

Working with transgender clients: Learning from others to improve occupational therapy practice

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Abstract

Background. Gender identity disorder and the process of transitioning involve both mental and physical health interventions. Yet there is virtually no discussion of transgender health care in occupational therapy. **Purpose.** This paper draws on interviews with primary care nurses and physicians about their experience with transgender health care, to make recommendations for occupational therapy practice with this population. **Methods.** Semi-structured interviews were conducted with 21 primary care nurses and physicians who had relevant clinical experience. **Findings.** Participants lacked knowledge about transgender care, manifesting in uncertainty in practice. Patient-clinician collaboration, acknowledging stigma, inclusive systems and procedures, assistance navigating healthcare, holistic interventions and advocacy emerged as key elements for quality care. **Implications.** Suggestions are provided for therapists to ensure space and interactions are welcoming to transgender clients, as well as suggestions for occupational therapy intervention in the transitioning process itself.

Keywords: Transgender health, gender identity, primary care, social exclusion, vulnerable populations

Introduction

Gender identity disorder (GID), or gender dysphoria, is a psychiatric diagnosis which means there is significant mismatch between biological sex and the individual's internal sense of their own gender (e.g. someone born with male genitals and XY chromosomes, yet a deep knowledge of themselves as a girl/woman). Individuals with GID often identify as transgender. Some transgender people accept the incongruence, seeing themselves as a kind of 'other' gender, while others take steps toward harmonizing body and gender identity, a process called transitioning. Transitioning can involve dressing and grooming to alter gender appearance, taking hormones to alter one's body, concealing or surgical removal of breasts and/or genitals. Transgender individuals may do any, all or none of these steps.

Gender identity disorder is a mental health diagnosis, and transitioning can involve significant physical health interventions, yet there is almost no mention of transgender issues in the occupational therapy literature. This paper begins to address that gap, drawing on interviews with primary care nurses and physicians about their experience working with trans-patients, and extending that analysis to make recommendations for occupational therapy practice with transgender clients.

Literature Review

Transgender Persons and Occupations

Research on occupational therapy with transgender persons is nonexistent. Yet there is growing awareness that transgender identity significantly affects occupations. An occupational science study found five transgender participants faced occupational deprivation, marginalization, and injustice (Beagan et al., 2012). Social gender norms demanded that they engage only in gender-appropriate occupations. Particular occupations were avoided, or secretly

engaged in, so as to convey convincing gender displays. Thus gender shaped occupational engagement. At the same time, participants used occupations to convey gender, changing focus over time. For example, an individual might choose male-dominated employment to demonstrate masculinity prior to transitioning, and later use grooming (makeup and wardrobe) to convey femininity. Transitioning brought its own required occupations, such as navigating the health care system, and managing relationships and identity disclosures. Transitioning brought both occupational gains and losses.

The study from occupational science builds on an emerging body of research in other disciplines with congruent messages. Studies repeatedly show that transgender status negatively affects productive occupations such as employment and schooling (Doan, 2010; McGuire, Anderson, Toomey, & Russell, 2010). One large survey in San Francisco notes that discrimination prevents many trans-people from obtaining satisfactory employment; consequently, 80% of their sample had been involved in sex trade work or survival sex (Clements-Nolle, Marx, Guzman, & Katz, 2001). In Canada, most trans-people live below the poverty line (Bauer et al., 2010); one B.C. study with 10 trans participants found one was a sex trade worker, while nine were on income assistance (Schilder et al., 2001). Not surprisingly, transgender persons move to jobs where they feel safer, such as lesbian/gay/bisexual/transgender/queer (LGBTQ) centres or helplines, the arts and music industries, or self-employment, or may even delay disclosure/transitioning until after retirement or job loss (Hines, 2010).

