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"Across Gender": A narrative medicine-based support group for transgender and gender non-conforming (TGNC) persons

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A capstone project submitted in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree from the University of Indianapolis, School of Occupational Therapy.

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A Capstone Project Entitled

"Across Gender": A narrative medicine-based support group for transgender and gender non-conforming (TGNC) persons

Submitted to the School of Occupational Therapy at University of Indianapolis in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree.

By

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OTS

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Abstract

Transgender and gender non-conforming (TGNC) persons experience a variety of health and psychosocial disparities, necessitating a need for unique, evidence-based interventions to facilitate occupational engagement and ensure occupational justice. In particular, TGNC individuals report experiencing social isolation. The purpose of this project was two-fold: (1) to demonstrate effective leadership and advocacy throughout the organization and implementation of a narrative medicine-based supportive group in order to (2) provide opportunities for social participation among individuals of similar culture, as well as to increase social perception, empathy, and companionship. The supportive group was held weekly for TGNC-identified individuals who were either patients of the Transgender Health and Wellness Program or members of the community. A brief survey that measured improvements in social participation, developed by the Doctoral Capstone Experience (DCE) student, was administered at the succession of each group. Average survey scores, with 15 being the highest possible score, ranged from 12.5 to 15. Anecdotal support was further evidence of the success of support groups in facilitating engagement in social participation and creating new routines. Overall, this particular DCE elucidated the importance of social participation among TGNC persons, as well as the effectiveness of advocating for occupational therapy's role in an emerging niche.

[1] Preferred pronouns include they/them/theirs

Background

The Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) community is one of advocacy, pride, and resilience. However, the LGBTQ community remains stigmatized and marginalized by society's strict perceptions of sexual orientation and gender identity norms, which is no secret amidst the nation's current political epoch. Recent issues such as bathroom laws and sporting team regulations caused great debate among politicians and denizens alike, thus registering individuals who identify as transgender or gender non-conforming on social and political radars.

Traditionally, the term *transgender* is used to describe an individual whose gender identity is opposite of their sex assigned at birth (Wagner, Kunkel, Asbury, & Soto, 2016). However, "opposite" implies that gender is binary (i.e. one is either male or female), thus excluding a number of individuals who identify as non-binary, some other gender, or neither gender. A broader definition of *transgender* includes "those whose gender identity 'transcends, breaks, transgresses, cuts through, or otherwise deviates from traditionally established gender categories'" (p. 51). A myriad of terms exist beneath the *transgender* umbrella, including but not limited to: transwoman [or MTF (male-to-female)], transman [or FTM (female-to-male)], intersex, gender non-conforming, gender fluid, and androgyne (Fenway Health, 2010). Definitions for the aforementioned terms may be found in Appendix A.

Canadian Model of Occupational Performance (CMOP)

Due to the unique relationship between gender and occupation, the Canadian Model of Occupational Performance (CMOP) will be used to guide the Doctoral Capstone Experience (DCE). The CMOP is a client-centered model that details the relational effects of the person, environment, and occupation on occupational performance (Cole & Tufano, 2008). At the center

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of the model is the person, composed of affective, physical, and cognitive components with the human spirit at its center (2008). Surrounding the person is occupation, which includes self-care, productivity, and leisure (Cole & Tufano, 2008). Lastly, the environment is composed of institutional, social, cultural, and physical elements (2008). It is within these environments that occupations are performed.

The person. According to this model, strength, range of motion, endurance, energy, flexibility, and pain fall within physical factors (2008). One or more of these factors may be influenced positively or negatively by the presence of cross-sex hormones. The decision to use cross-sex hormones is made individually, and such hormones may be used to "eliminate in as far as possible the secondary sex characteristics of the natal sex and to induce those of the new sex" (Gooren, Kreukels, Lapauw, & Giltay, 2015, p. 14). These physical changes may be evidenced by gains or loss in muscle mass, development of breast tissue, and growth of facial hair. Surgical interventions may also be performed, such as double mastectomy, breast augmentation, orchiectomy, labiaplasty, etc., which pose physical implications post-surgically (University Gender Affirmation Surgery, n.d.).

