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THE ROLE OF THE SPEECH-LANGUAGE PATHOLOGIST WHEN
WORKING WITH CLIENTS WHO ARE TRANSGENDER:
A GUIDE OF GENDER IDENTITY AND
CULTURAL COMPETENCY

A Thesis

by

BRETT WELCH

Submitted to the Graduate College of
The University of Texas Rio Grande Valley
In partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

May 2017

Major Subject: Communication Sciences and Disorders

THE ROLE OF THE SPEECH-LANGUAGE PATHOLOGIST WHEN
WORKING WITH CLIENTS WHO ARE TRANSGENDER:
A GUIDE OF GENDER IDENTITY AND
CULTURAL COMPETENCY

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May 2017

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ABSTRACT

Welch, Brett, The Role of the Speech-Language Pathologist When Working with Clients Who Are Transgender: A Guide of Gender Identity and Cultural Competency. Master of Science (MS), May, 2017, 107 pp., 3 tables, references, 90 titles.

It is within the scope of practice of a speech-language pathologist to work with a client who is transgender for voice. However, regardless of the setting, a speech-language pathologist is likely to encounter a person who is transgender on their caseload. The American Speech-Language-Hearing Association mandates that all of its members be culturally competent when working with clients from different cultural backgrounds, including those from the lesbian, gay, bisexual, transgender, and queer community.

This thesis pulls from sociological, linguistic, and queer theory literature to provide an in-depth understanding of identity, gender, and transgender identity formation. With this nuanced understanding of these topics, the thesis explores the practical implications to cultural competency, and voice and communication therapy. Additionally, this thesis reviews current topics for debate in Gender Spectrum Voice and Communication therapy.

DEDICATION

Pursuing my education and achieving my goals would not have been possible without the constant love, support, and encouragement from my family and friends. To my parents, Michael and Gretchen, thank you for everything that you have done to help get me to where I am today. To my brother, Kyle, thank you for inspiring me to be the best version of myself. And to my friends, Amber, Cipriano, and Steffen, thank you all for the ears when I needed to talk, the shoulders to rest my head on, and the laughter to remind me to not take anything too seriously. I would not be who, or where, I am today without everyone's love and patience.

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CHAPTER I

INTRODUCTION

The purpose for writing this is multi-faceted. First and foremost, the transgender population is an underserved community that frequently faces prejudice and discrimination (James et al., 2016). Additionally, while there are many resources available about the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, they are often widely distributed across multiple media/sources, requiring a personal time investment and general awareness of less-mainstream outlets. Third, many speech-language pathologists (SLPs), while familiar with common voice disorders, are not knowledgeable of protocols, procedures, and cultural competence when it comes to working with a client who is transgender. Fourth, with the increased visibility of transgender rights, more people are choosing to come out as transgender. The increased number of people who are transgender requires more knowledge and cultural competence from SLPs and other professionals in order to effectively and ethically serve this population.

Given these four factors, the purpose of this paper is to help educate SLPs about the Queer and Transgender community in terms of cultural competency, best practices for voice therapy, and how to create a client-centered, holistic approach for clients who are underserved, both by the field of speech-language pathology and the broader society at large. One aspect of being culturally competent is understanding and being able to use the correct terminology pertaining to the LGBTQ+ culture. This thesis will explore the current understanding and

connotations of some of the most relevant terms for clinicians to be aware of. Furthermore, the concepts of identity, gender, and the subsequent implications for gender identity within the United States will be discussed to provide context for the clinician to understand and be culturally competent. Details about working with a client who is transgender on voice is explored by reviewing current best practices, as well as exploring areas for further discussion. Finally, ways to create a safe environment for clients who are transgender and an SLP's ethical obligations to create and maintain this environment will be presented.

The phrase “lesbian, gay, bisexual, transgender, and queer” is frequently abbreviated to “LGBTQ+.” This acronym also includes sexual and gender minorities who are not lesbian, gay, bisexual, or transgender. Because there are other sexual and gender identities not addressed by “LGBT,” the “Q+” is added to include other sexual and gender minorities not recognized by mainstream society (Schmitz & Tyler, 2017). The LGBTQ+ community, also referred to as the Queer community, has undergone significant changes within the last several years. This movement, often termed as “gay rights,” has set into motion a drastic change in social attitudes about members of the LGBTQ+ community. The successes and triumphs, including the legalization of same-sex marriage, have radically changed the discourse surrounding the LGBTQ+ community.

Terminology specific to the LGBTQ+ community will be explored more in-depth in the section *Terminology*, but it is important to establish a basic working knowledge and understanding of terms used in this paper from the beginning. The term *queer*, historically a derogatory term for gay men, has since been reclaimed by the LGBTQ+ community and is frequently used as a sense of pride and a source of political activism (Watson, 2009). “Queer” is an umbrella term used to encompass any individual that does not fit into mainstream norms in

terms of biological sex, gender, or sexual orientation. For the purposes of this paper, the term queer will be used synonymously and interchangeably with the acronym LGBTQ+ to describe both individuals as well as the LGBTQ+ community as a whole. Additionally, the term *transgender*, sometimes abbreviated as *trans*, will be used as an umbrella term encompassing individuals who identify as transgender - both male-to-female (MtF) and female-to-male (FtM), transsexual, gender non-binary (GNB), gender non-conforming (GNC), and those who broadly do not identify as cisgender. Throughout the paper, except for where literary aesthetics prevail, the author purposefully uses person-first language (i.e, “a person who is transgender” instead of “a trans person”). This emphasizes one’s personhood, instead of reducing a person to a single aspect of their identity. To use person-first language is the choice of the author - a homosexual, cisgender man. The Queer community is a large and heterogeneous population, and professionals should inquire about their client’s personal feelings on these subjects and not generalize or assume. Additionally, there is much debate about whether or not working on voice with a client who is transgender is considered “therapy” or “training.” The author has chosen to use the term “therapy.” This is a complex issue with no clear or immediate resolution. This debate, and the author’s justification for this decision, will be explored more in section *Current Issues in Speech-Language Pathology*.

