT and its method of delivery (e.g. oral or injection) should be understood by the carer.

In the case of a male to female transsexual, the advantage of the male bone density can fall off at a speed equivalent to that of very old men who due to their declining testosterone can risk injury equivalent to that of women of a similar old age. However, the removal of the testicles in the male to female transsexual could lead to a heightened risk of osteoporosis too, again the importance of correct medication should not be overlooked.

Nevertheless, we should also address the issue of the transgender person possibly suffering from another contributory cause such as: *'diabetes; kidney or liver problems (which can affect the absorption of calcium) and,' medications for other chronic health problems such as: cortisone (arthritis); thyroid (hypothyroidism); phenobarbital (seizures); aluminium-containing antacids for ulcers or heartburn. Exercise and a nutritious diet are a must [...] they allinterfere with the body's ability to adsorb calcium from food and calcium supplements' [...]. Exercise and good diet rich in calcium;*

*phosphorous; magnesium; zinc and manganese coupled with *'Half an hour in the sun with 30 per cent of the body exposed several times a week [...] but be sure to avoid excessive exposure to the sun' (quoted in Shapiro, 1993)*

Anatomy

Care providers should understand anatomical differences post-operative transgender people. There is often incorrect information on the construction of genitalia. Methods of urination in female to male transsexuals can differ from birth males. Carers also need to understand the male to female's (post-operative) transgender person's need to use a [**dilator](#) and associated hygiene routines. Liaison with health care professionals must be sought if the care recipient is unable to advise on the matter. Confusion can occur in the case of male to female transsexuals during X-Ray examinations. Often the prostate is not removed during gender reassignment surgery. This can show as a shadow on an X-Ray. This could cause concern and be confused with a tumour. Carers should inform paramedics of the individual's transgender condition, as in the case of falls and emergencies there might not be time for A&E Departments to obtain medical records. The same would apply on holidays to different parts of the world.

*The skin's exposure to sun creates vitamin D that helps in the absorption of calcium.

** A dilator is usually made of acrylic (Perspex) and used to maintain the vaginal cavity. Care must be taken to avoid chipping the dilator. Keeping them in a mild solution of Milton Fluid can be helpful. They must be inserted slowly and coated with water-soluble lubricant. If pain or resistance is felt it should be withdrawn and tried again. Further information should be available from the surgeon who performed the surgery, but if the surgery was done abroad this may be difficult. Contacting the individual's GP or Press For Change for advice is recommended in the event of the care recipient being unable to advise on the matter. [Or click here....](#)

CONCLUSION

Rome wasn't built in a day and few people understand this more than transgender people. There is certainly increased awareness and understanding of transgender people, but the media can inflict considerable damage to the attempts of transgender campaigners to establish a level playing field in terms of rights, marriage and in the case of this booklet social care.

Understanding what it is to be transgender is the first hurdle in realising that the condition can be seen as very benign to society. By and large transgender people are no different from any other movement. Speaking of the disabled movement Bob Findlay, makes a good point, that most movements share common goals. This can equally be applied to transgender people, but in particular disabled transgender people:

'It has members [disabled movement] from other oppressed sections of society: women, black people, gay men and lesbians. It has a dual identity, and oppressive identity which has been imposed on us by societal perceptions of who we are, what we are, and importantly, what we are capable of, including our social worth' (Findlay, 1990).

Overcoming any prejudice that could exist prior to the meeting with a care recipient is essential if any trust and honest information is to be forthcoming. Discussing any concerns in a non-judgmental fashion is the way forward. If a transgender person is unable to communicate; assessment and discussion with their social circle will gain an insight as to the needs and preferences of the individual. Whereas if assessment is poor, considerable distress could be caused by assuming the care recipient is in a 'confused state'. When only **dressing** them 'properly' for example could rectify the situation.