Occupations of dressing and grooming are significant means of projecting identity. For some, dressing in opposite gender clothing (cross-dressing) may be a secret occupation, performed privately as an outlet for transgender identity. Others use clothing and grooming for

public displays of gender identity, or to disrupt or complicate societal gender assumptions (Connell, 2010). Doan provides a moving account of her first trip to the mall as a woman: “In preparation for the excursion, I donned my favorite dress, put on two pair of hose to cover my not yet shaven legs and took extra care with my make-up (to cover evidence of my male beard)” (Doan, 2010, p. 645). Over-dressed for the mall, and with a body type unconventionally large for a woman, she did not pull off an entirely convincing display of femininity, drawing stares and whispers. When safety and acceptance are attached to convincing gender displays, dressing and grooming may become highly consequential occupations (Connell, 2010). Before, during and after transition, trans-people face potential harassment, violence and sexual assault in public spaces such as restrooms, elevators, and public streets (Connell, 2010; Doan, 2010). In one survey in Philadelphia, more than half of the transgender respondents had been sexually and/or physically abused/assaulted (Kenagy, 2005).

Transgender Encounters With the Health Care System

When trans-people choose to transition, taking medical steps toward aligning their bodies with their felt-gender requires significant engagement with the health care system (Beagan et al., 2012). For example, they may require a family physician to refer to endocrinology for hormone prescriptions. If surgery is desired, the person must first undergo psychotherapy for an extended period of time. Multiple surgeries may be required, including possible facial reconstruction and vocal chord surgery. In preparation for medical interventions, transgender persons engage in extensive information-seeking, researching health care providers around the world, and the accounts of others who have transitioned (Beagan et al., 2012). Trans-people routinely educate professionals about trans-health care (Bauer et al., 2009; Dewey, 2008).

Despite their educational efforts, trans-people often face inadequate and unpleasant healthcare encounters. They are frequently denied care when they present at hospitals or clinics (Bauer et al., 2009; Dewey, 2008). Health care providers often refer trans-patients elsewhere, assuming that another practitioner may be better equipped to address trans-health concerns (Bauer et al., 2009). This may be interpreted by patients as unwillingness to access information that will adequately address their concerns (Bauer et al., 2009). When care is provided, it is often marred by administrative processes that invalidate trans existence. For example, hospital staff may not know which gender-segregated ward to put trans-patients in; health insurance requires patient names to match gender assigned at birth; getting prescriptions in the correct name is a constant struggle; and receptionists are often confused when gendered name and bodily presentation are at odds (Bauer et al., 2009; Dewey, 2008; Hussey 2008; Schilder et al., 2001; LGBT Health Program, 2009). Health care workers frequently convey with tone of voice and non-verbal communication that trans-patients are perceived as oddities that disrupt business-as-usual (Dewey, 2008; Hussey, 2008).

Healthcare Encounters with Transgender Patients/Clients

While occupational therapy has been largely silent on trans care, other fields have begun tentative discussion. Overwhelmingly, the available literature focuses on the basics of care, definitions of transgender vocabulary, medical options for transitioning and suggestions for trans-sensitive care provision (e.g. Burrows, 2011; Carroll, Gilroy, & Ryan, 2002; Feldman & Goldberg, 2006; Goldberg, 2006; Gooren 2011; LGBT Health Program, 2009; Polly & Nicole, 2011; Robinson, 2010; Williams & Freeman, 2007; World Professional Association for Transgender Health [WPATH], 2011). Very few published articles approach the concerns or hesitations health professionals experience when working with trans-people.

Given that most health care providers receive little or no education concerning trans-health (Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006; APA Task Force, 2008) they are left guessing at how to make their care strategies welcoming and competent (Coren, Coren, Pagliaro, & Weiss, 2011). Providers also struggle with the stigma attached to transgender status (“transphobia”), with their own fears and biases, and with concern about not fully grasping the complexities of trans-care. Not surprisingly, most providers do not approach gender identity with patients (Kitts, 2010) and as many as 50% of trans-people do not voluntarily inform their family physicians that they are transgender (Bockting, Robinson, Forberg, & Scheltema, 2005).

Occupational Therapy With Transgender Clients.

Nicola Jessop (1993) presented a clinical case report on a 22 year old male-to-female (MTF) client she called ‘Miss M’ – the only published account of occupational therapy with a trans-client. Jessop argues that occupational therapy can make significant contributions, given the mandatory requirement that trans-people live successfully in their chosen gender for a lengthy period of time to qualify for surgery. Jessop worked with Miss M to improve her ability to successfully present as a woman through focus on occupations of self-care, particularly skin care, makeup, hairstyling, and wardrobe choices. Miss M also required guidance with gait related to walking in high-heels. She identified goals of leaving her male-dominated field of work, and improving skills in typically-feminine domestic occupations (cooking, cleaning, laundry). As Miss M expanded her social circle, the therapist raised awareness of safer sex practices. A referral was made to speech therapy to assist Miss M with her ability to speak in a feminine manner through vocal modulation and practice expressing thoughts and feelings. Jessop (1993) concludes, “Occupational therapy has a major role to play in assisting new transsexuals to adjust to their chosen gender role” (p. 324).