CHAPTER II

SIGNIFICANCE

With the advances of queer rights in the United States over the last several years, most notably the legalization of same-sex marriage (*Obergefell v. Hodges*, 2015), civil issues facing the LGBTQ+ community have gained prominence in the social spotlight. While the legalization of same-sex marriage in the United States was a landmark victory for the Queer community, it is only one small component of ensuring equal rights and protections for individuals who identify as LGBTQ+. As it stands at the moment of publication, there are legal challenges and legislation being drafted that will have implications for protections of the LGBTQ+ community. Currently, there are 28 states in the United States where a person can be fired for their sexual orientation or gender identity. Two states, Wisconsin and New Hampshire, protect individuals from being fired for their sexual orientation, but not their gender identity. Three states, Arkansas, Tennessee, and North Carolina, currently have laws in place “preventing passage or enforcement of local nondiscrimination laws,” meaning there are no protections in place whatsoever for LGBTQ+ individuals (Non-Discrimination Laws, 2017).

While the available data on people who are transgender is limited, as of June 2016, it is estimated that in the United States, approximately 0.6% of the population (1.4 million Americans) identify as transgender (Flores, Herman, Gates, & Brown, 2016). Additionally, the youngest age group surveyed (18-24 year-olds) had the highest rate of identifying as transgender (0.7%) (Flores et al., 2016). These findings are double what The Williams Institute estimated in

2011, where approximately 0.3% of Americans identified as transgender (Gates, 2011). On one hand, it is hard to get an accurate estimate, as the U.S. census data does not ask respondents about their gender identity. Additionally, with the changing social climate around transgender rights, especially within the last few years, it is possible that more people are okay being “out” and identifying as trans.

The growing number of people who identify as transgender, and/or gender non-conforming, face staggering levels of prejudice and discrimination. Two reports that look at some of the discrimination faced by these individuals include *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (2011), and *Harsh Realities: The Experience of Transgender Youth in Our Nation’s Schools* (2009). Some key findings from these reports are listed in Table A and Table B, respectively. For further information and a more in-depth look at these statistics, the reader is encouraged to refer to the reports, both of which are accessible online. It is important to remember that these experiences do not apply to every person who is transgender. That said, these findings reveal that individuals who are trans experience disproportionately elevated rates of societal discrimination.

Children as young as three to nine years old often recognize they are different from their peers and experience extreme shame and guilt (Adler & Christianson, 2012; Shaefer & Wheeler, 2004). With the increased awareness and attention given to the transgender experience, younger children may have the language to recognize these feelings and come out, and become a part of the school-based SLP’s caseload. Furthermore, new research is emerging that shows a higher rate of gender dysphoria, the official diagnosis of being transgender, in individuals also diagnosed with autism spectrum disorder (Pasterski, Gilligan, & Curtis, 2013; VanderLaan, Leef, Wood, Hughes, & Zucker, 2014). This means that an SLP seeing a client for services relating to

autism spectrum disorder may also have to be knowledgeable about queer and transgender topics.

What are the implications for a speech-language pathologist? As per the American Speech-Language-Hearing Association's (ASHA) Code of Ethics, all members must abide by Principle I – C:

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, 2016a)

ASHA also mandates that all of its members be culturally competent when working with individuals from various cultures (ASHA, n.d.). It is important to remember that LGBTQ+ people are a subpopulation within the broader American culture. Members of the Queer community are also shaped by personal social differences. Furthermore, the Transgender community and culture is yet another sub-subculture with the broader LGBTQ+ community. As culturally competent professionals/SLPs, it is important to recognize the challenges and discrimination faced by the transgender community, and to help create a safe space in whichever setting that the SLP works with a client who is transgender. The goal of creating a safe space may be apparent for an SLP who works with a client who is trans in a private practice setting. However, this goal should be the aim of all SLPs when working with clients who are transgender, regardless of the setting. People who are transgender are still people and go through all of the stages of life that every person experiences. Speech-language pathologists in all settings need to be aware of the difficulties and discrimination frequently faced by the Transgender community and take steps to ensure that the profession does not perpetuate these

problems. Not only is this the moral thing to do, but ASHA's Code of Ethics explicitly dictates that speech-language pathologists, audiologists, speech and hearing scientists, audiology and speech-language pathology support personnel, and students do not discriminate. ASHA's ethics, and their implications for working with the Queer community, will be explored more in-depth in the section *Ethics*.

CHAPTER III

IDENTITY

Navigating and understanding identity can be a difficult task, as it requires a compromise of two opposite concepts. In one sense, *identity* is a private and personalized notion. It is who an individual is when they are alone. This sense of identity is subjective, belongs to a person who has agency, and is comprised of “memories, thoughts, and experiences” that help define and determine who that person is (Riley, 2006, p. 296). This concept of identity is called an individual’s *personal identity*. One’s personal identity is determined by the attributes and qualities that define their unique human experience. For instance, things like, “I am a nice person. I am a runner. I am a person who likes to travel,” are all qualities that make up one’s personal identity. At the same time, identity also refers to who someone is within a larger social context. This latter notion of identity is called a *social identity*. A person’s social identity is “the sum of all the social subgroups of which [a] person is a competent and recognised member,” and is defined in terms of characteristics shared with other members in society (Riley, 2006, p. 296). One’s social identity is how others view “you.” A social identity is comprised of things like “age, sex, religion, profession, region and so on,” that are constantly shifting as one moves across social contexts and situations (Riley, 2006, p. 296). While the former definition of identity is intrapersonal, the latter definition is interpersonal. One’s identity, then, is an ongoing negotiation between the opposing nature of one’s personal identity and one’s social identity.

To fully understand identity, however, one must also remember that identity is not black and white, and not as simple as a private and public notion. When conceptualizing this negotiation between personal and social identities, one must consider that an identity is defined by many factors and dimensions, and that no single aspect of identity operates in isolation. Jones and McEwen's (2000) *A Conceptual Model of Multiple Dimensions of Identity* articulates this concept well. In their model, Jones and McEwen argue that there is a core self which is defined by overlapping aspects of social identity (e.g., race, culture, sex, religion). Each aspect of one's social identity can be "understood only in relation to other dimensions," (Jones & McEwen, 2000, p. 410). Depending on the contextual and environmental factors in that moment, various dimensions of identity will be more prominent/influential on the "core" self (or personal identity). That is, a transgender Mexican man may more strongly identify as "trans" in some social contexts, and more strongly identify as "Mexican" in others. But in neither situation is he exclusively one or the other.