Feelings and attitudes that influence an individual's self-concept, motivation, and interpersonal relationships are included in the affective component of the model (2008). Although no criteria is needed to self-identify as transgender, a diagnosis of gender dysphoria is required in order to pursue medical and legal transitions (if desired). According to The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a diagnosis of gender dysphoria involves "a difference between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning for at least six months" (American Psychiatric Association, 2016, par. 8). The adolescent or adult must also show at least two of the following

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symptoms: (1) an identifiable incongruence between one's primary and/or secondary sex characteristics as well as one's experienced/expressed gender; (2) a strong desire to no longer have one's primary and/or secondary sex characteristics; (3) a strong desire to possess the primary and/or secondary sex characteristics of one's experienced gender; (4) a strong desire to be of one's experienced gender; (5) a strong desire to be treated as one's experienced gender; (6) a strong conviction that one reacts like and embodies the typical feelings of the experienced gender (American Psychiatric Association, 2016).

The aforementioned symptoms of gender dysphoria play a large role in the various psychosocial factors that hinder meaningful occupational engagement. The 2015 Trans Survey, the largest survey devoted to trans lives and experiences, reported that 39% of respondents experienced serious psychological distress one month prior to survey completion (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). Furthermore, 40% of respondents reported having attempted suicide in their lifetime, while seven percent (7%) reported having attempted suicide in the past year (2016). This prevalence of suicidal ideations and attempts may signal detriment of the human spirit, as a lack of opportunity to engage in meaningful occupations can elicit a loss of identity, limited expression of spirit, and a sense of meaninglessness (Townsend & Wilcock, 2004).

Human spirituality includes "the meaning of everyday activities and the symbolic significance of occupation as a part of one's culture" (Cole & Tufano, 2008, p. 28). According to the CMOP, the human spirit plays a central role in occupational choice, self-direction, and self-identity. Limited research detailing the dialectical nature between gender and occupation exists, but literature on the relationship between sexual orientation and occupation is growing (Beagan, De Souza, Godbout, Hamilton, MacLeod, Paynter, & Tobin, 2012). It was argued that

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occupational choice, meaning, context, and engagement are influenced by one's sexual orientation (Jackson, 1995). Similarly to gender identity, persons whose sexual orientation falls within the lesbian, gay, bisexual (LGB) umbrella may seek occupations or occupational contexts that connect them to their community (Beagan et al., 2012). For example, "a young lesbian may choose to play softball hoping to connect with other lesbians" (Beagan et al., 2012, p. 227). Dressing, communicating, and performing leisure activities that are congruent with one's experienced gender is not simply an attempt to "pass" but the delicate and intentional ways in which one may affirm their identity.

Environment. The components of the environment, as defined by the CMOP, include elements of the physical, social, cultural, and institutional (Cole & Tufano, 2008). Physical environments may include the workplace, classroom, and/or home, while social environments may include co-workers, peers, and/or family (2008). Cultural environments may include "religious, ethnic, and political factors, which can affect the opportunities for, and barriers to, participation in life" (Cole & Tufano, 2008, p. 28). Lastly, institutional environments may include political and social systems that set rules and limits to occupations (2008). Although gender is not explicitly identified as a component of the environment, its enigmatic relation to the physical, social, cultural, and institutional weighs heavily on the occupational justice for transgender individuals. For example, the lack of a hate crimes bill in the state of Indiana may implicitly allow bias to enter into the workplace and school systems.

As reported by the 2015 Trans Survey, unemployment rates among respondents were alarming (15%), which was three times higher than the country's unemployment rate (5%) (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). Higher rates of unemployment were prevalent among Black, American Indian, Middle Eastern, Latino/a, and multiracial respondents.

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For those respondents who held employment, 15% experienced verbal harassment, physical assault, and/or sexual assault at work due to their gender identity or expression. Verbal, physical, and sexual violences were also prevalent outside of the workplace. Fifty-four percent of school-age (K-12) respondents who were either out or perceived as transgender by peers were verbally harassed, 24% were physically attacked, and 13% were sexually assaulted. In some cases (17%) mistreatment was so severe that they left a K-12 school (2016).