The only other occupational therapy article addressing trans-care is an opinion piece about informed choice and client decision-making, specifically concerning dressing (Pope, Davys, & Taylor, 2008). One of the clients described is a transgender MTF who was concerned about being stared at in public, yet wore – in the therapist’s opinion – too much make up and inappropriate clothes. The authors describe the tension between remaining client-centered by supporting the client’s appearance choices, and helping the client to understand the social, political and cultural context in which women’s clothing and appearance convey complex messages about femininity and sexuality (Pope et al., 2008). This is an important comment that hints at a potential role for occupational therapy in working with transgender clients to recognize and understand societal gender roles and expectations, including negative aspects such as sexism.

This paper extends the emerging discussion within occupational therapy about practice with transgender clients. We draw upon our qualitative interviews with primary care nurses and physicians to explore their experiences with transgender care and extend the insights gleaned there to occupational therapy, examining recommendations concerning best practice, and how to apply these to occupational therapy.

Methods

This paper is based on data from a larger qualitative study of health care for LGBTQ women, in which we sought to examine how routine practices perpetuate or transform marginalization within the health care system. That study included in-depth, face-to-face interviews with family physicians (N=9), and registered nurses (N=12) in Halifax, Nova Scotia who self-identified as working with LGBTQ patients to any extent. Following research ethics approval, recruitment was conducted through advertisements, posters, letters to clinics, word of mouth, and snowball sampling. After receiving informed consent, in-depth, semi-structured

interviews were conducted with participants. Interview questions asked participants to describe how they experienced primary health care practice with LGBTQ women. Interviews were recorded, transcribed verbatim, and analyzed inductively, generating themes and subthemes which were coded using AtlasTi software by a team of researchers. Transcripts were read and re-read, and coded segments were interpreted both in the context of the larger interview, and in comparison with the other transcripts. For the current paper, transcripts were reviewed again attending specifically to how participants discussed their work with trans-patients.

Findings

Among the 12 nurses, eleven identified as women, one as a man. Each had Bachelors or Masters training and had practiced 10-30 years in various settings. Eight physicians identified as women, one as a man. They worked in clinics and private practice, and had practiced 10-40 years. None of the participants identified as transgender. Six nurses and two physicians had no experience of knowingly working with transgender patients. Three nurses and four physicians had worked with a limited number of trans-patients, while three nurses and three physicians had a considerable trans-patient population. Here we examine their perceptions of and experiences with transgender care.

Lack of Knowledge

Except for two nurses with extensive experience with trans-patients, participants routinely expressed concern about lacking knowledge to provide quality care. While some expressed comfort with LGBTQ care requirements, trans-patients specifically raised uncertainties. For example, one physician who worked with many LGBTQ patients said, “it’s the transgender that makes me uncomfortable” (Bruce NSP08), which he explained was due to his lack of knowledge. Similarly, a nurse said, “Gay is one thing. Okay, that’s fine. That’s just who you

have sex with. But, trans? ... Like, what does that even mean? ... I don't know what that anatomy is supposed to even look like. I have no idea" (Kathy NSN13). Lia's first trans-patient highlighted a range of uncertainties:

Policies, procedures, surgeries, how does it all work? No idea. ... We're working through this together... What's covered health care wise, what isn't? How do you handle this in the work context? When do you change your ID card to say you're male? Which washroom do you use? I hadn't had the opportunity to think about the full process before, 'cause I had never come across it. (NSN02)

Several nurses specifically mentioned their uncertainty concerning the use of gendered pronouns:

"You always are trying to be aware of what you say, and what you're doing. But, you're not always 100%" (Faith NSN11). Faith found it particularly challenging when the body she was treating did not align with the patient's gender identity, such as changing post-mastectomy dressings on someone who identifies as a man.