Having this deeper understanding of identity is essential for the culturally competent SLP that is working with a client who is transgender. As with any client, an SLP will create a client-centered approach to assessment and therapy. Before an SLP can create this client-centered approach, one must first possess a nuanced understanding of what identity is, and its role and function throughout a person's life. By possessing this knowledge, a clinician will have a better understanding of a client's conceptualization of their own identity and gender identity. This deepened understanding will be used to create a holistic and comprehensive approach to a client's specific needs for therapy.

CHAPTER IV

TERMINOLOGY

As one begins to work with clients in the LGBTQ+ community, it is important to become familiar with common terminology, jargon, argot, and slang that exist within the Queer sociolect. All languages experience change, and words within the Queer vernacular are not immune to the subtle shifts in semantics. Terminology is created to describe new identities and to help people bond over shared experiences. Words that were once offensive have been reclaimed and used as a source of pride; conversely, words that were once deemed “acceptable” are now considered dated and offensive. It is not the author’s intent to mandate or prescribe the use of language. Rather, the purpose is to describe words in their current connotations as it stands within the present social climate. Words and their meanings will continue to change and adapt to the needs of their speakers. Continued observation of these changes should be utilized to ensure that the professionals “stay in the loop” and do not commit a faux pas when working with clients. When in doubt - simply ask. An uncomfortable, yet genuine question of curiosity with the intent to better understand will fare much better than offending someone by using the wrong choice of words.

The following sections on biological sex, gender, sexual orientation, and other terminology will be a broad discussion on the terms themselves and their implications. A quick reference to the definitions of these terms can be found in Table 3. For readability, the terminology will be reviewed in their respective categories. Each category of sex, gender, and

sexual orientation refer to distinctive attributes, and how an individual identifies in one category will not necessarily determine how they identify in another. However, the reader should keep in mind that identity itself, in part, is a conglomerate of all three of these categories and that no one aspect of identity operates in isolation from another.

Sex

Referring to biological and physical characteristics, sex can be broken down into three categories: *male*, *female*, and *intersex*. Biologically, a *male* would have a penis, testes, and produce sperm. A *female* would have a vagina, mammary glands, and would menstruate. However, in contrast to this commonly perceived binary sex framework, there is *intersex*. The Intersex Society of North America (2008) defines *intersex* as “a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of female or male.” A person who is intersex could possess “atypical genitalia” or various expressions of the sex chromosomes (Wade & Ferree, 2015; Intersex Society of North America, 2008).

Gender

Defined as a societal construct, gender has a variety of manifestations and descriptions. *Gender* can be defined in terms of “man” and “woman,” but is more appropriately thought of in terms of “masculine” and “feminine,” respectively. When people hear the word gender, often times they immediately think of biological sex. Actions, behaviors, and objects inherently have no gender; however, societies often arbitrarily prescribe “masculine” or “feminine” attributes to certain actions and behaviors. These attributions are highly contextualized to place and time, as these are social constructs that change with social climates. For instance, wigs and high-heels

used to be masculine artifacts, however over time, they have become almost exclusively viewed as feminine items (Semmelhack, 2008).

In terms of gender identity, common terms that one might hear are cisgender and transgender. *Cisgender*, sometimes abbreviated as “cis,” describes a person whose gender identity matches their biological sex assigned at birth within normative societal expectations. That is to say, an individual who is born with male genitalia and identifies as “male” and/or “man” is considered cisgender. Conversely, a person whose gender identity does not correspond to their sex is considered *transgender*, or “trans.” Two categories that fall under the transgender umbrella are *Female-to-Male (FtM)* and *Male-to-Female (MtF)*, and describe a person’s biological sex assigned at birth and the sex or gender to which they are transitioning.

Additionally, some individuals identify as *gender non-binary (GNB)* or *gender non-conforming (GNC)*. Gender non-binary and gender non-conforming individuals exist outside of, and do not believe in, the binary gender paradigm created and perpetuated by society. This conceptualization argues that gender is a much more complex experience than just “man/woman,” and these individuals exist outside of these narrowly defined standards (Wade & Ferree, 2015). That said, gender and identity are not always easily categorized into clearly defined boxes. Some other identities include agender and gender fluid. A person who is *agender* also exists outside of the gender binary, but does not subscribe to the social concept of gender at all. Additionally, a person who is *gender fluid* may present as masculine in some contexts (e.g., has a beard and wears jeans), and present as more feminine in other contexts (e.g., wears a dress and makeup). In order to be their genuine self, people who are gender fluid may need “the freedom to switch back and forth from [a] masculine identity to another, feminine identity” (Levitt & Ippolito, 2014, p. 1743). While individuals who identify as gender non-binary, gender

non-conforming, agender, and gender fluid exist outside of the gender binary, for the purposes of this paper (and frequently in modern discourse of gender theory), these individuals are still considered transgender, because their gender identity does not correspond to their sex assigned at birth.

In relation to individuals who are transgender, there are a variety of opinions within the Transgender community about how individuals conceptualize their gender. For the purposes of clarity and consistency within this paper, a *trans man* refers to an individual who was biologically assigned female at birth, but whose gender identity is male/man; conversely, a *trans woman* refers to an individual who was biologically assigned male at birth, but whose gender identity is female/woman. However, some people within the transgender community do not share this view. For instance, some individuals feel that their gender identity is how they were born and who they truly are; therefore, the term “trans man” or “trans woman” is not appropriate. Some people feel that they were born as their true gender, even though society raised them as a different gender. That is to say, labeling a woman who identifies this way as a *trans woman* would be inaccurate because she has been a woman her whole life. Opinions on this perspective vary from person to person. Some individuals take great pride in being transgender, while others do not wish to be labeled as transgender because they feel it detracts from the legitimacy of their gender identity (Galupo, Henise, & Mercer, 2016). After sufficient rapport has been established, it is best to ask the client if they have a specific preference to maintain a respective, inclusive patient-centered environment.

By understanding that there are more than two genders, one can see why so much terminology exists to categorize gender identity. *Gender expression* refers to how a person is presenting themselves - i.e., what artifacts and behaviors are used to convey one's gender. A

professional understanding of this is essential, as a person who is transgender and just beginning to transition might identify as female, yet her gender expression may be entirely masculine. She is still in the process of coming out to others, and may be in a professional's office to seek further advice and guidance about transitioning, despite still doing and wearing stereotypically masculine things.

