Occupational Therapy’s Role in Gender-Affirming Surgeries
Transgender people (those whose gender identity does not correspond with their gender assigned at birth) may be seen by occupational therapy providers in all settings. However, there has not yet been development of specific occupational therapy interventions to address the occupational needs of transgender people.

A common barrier to occupational engagement for transgender people is gender dysphoria—discomfort or distress from the incongruence of gender identity and gender assigned at birth (Dhejne et al., 2016). To address gender dysphoria, transgender people may transition medically (using hormone replacement therapy or surgical intervention), legally (changing their legal name and gender marker), and/or socially (daily life changes) (Stroumsa, 2014). Although this article focuses on surgical transition, it is important to recognize that not every transgender person’s journey includes surgery. Non-surgical interventions can include hormone replacement therapy, feminization voice therapy, changes in gender expression and roles, chest binding, use of genital prosthetics, hair removal, and mental health or support groups (Mayo Clinic Staff, 2019).

Gender-Affirming Surgeries
In consult with their health care team, transgender people may elect to undergo surgical treatments to align their bodies with their gender. Available evidence indicates that these surgeries can support improvements in quality of life, body image, and overall mental health (Wernick et al., 2019).

Over the past several years, the University of Utah Hospital Transgender Health Program has grown considerably and works toward the goal of providing optimal care for transgender people. They offer several gender-affirming surgeries to meet clients’ needs. The team originally included specialists from urology, plastic surgery, physical therapy, nursing, pharmacy, pain management services, and social work. Three years ago, occupational therapy joined the team to support transgender patients in the acute care phase after certain surgeries (see Table 1).

Gender-Affirming Care
Providers working in this area must educate themselves and focus on treating the patient with respect and dignity. When working with a transgender person, it is important to use affirming language by referring to the person using their preferred pronouns, name, and roles. Providers should ask the person their preferences and follow through with their wishes. They should also confirm all information is correctly documented in their chart. It may be necessary to educate other health care providers on affirming language.

By the time patients decide to undergo surgery, they have a concrete understanding of what their personal transition includes, so there is no reason to ask why they had surgery or inquire about details of their past life. It is important to focus on the individual’s goals for their life after surgery. Statements such as “I could never tell you used to be a girl,” “You look really good for being transgender,” and “You totally pass” are micro-aggressions, can be hurtful to the person, and can damage the therapeutic relationship (Morris et al., 2020).

Occupational Therapy Role
Following the gender-affirming surgeries described in Table 1, patients remain inpatient and are typically placed on a modified bedrest protocol for 3 to 5 days. Patients may ambulate from the bed to the bathroom, stand briefly for ADLs, and sit upright for meals. It is not uncommon for patients to experience severe pain, orthostasis, and decreased functional activity tolerance. Patients are also placed on abdominal precautions to reduce activation of their abdominal and pelvic floor muscles. Mesh underwear are placed on the patient after surgery to support surgical packing, phallus, and foley catheter line.

Similar to the typical occupational therapy role in acute care (American Occupational Therapy Association, 2017), our occupational therapy services focus on facilitating function, preventing
secondary complications, and providing education and training to prepare for discharge. We also provide specialized education and task training aligned with the unique characteristics of the surgery and client-specific needs, including lower body dressing, showering, toileting/pericare, adaptive equipment (AE) and durable medical equipment (DME) recommendations, and long-term changes in routines related to health management and sexuality.

**Case Example 1: Abby**

Abby was a 22-year-old transgender female s/p vaginoplasty. Prior to her surgery, Abby was independent with ADLs/IADLs and a full-time college student. She was living with two friends in a house near campus; however, she planned to stay with her parents and younger sister during her recovery so her family could provide full-time assistance if needed.

Abby was placed on modified bedrest for 5 days, until her surgical packing and urinary catheter were removed. An occupational therapist (OT) evaluated Abby on post-operative day 1 (POD 1) to gather information about her prior level of function, home setup, and occupational profile. The OT asked Abby her preferred pronouns (she/her) and used gender-affirming language throughout her care. The OT educated Abby about how to follow surgical precautions prior to initiating movement. The evaluation also included an assessment of Abby’s occupational performance including functional mobility and ADLs (within the parameters of the modified bedrest protocol).

The OT administered the daily activity domain of the Activity Measure for Post-Acute-Care (AM-PAC) “6-clicks” (Jette et al., 2014). During the evaluation, the OT noted that Abby required maximum assistance to logroll out of bed and that her standing was limited by pain and dizziness.

Occupational therapy sessions focused on training Abby in the use of AE to increase independence with lower body dressing, standing tolerance for ADLs, and independence with toileting/pericare. The OT educated Abby about post-operative pericare, and provided a peri-bottle for use after removal of her urinary catheter. The OT also provided extensive education about establishing healthy routines after Abby was medically cleared (e.g., wiping front to back after urination, urinating after sexual activity). Abby reported concerns about controlling her stream of urine; the OT discussed this concern and recommended leaning forward during urination. The OT also provided pacing strategies to support energy conservation for ADLs/IADLs. Abby and the OT discussed sexuality and intimacy within the context of her recovery.