The importance of a confident(e) should not be overlooked, nor should the question of confidentiality, which is of particular concern to transgender people and their social circle, if they are to be involved. It seems that in society at large, sympathy and understanding is often in short supply, and for every three steps forward transgender people take (e.g. gaining adequate health authority funding for sex reassignment surgery) the media can make them take four steps backwards. This was the case when media hostility reached a crescendo in relation to the Judges Ruling concerning:

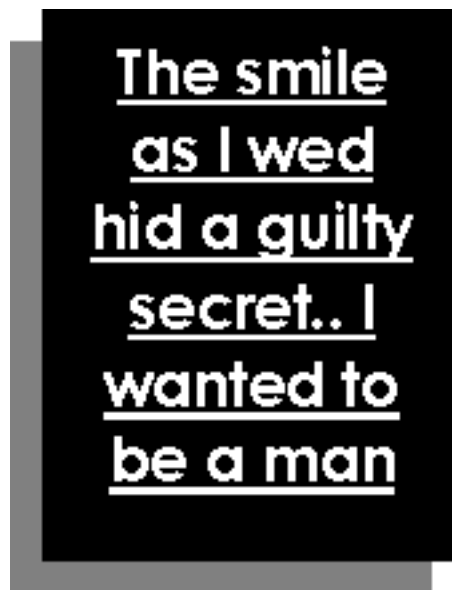
**JUDGES
SAY NHS
MUST PAY
FOR SEX
CHANGES**

Daily Mail 30/7/99

Free sex-change operations [...] health chiefs must give the estimated 4,000 transsexuals seeking surgery a place in their planning alongside victims of cancer, heart and kidney disease. At £10,000 an operation it could cost the cash-strapped NHS £40 million. Critics last night condemned it as a misuse of funds at a time when it is claimed that 500 people a year die when on the waiting list for cardiac surgery '

(Daily Mail, Headline, Friday July 30, 1999).

It's curious that cardiac, cancer and kidney patients are 'victims' and transsexuals are a misuse of funds. What if the person waiting for cancer treatment had smoked 40 cigarettes a day for 60 years and still refuses to give up, and the transsexual had waited four years for surgery and was twenty five? Furthermore the person waiting for cardiac, kidney and cancer treatment could themselves be transsexual!



The Mirror 6/2/2000

This woman is having £15,000 sex swap so she can play dad to her lover's baby...and you are paying for it' [rather extreme to play dad!].

'Tortured mind of ex-SAS man desperate to be a woman' (Daily Mail Saturday, March 25, 2000)

It's clear that from headlines such as these, resources are more likely to be made available if the disability one suffers, is one that the sympathiser could at some stage suffer from. If being transgender was an infectious disease with a recognised and understood pathology and attacked 50-year-old white middle-class men, or stressed-out journalists, resources and understanding would more than likely be easier to obtain. It's not all bad news as the following quotes show:

'William, a surgeon who attended the Queen Mother, has written to his patients asking them to call him Sarah'

(The Daily Telegraph, Tuesday, July 9 1996)

'Ali, the 6ft schoolgirl who hides an extraordinary secret' (Daily Mail, Saturday, August 28, 1999)

'He'll [?] be a hit as a miss, sex swop teacher gets the backing of parents' (The Express, Saturday, February 22, 1997)

'My Husband the Perfect wife, the former wife of the Sergeant Major who is to become the forces' first serving trans-sexual spoke last night of their unusual marriage' (Daily Mail, Saturday, August 8, 1998)

'New Labour New Gender, when councillor David Spry turned up for his first meeting dressed as a woman [...] Liberal Democratic opposition leader Councillor Barbara Janke said: 'We support him and feel he has been quite courageous' (Daily Mail, Thursday November 20, 1997)

And finally... *'Woman of the Week, Dana International,' She is much more than a Eurovision winner - she is a symbol of liberalism and religious enlightenment'* (Naim Attallah, The Express, 1998)

The only concern is what happens if the transgender people above, and the many thousands who don't make the headlines, who are unable (due to health reasons or personal choice) to have a 'sex-change' ever approached residential or community care providers - how would they be received? Best practice is to follow current trends in involving the service user (who may be well informed) in their care package. In some cases they may well organise their own care packages in line with the *direct payments and independent living funds. 'They may need support or care immediately, so there is not time to 'shop around'. They may not have access to information about possible alternative ways of providing support. They may be well informed, but there could be no services locally of the kind they would like [...]. However, we would argue that the main judges of the quality of services must be those who use them. A service may be well run, yet it may not seem to those using it to be the best way of meeting their needs' (Bornat and Connelly, 1993).

What should care providers do?

- Have an open mind.
- Offer information and access to informed sensitive service providers.
- Don't enter the partnership by treating the care recipient in a stereotypical or judgmental fashion - which can be humiliating and only starts the relationship off on the wrong footing.