Two other concepts, worth noting briefly to allow for a better breadth and depth of understanding of gender, are gender bending and drag. One must understand that these are two very different concepts from being transgender, yet operate within the same social paradigm. Both gender bending and drag utilize socially gendered artifacts (e.g., makeup and choice of clothes) to convey gender. However, the individual gender bending or in drag is usually cisgender and has no desire to transition. *Gender bending* is mixing elements of both masculine and feminine together, often to directly challenge societal gender norms. A famous example of gender bending is David Bowie, a cis male who frequently incorporated feminine aspects into his appearance. *Drag* is dressing as a different gender, however it is entirely for performance and entertainment value. Ultimately, most drag queens or drag kings remove their makeup and are still cisgender people. The word *transvestite* is a different matter altogether, as it is a fetish of dressing in gendered clothes for sexual pleasure, and should not be confused with being transgender or the LGBTQ+ community.

Words are ever changing and evolving. While at one point it was common, the term *transsexual* is no longer an acceptable term. Some individuals do identify as *transsexual*, implicating that they have undergone gender-confirmation surgery to match their biological sex to their gender identity. However, due to the very limiting nature of this term (i.e., one *must* undergo surgery) and its medical connotations, it is no longer considered appropriate. The more

inclusive term transgender is preferred in its place. Additionally, “transgender” is deemed correct and the term “transgendered” is seen as unacceptable. While individual opinions vary, it is the general consensus that a person has autonomy in expressing their gender identity, and that being transgender is not something that “happens to someone” as the term transgendered implies. Other terms that are dated and no longer acceptable include: *hermaphrodite* and *cross-dressing*. The appropriate terms are intersex and drag, respectively. The word *tranny* is an offensive slur and should not be used in any context. For further reading and more in-depth discussions of gender, see Wade and Ferree (2015).

Sexual Orientation

Referring to how a person frames their sexuality, sexual orientation generally operates independently from biological sex and gender identity. Some individuals have difficulty understanding sexual orientation in terms of how it relates to individuals who are transgender. Simply put, one uses their gender identity as the basis for their corresponding sexual orientation label, rather than the biological sex assigned at birth. For instance, if a trans woman was attracted to women, then she would be considered a *homosexual* or *lesbian*. Likewise, if a trans man was attracted to women, then he would be considered *heterosexual* or *straight*. Recognizing a person by their gender identity mitigates most confusion regarding sexual orientation. Additionally, how a person conceptualizes and chooses to label their sexual orientation is largely up to the individual.

Admittedly, an SLP has few-to-no concerns in this area with their clients, except to avoid the presumption and bias of *heterosexism* - the practice of assuming and perpetuating a gender binary and that men should be attracted to women, and women attracted to men. The author includes this section and discussion to help readers understand the distinction between sex,

gender identity, and sexual orientation, as well as the broader context of the LGBTQ+ community that impacts the lives of individuals who are transgender.

Other Jargon

There are many words and phrases specific to the Queer community; it is not within the scope of this paper to discuss all of the terms within the Queer sociolect. However, there are a select number of words that a clinician should be familiar with. When a person is *closeted* or *in the closet*, it means that their gender identity or sexual orientation is not publicly known. It can be that the person is just beginning to understand their own situation, or that the person has only told a select few friends and family members. If a person is in the closet, then it is imperative that a clinician takes steps to ensure that they do not accidentally reveal something that their client would not like to be known. For instance, if a client who is transgender is still in the closet to their family, then the clinician should check with the client to see what name should be used when referring to the client in the event that the clinician needs to leave a voicemail. When a person is in the closet, over time they may choose to *come out* of the closet. The coming out process is different for everyone, and can take place suddenly, or over the course of many years. For people who are transgender, the process of realizing and presenting as their gender identity is referred to as *transitioning*. There is no “right” way to come out of the closet or transition. For some, especially for those who do not fit into the *heteronormative* and *cisnormative* culture of the United States - i.e., “the suite of cultural, legal, and institutional practices that maintain normative assumptions that there are two and only two genders, that gender reflects biological sex, and that only sexual attraction between these ‘opposite’ genders is natural or acceptable,” coming out will be a life-long process throughout a person’s lived experience (Schilt & Westbrook, 2009, p. 441).

While coming out implies agency and choice, the term *outing* refers to an individual being forced out of the closet by a third party. Frequently, there is no malicious intent when this happens. However, it undoubtedly leads to uncomfortable feelings for the person who was just outed, specifically if they were not ready to divulge such personal information. Additionally, outing a person can be very dangerous, especially if that person is in an unsupportive environment/family, which, frequently, is why a person has not come out in the first place. And while the social climate in regards to sexual orientation has become much more accepting, the aforementioned data on discrimination indicate that the same does not necessarily hold true for people who are transgender.

If a person is *presenting*, then they are dressed as/showing their true gender identity. For trans men who have not medically transitioned, a part of presenting may include *binding*, the act of using a constricting material to flatten the breasts to present with a more masculine figure. When the person is presenting and socially perceived as their identified gender, then they are considered *passing*. A trans woman who is passing would be called “ma’am” and addressed with feminine pronouns by strangers. The opposite of passing is being *clocked*, and occurs when strangers do not perceive a person as their presented gender identity. In the academic literature, being clocked is called *gender policing*, and is the result of a person who experiences something that does not conform to their internalized values of gender (Wade & Ferree, 2015). For trans women especially, their gender may be policed when speaking in a way that too closely reflects a “masculine” pattern of speech or voice. Gender policing can be very dangerous, especially if it is a transphobic person who is policing someone who is trans. Additionally, the colloquial term “clock” has regional variations in the U.S.; for instance, in New York City, gender policing is

referred to as being *spooked*. For more information on gender policing and cisnormativity, see Carter (2014); Schilt and Westbrook (2009); Wade and Ferree (2015).

It is important for a clinician to have an understanding of these words, as clients may use them in their natural speech. However, it is not appropriate for a clinician, especially one who is outside of the Queer community, to use them. When talking about “passing,” “not passing,” or “being clocked,” there are deeply engrained negative connotations implicated by those terms. A full discussion on the sociolinguistic connotations behind these terms is beyond the scope of this paper. For the sake of brevity, a clinician should understand that negative connotations exist with these terms. In their place, a clinician should use the terms “visibly transgender” or “not visibly transgender” (James & Walsh, 2017).