Occupation. Through the lens of the CMOP, self-care, productivity, and leisure are the three categories of occupation (Cole & Tufano, 2008). Self-care can be affected in a number of ways, such as avoiding primary and preventative care visits for fear of being stigmatized (Beagan, De Souza, Godbout, Hamilton, MacLeod, Paynter, & Tobin, 2012). Transgender individuals may "do" or "play" gender through the occupation of dressing (Beagan et al., 2012). Often times the outward presentation of gender, typically through the means of self-care, is how transgender individuals strive to "pass" as their experienced or identified gender. For example, transmasculine individuals who take testosterone may intentionally grow and maintain a beard, as it facilitates a more accurate perception of his gender identity.

Occupations such as community mobility, shopping, driving, and toileting were also negatively affected among transgender individuals. Discrimination in these settings took many forms: denial of services and/or treatment, denial of access to restrooms, harassment, and violence (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). Occupational implications were plenty. For example, 32% of respondents "limited the amount that they ate and drank to avoid using the restroom in the past year" (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016, p. 17). Furthermore, one in five transgender persons did not use at least one type of public accommodations (transportation, retail stores, gyms, etc.) due to fear of mistreatment (2016).

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Due to the environmental and personal limitations on occupational performance, there is a need for occupational therapists to enable occupation (Cole & Tufano, 2008). Use of a client-centered model, such as the CMOP, is imperative in order to provide client-therapist collaboration. Interventions should be designed in a way that is meaningful for the client "both personally and within his culture or social group" (Cole & Tufano, 2008, p. 28). It is through narrative medicine-based support groups that this intentional design may be achieved.

Narrative Medicine

Support groups consisting of members who identify as transgender provide occupational engagement (i.e. social participation) within their culture. Attending a support group each week at a designated time provides an opportunity for time management as well as the creation of new roles and routines. In addition to temporal and physical consistencies, using elements of narrative medicine can enhance participation and the experience of deep personal meaning to support groups.

Although narrative medicine curriculum is typically for healthcare professionals, the contents of its teachings, specifically through close reading and attentive listening, are transferable. Training in philosophy, literary theory, and literary fiction increases the capacity to perceive and empathize with suffering and turmoil (Charon, DasGupta, Hermann, Irvine, Marcus, Rivera Colon, Spencer, & Spiegel, 2017). Literature itself poses a unique opportunity to explore relationality by opening "a bottomless resource for observing, thinking, and talking together about human interactions" (Spiegel & Spencer, 2017, p. 15). Reading literary fiction has been empirically shown to increase theory of mind, emotional intelligence, and social perception (Kidd & Castano, 2013). Furthermore, attentive listening can facilitate "deep companionship between teller and listener, mutual investment, reciprocal clarity, and affiliation" (Charon, 2017,

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p. 157). Narrative medicine-based support groups have the potential to be a unique and efficacious intervention due to their ability to provide increased emotional intelligence and social perception, empathy, and companionship.

Screening and Evaluation

While at the outpatient-based Doctoral Capstone Experience (DCE), an informal, client-centered evaluation was completed in order to determine the needs of both the organization (Transgender Health and Wellness Program) and its population (transgender and gender non-conforming patients). I met with the clinic's patient care coordinator in a conference room on the fifth floor of the hospital. It was discussed that support groups were the most pressing need, as patients consistently expressed a desire to attend. The patient care coordinator verbalized their[1] desire for support groups to not be therapeutic (i.e. pertaining to psychotherapy) in nature. The patient care coordinator also reiterated the primary care physician's desire for the support groups to include an educational component related to trans-care. I introduced he idea of incorporating elements of narrative medicine into the support groups. It was explained that narrative medicine would provide psychosocial benefits (i.e. empathy, introspection, and emotional intelligence) without being overtly therapeutic, like running groups that explicitly target outcomes such as improved coping skills. The patient care coordinator was receptive and in favor of incorporating these elements.