For most of the physicians, unfamiliarity with the medical care required for trans-patients was most daunting. As Debbie said, "I'm not prepared to give hormones first of all because I don't know enough about them" (NSP05). This was particularly challenging given that physicians play a gate-keeping role concerning patient access to other health care services and medications. Some felt considerable responsibility for decisions that have significant and permanent implications. For example, Bruce (NSP08) felt inadequately prepared to assess someone's candidacy for sex-realignment surgery.

Shannon noted that health professionals are often uncomfortable with not knowing what to do, and this may be read by patients as judgment or resistance: "Sometimes, some of the resistance that you will read non-verbally from a practitioner is from 'Oh my God, I have no idea what to say or do'" (Shannon, NSP07). Liza summarized the current state of knowledge among

most family physicians concerning trans-health: “You have to hustle to learn, you really have to want to learn” (Liza NSP03).

Learning About Transgender Care

Most participants accepted their lack of knowledge, and set about reading and researching about trans-health, seeing this as current best practice. As Kira said, “Okay, I don’t know everything. But I know I can go and look for the resources. And I’m very good at that” (Kira, NSN05). Lia spoke of the learning process as collaboration with her client: “I had to do research... It didn’t make me feel incompetent ... it was almost empowering, like let’s see what we can do with this, if you want to, I’ll work with you” (NSN02). Shannon, too, set out to do research when she encountered unfamiliar territory with trans-patients, accepting that her client had much to share:

When I don’t know something, the person in the chair across from me is the expert in it. That’s the bottom line... I do the legwork that I can, and find out as much as I can. And then I give them that information. (NSP07)

Participants also spoke about learning from patients. One nurse had learned simply from observing and participating in a patient’s step-by-step transition process. A physician warned that trans-people may be bothered by provider lack of knowledge and the need to always be experts on their own care: “They can be frustrated. This guy was always frustrated with me ‘cause [my lack of knowledge] was a total inconvenience” (Liza NSP03).

Some participants had learned about trans-health from more personal sources like family members and friends. The advantage was that they learned as much about the lived transgender experience as they did about health care. Several participants had attended a recent local conference on trans-care, and many learned through professional networks, which included more experienced colleagues popular with trans-patients. Most participants knew the names of the 4-5

local health professionals who work extensively with the trans community, and turned to them for information. Participants also sought information from networks across Canada, especially in Vancouver and Toronto, often directed there by patients.

Elements of Quality Care in Trans-health

A number of themes emerged about what constitutes quality care for trans-patients: collaboration, acknowledging stigma, inclusive systems and procedures, navigating health care, holistic care, and advocacy. A key element was **collaboration with patients**, given patients often knew more about trans-health than did their providers. On this subject, Kira (NSN05) said, “In most situations, I would say ‘Let’s go look for [information] together.’” Practitioners typically brought information to patients for collaborative decision-making. One physician had learned to book double-length appointments with trans-patients, so she had adequate time to discuss options. A nurse who specialized in hormone injections focused on teaching patients to self-administer hormone injections, to enhance autonomy and avoid work disruptions. Through collaboration she aimed to maximize client self-management.

Participant emphasis on **acknowledging the stigma, marginalization and oppression** transgender persons typically face demonstrated recognition that trans-patients may encounter many health professionals who are not “trans-friendly” and may even express intolerance. Many participants discussed the importance of making sure **systems and procedures were not exclusionary**, specifically in regards to the information obtained and language used on intake forms. One clinic had expanded the gender options beyond male/female, adding a choice for ‘Other.’ A nurse from that clinic noted that this still implied marginalization, as in something ‘other’ than what is expected or ‘normal.’ Another clinic offered male/female/transgender as options. A physician who thought the intake forms at her practice were still traditional and

exclusionary talked through the forms with patients, allowing her to express things verbally in less exclusionary ways. Liza asked all patients about sexual orientation by routinely inquiring about sexual relations with men, women or both – yet recognized that this excludes trans-patients, who may identify as both or neither: “There is a male/female bias in that. And I can’t quite wrap my head around how not to do that, to make it more trans-positive” (NSP03). A nurse detailed the complexity of name use:

The fear of identification in going to the lab and staff call out their name and when they walk up to the desk staff go, ‘No, I called out a woman’s name’... and they fear that someone in that room has just heard that (Carole NSN04)

For patients still in transition, one physician used their legal name for health insurance billing, but office forms allowed a ‘preferred’ name to be used everywhere else.