The act of identifying a person by a gender other than their gender identity, such as using the wrong pronouns, is called *misgendering*. Unless specifically requested by the client, one should avoid misgendering someone at all costs. Misgendering can be intentional or unintentional. If it occurs intentionally, then it is considered a *transphobic* act. In order to avoid misgendering someone, simply ask them which pronouns to use. This is especially important for individuals who identify as gender non-binary who may use gender-neutral pronouns such as they/them or ze/zim, which will be discussed in detail in the section *Pronouns*. Another term a clinician may come across is *deadname*. This noun can be inflected to the present progressive verb form, “deadnaming,” or the infinitive “to be deadnamed.” Whatever the inflection, it means the name, or to be called the name, that a person was given at birth. As one’s transgender identity emerges socially, a person will frequently go by a different name that fits their true identity. This is that person’s name. To call or to ask a person who is trans what their name was before they transitioned is rude and offensive on an interpersonal level. Professionally, the only caveat to this

is if a client has not legally changed their name, and the name used by a third-party payer is different from their current name. In which case, a clinician should ask something along the lines of “What is the name that should be used for insurance paperwork?”

Before discussing the next set of terms, the author would like to preface this section by saying that surgery is a very personal and sensitive topic to discuss. It is within the scope of practice of the speech-language pathologist to discuss surgery with their clients, especially when gathering case history and creating a “transition timeline” to better understand the role of voice therapy during transitioning (Davies, Papp, & Antoni, 2015). However, unless a client is seeking professional services, to inquire about surgery in the interpersonal realm is extremely offensive, invasive, and entirely inappropriate. Because this is a very delicate and sensitive topic, unless a client who is transgender broaches the topic, it is also acceptable for a clinician to avoid inquiring about surgery in order to preserve rapport, especially if they do not feel comfortable asking. Examples of effective and tactful questions will be discussed later in the paper in section *Case History*.

This section informs SLPs working with clients who are transgender of terms that they might encounter when discussing medical transitioning. *Sexual reassignment surgery* (SRS) or *gender confirmation surgery* (GCS) are the surgeries one goes through to match their biological sex with their gender identity. Medical literature may continue to use the term sexual reassignment surgery; however, the latter term, gender confirmation surgery, is more acceptable, because it affirms a person’s identity. Some people who are transgender elect to undergo GCS, however not all do, and some have no desire to do so. Additionally, not everyone who is trans wishes to have *hormone replacement therapy* (HRT). These decisions to not have GCS or HRT do not make an individual any “less-transgender.”

Gender confirmation surgery is not one individual surgery that a person goes through. People frequently refer to the different components of GCS as *top surgery* and *bottom surgery*. The former refers to one's chest, either having breast implants placed, or the breast tissue removed. The latter refers to sexual genitalia. Additional surgeries include a *thyroid chondroplasty* (which reduces the size and appearance of the thyroid cartilage, but does not change one's pitch) and *phonosurgery* (which raises the speaker's fundamental frequency) (Sandhu, 2007; Spiegel, 2006 cited in Davies et al., 2015). A variety of phonosurgery techniques to increase the speaker's fundamental frequency exist; however, the most researched surgery is the *cricothyroid approximation* (Davies et al., 2015). Surgeries most relevant to SLPs are those involving top surgery, thyroid chondroplasty, and phonosurgery, as these will have a direct impact on an individual's respiration, breath support for healthy phonation, and laryngeal function.

Pronouns

For individuals who identify as male or man, the pronouns "he, him, his" are appropriate; conversely, individuals who identify as female or woman, the pronouns "she, her, hers" are appropriate. When referring to more than one person, "they, them, their" are appropriate. However, "they" and its corresponding derivations have evolved with the cultural understanding of gender to be appropriate to refer to a single person in the instance that the gender of the referent is unknown, or for individuals who do not identify with the gender binary. This practice has been labeled as "singular they," and has received much pushback from prescriptivists of the English language. However, singular they is so ubiquitous that the people who complain about singular they frequently use it themselves without realizing it (Nunberg, 2016). Singular they has been around for a long time, and was used by Shakespeare, Dickens, and George Bernard Shaw

it as well (Nunberg, 2016). The need for a gender-neutral third person pronoun has long existed. People have tried to circumvent the “ungrammaticality” of singular they by inventing many different gender-neutral pronouns. However, very few catch on, and those that do, frequently fade away from the zeitgeist. Some of the more notable examples of gender-neutral terms that have been invented include ze/zim/zir, zie/hir/hirs, xe/xem/xyr (Baron, n.d.; The Need for a Gender-Neutral Pronoun, 2010). In 2012, Sweden successfully implemented the gender-neutral pronoun “hen” into their language, alongside the masculine “han” and feminine “hon,” (Sendén, Bäck, & Lindqvist, 2015). This is significant as it is the first known successful institutional implementation of a gender-neutral pronoun in a naturally gendered language that exists alongside its gendered counterparts (Sendén et al., 2015). Additionally, this shows that the need for a third genderless pronoun is not exclusive to the U.S. or English. Language is naturally shifting and evolving to meet the needs of its speakers, and in English, singular they has taken on this role to fill the need for a gender-neutral pronoun.

Asking a person what their pronouns are is a common courtesy in the Queer community and is not something that a clinician should shy away from, especially if in doubt. Additionally, there was a well-intentioned trend for a period of asking someone’s “preferred pronouns.” To use the term “preferred” undermines the legitimacy of a person’s identity by establishing it as a preference, rather than the true, lived experience. For this reason, avoid the term “preferred,” and simply asking someone, “What are your pronouns?”

Respecting a person by using their correct pronouns is essential to working with clients who are transgender, and a vital part of being culturally competent with the LGBTQ+ community. A clinician, and any other staff, should *always* strive to use the correct pronouns - unless specified by the client. A mistake is bound to happen at some point, especially for

individuals whose gender expression does not match their gender identity. When this mistake occurs, pause, correct the mistake, and move on. Do not draw more attention to the mistake than is necessary to fix it. However, to shy away from correcting it can cause lasting damage to trust and rapport. Mistakes will happen, but it is necessary to try one's best, and to correct oneself when they happen. To recognize the mistake and correct it shows that the person is trying. To ignore the mistake, or shy away from correcting it, undermines a client's legitimacy. People who are transgender report that being misgendered can cause an extreme sense of dysphoria (Glynn et al., 2016).