Throughout the first four weeks of the DCE, many informal conversations were had involving the need for trans-competent healthcare practices. Although the hospital's Transgender Health and Wellness Program utilizes best practice for their patients, there is a great need among other disciplines, including occupational therapy. When defining trans healthcare, it is imperative to distinguish between three subsystems: "(1) preventative healthcare, (2) critical care, and (3)

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transcare" (Wagner, Kunkel, Asbury, & Soto, 2016, p. 51; Rachlin, Green, & Lombardi, 2008). *Preventative healthcare* (i.e. annual checkups) may contribute to anxiety due to a need to correct medical staff on one's preferred pronouns and chosen name (Wagner, Kunkel, Asbury, & Soto, 2016). Gynecological exams for trans-masculine patients can be disparagingly dysphoric, thus forcing these individuals "to choose between mental health (i.e., forgo a gynecological exam to avoid identity-related triggering) and physical health (i.e., undergo a gynecological exam but risk stigma or discrimination)" (Wagner, Kunkel, Asbury, & Soto, 2016, p. 51). *Critical care* includes urgent responses to acute health issues and/or serious medical events (2016). This inherent urgency acts as a hindrance to trans patients having the time and/or resources to pre-identify inclusive healthcare environments and practitioners, leading some to hesitate seeking necessary healthcare (2016). Lastly, *transcare* focuses specifically on one's biophysical transition (2016). Gender affirming care may include hormone replacement therapy (HRT), mental health services, and/or surgery (2016).

Stigma and discrimination may enter these healthcare subsystems in three modes: individually, interpersonally, and/or institutionally/systemically (Wagner, Kunkel, Asbury, & Soto, 2016). *Individual stigma* has the ability to inhibit a trans individual from seeking help or communicating with healthcare providers in order to avoid discomfort (2016). *Interpersonal stigma* occurs during routine communication, such as between healthcare professional and patient, and may include hostility, pandering, and/or unnecessary/inappropriate inquisitiveness (2016). These interactions are likely to result in avoidance on behalf of the trans patient. Lastly, *institutional stigma* is systematically oppressive in nature (2016). Institutional stigma occurs in a number of ways, including "erasure from medical information and healthcare policies, systemic microaggressions, and health insurance disparities" (2016, p. 54). For example, transgender

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individuals are less likely to be hired by an employer, limiting access to health insurance and thus trans-related healthcare services (Poteat, German, & Kerrigan, 2013). The prevalence of stigma and discrimination experienced by trans patients in healthcare settings acts as a hindrance on meaningful occupational engagement.

Wagner, Kunkel, Asbury, & Soto (2016) conducted qualitative interviews with trans participants in order to provide insight into the effects of gender identity on health experiences. One participant's response highlighted money management deficits: "There were times where I had to choose between—you know—hormones or food…I generally wait for food and electricity" (2016, p. 57). Another participant engaged in risky occupations in order to financially sustain his transition. He noted, "I did sex work to get my first injection of testosterone" (2016, p. 57). Anecdotal stories of discrimination also play into one's fear. After hearing a story of a trans-woman who was denied care by an EMT and subsequently died, a participant stated that "she was constantly worried if she was 'seconds away from getting thrown out because the nurse thinks I'm a freak or pervert or something…that I'm going to get in a car accident and I'm going to die because the EMT won't assist me" (2016, p. 59). The aforementioned qualitative statements signaled a need for occupational justice within the healthcare environment. Generally, it is considered best practice to stay relaxed and make eye contact, avoid unnecessary questions, avoid gossip or jokes regarding transgender non-conforming (TGNC) patients, continue to use preferred name and pronouns in a patient's absence, and create an environment of accountability (National LGBTQ Health Education Center, 2016). Resources from organizations such as Fenway Institute and the World Professional Association for Transgender Health (WPATH) provide best practice standards for organizations to follow.

Trans-Affirming Environments

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A trans-affirming healthcare environment begins with the front-line staff. Customer service principles (i.e., accountability, communication, open-mindedness, reliability, responsiveness, and respect) serve as strategies for working with TGNC patients (National LGBTQ Health Education Center, 2016).