How difficult is it to explain exactly what a transsexual is to someone who cannot grasp the concept, or to a fellow resident who may have learning difficulties? To finish I'd like to quote from an interview I did with Julie Hesmondhalgh who plays the character 'Hayley' in the television soap Coronation Street. Although she is not a transsexual she has researched the role with the support of Press For Change. When I quizzed her as to what she would tell her children if they asked 'what is a transsexual?' She replied:

"I'd say, 'a transsexual is a person who feels they have been born in the wrong body. So although they grew up looking and acting like a little boy, for example, they know deep inside that they are really a girl. There's an operation you can have to change the outside to match the inside. A man's body can be transformed into a woman's body, or a woman's into a man's." (quoted in Johnson, 1999)

***The Community Care (Direct Payments) Act 1996** allows service users the opportunity to hire and organise personal assistants and control their own finances moving from service-led to user-controlled services.

Good Practice Guidelines

The guidelines that follow are tailored to residential care, but many of the points apply equally to home/ community care:

Care providers should work to achieve:

- a) clear aims and objectives that accommodate the needs of transgender people;
- b) ensure that all staff recruited are aware of the needs of transgender people and are trained accordingly;
- c) the right to have the care receiver's emotional, cultural, religious and sexual needs accepted and respected;
- d) a transgender perspective fully integrated into policies and practices;
- e) that all staff working with or on behalf of transgender people understand the needs of transgender people;
- f) the transgender care receiver's right to attend to their own medication;
- g) and develop links with transgender organisations within the community;
- h) regular reviews of the care receiver's needs (not exceeding 1 year);
- i) the right for the transgender person to participate in any decisions which affect their daily living arrangements; and develop processes of supervision of staff which incorporate exploration of transgender dimensions;
- j) all the physical needs of the residents/clients met; this includes health, skin care, dressing and social activities;
- l) the individual's right to access specialist gender counselling and/ or treatment, and access to self help groups in person, or by help line on an equitable basis whenever necessary;
- m) the transgender person's right to have any comments investigated to their satisfaction;
- n) the right for the transgender person to request a move to another location;
- o) the right for the transgender person to expect the same dignity and accorded to other people;
- p) the right for the transgender person to raise concerns and be heard in a safe, fair and non-discriminatory way;
- q) the right for the transgender person to manage their own finances;

- r) the right to privacy, homes should avoid use of multiple occupancy rooms;
- s) the right to a balanced healthy diet which offers variety and takes into account cultural and ethnic needs;
- t) the opportunity to eat meals in own rooms;
- u) the right to choose when to get up in the mornings;
- v) wherever possible use of an en suite toilet and resident-lockable rooms;
- w) the right to personalise surroundings and if possible take their own bed and wardrobe into the home;
- x) visiting, which should be encouraged;

Local authorities and funding bodies must:

- 1) ensure that assessment procedure and processes incorporate the transgender reality;
- 2) make available to residents and potential residents or clients of care services information necessary to enable them to make personal choices;
- 3) ensure that transgender projects are supported not only in terms of financial concerns, but also other broader resource issues, e.g. training opportunities;
- 4) establish and maintain fruitful relationships with transgender projects;
- 5) review their terms and conditions of funding to be aware of the possibility of the abuse of transgender projects.
- 6) insure social services inspection teams are aware of and understand transgender needs.
- 7) cooperate with transgender groups and allow lay assessors to be involved with inspection teams if there are concerns for transgender people in residential care.

References

- Aitken, J.M., Hart, D.M. and Lindsay, R (1973) 'Oestrogen replacement therapy for prevention of osteoporosis after oophorectomy', *British Medical Journal*, 8-18 September: 515.
- Bond, J. Briggs, R. Coleman, P. (1993) *The Study of Ageing: in Ageing in Society, an introduction to social gerontology*, p.47 Sage, Open University, London.
- Bornat, J. Connelly, N. (1993) *Changing*

Practice: Quality assurance and quality control, In: Provision and practice in community care, The Open University. Department of Health and Social Security (1981), Growing Older, HMSO, London.

Dyer, R. (1979) The Role of Stereotypes. In: Cook, J. and Lewington, M.(eds) Images of Alcoholism. BFI, London.

Feldbaum, E. and Dick, R. (1997) Electronic Patient Records, Smart Cards and Confidentiality, Financial Times Pharmaceuticals and Healthcare Publishing, London.