Furthermore, pronouns and their meanings vary across different cultural contexts. While some languages have gender-neutral pronouns embedded in them (e.g., German), other languages do not. Due to the increasing recognition of queer experiences in society, languages without existing non-binary genders markers are creating novel ways of recognizing people who are gender non-conforming. Another language facing this task is Spanish, a language with gender markers throughout the language. With the growing population of the Latin and Hispanic community in the U.S., Spanish has become commonplace, and SLPs frequently have Spanish-speakers on their caseload. Queerness is not limited to certain ethnicities, and people who are transgender can be found all over the world, although no exact estimate is available (Kritz, 2014). One term that has risen in popularity for people who speak Spanish and identify as gender non-binary is *latinx*, pronounced [la.'tĩ.nɛks] (“la-tee-nex”) or [læ.'tĩ.nɛks] (“Latin-ex”). Additionally, the corresponding non-binary pronoun in Spanish is *ellx*, pronounced /e.jeks/ (“ay-yex”). The pattern of using <-x> is analogized across other words, creating a novel gender-neutral morpheme for Spanish, (e.g., *amigx* (“friend”). Speakers can use this morpheme to specifically refer to a person who is gender non-conforming, or in reference to a group of people

that consists of male, female, and/or other genders. For example, “ellx es mi amigx” (‘they are my friend’ - a single person), or “mis amigxs son amables” (‘my friends are nice’ - multiple people including men, women, and GNC individuals).

Terminology is an important aspect of cultural competence when it comes to working with the LGBTQ+ community. Having a working knowledge of words used to describe sex, gender, sexual orientation, as well as other terms used within the queer sociolect, allows for the SLP and their clients to communicate using a common set of terms that are specific to the LGBTQ+ experience. Mistakes are inevitable, and it is vital for professionals to correct themselves when they do occur. By having a basic understanding of these terms, the SLP will have the tools to ask the right questions when these mistakes occur or when the SLP is unsure. Again, an uncomfortable, yet genuine question of curiosity with the intent to better understand will fare much better than offending someone by using the wrong choice of words. By now, the reader has an understanding of the distinction between sex, gender, and sexual orientation. The next section will dissect gender further, and look at gender as a social construct, gender identity, and transgender identity.

CHAPTER V

GENDER AS A SOCIETAL CONSTRUCT

Before one can ask, “What does it mean to be transgender?” one must zoom out and first understand gender and gender identity. While it is important to understand how gender and its implications function in society, to cover this topic in its entirety is outside the scope of this paper. Therefore, a cursory overview of gender will be discussed, as being familiar with gender and gender identity are essential to being a culturally competent with the Transgender community. For further information and a more in-depth discussion of gender please see: Butler (1990, 2004a), Carter (2014), Schilt and Westbrook (2009), and Wade and Farree (2015).

First and foremost, one must understand that gender is a product of society. One might then ask, “Where does the notion of gender come from?” Essentially, gender is engrained into people from the moment they are born (e.g., pink and blue hats put on newborn infants), and perpetuated through social norms and cultural stereotypes from a very young age. This process is known as *gender socialization* (Carter, 2014). How children are treated by society becomes internalized and shifts into *identity standards* for people. Identity standards are “the references in which interactions, settings, and contexts are used to compare the self to others” (Carter, 2014, p. 244). Families have the most direct impact on identity socialization and gender socialization (Carter, 2014). This means that one’s family has a significant impact on how someone negotiates their identity and understands their place and gender within society. Once internalized, these beliefs are very difficult to change, and these standards for how a specific gender should behave

become perpetuated by the actions of the members in society. These internal beliefs lead to an *identity control loop*, which causes individuals to police others' behaviors and to feel uneasy when they see someone/something that does not conform to their own internalized beliefs (Carter, 2014).

Gender as a Performance/Transaction

Given that gender is perpetuated and passed on by older members within a society, how does it manifest itself? Judith Butler (1990, 2004a), arguably one of the most well-known and prominent philosophers on gender theory, argues that gender is performative. Shakespeare's "All the world's a stage, / And all the men and women merely players," (*As You Like It, Act 2, Sc 7, line 139-140*) resonates deeply with the performativity of gender. Society assigns roles (i.e., male/female, man/woman), and like actors in an improvised play, people are expected to behave and act accordingly throughout their lives. This view on gender is philosophically grandiose with far-reaching implications that extend into every context and moment in one's life. It can be overwhelming if one tries to think about each of the countless ramifications of gender as a performance. In order to provide practical knowledge on gender to use in therapy, this paper will pull from Butler's performativity of gender as well as examine gender manifestations as social transactions. These transactions are more immediately tangible in one's day-to-day life.

As previously discussed, social artifacts inherently have no gender. However, society marks certain objects and behaviors as having "masculine" or "feminine" qualities. In the U.S., things like makeup, high heels, and shaving legs are marked as feminine. Things like sports, aggression, and beer are marked as masculine. Nothing prevents a person from crossing these boundaries, except the perception of others, and/or the fear of rejection from others for crossing these lines. Every morning when a person wakes up, merely by the choice of clothes they put on,

they have subconsciously begun to engage in gendered transactions. Does one put on a dress or a suit? Does one put on makeup? What about shaving facial hair? While most of these decisions (i.e., transactions) are not conscious subscriptions to gender, they are a result of one's upbringing and gender socialization, which produces patterns of habit and lifestyle. The subsequent lifestyle that one develops is identity socialization in action. One's internalized beliefs about what is or is not acceptable, is the identity socialization people use to police others based on their internalized identity control loop. There is nothing stopping a man from going to buy a dress. But this man will likely encounter judgmental looks and stares, and may face discrimination if trying the dress on. This is gender policing taking place. Seeing a man wearing a dress does not conform to most people's internalized control loop and how their identity was socialized. Therefore, the observer experiences negative emotions and/or discomfort when confronted with this input (i.e., seeing a man in a dress).

Gender identity is so engrained that people can live their entire lives without giving it much thought. Things like crossing one's legs or how much room they take up when they sit are included in this. Additionally, things like believing that house chores are for a specific gender, or if a person stops themselves from doing something because it is "unladylike." Does a man prevent himself from crying because "boys don't cry?" Each of these involves a transaction, an acceptance or denial of how one "should" behave, and the resulting consequences are the artifacts that define and perpetuate a society's gender norms.