Gender-neutral language. Assumptions regarding a patient's name should be avoided. When addressing patients, avoid the use of gender-specific terminology, such as "sir," "ma'am," and "Mr./Mrs./Miss/Ms." (National LGBTQ Health Education Center, 2016). When referring to patients in conversation with other staff members, avoid the use of pronouns. For example, rather than stating, "She is in room 4," one may say, "The patient is in room 4" (2016).

Names and pronouns. Politely asking a TGNC individual if they use a preferred name is acceptable; their preferred name may or may not match their records or identification. For example, a healthcare professional may ask, "What name would you like me to use?" (National LGBTQ Health Education Center, 2016, p. 10). The healthcare professional should also routinely ask for a patient's preferred pronouns. She/her/hers and he/him/his are common pronouns preferred by some TGNC individuals, but for some, particularly those who identify as non-binary, may prefer they/them/theirs or ze/hir/hirs (2016, p. 10). The collection of gender identity data is now recommended by both the Joint Commission and Institute of Medicine; furthermore, it is required by the U.S.'s Health Resources and Services Administration (HRSA) and all HRSA-funded centers (2016). The collection of a patient's preferred name and pronouns allows healthcare professionals to insert them into a patient's chart, allowing all staff to see gender identity and preferences consistently (2016).

Name and gender markers. Asking, "Could your chart be under a different name?" or, "What is the name on your insurance?" are acceptable in situations where a patient's name or

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gender identity does not match their medical records or insurance (2016). A TGNC person should never be asked what their "real" name is, as it highly offensive (2016). If a healthcare professional slips on using the correct name and/or pronouns, it is acceptable to say, "I apologize for using the wrong pronoun/name. I did not mean to disrespect you" (2016, p. 11).

Other generalized organizational strategies that can be used in order to create a gender-affirming environment are plenty. For example, documentation systems that include Electronic Health Records (EHRs) can be used to track and record preferred name, pronouns, and gender identity (National LGBT Health Education Center, 2016). Non-discriminatory gender identity and expression policies should be included and posted. Single occupancy restrooms that are marked as "All-Gender" is preferable; however, if this is not allowed, create a policy that ensures TGNC patients may use the bathroom that matches their gender identity. Annual TGNC cultural competency trainings for staff should be provided, and new staff should be trained within 30 days of hire. Policies and procedures that hold staff accountable for any discriminatory actions or words against TGNC patients should be in place, and staff should be aware of these procedures (2016).

Implementation

Organization and Structure

Following an interpretation of the needs assessment, I organized the service delivery of support groups. Essays, poetry, fictional works, and art written or created by transgender individuals were reviewed and selected. The selection of transgender authors and artists was intentional as to ensure authenticity and representation of the transgender experience. Literary works were analyzed and selected based on components of narrative medicine, including time,

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space, metaphor, and voice. Based on these analyses, I assigned open-ended prompts to each narrative for group members to respond following the reading. Concurrently, I sent individual emails to the Transgender Health and Wellness Program team members. These emails explained the structure of the support groups, as well as dates and time. Team members were asked to prepare a 30-minute educational presentation (within their individual scopes of practice) to be given at the start of each support group. Team members were scheduled by subjective availability, and subsequent confirmation emails were sent. Twelve weeks of support groups were scheduled, and an informational document that detailed dates, time, educational speaker and topic, and narrative was created and distributed to team members (Appendix B). The support groups were advertised to clinic patients via a MyChart message. MyChart is personalized and secure online access to their medical records; it also allows patients send and receive messages to and from their medical provider(s). Subsequently, a flyer that included the group's details were distributed to patients during their clinic visits, and the patient care coordinator informed new patients of the support group when scheduling initial visits over the phone.

