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Voice and Communication Therapy for the Transgender or Transsexual Client: Service Delivery and Treatment Options

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Voice and Communication Therapy for the Transgender or Transsexual Client:

Service Delivery and Treatment Options

Carly J. Clark

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Introduction

In 1952, Christine Jorgenson was the first American to have a documented sex change. Since then, it is estimated that there are nearly 1.4 million transgender individuals living in the United States (Hoffman, 2016). Transgender (TG) is an umbrella term used to describe those whose gender identity differs from their sex assigned at birth (Gay & Lesbian Alliance Against Defamation [GLAAD], 2016). Transsexual (TS) is an older term that may be preferred by some, meaning those TG individuals who have permanently changed or seek to change their bodies through medical intervention (GLAAD, 2016). TG/TS individuals often face discrimination when seeking health care services such as provider judgment. Further, TG/TS individuals may be unaware of culturally competent service providers or the range of services that exist to aid them in their transition. Through extensive review of the literature, these issues will be highlighted in the coming pages to help future clients and clinicians gain the information necessary to obtain and provide effective interventions, respectively.

Transgender Experience in Health Care

The World Professional Association for Transgender Health (WPATH) has proposed a comprehensive definition of access to health care as

“the degree to which individuals or groups . . . regardless of race, color, ancestry, place of origin, political belief, religion, language, age, sex, gender, sexual orientation, disability, or socioeconomic status . . . are able to obtain high quality medical services from a health care system in a timely, safe, and accountable fashion.” (Corneil, Eisfeld, & Botzer, 2010, p. 108)

Unfortunately, many TG individuals' experience with health care does not meet this definition. Prior studies have indicated that TG/TS individuals often have difficulty obtaining services across all health care settings, whether public or private, regardless of the type of care sought (i.e., routine care, emergency service, preventative medicine, medical services related to sex change). Likewise, discrimination, harassment, disrespect, and violence from the medical community are frequently reported by TG/TS persons attempting to access health care. Given these circumstances, TG/TS individuals are at a great risk for low quality health services or no service delivery whatsoever. Providers' refusal to treat TG/TS individuals translates into a denial of human rights (World Health Organization, 2016) and is also a violation of the ethical responsibilities of health care employees (American Medical Association, 2016). Thus, improving health care providers' cultural competency with knowledge of, and attitudes toward TG/TS patients is crucial to foster culturally sensitive, quality health care services.

The National Transgender Discrimination Survey (NTDS) reported alarming statistics regarding the dire state of health care for TG/TS individuals (Grant, Motett, Tanis, Herman, Harrison, & Kiesling, 2010). Specifically, 19% of the survey's more than 7,000 TG/TS respondents reported that they had encountered at least one health care provider who refused to serve them. A large number of individuals who had experienced this refusal were TG/TS persons of color. Further, 2% of respondents indicated that they were physically assaulted and 28% reported experiencing verbal harassment in a medical setting. Given these findings, it is not surprising that 25% of respondents indicated delaying their health care needs or refraining from seeking out services in the first place (Grant et al., 2010).

While at its worst, some TG/TS individuals have experienced overt discrimination, harassment, and even violence, many TG/TS persons have also reportedly encountered providers who are willing to serve them, but lack appropriate knowledge of their unique needs. Specifically, half of the NTDS respondents reported the need to educate previous health care providers about aspects of their needs. Despite the barriers documented in the NTDS, a majority of the respondents were able to receive some transition-related care such as counseling and hormone therapy (Grant et al., 2010). Still, these data support the need to examine and improve current health care practices, as well as address providers' attitudes and biases toward TG/TS individuals via education.

Another study built upon the survey findings reviewed above. Specifically, Roller, Sedlak, and Draucker (2015) developed a theoretical framework for understanding TG individuals' experiences with health care by interviewing 25 TG/TS individuals. Interviewees primarily indicated struggling to find culturally sensitive services. In addition, participants described barriers consistent with NTDS findings such as "discrimination by health care systems, lack of knowledge and hostility by providers, and lack of health insurance to cover transgender-specific health care needs such as hormone therapy and gender confirming surgery (GCS)" (Roller et al., 2015, p. 419). As a result of these barriers, many TG/TS individuals were forced to advocate for themselves and find alternative ways of getting their needs met. Roller et al. (2015) categorized these alternatives into four different sub-processes including moving forward, doing due diligence, finding loopholes, and making it work. "Moving forward" is described as the decision to begin seeking satisfactory health care with accepting providers. The search for trans-competent and trans-sensitive care also requires that TG/TS individuals engage

in “doing due diligence” defined as the persistence associated with finding care that they want or need. Once the search concludes, it is often necessary for TG/TS persons to “find loopholes” within the existing health care systems. “Finding loopholes” involves negotiating the system so that unique health care needs may be met; for example, this might involve bending the truth to receive insurance coverage. Once a provider is established, the TG/TS individual often finds themselves responsible for “making it work”, or the long-term maintenance of the relationship with the provider to ensure that their complex and evolving health needs continue to be met.

Cultural Competency

As previously indicated in the Grant et al. (2010) and Roller et al. (2015) studies, TG/TS individuals often struggle to find adequate services and providers without encountering some form of discrimination, harassment, or violence. This issue may arise due to a lack of cultural competence, which can be characterized by potentially ignorant, inappropriate, and insensitive behaviors during service providers’ interaction with TG/TS individuals (Turner, Wilson & Shirah, 2006). These actions, in addition to the discrimination, harassment, disrespect, and violence often encountered in health care settings, demonstrate the need for change. According to the American Medical Association Code of Medical Ethics (2016) physicians should “examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic features, or other nonclinical factors, do not affect clinical judgment.” Thus, physicians and other health care providers are expected to give ethically sound suggestions and services to patients regardless of their gender identity. For example, speech-language pathologists (SLPs) specifically, are certified professionals

who are held ethically responsible for providing culturally competent speech, language, and swallowing services (American Speech-Language Hearing Association, 2016), but recent research indicates that SLPs' cultural competency in service delivery to TG/TS clients is largely inadequate (Hancock, 2015). Barriers to culturally competent health care services to TG/TS individuals are often related to SLPs and other health care service providers' preconceived opinions regarding gender.

Because of the need for more culturally competent services, Turner et al. (2006) published a framework for training cultural competency to public health providers serving Lesbian Gay Bisexual Transgender Queer (LGBTQ) individuals. This framework suggests that educated instructors provide training that is may be interwoven with existing educational and clinical experiences for public health students, or at annual in-service trainings in the workplace. Additionally, the training environment should be safe, challenging, nonjudgmental, and supportive such that health care trainees may discuss their own differences of opinion with peers. The suggested contents of the training include coursework that facilitates students/professionals movement through four stages arranged in a hierarchy. Thses stages include awareness, sensitivity, competency, and mastery. Beginning with the awareness stage, instructors may present general information regarding LGBTQ individuals. The goal of this stage is for health care providers to recognize how their conscious or unconscious assumptions and biases affect their interactions with LGBTQ patients and the quality of services they provide. Transitioning from the awareness stage to the sensitivity stage begins as one seeks to learn more about LGBTQ cultures including social norms, behavior, language and communication styles. An essential aspect of this stage is cultural flexibility such as validating diversity in

sexual orientation and gender identity of patients, respecting differences in family structure, function, and roles, and understanding social norms of LGBT individuals. In this stage, the instructor should encourage practitioners to confront their own personal beliefs and biases, while maintaining respect for others, which may be different from their own. The competency stage concludes the training by incorporating practical, realistic, and relevant opportunities for practitioners to practice their skills with LGBT clients such as critical analysis regarding public health scenarios, and group work designing LGBT-inclusive materials, public health policies, research, and measures that would inform and improve service delivery to LGBT clients. Finally, the mastery stage is not a distinct part of training, rather it begins when one is comfortable enough and willing to train others. Turner et al. (2006) indicates that mastery in each of four stages of training is not objectively evaluated, but is reflection and discussion following each stage should be included to ensure that trainees have met the objectives of each stage. Overall, the training stages described and suggested by Turner et al. (2006) are instructive to health care institutions and providers, such as SLPs, seeking to provide training in culturally competent service delivery to TG/TS individuals.