Participants also reflected on how they **navigated the health care system** to optimize care for trans-patients. For some, this meant reporting their billing in particular ways to ensure patients were covered. Given that patients need a diagnosis of GID before any medical transitioning can begin, both nurses and physicians helped trans-patients find mental health professionals skilled in assessment. One nurse described using the assessment to help patients access services, yet conveying to individuals that it was a bureaucratic requirement rather than misgiving about their mental health: “We have to refer you to psychiatry, you know there’s nothing wrong with you mental health wise, but we have to have the official diagnosis” (Lia NSN02).

The two most consistently identified elements of quality trans-care were holistic care and advocacy. **Holistic care** involved recognizing that transitioning and transphobia can affect someone’s wellbeing broadly, including employment, housing, family and leisure. As one physician said, “Just going through the whole transformation I think in itself causes all sorts of

social and psychological challenges” (Fiona NSP04). Participants spoke about working with patients on issues related to workplace disclosures, navigating strained family dynamics, coping with stress from harassment and stigma, navigating safety in sexual relations and everyday life, and even suggesting travel destinations where trans-people may be least at risk. Holistic care often meant listening well and building relationships. Jeannette described her approach with one of her first trans-patients:

She was male to female and was being beaten up every day as soon as she stepped foot outside her house. Was living on social assistance, but just couldn't afford so much of what she needed. Didn't know how to access healthcare, so was getting one of her friends to get her birth control pills as her estrogen source, but it's not the proper estrogen. Couldn't get employment, because she wanted to work as a female, but every place she'd go... they just wanted to pigeonhole her into, 'Well, no you're a guy.' (NSN01)

Jeannette worked with this woman to find safer housing and connected her with an agency that finds supportive work situations for persons with mental illness, arguing that she might as well take advantage of her GID diagnosis.

Jeannette's actions with this client demonstrate the advocacy that is a key component of quality care. Often **advocacy** involved screening specialists before making referrals, ensuring that providers were trans-positive (or at least did not have a reputation for overt intolerance). As Jeannette said, “There's still some doctors out there that aren't queer/trans-friendly” (NSN01). Advocacy also meant advocating for health care coverage. Lia worked for a major employer, and fought for funding approval for a trans-patient each step of the way: “I actually got approval from [employer] to pay for top surgery. We were really quite pleased. We said this is medically-necessary surgery, this is not cosmetic surgery” (NSN02). Given the very exorbitant cost of surgeries, and the absence of clearly outlined coverage policies from insurers, such advocacy is often crucial.

A few participants spoke about advocacy in terms of educating others in their practice setting. For example, when Anna had an appointment with a transwoman at the women's hospital, she did her best to smooth the way: "I actually went to admitting and told them this person is coming to the women's clinic, they're male but just, it's all cool, let them in" (NSN03). She also spoke with the clinic staff, hoping they would not do or say anything to offend. Anna was very aware that even coming to a women's hospital was a challenge, because by definition the space was already gendered in a binary way, and she wanted to help the patient avoid any hostile, shocked or confused reactions.

Two of the physicians used their authority to reduce negative staff reactions to trans-patients. When interviewing staff for clinic positions, Jennifer made sure she asked about their comfort with LGBTQ patients. She also worked to educate staff: "We make it clear about pronouns which name to use and things like that" (NSP02). Alice, another physician, addressed and educated staff if an incident arose where a trans-patient was treated disrespectfully: "I do approach the topic immediately you know. I do that because I feel my patients should be treated well from the front staff" (NSP09). This type of advocacy is critical because poor treatment is often more about ignorance than intolerance, yet regardless of origin it is hurtful to patients, and may add to an already significant burden of exclusion, marginalization and ill-treatment experienced by trans-people in health care.