Implementation of Support Groups

Support groups took place each Tuesday from 6:00 pm to 7:30 pm over the course of twelve weeks. After finalizing a social participation outcome measure (Appendix C), outcomes were collected after nine of the 12 groups. Each group began with introductions, including name and preferred pronouns. Following introductions, a pre-scheduled staff member led an informal informational session on a particular topic. For example, during week three, the clinic's social worker discussed differences and relationships between gender dysphoria and depression. Following the educational component, copies of the scheduled narrative were dispersed. If the narrative was poetry, a group member volunteered to read it aloud. In the cases of longer pieces

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of literature or artwork, close reading or visual analysis was done privately. During the first three weeks of support group implementation, I stated the open-ended prompt, and group members responded to the prompt via free-write for five to eight minutes. Following free-write, the group had an open discussion of their thoughts, reactions, and questions. However, the group expressed their desires to verbally respond to prompts without free-writing. In order to ensure client-centeredness, this change was made. Groups were facilitated by me and the patient care coordinator. After the narrative discussion, the facilitators allowed members to bring up life events that they felt comfortable discussing with the group. At the conclusion of group, members were given the social participation outcome measure.

Leadership and Staff Development

A myriad of factors were equally integral in the development of my leadership skills. These factors included: awareness of role, attentive listening, collaboration, advocacy, and evidence-based practice. Being aware of one's role as a DCE student implicitly communicated a sense of respect toward the established team members. It is not beneficial to assert oneself into a team without first being invited; one should allow interprofessional communication to arise organically. This stage of role awareness involved attentive listening in order to gain perspective on the inner-workings of the clinic, including the various interdisciplinary roles. It was through this lens that I was able to envision the role of occupational therapy in a pre-established team within an emerging area of practice.

As organic conversations between the team and I arose, specifically regarding the needs of the clinic, it was imperative to collaborate and identify common goals. While the clinic had a variety of needs, these were not occupation-based in their entirety. I collaborated with the patient

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care coordinator on the topic of support groups, explaining that social participation is considered an occupation within the profession's scope of practice.

Advocacy and evidence-based practice were inherently symbiotic in the early stages of the DCE. Before advocating for occupational therapy's role in an emerging area of practice, it was imperative to re-familiarize myself with the fundamental nature of occupational therapy, as well as the small body of literature supporting the profession's role in transgender care. It was through this deep level of understanding beyond a generalist's knowledge that I was able to educate about and advocate for the intricate relationship between occupation and gender. Although intentional, the retroactive awareness of my role indirectly aided in the clinic's receptiveness toward these ideas, thus creating a healthy atmosphere for subsequent staff development. Staff development is a process that will continue to develop throughout the DCE. Through advocacy and education, the clinic is acutely aware of occupational therapy's role in a psychosocial setting; however, the ways in which occupational therapy can best serve within the clinic is continuously being investigated throughout this process.

Discontinuation and Outcome

In preparation of discontinuation, an analysis of outcomes was completed. Social participation outcomes were measured over a nine-week duration. The maximum score on the social participation outcome measure was 15 points; average scores over the course of nine groups ranged from 12.5 to 15, while number of attendees ranged from five to 13. A graph detailing these outcomes is shown in Table 1.

Anecdotally, group members who attended the first session returned for the remaining groups and were thus referred to as the "core group." Exceptions to the core group's attendance

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included change in work schedules and illness. This core group of attendees exchanged cell phone numbers and created an ongoing group chat wherein they made regular contact with one another. Furthermore, this group began going out for "dinner and drinks" at the cessation of each session, and they extended this invite to new attendees. This anecdotal evidence is in support of the DCE's purpose: to facilitate engagement in social participation. The support group allowed members of the transgender and gender non-conforming community to make real-life connections with peers and create new routines.

As previously stated, support groups were led by me and the patient care coordinator. Co-leading the support groups with an individual who has a long-term role within the clinic was advantageous, because they[1] are aware of the structure and format, group dynamics, and facilitation skills. This continuity alone serves as one step toward the ensured quality of services. Furthermore, I created a list of open-ended prompts for the patient care coordinator to continue to utilize when facilitating discussion in future support groups.

Due to the established need of occupational therapy services, as well as the success of the support groups, my faculty mentor, one of the primary care physicians, and I met with grant writers in order to initiate the process of funding an occupational therapist. Ideally, this would be the pinnacle of ensuring quality improvement, as the occupational therapist could partake in continued program development, research, and occupational therapy services.