Findlay, B. (1990) Kenneth Brill Lecture, British Association of Social Workers, Birmingham, in: Community Care, Provision and Practice in Community Care, p.39, The Open University.

Garland, J. (1991) Making Residential Care Feel Like Home. Enhancing the quality of life for older people. Winslow Press, Bicester.

Gomm, R. (1998), Information, Involvement and Accountability: Records and Confidentiality, p. 102, The Open University, Milton Keynes.

Griffiths, R. (1988) Community Care: Agenda For Action, HMSO, London.

Hirschfield, M. (1934). In: Haire, N. (eds) Encyclopaedia of Sexual Knowledge, p. 402, Encyclopaedic Press, London.

Harvey, C.D. and Bahr, H.M (1974) Widowhood, morale and affiliation. Journal of marriage and the family.

Izzard, E. (1998) Dress to Kill: Male Tomboys and Action Transvestites, pp. 62-75, Virgin, London :in Beaumont Magazine, (ed.) Johnson, S. (1999) p. 29, Volume 7. Number 2.

Johnson, S. (1998) When Julie Met Hayley, p. 39, Beaumont Magazine, Published by The Beaumont Society: Vol 6 Number 4.

Jung, C.G. (1972) The transcendent function. In: Read, H., Fordham, M., Adler, G. and McGuire, W. (eds) The Structure and Dynamics of the Psyche, 2nd edition, Volume 8 of the collected Works of C.G. Jung. Routledge and Kegan Paul, London.

Kalus, C. (1994) Counselling Older People: in Documents File, K256 An Ageing Society, p. 38, The Open University.

Murphey, E. (1982) Social origins of depression in old age. British Journal of Psychiatry.

Pitkeathley, (1989), in Community Care: Meanings and Perspectives in Community Care, p.44, (1998), The Open University.

Shapiro, J (1993) Ageing in Later Life: Osteoporosis in Women, pp 88-89, Sage, London.

Sidell, M (1993) Death, Dying and Bereavement: in Ageing in Society, p. 177, Sage, London.

Stewart, G. (1999) Understanding Gender Dysphoria, Mind Publications, London.

Walker, A. (ed.) (1982) Community Care: the Family, the State and Social Policy, Basil Blackwell, Oxford.

Whittaker, A. (ed.) (1990) Involving People with Learning Disabilities in Meetings, in: Community Care (1993), The Open University.

Illustrations: Front Cover Art, Cartoons, Copyright Samantha Johnson

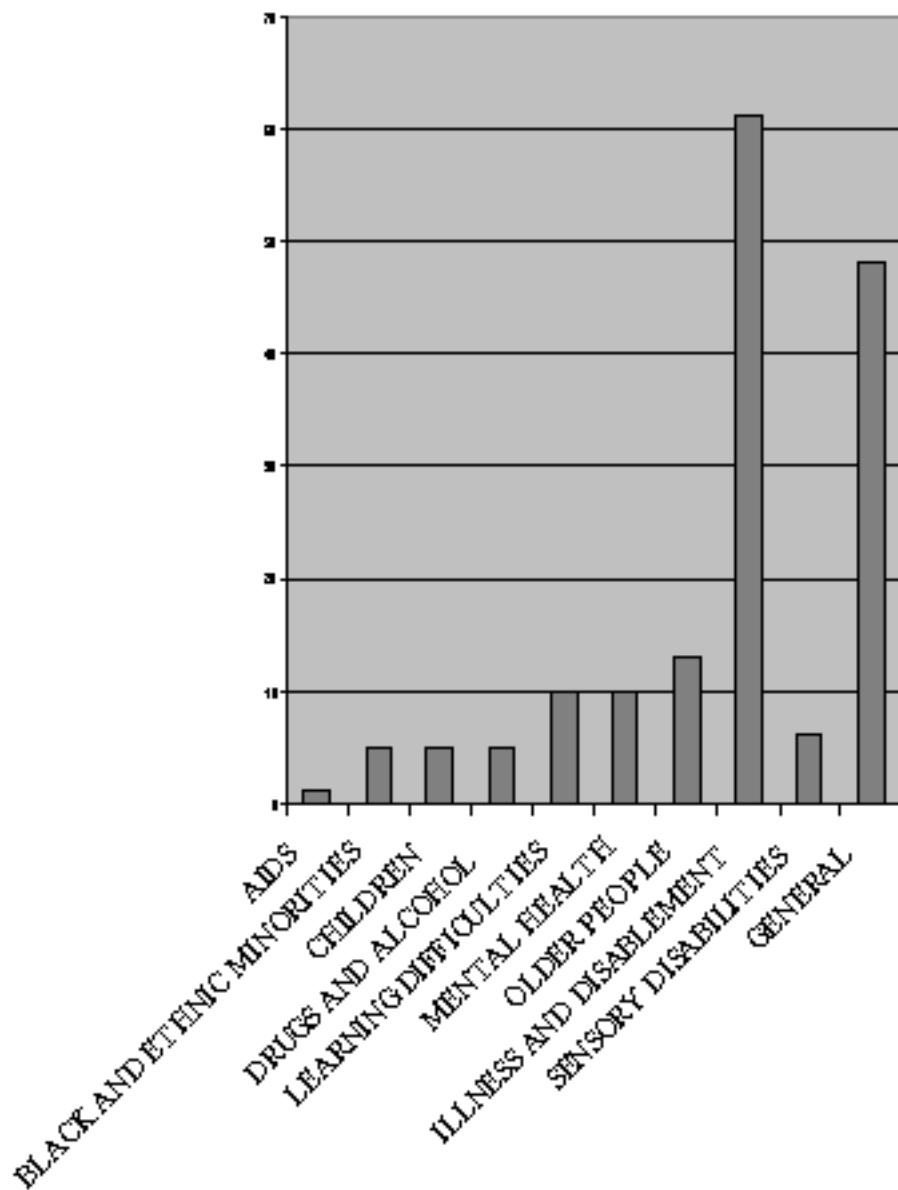
Other readings of interest: Who Cares? Looking After People at Home, by Cherill Hicks, Virago, London 1988, (pp 186-8 (a Gay man caring for his lover))