While cultural competency is important for all current and future health care providers, it is especially important for SLPs, considering their role in providing voice/communication treatment. The American Speech and Hearing Association (ASHA) certifies SLPs to provide services congruent with the Code of Ethics (2016) which asserts that “individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability,

culture, language, or dialect” (ASHA, 2016). Despite this obligation, many SLPs feel inadequately prepared to work with TG/TS individuals. In fact, Hancock and Haskin (2015) found that 47% of 279 SLP survey respondents across the world stated that providing communication services for TG/TS populations, such as voice feminization, was not covered in their master’s curriculum. Further, 51% of individuals did not know how to adequately describe voice/communication treatment for these individuals and when asked to rate feelings regarding LGBT subgroups, they were relatively more negative towards TG versus lesbian, gay or bisexual individuals (Hancock & Haskin, 2015). Despite this, respondents who were graduate students and/or SLPs in their clinical fellowship year (CFY) were significantly better at defining LGBTQ-related terminology on the survey. This is certainly a positive indicator for the future relationship between SLPs and TG/TS individuals seeking voice and communication treatment. Thus, although some SLPs may be uncomfortable working with the LGBTQ population, the responses from graduate SLP students and CFYs indicated that they may have more exposure and experience with terminology relevant to TG/TS individuals. Therefore, individuals who have been practicing SLP for fewer years may be more likely to seek out additional coursework and training to become more culturally competent and better serve these clients (Hancock & Haskin, 2015).

Voice and Communication Treatment Options

Although SLPs may lack knowledge and experience with TG individuals, it does not excuse them from their duty to provide voice and communication therapy to these clients when requested. The importance of cultural competency has been established, however familiarity with treatment options for this population is equally as important.

Often times, persons' physical appearance indicates their gender. Listeners are equally interested in identifying gender by listening to individuals' voices. Typically, if the physical appearance of an individual appears male, the listener is expecting to hear a lower, deeper voice. In turn, if an individual appears female, a listener will typically expect that individual's voice to sound higher and softer. Given these listener expectations, TG individuals are faced with the challenge of matching their voice to their authentic gender.

The two voice characteristics most representative of how listeners perceive a speaker's gender are fundamental frequency and resonance (Hancock & Garabedian, 2013). Fundamental frequency (pitch) is often the most compatible voice characteristic used to distinguish gender, however there are many other influences that signal whether a speaker is female or male such as their intonation, voice quality, pragmatics, and non-verbal communication. Given these characteristics and their effect on the voice, it is common for TG/TS individuals to seek assistance to help them modify their voice and communication such that it matches their preferred gender. Communication and voice treatments for TG/TS individuals often involve the client modifying resonance, fundamental frequency/pitch, intonation, phonotraumatic behaviors, breath control, and vocal hygiene habits (Hancock & Garabedian, 2013); ultimately however, the treatment targets depend on the unique needs of the client.

In order to establish a knowledge base of treatments for TG clients, SLPs may need to familiarize themselves with treatment options, therapy goals, and efficacy data. In a chart review of 25 cases, Hancock and Garabedian (2013) examined male to female (MtF) TG individuals' experience with voice feminization treatments at a George

Washington University Speech and Hearing Center (GWUSHC). The participants included 25 MtF TG individuals who were in different stages of transition, but all sought out voice feminization treatment to achieve a voice congruent with their gender identity. At the start of treatment, only 16% of participants identified as female 100% of the time. After collecting demographics and history from each of the participants, treatment goals were decided upon and therapy began. Sessions typically took place once a week at GWUSHC with an average of 22.34 sessions throughout an academic semester.

Many of the clients' long-term goals focused on achieving feminine voice production with feminine language 100% of the time. Additionally, each of the clients also worked on reducing phonotraumatic behaviors to decrease risk of vocal pathology, improving vocal hygiene, using relaxation techniques to decrease muscle tension during phonation, increasing fundamental frequency, and using more varied intonation, resonance, vocabulary, pragmatics, nonverbal communication, and respiration (Hancock & Garabedian, 2013). Fundamental frequency was the most frequent therapeutic target with 23 of the 25 individuals working to attain a higher and more feminine pitch range. Accordingly, clients focused on increasing fundamental frequency by 5 Hertz (Hz) increments during the production of vowels /e/, /o/, /i/, /a/, and /u/ and when saying the days of the week, reading from a passage, or delivering a monologue.

The program of therapy documented in this study consisted of therapy practices and goals that are typical for voice and communication therapy delivered to TG/TS individuals. Further, the therapy practices used appeared to be efficacious given that, at the end of treatment, 80% of the clients identified as female 100% of the time and speaking fundamental frequency had increased in sustained vowels, reading, and

monologue tasks by 5-6 semitones (Hancock & Garabedian, 2013). This study presents valuable information regarding efficacy of voice and communication treatment in helping TG/TS individuals match their voice with their chosen gender identity.

While research studies such as the one just documented indicate that voice and communication treatment is efficacious and offers consistently positive outcomes for MtF TG/TS individuals, research into communication and voice treatment options for female-to-male (FtM) TG/TS individuals is limited. For example, a literature search by Azul (2014) revealed that research articles related to transfeminine (MtF) people outnumbered transmasculine (FtM) people by a ratio of approximately 3:1. One potential reason for the dearth of research may be that, in some cases, testosterone treatment may be sufficient for facilitating voice masculinization (Pettit, 2004). That being said, it cannot be assumed that all transmasculine/FtM individuals desire the same approach for gender transitioning and that, specifically, testosterone treatment meets their unique needs for voice change.

To better understand how well androgen (testosterone) therapy facilitates perceived voice changes in FtM TG individuals, Van Borsel, De Cuypere, Rubens, and Destaecke (2000) surveyed 16 FtM subjects on their experience with androgen therapy. Of the 16 subjects, 14 reported a voice change following implementation of hormone therapy and were subsequently pleased with their voice. These individuals also acknowledged that voice changes were just as important as surgical alteration to their body when attempting to live as their chosen gender. That being said, most subjects reported that their course of hormone therapy was long and anxiety-provoking, with some encountering adverse effects to their singing voice. A follow-up longitudinal study

documented a significant drop in fundamental frequency in the voices of 2 FtM TG/TS individuals across 13- and 17-month periods of androgen therapy, respectively. These positive results indicate the utility of androgen therapy in facilitating voice change in FtM TG/TS individuals; however, results should be interpreted with caution, given that the speed of voice change and presentation of adverse affects varied across respondents. Given the previously discussed research findings, it is unclear whether or not the addition of speech therapy would positively supplement the implementation of androgen therapy, and therefore more research needs to be done (Van Borsel et al., 2000). It can also be noted that while androgen therapy alters the characteristics of the voice, it does not affect nonverbal or pragmatic aspects of communication. Thus, androgen therapy may sufficiently alter voices in TG FtM clients, however, additional treatment may be desired to facilitate more masculine nonverbal communication and pragmatics such as conversational skills, body language, facial expressions, gesture use, etc.

In summary, MtF and FtM TG/TS individuals may benefit from voice and communication treatment with focused goals dependent on their unique needs. Research indicates that while voice and communication services are beneficial for MtF TG/TS clients, it is unclear whether or not they are effective or necessary for FtM TG/TS individuals. Although there is a dearth of research regarding these clients, there are some resources for SLPs in the event that they are presented with a FtM TG/TS client. Further information will be presented on treatment for both MtF and FtM TG/TS clients in the handbook following this review.