Gender Identity

It is easiest to think of gender categories as a spectrum rather than discrete, mutually exclusive entities. On one side of the spectrum would be "masculine" and the other side of the spectrum would be "feminine." In the middle of the spectrum are individuals who ascribe to

neither masculine nor feminine aspects of gender (i.e., gender non-binary/non-conforming). Another conceptualization of gender argues that masculine and feminine are separate scales. The two scales are “less/more masculine” and “less/more feminine.” This latter conceptualization allows for more fluidity of gender identity, where one can incorporate both masculine and feminine aspects into one’s identity. The inherent fluidity in the spectrum allows for a much more dynamic approach to understanding and performing gender. An individual may choose to incorporate and mix both strong masculine and feminine features, while another individual may choose to forego masculine or feminine features altogether.

Transgender Identity

Now that the reader has a better understanding of identity, gender, and gender identity, the reader may ask, “What does it mean to be transgender?” This section explores models and discussions relating to transgender identity, identity development, and the commonalities in the process of transitioning. Transitioning is a multifactorial, complex, and unique experience for everyone. While there is no one-size-fits all model or process, there are certain experiences that are prevalent patterns. The author cannot emphasize enough that everyone’s situation and experience is unique, and that one piece of information should not, and must not, be generalized to an entire population of individuals. Some individuals may go through only some of the stages discussed, while others may experience each stage more than one time.

People who are transgender have described feeling uncomfortable in their own skin. Being transgender does not simply correspond to the binary framework that a boy “wishes to be a girl,” or vice-versa. Individuals who recognize that they are transgender, but are prevented from transitioning and having their gender identity recognized are at an increased risk for a host of adverse mental health consequences (American Psychiatric Association [APA], 2013; Davies

et al., 2015; Olson, Durwood, DeMeules, & McLaughlin, 2015). There can be great distress that comes with being misgendered and not having one's gender identity validated, yet there are positive mental health benefits for individuals who are able to socially transition and receive support from their friends and family (Olson et al., 2015). The formal diagnosis of *gender dysphoria* and its implications will be discussed in more depth in the section titled *Gender Dysphoria*.

Devor's (2004) landmark fourteen-stage model of transsexual identity laid the framework for understanding gender identity development. Previously, there have been models on queer and homosexual identity development, but not specifically for transgender identity. Devor's (2004) model describes gender identity development in the following fourteen stages: 1 - *abiding anxiety*, 2 - *identity confusion about originally assigned gender and sex*, 3 - *identity comparisons about originally assigned gender and sex*, 4 - *discovery of transsexualism*, 5 - *identity confusion about transsexualism*, 6 - *identity comparisons about transsexualism*, 7 - *tolerance of transsexual identity*, 8 - *delay before acceptance of transsexual identity*, 9 - *acceptance of transsexualism identity*, 10 - *delay before transition*, 11 - *transition*, 12 - *acceptance of post-transition gender and sex identities*, 13 - *integration*, and 14 - *pride*.

Cass' (1979) model of homosexual identity development consists of six stages: 1 - *identity confusion*, 2 - *identity comparison*, 3 - *identity tolerance*, 4 - *identity acceptance*, 5 - *identity pride*, and 6 - *identity synthesis*. Additionally, Hiestand and Levitt (2005) developed a 7-stage model of gender identity development of butch lesbian women. Hiestand and Levitt's (2005) model consists of the following stages: 1 - *gender conflict*, 2 - *collision of gender conformity and sexual orientation pressures*, 3 - *gender awareness and the distinguishing of differences*, 4 - *acceptance of lesbian identity leading to gender exploration*, 5 - *gender*

internalization and pride in sexual orientation, 6 - gender affirmation and pride, and 7 - integration of sexual orientation and gender difference.

Although each of these models discusses a different aspect of sexual orientation and/or gender identity, they all discuss the evolution and development of queer identity. It is imperative to remember that these models and stages do not dictate what one must go through. Some people may experience a stage of the model for a long time, while others experience the stage minimally, if at all. While Cass' (1979) model focuses on male homosexuality development, Hiestand and Levitt's (2005) model integrates butch lesbian identity development. Although Hiestand and Levitt (2005) primarily focus on sexual orientation, it begs the question of gender, masculinity, and what it means to be "butch." Devor's (2004) model is the only one that solely focuses on transgender identity. However, people who are transgender might also have to navigate questions about their own sexual orientation, while their understanding of gender identity develops (Levitt & Ippolito, 2014). By synthesizing the broader implications of these models and understanding the trends seen throughout, the culturally competent clinician will have a deeply nuanced understanding of identity development as it pertains to the many facets of the Queer community. For specific information pertaining to each of these models, see Cass (1979), Devor (2004), and Hiestand and Levitt (2005), respectively.

In all of the models mentioned, the beginning stages are marked with turmoil, anxiety, confusion, doubt, and isolation, as the individual feels and maybe realizes that they are "different" from their peers, but cannot quite articulate how they are different. Some people might feel tension to conform to standards put in place by society, which are often enforced by family and the media. Additionally, an individual might experiment privately "with alternative gender consistent identities" that allow for them to live as their biological sex while also

fulfilling their needs of self-expression (Devor, 2004, p. 2). After these initial stages, the next process is encountering someone who is transgender, or discovering that the Transgender community exists. Along with discovering the Transgender community comes the language used to describe certain experience and feelings, which can legitimize “the feelings with which they have been living for many years,” (Devor, 2004, p. 9). Although now an individual knows about the Transgender community, they may continue to distance themselves. Cass (1979) describes this in stage three - *identity tolerance*, Devor (2004) as stage five - *identity confusion about transsexualism or transgenderism* and stage six - *identity comparisons about transsexualism or transgenderism*. While discovering that the Transgender community exists can be a significant point in one’s life, an important next step is understanding oneself in light of the new information.

Before an individual fully accepts themselves as trans, there is a period of tolerance and contemplation. These stages are vital as it allows a person to learn more information and understand “the enormity of what it means to identity oneself as [transgender]” (Devor, 2004, p. 11). Additionally, some people may “become overwhelmed with shame and fear about the social and psychological implications of their expressions,” (Devor, 2004, p. 13). After one navigates these emotions, one can begin to embrace their gender identity. For some, embracing this identity comes relatively quickly after learning about transgenderism, while others will require more time to understand and negotiate their sense of self. Devor (2004) includes another stage of delay after acceptance where an individual learns more about transitioning. Generally, after a person has accepted themselves, the next step is disclosing one’s gender identity and coming out. After coming out, a person will then begin to transition. The transitioning stage is arguably the most varied stage, as transitioning will be different for everyone. A person may socially

transition by wearing different clothes, and going by a different name. A person may begin to medically transition by seeing a mental health provider if they have not already done so, or beginning HRT or GCS. How a person decides to transition and when their transition “is complete” will ultimately depend on that person’s individual sense of gender. A gender non-binary individual may wish to incorporate strong masculine and feminine traits. Conversely, a gender non-binary individual may wish to have neither masculine nor feminine presentation and present as androgynous.