Reid, R (Dr). de Cegalie, D (Dr). Dalrymple, J (Mr). Gooren, L (Prof). Green, R (Dr). Money, J (Prof). British Post Graduate Medical Federation, University of London. (1996) Transsexualism: The Current Medical Viewpoint, Published by Press For Change, London. (ISBN:0 9527842 0 3) Available from Press For Change.

Some extracts and Newspaper extracts have been reproduced under the publishers' fair dealings scheme. No part of this publication may be copied or reproduced in any way without the permission of the writer and/or publisher.

In the preparation of the supplementary ***Resources Guide**, the author contacted over one hundred and fifty agencies who specialise in health and social care. Details of transgender groups were supplied on the initial contact. However, many agencies were interested in developing policy in the care of transgender people.

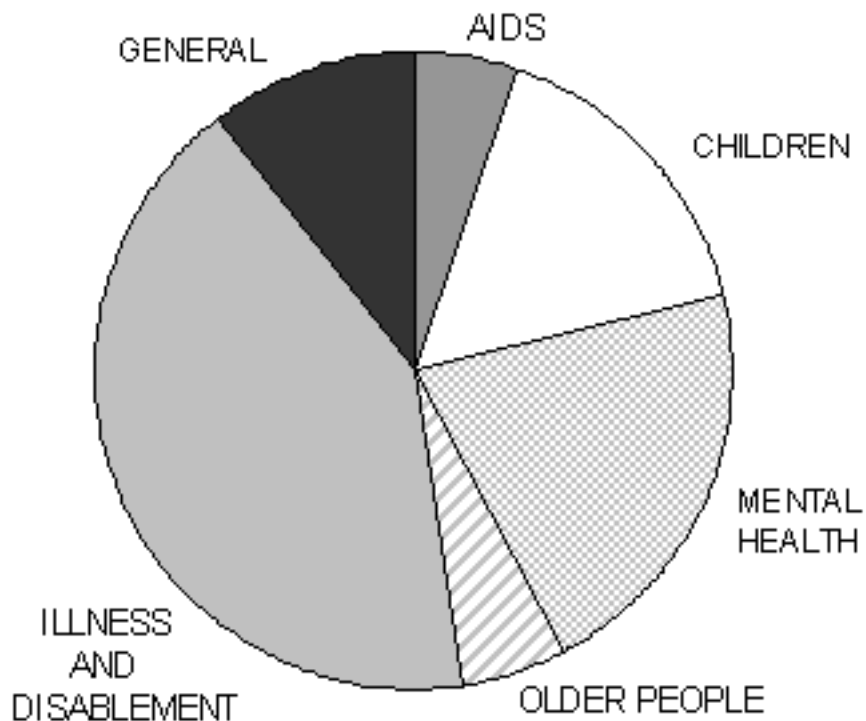
AGENCIES CONTACTED FOR RESOURCES GUIDE



Source Samantha Johnson

Of those contacted the following categories showed a particular interest in transgender policy development