Service Delivery: Identifying Barriers and Recommendations for Becoming an Ally

Given the previously outlined studies, it is evident that communication services

are available and potentially efficacious for TG/TS individuals; however, many TG/TS individuals may not be aware of them or have limited access to SLPs who provide such services. Potential barriers to service include SLPs' lack of knowledge or experience, client resistance to the therapy process, and client mental health status. SLPs have an opportunity to work past these barriers by providing appropriate and respectful care in accordance with their accreditation and ethical contract. In addition to the many options for voice and communication treatment, SLPs can create a welcoming environment for TG/TS individuals and work to become an ally for current and prospective clients.

SLPs' lack of knowledge or experience in working with TG/TS individuals may lead to difficulties accessing services as noted above. For example, LGBTQ terminology may be unfamiliar to most SLPs. Also, many SLPs are trained in voice, but do not encounter voice clients until their clinical fellowship year (CFY) or later, which may explain their lack of knowledge (Adler, 2015). A survey sent to SLPs who are members of the Illinois Speech and Hearing Association confirmed this to be the case. In particular, 86 of the 228 respondents indicated that they had no idea what LGBT stood for, while 43 individuals incorrectly defined or were unable to define transgender (Sawyer, Perry, & Dobbins-Scaramelli 2014). Before an SLP treats a TG/TS individual, resources regarding pertinent terminology to TG/TS individuals is crucial. Not only is it important to be educated prior to meeting a TG/TS client, but SLPs and providers alike should be prepared to ask questions for clarification when necessary in order to facilitate a trusting, open provider-client relationship (Makadon & Goldhammer, 2015).

Another common barrier to service delivery is the mental health status of the client. Very often, TG/TS individuals are experiencing or have experienced gender

conflict which can result in depression, social anxiety, substance misuse, addiction, and self-harm (Antoni, 2015). Many clients are motivated and therefore succeed during therapy, however some may struggle due to personal issues or emotional turmoil related to their transitioning. In this case, it may be necessary for SLPs to refer the client to a psychiatrist or psychologist or suggest support groups or other support services.

Additionally, TG/TS individuals may have high anxiety upon initial evaluation for voice and communication services, which may very well carryover across all sessions thereafter. These anxieties may be related to the fact that they are early in their transition, have traveled far for services, are experiencing financial or home-life difficulties, etc. (Antoni, 2015). These factors can greatly contribute to the client's willingness to participate, therefore it is crucial for SLPs to maintain sensitivity throughout the first and subsequent sessions. It is equally important for the SLP to maintain a positive outlook, assuring the client that the modification of their voice is a part of a process, typically consisting of small changes before a lasting change is achieved (Antoni, 2015).

Sometimes a TG/TS client may be resistant to participating in voice or communication treatment due to past negative experiences with health care professionals or health care settings. In this case, an SLP should reassure the client that the goal of achieving an authentic voice congruent to their gender identity is a joint goal. Lastly, the environment or space in which an SLP practices should be LGBT-friendly with inclusive health-related materials, gender neutral bathrooms, and open, comforting, and non-judgmental providers (McClain, Hawkins, & Yehia, 2016).

With all of this in mind, TG/TS individuals can be assured that SLPs and other health professionals are working to become more knowledgeable service providers.

Consequently, SLPs can maintain confidence when presented with a TG/TS client based on the fact that there are already published resources for their use as well as a demand for more.

Conclusion

Since the first public appearance of a TG individual in 1952, attitudes, research, and knowledge of this population have expanded exponentially (Halloran, 2015). Current statistics report that there are nearly 1.4 million TG/TS individuals in just the United States alone (Hoffman, 2016). Along with the growth in numbers, there has been more examination of health care experiences of the TG/TS community. Findings have indicated that discrimination and denial of health care exists for these individuals in addition to a lack of culturally competent providers. SLPs are one group of health care professionals responsible for delivering voice and communication treatment for TG/TS individuals seeking voice and communication patterns congruent with their desired gender identity. Effective SLP treatments for this community facilitate alterations of fundamental frequency (pitch), changes in intonation patterns, reductions in phonotraumatic behaviors, improved breath control for voice and speech, and improved vocal hygiene (Hancock & Garabedian, 2013). While voice and communication interventions for TG individuals have been proven efficacious, treatment does not come without challenges for both the SLP and the TG/TS client. SLPs must work around the existing barriers for TG/TS individuals (i.e. access to care, willingness to participate, mental health status of client, etc.) to treatment and become a supportive ally to their current and future clients. In conclusion, SLPs are a crucial provider in supporting TG/TS individuals through transitions in their voice and communication. To provide this

support, they must preserve adequate knowledge, deliver culturally competent care, and provide evidence-based treatment options. Only then will SLPs become an ally to TG/TS individuals and provide them with the best care.

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Running head: HANDBOOK FOR THE TRANSGENDER OR TRANSSEXUAL
CLIENT

A Handbook for the Transgender or Transsexual Client: Voice and
Communication Therapy Options

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Table of Contents

- i. Introduction
- ii. Terminology
- iii. Treatment
 - a. Where to go
 - b. Beginning Therapy
- iv. Other concerns
- v. Conclusion
- vi. Additional Resources

Introduction and Purpose

This handbook is for transgender (TG)/transsexual (TS) individuals seeking more information on voice and communication therapy for their transition. Information has been compiled by a graduate student pursuing a degree in speech-language pathology at Illinois State University under the guidance of a faculty mentor. It is hoped that this handbook may be used to orient TG/TS individuals to important terminology, the voice and communication therapy process for TG individuals, where a TG individual might go to receive voice and communication services, and also address common concerns that a TG person might have when seeking out these types of services.

Terminology

Language used to describe voice and communication and the health professionals that may be involved in therapies or medical interventions related to either can be complex. Thus, the first section of this handbook was created to expose you to common terminology often used by both clinicians and clients during voice and communication therapy.

Speech-language pathologist (SLP)

Professionals working with children and adults to prevent, assess, diagnose, and treat communication and swallowing deficits. These professionals obtain a national certification called the Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) (ASHA, 2016). Prospective SLPs must earn a masters degree, successfully complete a nine months of a clinical fellowship, and pass a national examination.

Otolaryngologist

Physicians trained specifically to diagnose and manage diseases and disorders related to the ears, nose, throat, and head and neck. These physicians are often referred to as “ENTs” (i.e. Ear, Nose, Throat).

Vocal/Voice coach

Professionals who typically have background, education, or experience in vocal performance, theater, etc., and who may facilitate improvements in clients’ speaking or singing voices and performance style, or help them find appropriate repertoire (i.e songs, monologues). Voice coaches may be sought out by singers

or actors preparing for a particular role or performance. No formal credentials regarding training and certification currently exist for voice/vocal coaches.

Foundations of speech:

Communication

The act of exchanging information through the use of mutually understood symbols (words, sounds, signs, behaviors, etc).

Communication difference/dialect

Variation in the communication system of a certain group influenced by regional, social, or cultural/ethnic factors. These differences are not considered disorders of speech or language.

Speech

The expression of language through articulated sounds.

Nonverbal Communication

The act of exchanging information through the use of nonverbal symbols, signs or behaviors such as facial expressions, gestures, body language, and eye contact.

Voice

The sound produced by vibrating vocal folds and further modified by structures of the head and neck.

Articulation

Shaping sounds for speech using the lips, tongue, teeth, and jaw.

Resonance

The unique quality of the voice influenced by the shape of the vocal tract.

Respiration

The act of breathing or inspiring and expiring. Expired air is the power source for vocal fold vibration and allows for voice and speech production.

Phonation

The production of sound by vocal fold vibration in the larynx.