The current political climate, including a lack of anti-discriminatory legislation and anti-hate crimes bill in the state of Indiana, necessitates a call to action among occupational therapists (Cook, 2018). Of utmost importance are the things that people do, who people do things with, and how often. Occupations are the means by which we construct and express our identities, and this is especially true in regards to gender. "I think, therefore I am" suddenly becomes "I do,

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therefore I become." When deprived of meaningful occupational engagement, an already compromised identity may be weakened further. Support groups provided one means of occupation (i.e. social participation) for the transgender population. However, further occupational opportunities, such as theatre and/or life skills groups, are needed in order to continually satisfy this societal need and promote occupational justice for this population.

Overall Learning

In 2011, the American Occupational Therapy Association (AOTA) stated that emerging practice areas, or emerging niches, were one way to respond to societies' ever-expanding occupational needs. AOTA researched trends in the six identified practice areas (i.e. Children & Youth, Health & Wellness, Mental Health, Productive Aging, Rehabilitation, Disability, & Participation, Work & Industry, and Education), but the topic of gender identity was not highlighted, signaling that gender identity as seen through an occupational lens remains scarcely explored. In 2014, AOTA published "Occupational Therapy's Commitment to Nondiscrimination and Inclusion," which explicitly stated, "We value individuals and respect their culture, ethnicity, race, age, religion, gender, sexual orientation, and capacities…" (p. S23). Furthermore, the document highlighted the profession's affirmation of every individual's right to access and fully participate in society (2014).

As previously discussed, the transgender and gender non-conforming (TGNC) community faces unique occupational challenges, including deprivation, but also esteems different occupations than those of the cisgender population in an effort to convey their true gender identity. The lack of a trend toward transgender healthcare within emerging areas of occupational therapy practice highlights a detrimental disservice to a large subset of individuals that AOTA inherently values, respects, and affirms. A lack of competency among occupational

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therapists, occupational therapy assistants, and occupational therapy students regarding TGNC care is a rejection, however implicit, of occupational justice. An acute awareness of this occupational injustice was the cornerstone of my involvement within the Transgender Health & Wellness Program. It was not until I was fully immersed in their interdisciplinary team that I could hold a candle to occupational therapy's unique role in promoting access to occupational engagement for the TGNC population.

Communication of occupational therapy's role within the transgender clinic specifically, as well as the TGNC population generally, took many forms. My time was often spent writing the background section, including a literature review, for an upcoming research project that aims to elucidate the occupational experiences among the TGNC population. The ultimate goal of this research is to highlight the relevance of the profession in serving this population and advocate for the need of these services. It is imperative that the TGNC population has a voice in this advocacy, which is the justification for conducting participatory action research (PAR). This research led me on an educational journey separate from that of occupational science and into territories of the philosophy of biology, anthropology, evolutionary psychology, and a myriad of other disciplines. Having a foundational knowledge, no matter how novice, of other disciplinary theories allowed me to tailor occupationally-relevant gender science discussions to a variety of professionals, thus improving the adequacy of my advocacy.

The success of my advocacy is best evidenced by the clinic's desire to offer occupational therapy services to its patients. The clinic's medical director, who also serves as one of the two primary care physicians, continues to play an active role in satiating this desire. For example, she attended a meeting with me, my faculty mentor, and one of the hospital's grant writers in order to fund a full-time occupational therapy position, as well as an ongoing theatre project in

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collaboration with a local non-profit organization. This work has the potential to provide necessary research opportunities, as well as social participation, self-efficacy, and quality of life for TGNC persons.

Overall, this particular DCE elucidated the importance of social participation among TGNC persons, as well as the effectiveness of advocating for occupational therapy's role in an emerging niche.

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Appendix A

Androgyne: Refers to someone whose gender identity is both male and female, or neither male nor female. A person might present as androgynous, and/or as sometimes male and sometimes female, and might choose to use an androgynous name.

Gender fluid: Refers to gender variations other than the traditional, dichotomous view of male and female. People who self-refer with this term may identify and present themselves as both or alternatively male and female, as no gender, or as a gender outside the male/female binary.