Discussion

While a significant limitation of this study is the lack of interviews with occupational therapists, we nonetheless believe that the experiences of primary care nurses and physicians hold valuable insights for occupational therapy. Lack of knowledge was a significant concern. Participants emphasized their openness to learning – from patients, colleagues, experts, and

literature – and their willingness to seek out information for patients. According to the data collected, quality care for transgender patients involves collaboration with the patient, understanding their experienced social stigma and exclusion, willingness to challenge exclusionary processes, engagement in holistic care that recognizes how marginalization affects health, and advocacy for patients well beyond finding appropriate referrals. It is likely that occupational therapists would encounter similar challenges and strive to implement quality practice in similar ways to those described by our sample. The identified key elements of care fit well with the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend & Polatajko, 2007), particularly with its emphasis on client-centered enablement through advocacy, collaboration and engagement within a framework of person, environment and occupation.

Occupational therapists may encounter transgender clients in two significantly different contexts: 1. Individuals referred to occupational therapy for physical and/or mental health issues unrelated to the fact that the client is transgender; or 2. Individuals referred for occupational performance issues concerning transitioning. In the first instance, the primary focus must be creating an inclusive, trans-positive environment during client-therapist interactions. The second entails assessment of issues and occupational enablement primarily through teaching skills and advocacy.

Creating Trans-Positive Environments and Interactions

Many recommendations have been published for creating trans-positive health care environments (e.g. Bauer et al., 2009; Coren et al., 2011; Feldman & Goldberg, 2006; Polly & Nicole, 2011; Robinson, 2010; WPATH, 2011), which can be extrapolated and applied to occupational therapy settings. To enhance trans-positive care, therapists might:

- Develop intake forms that allow trans-patients/clients to self-identify, and to convey the agency's openness to transgender persons. For example, using 'Gender: _____' allows the person to self-identify. More explicitly stating trans options can convey an even stronger message, for example, 'male/female/transgender/MTF/FTM/other: _____.'
- Always refer to transgender clients by their preferred names and pronouns. In general, the gender someone is transitioning *to* is the gender they know themselves to be and prefer to be called. If there is uncertainty, politely ask.
- Ensure places to record both 'legal name' and 'preferred name' in documentation.
- Ask client consent to connect with other members of the care team, since therapists are unlikely to be the initial point of contact. Communication can reduce client frustration about lack of knowledge.
- Ensure clients are in control of interventions and their choices to perform/engage in occupations however they choose are respected.
- Ensure the health care team is educated on quality care for transgender clients.
- Establish and display a statement of non-discrimination committing to equal care being provided regardless of gender identity.
- Display posters and magazines aimed at the LGBTQ community; display brochures that discuss LGBTQ health concerns and risks.
- Provide at least one unisex washroom for transgender patients.
- Eliminate sex-segregated aspects of clinical space where possible, and where space must be sex-segregated (e.g. hospital wards), develop written policy for use of the space with trans clients, respecting the individual's self-identification and right to privacy.

Trans-positive interactions are ensured by what Goldberg (2006) identifies as core competencies of sensitivity and awareness: "Understanding and awareness of transgenderism, [ability] to respond appropriately if patient discloses transgender identity... [ability] to provide referrals" (Goldberg, 2006, p. 221). Therapists and other clinic staff should be educated regarding transgender issues. In particular, they should be aware of differences between sex, gender, and sexual orientation; familiar with the range of diverse gender identities and gender expressions; accustomed to transgender vocabulary; and should acknowledge the authenticity of transgender identity and lived experiences (Feldman & Goldberg, 2006). Taking responsibility for initiating discussions of trans issues is valuable, given this is uncharted territory for many health professionals. Ideally, clinic staff will express attitudes that are respectful, accepting, validating, and affirming. As is expected of any occupational therapy interaction, therapist and client should collaboratively identify goals and plans.

Occupational Performance Issues of Transitioning

The biggest concern raised by participants was lack of knowledge, particularly about specialized aspects of care when clients are transitioning. Interestingly, the approach to care described by participants is exactly what occupational therapists are accustomed to providing: addressing mental health and physical health, discussing leisure, safety, housing, financial supports, self-care, and employment, and understanding the institutional, cultural, and societal constructs and policies that may have an impact. Occupational therapy's focus on the whole spectrum of person, environment and occupation can significantly benefit trans clients in occupations required for transitioning. Table 1 outlines some anticipated areas of focus.