Vocal folds

Paired membranous tissue, residing within the larynx, that creates sound when vibrated against one another. Vibration is facilitated by air pressure beneath the folds.

Foundations of Language:***Language***

The comprehension and/or use of spoken, written, or other symbol system that is established by a group to communicate ideas, intent, thoughts or feelings.

Syntax

The study of rules governing the arrangement or sequence of words used to create phrases or sentences in a given language.

Semantics

The study of meaning in language including analyzing the relationship between words, phrases, symbols or signs in a given language.

Phonology

The study of the distribution and organization of sounds (phonemes) in a given language. Additionally, it includes the rules for combining or using phonemes.

Morphology

The study of the rules governing how morphemes (smallest units of meaning) are used in language.

Pragmatics

The study of the function of words in different contexts or situations. The relationship between language and the environment in which it is used otherwise known as the social use of language.

Discourse

Verbal or written exchange of ideas during conversation, narrative, or expository.

Voice characteristics:***Voice quality***

Characterized by terms such as hoarseness, breathiness, etc. Results from the interaction between vocal fold vibration and the configuration of head and neck anatomy. Vocal quality can be modified and altered.

Fundamental Frequency

Physical measure of perceived pitch measured in Hertz. Hertz refers to cycles per second and is directly related to the number of times the vocal folds vibrate (open and close) per second. Adult males have lower pitched voices on average (i.e. 85-155 Hz), and adult females have higher pitched voices on average (i.e. 165 to 255 Hz).

Pitch

Perceptual correlate of fundamental frequency.

Intonation

Melody of speech (up and down inflectional changes in pitch) dependent on emotion, dialect, or the specific purpose of the message (i.e. the pitch of the voice rises at the end of questions).

Fluency

The ability to speak easily and smoothly using proper speed, accuracy, and expression.

Rate

The speed of speech, calculated as the number of words per minute (WPM).

Intensity

The physical pressure of sound measured using decibels (dB) and perceived as loudness.

Loudness

The perceptual correlate to intensity (i.e. how loud sounds are perceived to be).

Prosody

An umbrella term to describe the rhythm, intonation, and stress of speech and how it affects meaning.

Rhythm

The arrangement of spoken words, alternating in stressed and unstressed elements.

Stress

The degree of emphasis placed on a given element of speech (sound, syllable, word, etc.)

Strain

Perceived as vocal effort or excessive muscular tension during phonation.

Roughness

Subjectively, often characterized as a hoarse/harsh voice. Often correlated with perceived irregularity in the voice signal.

Breathiness

Audible air escape during phonation.

Hoarseness

A combination of rough and breathy voice qualities.

Asthenic

A thin voice quality potentially resulting from muscle weakness or fatigue.

Nasality

Abnormal resonance perceived as excessive nasalization of the voice due to airflow through the nose while speaking.

Disorders:***Communication disorder***

Impairment in the ability to receive, send, process, and comprehend communication.

Voice disorder

A voice that draws attention to itself through abnormal voice characteristics, that is inconsistent with an individual's age and/or gender, or that does not meet an individual's needs.

Language disorder

Impaired ability to comprehend (receptive) or express (expressive) spoken, written, or other symbols used to communicate.

Assessment of speech:***Stimulability***

One's ability to produce a new behavior given cues or prompts. If a person is stimuable for a new behavior or behaviors, therapy can be initiated to improve prognosis and facilitate adoption.

Prognosis

A judgment or prediction regarding the likely outcome of a treatment for a disorder or disease.

Auditory-Perceptual Voice Analysis

This evaluation technique involves the clinician's listening to the client's voice and describing it in relationship to parameters such as roughness, breathiness, hoarseness, strain, pitch, and loudness etc.

Acoustic Analysis

The evaluation of the voice in terms of physical acoustic properties (measured using a computer and microphone) such as fundamental frequency and intensity. Usually performed in combination with auditory-perceptual analysis.

Biological constraints

Aspects of a person's laryngeal anatomy (i.e structure, size) that may make it difficult to alter vocal characteristics.

Videostroboscopy

A visual examination in which an endoscope is placed either in the oral or nasal cavity to view the vocal folds and their movement.

Treatment of speech:***Evidence-Based Practice***

A term that is used to describe the integration of clinical expertise, scientific evidence, and client/caregiver/family needs in the provision of services.

Voice therapy

Treatment focused specifically on facilitating healthy changes in vocal behavior and technique.

Goal setting

The collaborative process between the professional and the client in selecting targeted outcomes for therapy.

Long-term objective

Performance goals typically addressing broader targets within a longer time frame.

Short-term objective

Performance goals that contribute to the progress of long-term objectives using specific and measurable data.

Treatment

Now that common terminology associated with voice and communication has been introduced, the voice and communication treatment process for TG clients will be discussed. This section has been organized into frequently asked questions that you or other individuals may have when seeking voice or communication services.

Where to go?

Finding a skilled provider, experienced in providing voice and communication services to TG clients, is extremely important. Thus, the next section will provide you with some information about speech-language pathologists (the professionals who will typically provide these services) and the type of therapy they might provide to you.

What is a speech-language pathologist and where do they work?

Speech-language pathologists (SLPs) are certified professionals who are trained to prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication, and swallowing disorders in children and adults. Specifically, SLPs are trained to evaluate voice use and vocal function as well as treat voice problems by facilitating optimal vocal behavior (ASHA, 2016). You will want to ensure that any SLP that you are considering working with is properly trained and certified. Specifically, all SLPs should hold a Master's degree as well as a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA). ASHA is the governing and certifying body of SLPs. Individuals with the proper education and credentials to practice independently as SLPs will have "M.S. CCC-SLP" following their name. You should not proceed with therapy with a clinician who does not hold proper certification or experience in treating voice or voice disorders. It may be appropriate to set up a

consultation prior to beginning therapy to determine the clinician's comfort level and experience in working with TG clients.

SLPs work in a variety of settings: schools, hospitals, physicians' offices, private clinics, college or university clinics and other health care facilities. Typically, a healthy individual seeking outpatient services will pursue treatment at a hospital, college/university clinic, or private clinic depending on their accessibility. While all SLPs are trained to provide voice and communication services, some may specialize in particular communication needs and client population. There are some SLPs who have committed to working exclusively with the LGBTQ+ population and even more specifically, TG/TS individuals. Ethical guidelines state that SLPs should only provide services that are within their scope of professional practice and competence, with consideration to education, training, and experience. Therefore, before initiating treatment, meeting with the potential SLP service provider may give you a sense of their experience in working with TG individuals on voice and communication.

How can an SLP help me with my transition from female to male (FtM) or male to female (MtF)?

Like previously stated, SLPs are trained to assess and treat disorders of voice and communication and may also help you change your voice and communication patterns so that they are in line with the gender with which you have chosen to live. For example, an SLP may facilitate changes in your baseline vocal pitch in a healthy and safe manner (i.e. minimizing vocal strain or discomfort).

Beginning Therapy

What would voice and communication therapy, addressing my unique needs, consist of?

Once you have found the right SLP, you may not know what to expect. Before treatment begins the SLP will assess your voice and communication skills. The assessment will typically include an interview and case history where information is gathered by the SLP regarding your background, referral information, medical history, and personal goals for therapy. Additionally, the SLP may administer an assessment or questionnaire to determine your perceptions of your current voice and how closely it matches your desired voice. In some cases, the SLP may examine your vocal folds via a rigid or flexible endoscopy and stroboscopy. Both imaging procedures are painless, but allow the SLP to examine vocal fold movement and vibration, look for laryngeal tension, and ensure that no irregularities exist on the vocal folds. If any irregularities or lesions are detected during this exam, the SLP may refer you to an ENT for further medical management.