Gender identity: A person's innate deeply-felt psychological identification as a man, woman, or something else, which may or may not correspond to the person's external body or assigned sex at birth (i.e., the sex listed on the birth certificate).

Gender non-conforming: People whose expression is (1) neither masculine nor feminine or (2) different from traditional or stereotypic expectations of how a man or woman should appear or behave.

Intersex: A spectrum of conditions involving anomalies of the sex chromosomes, gonads, reproductive ducts, and/or genitalia. The most traditional definition of intersex refers to individuals born with male and female genitalia, or genitalia that are not clearly male or female. A person may have elements of both male and female anatomy, have different internal organs than external organs, or have anatomy that is inconsistent with chromosomal sex.

Transman [or FTM (female-to-male)]: Generally refers to someone who was identified female at birth but who identifies and portrays his gender as male. People will often use this term after taking some steps to express their gender as male, or after medically transitioning. Some, but not

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all, transmen make physical changes through hormones or surgery. Some people prefer to be referred to as men rather than transmen or transgender men.

Transwoman [or MTF (male-to-female)]: Generally refers to someone who was identified male at birth but who identifies and portrays her gender as female. People will often use this term after taking some steps to express their gender as female, or after medically transitioning. Some, but not all, transwomen make physical changes through hormones or surgery. Some people prefer to be referred to as women rather than transwomen or transgender women.

[1] Preferred pronouns include they/them/theirs

Appendix B

Support Group Dates and Educational Topics

February 13, 2018

"Importance of Primary Care"

February 20, 2018

"Dysphoria and Depression"

February 27, 2018

"Self-Management"

March 6, 2018

"Post-Op Precautions"

March 13, 2018

"PrEP"

March 20, 2018

"Pelvic Health"

March 27, 2018

"Legal Information"

April 3, 2018

"Faith/Religion"

April 10, 2018

"Dietary Information"

April 17, 2018

"Feminine and Masculine Vocalizations"

April 24, 2018

"Role of OT"

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Appendix C

1 = Not At All Likely, 2 = Somewhat Likely, 3 = Very Likely

After tonight's group, how likely are you to…

Accept a social invite from peers?	1	2	3
Initiate conversation with peers?	1	2	3
Invite a peer to an outing?	1	2	3
Open up to trusted peers?	1	2	3
Seek community resources and/or attend community events?	1	2	3

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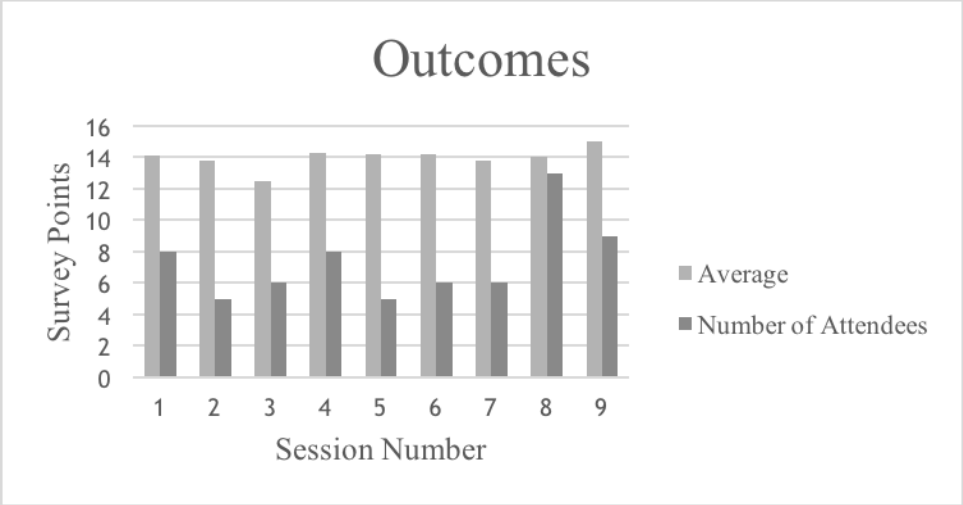
Appendix D

Number of Attendees an Average Scores on Social Participation Outcome Survey



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