On POD 5, Abby’s surgical packing and urinary catheter were removed. The OT guided Abby through her daily ADL routine from start to finish, creating an open dialogue to address any questions or concerns from Abby or her mother. During showering, Abby demonstrated limited standing tolerance; the OT trained Abby and her mother in how to use an inflatable donut and shower chair to complete this activity.

Upon her discharge home on POD 5, Abby performed ADLs with modified independence and was independent with functional mobility. She was scheduled to follow up 2 days after discharge with her surgeon and outpatient pelvic floor therapist.

Table 1. Types of Gender Affirming Surgeries, Descriptions, and Acute Care Occupational Therapy Needs

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<tr>
<th>Gender-Affirming Surgeries</th>
<th>Surgical Procedure Description</th>
<th>Acute Care OT Needs</th>
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| Vulvoplasty (Transfeminine) | • Skin from penis and scrotum used to build inner and outer labia  
• Clitoris created out of the glans  
• New opening created for the urethra | • Wound care  
• Pain management  
• Peri care  
• Energy conservation  
• Adaptive equipment for lower body ADLs  
• Sexuality  
• Caregiver training  
• Patient advocacy |
| Vaginoplasty (Transfeminine) | • All procedures from vulvoplasty (see above), with the addition of a vaginal canal  
• Foreskin tissue used to build opening of the vagina | |
| Metoidioplasty (Transmasculine) | • Tissues that hold the hormonally enlarged clitoris are divided  
• Urethra is lengthened to move the opening to the tip of the penis  
• Vaginal canal lining is removed and canal is closed  
• Scrotum is created from vaginal tissues of the labia majora  
• Testicular implants may also be placed at a later date. | |
| Phalloplasty (Transmasculine) | Stage 1:  
• Creation of penis using skin graft from forearm or thigh  
• Urethra lengthened to move opening to the tip of the penis  
• Suprapubic catheter placed for 1 month to allow urethra to heal  
• Scrotum created from vaginal tissues of the labia majora | • All needs listed above, as well as:  
• One-handed ADL techniques  
• Hand therapy, including splinting, for donor arm  
• Phallicus positioning and support to maintain blood flow to graft |
| Stage 2 (optional): | | |
• Placement of testicular implants and erectile device |

**Note.** a Hassan et al., 2021; b University of Utah Health, 2019. The surgeries listed here are those our OT team is currently involved with during patient recovery; this is not an exhaustive list of gender-affirming surgeries.
Case Example 2: Sean

Sean was a 33-year-old transgender male who was s/p phalloplasty with radial forearm flap. Sean’s initial occupational therapy evaluation followed the same approach as Abby’s. Sean reported he lived with his wife, and indicated his preferred pronouns were he/him and requested to be referred to as husband to his wife.

He was placed on modified bedrest for 5 to 6 days after his surgery, until his forearm wound vacuum was removed and vascular doppler checks on his phallus (surgically created penis) confirmed sufficient blood flow. Within the parameters of modified bedrest, Sean was encouraged to get out of bed into a chair on POD 1 and walk short distances in the room on POD 2. While out of bed, Sean’s phallus needed to remain supported away from the incision site to prevent blocked blood flow and subsequent graft failure.

During the acute healing phase of the full thickness skin graft on his forearm (approximately 4 weeks), Sean was not permitted to bear weight through his arm and had a temporary resting hand splint.

On POD 1, Sean reported a significant amount of pain in his perineum and forearm, as well as feeling lightheaded and dizzy when sitting up at the edge of bed. The OT supported breathing techniques and monitored Sean’s vitals while assisting him to stand and transfer to a chair.

During treatment sessions, the OT trained Sean and his wife on his activity restrictions, abdominal precautions, positioning and management of his arm and phallus while performing ADLs, and energy conservation. The OT also provided training on one-handed techniques, which Sean needed to follow his weight-bearing precautions. The OT also discussed appropriate DME and home set-up with Sean and his wife to maximize patient independence with ADLs, conserve energy, and support caregiver health and safety during recovery. The OTR encouraged open dialogue about long-term changes in routines, including toileting hygiene, sexuality, and leisure activities. They discussed sexuality and intimacy across the different phases of Sean's surgeries and recovery.

On POD 5, Sean was cleared from bedrest, allowing the OT to address additional ADL needs with him and his wife prior to discharge home. Sean continued to require assistance with ADLs due to the weight-bearing precautions of the donor arm, phallus positioning to maintain good circulation, pain, and decreased activity tolerance. Later on POD 5, Sean discharged home with his wife and recommended DME. He had follow-up appointments scheduled 2 days later with his surgeon and a hand therapist to have a resting hand splint created.

Conclusion

Occupational therapy providers are uniquely positioned to apply client-centered approaches to facilitate transgender people’s participation in meaningful occupations. There is a distinct occupational therapy role with transgender people after they undergo surgeries to align their bodies with their gender. More work is needed to develop additional ways occupational therapy can support transgender people in navigating the intersections of society, gender, occupation, and health.

References


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