Following assessment, the SLP will work with you to determine your communication and voice goals. Although the clinician may suggest treatment goals based on their unique expertise and any assessments previously completed, the generation of treatment goals should be a collaborative process between client and clinician. Goals for treatment may address articulation, resonance, prosody, rate and volume, syntax, semantics, expressive language and nonverbal communication in address to vocal features such as pitch and loudness.

I am a female, who would like to live 100% of the time as male, what kinds of things would we work on in therapy? (FtM)

Resonance

It is typical for male speakers to use chest or throat resonance (focusing the sound energy of their voices in the chest or throat) whereas female often focus the sound energy of their voices in their head. Thus, an SLP may help you adopt chest resonance through alterations in body alignment and reductions in bodily tension. Further, the SLP may guide you through specific vocal exercises that facilitate the use of chest resonance and help you identify the difference between head and chest resonance so you can self-monitor your use of either. Such voice exercises may further facilitate your adoption of a lower fundamental frequency/pitch without excessive tension. It is important to note however, that typically FtM TG/TS individuals who receive androgen (hormone) treatment report that their vocal pitch naturally decreases during or following treatment. This is something to keep in mind regarding your pursuit of treatment.

Breathing Exercises

Establishing healthy breathing patterns is crucial for supporting the voice and allowing for healthy vocal behavior change. For FtM TG/TS individuals, a diaphragmatic breathing pattern should be implemented with the help of a clinician. Diaphragmatic breathing can also help lower resonance during speech from the head to the chest.

Relaxation Exercises

Relaxation exercises may also facilitate the reduction of tension in the jaw and tongue as well as diminish vocal strain resulting from attempts to lower vocal pitch prior to the initiation of voice and communication treatment.

Rate and Loudness (FtM)

Males typically produce speech that is faster in rate and louder than that of females. Therefore, therapy tasks may work on increasing both of these parameters during structured conversation.

Language

Males may use more assertive language, relate information using fewer words, and speak using more statements and fewer questions than females. Thus, all of these may be linguistic targets in therapy. The clinician may also point out other aspects of your language that are more congruent with a female presentation and work with you to masculinize them.

Nonverbal communication is equally as important for achieving gender congruency as spoken communication. Males typically exhibit fewer facial expressions and gestures, and may not lean into their conversational partners to the same extent as females. Thus, you may work on decreasing the habits of feminine facial expression and hand movements during conversation in therapy. Additionally, the focus will be on increasing use of masculine gestures, facial expressions, and gait. Your clinician may video record you during communicative exercises so that you can self-assess and actively modify your communicative behaviors.

I am a male, who would like to live 100% of the time as female, what kinds of things would we work on in therapy? (MtF)

Articulation

Typically, treatment regarding articulation will focus on addressing broad articulatory differences between males and females. For example, vowels produced by females are typically easy, smooth, and gradual. The use of harder vowel onsets, may be eliminated by working on easy onsets in vowel-initial words and sentences. Additionally, female speakers typically elongate their vowels and speak with greater articulatory precision, so either of these may be a focus of your therapy program.

Resonance

Reduction in “chest” resonance is a frequent target in therapy for individuals transitioning from MtF. In particular, this reduction may be accomplished by focusing vocal output in the face, head, and neck via various voice exercises on words, sentences, and finally in conversation. Achieving head resonance can be difficult, but is essential for achieving a feminine voice.

Pitch

A frequent focus of voice and communication therapy for MtF clients is increasing vocal pitch in a safe and appropriate manner. You may work on raising your pitch in a slow and controlled fashion using the notes on a keyboard with your voice. You and the clinician will work together to find a comfortable, more feminine pitch. Then you will practice using and identifying this ideal pitch in sounds, words, sentences, and conversation during and outside of treatment sessions.

Rate and Vocal Loudness (MtF)

Because males typically speak more quickly than females, speech rate reduction is a frequent therapy target for MtF clients. You may work on introducing more pauses in your speech and elongating individual speech sounds to increase your speech rate. Further, decreasing vocal loudness may be worked on in conjunction with increasing rate.

Language

Females typically engage in more elaboration when explaining something to another individual, ask more follow-up questions, and use more emotionally-expressive language. These skills are best targeted within group settings to provide you with realistic and relevant practice with other MtF TG/TS individuals. If group therapy is not an option, you may be asked to engage in social interactions outside the treatment room while practicing the use of more feminine linguistic characteristics.

Nonverbal Communication

Women are more likely than men to communicate by mirroring the head movements of their conversational partners, leaning towards conversational partners, moving their arms closer to the body, and using expressive and fluid hand and finger movements. Women may also walk differently (i.e. with hip swing, using a shorter, narrower gait), communicating subtle information about a speaker. Thus, modifications of these nonverbals may be targeted throughout voice and communication therapy also.

Other Concerns

What if I am curious about seeing a speech-language pathologist for these services, but am concerned about being discriminated against?

Scientific research indicates that TG/TS individuals may experience anxiety when seeking health services due to fear of discrimination, uncertainty about providers' knowledge of their unique needs, and apprehension about disclosing personal information. However, health professionals, including speech-language pathologists, are ethically bound to provide quality care to all clients seeking services, regardless of their gender identity and expression, sexual orientation, race, religion, age, and cultural or ethnic heritage (ASHA, 2016). If an SLP or other service provider does not demonstrate this to you, they have violated their code of ethics and you may choose to report this violation to the provider's superiors or certifying body (i.e. the American Speech-Language Hearing Association).

How do I find a speech-language pathologist who will knowledgeably and competently help me feminize or masculinize my voice and communication?

SLPs are trained to work with individuals with a variety of communication needs. They are well-equipped to facilitate communication changes in TG/TS clients due to their unique training and expertise in voice and communication, knowledge of the anatomy and physiology underlying voice and speech, and understanding of the differences between males' and females' communication. However, some SLPs have dedicated time to working exclusively with the TG/TS population. These individuals most likely have sought out additional training in cultural competency for the TG/TS individual and may have more specialized knowledge than SLPs with more limited experiences with TG/TS clients. That being said, it is an SLP's job to address client's unique values and cultural

and linguistic characteristics when providing assessment and treatment for communication and continue their education and training throughout their career (ASHA, 2016).

Conclusion

Seeking out voice and communication treatment may be one major step in the process of transitioning from male to female or female to male. This handbook serves as a resource to get you started on this aspect of your transition; however it is not exhaustive in its scope. Additional resources that may help answer additional questions you may have about SLPs and TG voice and communication treatment and the settings in which it might be offered are provided below.

Additional Resources

While it is hoped that the information presented was concise, clear, and helpful, it is not meant to be comprehensive. Therefore, additional resources have been provided to you as a guideline for retrieving more specific and relevant information for you. While information and research is scarce, there are some established treatment programs that may be helpful for structuring your future therapy sessions. Provided below are links to brochures and preexisting treatment programs as well as general resources for additional information on the treating the transgender/transsexual population.

Treatment Programs/Brochures

Transgender Voice Therapy Brochure at

http://people.umass.edu/mva/pdf/ComDis%20612%20Student%20Presentations_09/Transgender%20Voice%20Therapy%20Brochure.pdf

Transgender Voice Therapy Program at

<http://www.provoicecenter.com/Brochures/Provoice%20Transgender%20Outreach.pdf>

General Resources

Center of Excellence for Transgender Health at

<http://transhealth.ucsf.edu/trans?page=guidelines-vocal-health>

World Professional Association for Transgender Health at

http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1352&pk_association_webpage=3932

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Running head: HANDBOOK FOR TREATING TRANSGENDER OR TRANSSEXUAL
CLIENTS

A Handbook for Clinicians Treating Transgender or Transsexual Clients:

Voice and Communication Service Delivery

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Table of Contents

- i. Introduction and Purpose
- ii. Terminology
- iii. Common Concerns
- iv. Assessment
- v. Treatment
- vi. Additional Resources
- vii. Appendix

Introduction and Purpose

This handbook provides background and introductory information to speech-language pathologists (SLPs) who are new to providing communication and voice services to for transgender (TG)/transsexual (TS) individuals. Information has been compiled by a graduate student pursuing a degree in speech-language pathology at Illinois State University under the guidance of a faculty mentor. This handbook includes common terminology relevant to working with TG/TS individuals, questions commonly asked by SLPs preparing to treat this population, and information about TG/TS communication and voice assessments and treatments. A section providing links to additional resources is also included.