Adequate gender presentation – presenting as indisputably masculine or feminine – will be at the centre of many transgender occupational issues. Gender performance is learned behavior, and can be taught. Occupational therapists are particularly skilled at breaking performance down into components amenable to intervention. In contrast to typical occupational therapy interventions, clients are not relearning or adapting occupations. They are learning gendered occupations that have not been taught to them before. Recall that in her work with Miss M, Jessop (1993) focused on clothes shopping, dressing, skin care, makeup, laundry, cooking, and sexual practices to enhance gender display. Therapists should be sensitive to the possibility that trans clients face difficult relationships with their own bodies, having spent years in bodies that do not match their gender identity.

Work-related occupational issues are also a likely focus (Beagan et al., 2012). Trans clients may need support concerning opportunities for employment, employment insurance applications, employability self-assessment, developing skills for gendered work, career exploration and decision making, job searching and résumé-writing to manage gender transition.

Many trans clients will need support concerning how to disclose their gender identity at work (Beagan et al., 2012). Occupational therapy expertise in mental health and vocational rehabilitation may be great assets for trans clients in these areas of transition.

Many trans-people lose social networks once they begin transitioning, and may face considerable isolation, including from family (Beagan et al., 2012; Williams & Freeman, 2007). It may be beneficial for occupational therapists to help transgender clients connect with new social networks (Carroll et al., 2002). Involvement in LGBTQ communities is an effective approach (Beagan et al., 2012; Jessop, 1993).

Finally, our participants suggested that advocacy is crucial to quality care with trans-people – a key enablement skill in the Canadian Model of Client Centered Enablement. Holman and Goldberg (2006) warn that health professionals should always contact any referrals in advance to screen for trans-sensitivity, and educate where needed. They note that advocacy may be needed with schools and workplaces to address discrimination, bullying, and harassment; with private or public health insurance for coverage of particular procedures; with government agencies concerning legal identification; with residential services and social assistance concerning appropriate and safe housing; and with residential facilities such as prisons and long term care facilities concerning safety and access to washrooms. This is particularly pertinent for occupational therapy, due to the profession's widespread engagement in communities, homes, worksites, and care, forensic and educational facilities.

Conclusions

This paper is a preliminary step in addressing how occupational therapy might effectively engage with transgender clients. Drawing on literature from other professions, and interviews with primary care nurses and physicians, we have outlined some of the challenges faced, as well

as elements of quality care for trans-people. (See Table 2 for further resources.) Occupational therapy's commitment to social justice and equity should compel us as a profession toward increased understanding of this underserved and marginalized population. It is encouraging to note that many identified elements of quality care correspond with core competencies of occupational enablement, as well as with the broad scope of practice of the profession. Unquestionably, more occupational therapy-specific research is needed to help ensure that the transgender community can access appropriate, safe, and competent care. Meanwhile, it is noteworthy that making small changes using the suggestions presented can make a significant difference to the safety and dignity of our clients.

Key Messages

- Though there is virtually no occupational therapy literature concerning practice with transgender clients, we can learn from primary care experiences of other professions.
- Creating a trans-positive environment involves collaboration, advocacy, recognition of stigma, sensitivity, awareness, and challenges to exclusionary language and procedures.
- Focus on person, environment and occupation can significantly benefit clients in occupations required for transitioning, such as those concerning gender presentation, employment, social isolation reduction and anxiety management.

Acknowledgements

Funding was provided from CIHR (operating grant # 201339). Thanks to the rest of the larger research team, Lisa Goldberg, Sue Atkinson, Cressida Heyes, Mary Bryson, Erin Fredericks, Ami Harbin, Brenda Hattie, Linda Dame.

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Table 1: Occupational therapy in transitioning
Holistic care Person, environment, occupations
Gender presentation Shopping, dressing, skin care, makeup, laundry, cooking, sexual practices
Work-related occupations Gendered job skills, career change, managing gender disclosures
Social isolation reduction and anxiety management
Advocacy Schools, employers, unemployment insurance, health care benefits, legal identification, housing, residential services

Table 2: Resources:
Canadian Professional Association for Transgender Health (CPATH) http://www.cpath.ca
Sherbourne Health Centre http://www.sherbourne.on.ca
Transgender Health Program. Vancouver Coastal Health. www.vch.ca/transhealth
Transpulse http://www.transpulseproject.ca
The World Professional Association for Transgender Health (WPATH) http://www.wpath.org