RESOURCES GUIDE - POSITIVE RESPONSES



Source: S. Johnson

TRANSGENDER GROUPS

The Beaumont Trust: BM Charity, London WC1N 3XX Trustline - 07000 287878 (7pm to 11pm Tues & Thurs)

FTM NETWORK: BM NETWORK, London WC1N 3XX.

Helpline: 0161-432 1915 (Weds 8pm to 10.30pm only)

Offers advice and support to 'female to male' transsexual and transgender people, and to families and professionals. Also a 'buddying' scheme, newsletter. 'Boys Own' and an annual national meeting. Website: <http://ourworld.compuserve.com/homepages/ftmnet>

GENDER

A charitable trust offering confidential help, referral and a membership organisation: GEMS at The Gender Trust, PO BOX 3192, Brighton BN1 3WR. Information line for transsexuals: 07000 790 347 (before 10pm please)

GENDYS NETWORK, BM Gendys, London WC1N 3XX.

Transsexuals, transgender & partners

GIRES: Gender Identity Research and Education Society: Molverley,

The Warren, Ashstead, Surrey, KT21 2SP.

Tel: 01372 801554.

Exists to promote and communicate research that improves the lives of people affected by gender identity and intersex issues. Website: <http://www.pfc.org.uk/gires/>

Greater Manchester

TV/TS Helpline: 0161 274 3705. (Wed & Thurs 7pm to 10pm).

MERMAIDS: BM Mermaids London WC1N 3XX. Helpline: 07071 225895

(12noon to 9pm).

Support and information for children and teenagers who are trying to cope with gender identity issues and their families and

carers. Please send SAE for further information.

Website: <http://www.geocities.com/westhollywood/village/2671/>

PRESS FOR CHANGE: BM Network London WC1N 3XX.

In emergencies ONLY ring: 0161-432 1915.

Campaigns for equal civil rights for transsexual and transgender people. Also provides legal help and advice for individuals, information and training for professionals, speakers for group. Produces a newsletter and publications. Please send SAE for further details. Website: <http://www.pfc.org.uk>

SWINDON

TV/TS Helpline: 0793 420262 (Friday 7pm to 11pm)

ESSEX

TransLiving, PO BOX 3, Basildon, Essex. Tel: 01268 583761.

WEST MIDLANDS

Birmingham Midland Connexion.

Tel: 0121 559 3181 (Tues, Weds, Thurs 7pm to 10pm)

WOBS (Women of the Beaumont Society) Offers support and advice to partners of transvestites and transsexuals.

Helplines - South: 01223 441246 & 020 8274 9243;

Central & Wales: 01684 578281; Scotland: 01389 380 389.

SCOTLAND

East - TV/TS Group c/o Edinburgh Gay Switchboard.

Tel: 0131 556 4049; West - CrossLynx TV/TS Group c/o Strathclyde Lesbian and Gay Group. Tel: 0141 332 837267 (7pm to 10pm);

North - Grampian Gender group. Tel: 01224 633108 (9am to 8pm). Crosslynx - Tel: 0141 332 333 (Mon. 7.30 to 9.30pm). Northern Ireland

NORTHERN IRELAND

Belfast Butterfly Club. Tel: 0585 430408 (Weds. 8pm to 10pm)



The author has written and researched the field of transgender studies for the **Beaumont Society** (a Transgendered Charity who publish a magazine and offer support primarily for transvestites) and has campaigned for the political pressure group **Press For Change** (who campaign for civil rights for all transgender people). Both of these groups were particularly helpful in facilitating the writer. The author would also like to thank **Dr James Barrett** of Charing Cross Hospital Gender Identity Clinic, London for his overview on some points.

Copyright © Samantha Johnson

All rights reserved; no part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without either written permission from the writer and/ or publisher, **although the saving and printing or by highlighting the text and right clicking and copying of this document from this Website is permitted for personal reference purposes only.**