Terminology

Before treating a TG/TS individual, it is important to become familiar with some of the common terminology used when speaking about and with TG people. Thus, the following pages include definitions for some of the most commonly used terminology in order to facilitate cultural competency with this population. While these terms may not be appropriate and applicable to all clients, they are still important for anyone interacting with the Lesbian Gay Bisexual Transgender Queer+ (LGBTQ+) population. Additional resources regarding terminology are provided at the conclusion of this handbook.

General

Transgender

An umbrella term used to describe people exhibiting gender identity, expression, or behavior that is different from the sex that was assigned to them at birth. It is sometimes shortened to just “trans”. This term should be used as an adjective, not a noun. For example, avoid describing this population as “transgenders” or “transgendered,” but refer to them as “transgender people” or “individuals.”

Transsexual

An older term which refers to those individuals who have sought out surgical and/or medical intervention in order to transition from one gender to the other. Note that not all transgender people identify as transsexual because they have not received these interventions, but most transsexual people will identify as transgender.

Cisgender

Describes a person who identifies as the sex assigned at them at birth.

Non-binary

An umbrella term used to describe individuals who do not identify as male/female or man/woman and may describe themselves as having no gender. Some individuals who identify as non-binary may also describe themselves as transgender.

Gender non-conforming/Genderqueer

Individuals who may identify as “in between” genders such as male-female or as neither male nor female.

Gender dysphoria

A psychological diagnosis, from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), applied to those individuals who do not identify as the sex assigned to them at birth.

Gender identity

A person’s internal sense of being male, female, neither, both, or other.

Gender expression

The image a person presents to communicate their gender identity to others. Gender expression may be communicated through persons’ names, the pronouns they use to refer to themselves, their outward behaviors, clothing, hairstyle, the sound of their voice, body shape, etc. Gender expression is sometimes classified into feminine and masculine categories, however, the characteristics of feminine and masculine gender expression typically change over time and vary by culture.

Gender-neutral/Agender

A term to describe a person with no clear gender identity or who feels neutral (does not clearly identify with one gender or another) about the gender assigned to them at birth.

Gender fluid

Describes an ever changing or fluid gender identity. For example, a person who is gender fluid may identify as female for a period of time, and then identify as male during a different period of time.

Transition

Refers to the process TG/TS individuals go through to align themselves with a gender other than the one assigned to them at birth.

Male-to-female (MtF)

Also known as transgender female, MtF is an adjective or noun to describe a female who was born as a male, and who may be in the process or already have transitioned to living as a female in society.

Female-to-male (FtM)

Also known as transgender male, FtM is an adjective or noun to describe a male who was born as a female and who may be in the process or already have transitioned to living as a male in society.

Sexual Orientation***Sexual Orientation***

How one identifies in terms of their sexual, physical, emotional, or romantic attraction to others. Often times, sexual orientation describes attraction to the opposite sex, same sex, both, or neither. Terms that describe sexual orientation include straight, lesbian, gay, bisexual, asexual, pansexual, queer, etc.

Homosexuality

Sexual or romantic attraction to a person or persons of one's own sex.

Heterosexuality

Sexual or romantic attraction between persons of the opposite sex.

Lesbian

Describes homosexuality between females.

Gay

Describes homosexuality between males.

Bisexual

Sexual or romantic attraction towards both males and females. Persons who are bisexual may not be attracted to both genders equally and have a preference for one over another.

Homophobia

A fear of, aversion to, or discrimination against homosexual individuals.

Transphobia

A fear of, aversion to, or discrimination against transgender individuals.

Closeted

A person who is homosexual, bisexual, queer, trans, or other who does not or has not yet disclosed their sexual and/or gender identity to others.

Coming Out

Refers to the moment when a person shares information regarding their sexuality or gender identity with others (family, friends, coworkers, etc.). May also refer to the process an individual goes through leading to the acceptance of their own sexuality or gender identity.

LGBTQ+

An acronym referring to individuals who identify as lesbian, gay, bisexual, transgender, queer/questioning, or other.

Medical Treatment***Sex reassignment surgery (SRS)***

Describes surgery that a transgender individual may elect to undergo as part of their transition. Typically the term “bottom surgery” is used to describe the following procedures: vaginoplasty (creation of a vagina), metoidioplasty and phalloplasty (two different surgical procedures which result in the creation of a penis). The term “top surgery” is used to describe chest surgery known as a mastectomy (removal of the breasts) or breast augmentation (creation of breasts).

Cross-gender hormone therapy

The introduction of hormones into the body, via injection, pill, or skin patch, to facilitate a transition from female-to-male or male-to-female. Hormone therapy for FtMs increases testosterone levels while lowering estrogen levels. Hormone therapy for MtFs increases estrogen levels while lowering testosterone levels, resulting in internal and external bodily changes.

Pre-op

Label used to describe a person who wishes or plans to have sexual reassignment surgery, but has not yet undergone it.

Post-op

Label used to describe a person who has completed sexual reassignment surgery.

Non-op

Label used to describe a person who does not plan to undergo any surgeries as part of their transition to a new gender.

Common Concerns

What is the importance of correct pronoun use with this population?

Pronouns are important for establishing gender identity and are often “gender-specific.” These include he, his, him, and himself when referring to a male and she, hers, her, and herself when referring to a female. These pronouns are exclusive to those individuals who identify as either female or male. Therefore, gender-neutral pronouns may be used by a TG/TS individual who does not wish to be identified in such a way. One set of gender-neutral pronouns that is most common include ze, hir, hir, hirs, and hirsself. In general, it is good practice for you to begin any interview, other assessment, or treatment process by establishing the pronoun your client wishes to be referred by. Considering this information and making efforts to use the preferred pronoun of your client is part of what will establish you as an ally for TG/TS individuals seeking medical treatment.

How do I know which pronouns to use?

There are several ways to find out which pronouns your client prefers. First, it may be identified on the intake form that was filled out prior to their first visit. If you are unable to find it there, you may listen carefully to which pronouns a family or close friend of the client uses. If you are not able to do either, it is acceptable and encouraged that you ask your client directly. You may introduce yourself the first time by identifying your own pronouns such as “Hi Sally, it is nice to meet you. I’m Rachel and my preferred pronouns are she/her”. This will provide a cue to your client that you are curious and open to knowing this about them. If you still are unsure, you may directly ask them in a polite way such as “I want to be sure that I am using the correct pronouns with you.

Which pronouns do you prefer I use?” While it may be an awkward or uncomfortable question to ask a person whom you have just met, it is likely going to be received positively by your client. Many TG/TS individuals prefer to be questioned directly about this matter so that assumptions are not made without taking into account their unique perspective. Keep this in mind as you are planning for your first meeting with a new TG/TS client.

How much should I know or ask about my client? (gender identity, sexual orientation, transition stage, operative status)

As the clinician, you will have access to any forms that your client has completed and additional documentation that they may have provided. It can be assumed that they are aware of your knowledge of the information within the documentation, however it is not always appropriate to discuss it. You should maintain a point of view that only what is needed to be known to facilitate effective communication treatment should be discussed. For example, it is not appropriate to ask your client about details regarding their transition stage including surgical status or sexual orientation. This information is not necessary for you to effectively assess or treat your client; therefore it is not important or relevant for your records. It should be noted, as a rule of thumb, that discussion about features non-pertinent to the communication therapy process are only acceptable to discuss in a therapy session if they are first addressed or disclosed by the client themselves. Your goal and duties include providing a comfortable and non-threatening environment for your client.

How do I get further training or information for working with TG/TS individuals?

Even after reviewing this handbook, you should seek additional support or training prior to treating your first TG/TS client. Unfortunately there is not a plethora of

resources or trainings specifically designed for speech-language pathologists who are new to working with TG/TS individuals. However, there are some general resources available for medical providers, one of the most popular being the World Professional Association for Transgender Health (WPATH). This organization's website contains resources for all professionals treating TG/TS clients, information on conferences, memberships, and trainings, and general news regarding TG/TS individuals. The WPATH website is a great place to start for focused material on this population and their unique needs. A link to WPATH website is included at the conclusion of this handbook under "Additional Resources."

Additionally, you may want to seek out additional support from the American Speech-Language Hearing Association (ASHA). If you are a member of ASHA, your membership provides you with access to thousands of research articles. Thus, a search of the available literature on communication treatment for the TG/TS individual may provide you with the latest scholarly information. Likewise, if you would like to receive specific information on voice assessment and treatment for TG/TS clients, you may find it helpful to join ASHA's Special Interest Group 3 (SIG) titled "Voice and Voice Disorders." With your membership, you will receive a newsletter that may document information related to working with TG/TS individuals. As a SIG 3 member, you will also have access to a listserv which networks SLP colleagues so they may ask one another questions about a large range of voice clients, including TG/TS clients. A link to this resource is also included at the conclusion of this handbook under "Additional Resources".

Assessment

An assessment with a TG/TS client may begin with a case history/intake form to obtain information on their medical, surgical, social, and occupational history. In this form you will also allow the client to explain their current concerns about their voice or communication, identify why they are seeking therapy, and their goals or desires for the treatment process. Often times it is hard to use a standard or general intake form used for clients with voice disorders for TG/TS individuals due to their unique needs. Many of the general voice questions will not apply to them, rather you may want to ask more specific questions relating to their goals for treatment.

One aspect of the intake form that is important for these individuals is the identification of gender. Most medical forms require a name, birth date, and gender. For these clients, this information might not always be straightforward. For example, they may have a legal name that will be written on the form, however, they may want to be called something different. On the intake form, it might be helpful to have a spot for them to write their legal name, as well as their preferred name. Additionally, intake forms typically have the standard check boxes entitled “male” or “female,” which may exclude TG/TS individuals. It is important to include options for “transgender,” “transsexual,” “gender-neutral,” etc. on intake forms. It would also be beneficial to have a blank space for any other classifications they may identify with. There is an example intake form in Appendix A following the conclusion of this handbook.

In your preparation for evaluating and meeting a TG/TS client for the first time, you should familiarize yourself with the client’s current status and their gender pronouns. You may also examine your own personal biases and potential scenarios that may be

perceived as discriminatory by the TG/TS client. If you feel your own personal biases may prevent you from treating the client appropriately, you should refer them to another clinician. Once you are prepared and educated, it is necessary to determine what types of assessment you will administer. This situation is unlike most assessment situations, in that there is no clear protocol or focused assessments to be used with these clients. However, there are some common themes that should be addressed within the assessment process.

Typically the assessment stage will include visualization of the larynx via endoscopy. A full case history will also be collected and likely include identifying information, referral source, medical history, social information, employment, and questions addressing the impact of gender-incongruent communication characteristics on TG/TS individuals' quality of life. Within the voice evaluation, you may screen for a potential voice disorder, discuss current vocal hygiene habits, and assess auditory-perceptual features of the voice. In this way, it is very similar to assessing any person with a voice problem seeking treatment. The unique challenge is presented when you are determining the how congruent their current voice is with their desired identity. In this case, you may use self-rating scales and questionnaires to get a better understanding of your client's perceptions and status, and determine a baseline before treatment for comparison after treatment.

Upon conclusion of the assessment process, treatment goals and objectives need to be determined. At this stage, you should connect your knowledge about gender differences and perceptions with the clients wants and needs. Doing so will allow you to create a treatment plan, for that will facilitate communication changes in line with your

client's gender identity. Your expertise will provide a framework for beginning therapy, however it is the client's individual set of circumstances that will determine the direction of therapy. Factors to consider when planning therapy include the client's needs and the amount of time it may take to meet goals. Additionally, you will want to address biological constraints with your client. That is, the anatomical and physiological constraints that cannot be controlled or adapted, even with the implementation of therapy. For instance, the size of the larynx and vocal folds will not change through behavioral therapy; however, you can continue to work on verbal and nonverbal communication that is not affected by this constraint. In summary, the assessment stage carries extreme importance for facilitating a productive, appropriate, and motivating plan that meets the needs of the TG/TS client you are serving.

Treatment

Many times, TG/TS clients seek treatment after attempting some “self-therapy.” This is an important piece of information to gather before beginning treatment, because it may affect your treatment approach. In particular, clients may experience voice problems if they try to change their voice on their own due to the development of maladaptive vocal behaviors or habits. In order to work through the specific and unique goals of each client, first we must guide the client to safely use their voice before treatment ensues via vocal hygiene training. Examples of vocal hygiene techniques include minimization of throat clearing, and addressing optimal vocal behaviors versus unproductive vocal behaviors. Additionally, although there is some commonality between treatment for male to female (MtF) clients and female to male (FtM) clients, the therapeutic process will differ in some key ways.

Treatment for Female to Male (FtM) Clients

Often times, FtM clients do not seek additional therapy due to the automatic voice change induced by androgen hormone therapy. However, that is not always the case. There are many aspects of voice and communication that may be targeted for these individuals including pitch, respiration, phonation, resonance, language and nonverbal communication.

Pitch

For clients seeking a more masculine voice even after hormone therapy, you may incorporate some vocal exercises to safely lower their fundamental frequency. These individuals may have excessive tension due to the pressure placed on their larynx from self-therapy strategies. Therefore, the number one

goal in the beginning is to improve overall vocal health. Following that, you may work more directly on lowering the client's fundamental frequency to match typical males (100-105Hz).

Rate and Loudness

Males typically produce speech that is faster in rate and louder than that of females. Therefore, therapy may focus on structured tasks that facilitate increases in both of these parameters during structured conversation. Tasks might include oral reading, use of checklists for conversational speech parameters, decreasing the duration of certain sounds, and decreasing pausing time during conversational speech.

Respiration

In order to facilitate effective lowering of pitch, breathing patterns must be addressed. Thus, therapy focused on respiration should incorporate instructions on using abdominal/diaphragmatic breathing patterns, rather than a thoracic breathing pattern. This will allow for proper breath support throughout the rest of treatment and during communication situations in daily life.

Phonation

There are many ways in which females and males differ in terms of phonatory patterns. For example, FtM clients may need to diminish the use of hard glottal attacks and instead replace them with easy onsets. The harsh glottal attack is most likely due to improper self-training or attempts to lower pitch without proper instruction. Be careful in your implementation of easy onsets due to the fact that many people will associate it with more feminine sounding voices.

However, it should be explained that the goal of easy onsets are not to be soft and melodic, but instead to facilitate safe and easy phonation at the desired vocal pitch. Additionally, relaxation techniques may be implemented to promote overall body tension release. Tension throughout the body, and in the larynx specifically, can have negative affects on the production of the voice.

Treatment for Male to Female (MtF) Clients

Pitch

Although it is usually the most desired change in voice, increased speaking fundamental frequency (SFF) is not sufficient on it's own to create an authentic feminine sounding voice. However, it is still one of the most common treatment goals for voice feminization. Voice therapy should begin by establishing habitual SFF or physiologically normal SFF so that it can be targeted throughout the course of therapy. Raising pitch above the identified physiologically normal SFF could result in voice problems. To determine habitual SFF, an acoustic analysis system should be used during the clients production of multiple tasks such as a throat clear into sustained phonation, response to a question with “uh-huh”, humming, and counting from 1 to 5 while going from low to high pitch. Once habitual SFF and physiologically normal SFF are determined, you can begin working toward a more gender-acceptable pitch. Therapy can include a combination of targets focused on decreasing muscle tension while progressing toward the target SFF. Tasks for decreasing overall muscle tension may include visual and tactile cues, relaxation exercises, alternating yawn-sigh productions, and encouraging the use of a softer, breathier

voice. Specific pitch exercises include working through a progression from isolated sounds to sentence productions and further into conversation using the target SFF. The ultimate objective in this process is for the client to use a comfortable, perceptually feminine voice that is congruent with their desired gender identity.

Rate and Loudness

Due to the fact that males have a higher vocal intensity and faster rate than females, decreasing intensity and decreasing rate may be targets for therapy. As with other goals, it is most important to first explain to the client the differences between their current rate and loudness levels and their target. This will help to facilitate self-awareness and promote the client's role as a stakeholder in the treatment process.

Articulation

In order to begin treatment involving articulation, it is imperative to know the differences between male and female speech. Typically, females use more articulate speech than men do. For example, females may emphasize the verb ending /ing/ and produce voiceless /th/ and postvocalic /r/, whereas men may shorten verb endings and replace or omit certain sounds. These findings are consistent with the idea of gender differences in tongue movement patterns, vocal tract dimensions, and articulatory speed. With a MtF client, articulation therapy can include both vowel and consonant modification. For vowel modification therapy, the introduction and explanation of easy onsets versus hard glottal attacks is a good place to begin. Thus, goals may focus on feminine articulation patterns

such as using soft, easy onsets accompanied by prolonged vowels. As stated previously, females tend to produce words with greater articulatory precision. Thus, a focus on over-articulating sounds in isolation, words, sentences, phrases, conversation, etc. may be targeted. Potential techniques for promoting more precise articulation include the use of light contacts, which include delicate productions of consonants with the lips, tongue, and teeth. In sum, articulation targets for TG/TS clients may be similar to what you may use with any given population, however it is most important to be familiar with the articulatory differences between in male versus female speech.

Resonance

Including resonance as a target for therapy is essential, however it not always a simple task. The target is typically to work on raising the subjective focus of the tone up into the face and head (i.e. establishing head resonance and eliminating the chest resonance typically heard in male speech). To facilitate head resonance, you may draw your client's attention to the sensations of their voice such that they are able to perceive vibrations in their head or on their lips or palate. Identifying differences between chest and head resonance during speech production will also help your client produce the target resonance pattern. Resonant voice therapy includes a fusion between multiple voice components and scientific justifications. It includes a combination of hygiene, sensory cues, respiratory control and articulation. In general, it is thought to be more of a "discovery process" rather than drill-based therapy. It may be necessary to begin with ear training to establish client self-awareness of chest versus head resonance.

Once ear training has concluded, resonant voice therapy should continue in conjunction with respiration goals due to the fact that breath support is a basis for sound production. You may include vocal play with high front vowels and voiceless consonants to shorten the vocal tract thereby lightening the vocal tone. Although you may feel uncomfortable facilitating changes in resonance due to minimal experience in doing so, this aspect of voice and communication is a crucial target for TG/TS clients.

Nonverbal Communication

Although it may not be the main target of therapy, including nonverbal communication in the treatment plan is important. There are many aspects of voice that are contingent upon proper language and nonverbal usage, based on the theory that voice and communication cannot be completely separated. Differences between male and females regarding this target are both basic and complex. There are basic differences in head movements, facial expression, gait, and posture and more subtle complex differences such as eye expression, finger expression, smiling habits, etc. In your session with a MtF client, you may address nonverbal behaviors that are typically more consistent with male communicators and facilitate their replacement with nonverbals that are generally perceived as more feminine. Potential goals for therapy may address incorporating more head movements, increasing the amount of facial expression, and facilitating changes in posture and gait while standing and walking. Females typically display a swinging motion while walking whereas men move on a more linear plane. Additionally, female posture is counterbalanced using their entire body to move

and lean during communication, while males tend to contain their overall body movements. All of the above targets can include video modeling, mirroring, and role-play techniques. Something to consider with this target is group therapy or providing real-life scenarios for practice to facilitate carryover/generalization.

Conclusion

This handbook provides SLPs with an introduction to the assessment and treatment of TG/TS individuals. It is hoped that with the given information, SLPs may begin to familiarize themselves with considerations and information crucial to effectively treating TG/TS individuals. In the last and final section, additional resources have been provided that extend upon the information in this handbook.

Additional Resources

While this handbook provides basic information about assessing and treating a TG/TS individual for voice and communication treatment, it is not comprehensive. Therefore, a list of recommended additional resources have been provided so that you may seek out additional details regarding this population.

For more information on terminology refer to the following websites:

Trans Student Educational Resources (TSER) at

<http://www.transstudent.org/definitions>

Gay and Lesbian Alliance Against Defamation (GLAAD) Media Resource Guide at

<http://www.glaad.org/reference/transgender>

National Center for Transgender Equality at

<http://www.transequality.org/issues/resources/transgender-terminology>

General Resources:

World Professional Association for Transgender Health (WPATH) at

www.wpath.org

American Speech Language and Hearing Association at www.asha.org

SIG 3: Voice and Voice Disorders


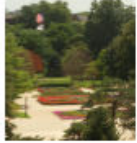


<http://www.asha.org/SIG/03/About-SIG-3/>


Multicultural Constituency Group: L’GASP

<http://www.noglstp.net/LGASP/join-lgasp/>

Voice and Speech Trainers of American (VASTA) at www.vasta.org

Appendix A



**ECKELMANN-TAYLOR
SPEECH AND HEARING CLINIC**
Illinois State University

Transgender Voice and Communication Therapy - Case History Form

General Information

Legal Name _____ Date _____

Preferred Name _____ Pronouns _____

Gender Identity _____ Sex Assigned at Birth _____

Date of Birth _____ Age _____

Address _____

Phone _____ Email Address _____

Occupation _____ Employer _____

Highest Level of Education Completed _____

Emergency Contact _____ Phone _____

Native Language _____ Primary Language _____

Physician's Name _____ Phone _____

Referral Source / How did you hear about us? _____

Person Completing this Form _____ Relationship _____

Additional Information

1. Do you ever change your voice in specific situations? Yes No
If yes, how and in what situations? _____

2. Do you ever experience discomfort (e.g., strain, fatigue, dryness, "scratchy" voice, etc.)? Yes No
If yes, please explain _____

3. Which communication partners do you feel most comfortable speaking with? _____

4. What situations and settings do you feel most comfortable speaking in? _____

5. Are you undergoing hormone treatment? Yes No
If under hormone treatment, are there any side effects (calming, emotional lability, mental concentration, changes in voice, etc.)? Please explain. _____

6. Are you on any other medications? Yes No
Do have any side effects? Yes No
If yes, please explain. _____

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www.csd.ilstu.edu/clinic/

7. What qualities do you like about your current voice? _____

8. What qualities do you dislike about your current voice? _____

9. What would you like to change about your current voice? _____

10. Who and/or what do you want your voice to sound like? _____

11. What are your personal goals for using your voice (phone, social, etc.)? _____

12. Have you been treated by an SLP in the past? Yes No

If yes, please describe your experience and/or results. _____



References

Adler, R. K., Hirsch, S., & Mordaunt, M. (2012). *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide*. San Diego: Plural Pub.

GLAAD Media Reference Guide - Transgender. (n.d.). Retrieved November 09, 2016, from <http://www.glaad.org/reference/transgender>

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