One important aspect of the transitioning model that is specific to Devor’s (2004) conceptualization is death. While it is not a literal death, it is a death of a part of oneself. The transitioning process means leaving behind one way of life, which can have tremendous emotional consequences for the person transitioning, as well as close friends and family, who may “[grieve] for the person that once was but no longer will be,” (Devor, 2004, p. 15). This can be a particularly difficult stage of transitioning, especially if individuals suppress and do not recognize these emotions.

Once a person has internalized and integrated their identity, it can become a source of pride. This pride can manifest itself as political activism and/or personal pride. Depending on a person’s disposition, this may involve political protests, or something more private on the interpersonal level that advocates for social understanding and acceptance (Cass, 1979; Devor, 2004; Hiestand and Levitt, 2005). These stages represent an abstract sense of identity development that falls along a continuum with no discrete boundaries. Some stages may coexist with each other; additionally some individuals may experience a stage more than once. This represents a discussion of how identity develops. As discussed previously, identity is an ongoing

negotiation between many different factors that is always developing and evolving throughout one's life.

The models provided by Cass (1979), Devor (2004), and Hiestand and Levitt (2005) provide a framework to understand how one's queer identity develops. However, identity development models alone do not provide complete insight to the experiences that shape one's identity. For this, the author turns to Levitt and Ippolito's (2014) *Being Transgender: The Experience of Transgender Identity Development*, which discusses common themes collected from people who are transgender about their own process of identity development. Three main clusters were discussed in their study, with subcategories that pertain to common themes, which will be summarized below.

Cluster one from Levitt and Ippolito (2014) is "From childhood treated like damaged goods: Pressure to be closeted about gender can lead to self-hated and isolation; all while under others' scrutiny," (p. 1735). Frequently in childhood, individuals feel pressure from societal sources (e.g., family and media) to conform to cisgender norms (i.e., cisnormativity). This pressure can lead to "self-hatred and profound loneliness" upon realizing that their gender is perceived as dysfunctional, and were forced to hide and ignore their true self (Levitt & Ippolito, 2014, p. 1737). Many individuals also report that they are viewed as "freaks" and "objects of curiosity," because of their gender nonconformity (Levitt & Ippolito, 2014, p. 1738).

The second cluster discussed is "The power of language in fostering acceptance: In hearing transgender narratives and becoming aware of social processes that enforce traditional gender standards, the possibilities for self-exploration expand" (Levitt & Ippolito, 2014, p. 1740). This second cluster details how crucial learning about the transgender community was for a person to understand their own gender identity. Finding an affirming community that provided

a safe space to explore nontraditional gender expressions is life saving for many individuals. Additionally, the power of language to help a person understand their gender identity is paramount to one's transgender identity development. By hearing about other people's experience being transgender, many participants "realized that a category did indeed exist that represented their experiences of gender and validated their existence," (Levitt & Ippolito, 2014, p. 1741).

The third cluster found by Levitt and Ippolito (2014) was "Identity formation is an ongoing process of balancing authenticity and necessity" (p. 2742). This describes the negotiation between being true to oneself while also understanding that there are limitations (e.g., safety, financial resources) to fully expressing oneself. Participants discussed how presenting as their authentic identity boosted their self-confidence. However, some participants mentioned that by presenting their authentic gender, they became conscious to different societal standards (e.g., to be thin), or how their mannerisms did not match the traditional gender categories.

Additionally, participants discussed the transitioning process. Levitt and Ippolito (2014) found that some people were very comfortable with their sex assigned at birth but were more comfortable presenting as a different gender, while other individuals' sense of authenticity depended heavily on having the physical characteristics of a different sex. This continuum of identity underscores the individuality of the transitioning process and that each person will have different and unique goals when transitioning. While transitioning, a person's sexual orientation may shift (Levitt & Ippolito, 2014). This shift can be an expansion or narrowing of preference in partners. For some individuals, embodying their authentic gender allowed for them to be more comfortable during sex, thereby increasing their potential partners. For others, though, their

comfort with their gender allowed for them to become more confident in their sexual orientation (Levitt & Ippolito, 2014). This process of exploration and discovery of one's sexual orientation will also play a role in one's identity development, and may follow a process more similarly described by Cass (1979) or Hiestand and Levitt (2005). Therefore, having a general understanding of the development process, as it pertains to sexual orientation and gender identity, is key for the culturally competent clinician. To learn more about these identity development models, please see Cass (1979), Devor (2004), Hiestand and Levitt (2005), and Levitt and Ippolito (2014).

Gender Dysphoria

The official diagnosis according to the fifth iteration of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of being transgender is gender dysphoria (GD). This diagnosis, however, is an area of contentious debate and discussion for both those within the Trans community and professionals who work with this community. Here the author will explore this debate in a cursory manner. For a more complete understanding of the debate and its implications, please see Butler's *Undiagnosing Gender* (2004), and the World Professional Association for Transgender Health (WPATH, 2011).

Gender dysphoria is defined as an individual who has “a marked incongruence between the gender they have been assigned to [at birth] and their experienced/expressed gender” (APA, 2013, p. 453). Previously, in the DSM-III and DSM-IV, the diagnostic term was *Gender Identity Disorder* (GID). While the diagnostic criteria remains relatively unchanged, the revised diagnosis reflects the American Psychiatric Association's shift in perspective regarding the issue being one's *identity* versus the distress of incongruence of one's gender and sex (Parry, 2013).

For more information about the formal diagnosis and its diagnostic criteria, please see DSM-V, *Gender Dysphoria in Adolescents and Adults* – ICD-10-CM: F64.1 (APA, 2013).

While the shift in perspective about the diagnosis' origin was welcomed (DeCuypere, Knudson, & Bockting, 2010), the existence of a diagnosis at all is problematic. While WPATH (2011) points out that some people who are transgender may experience gender dysphoria (i.e., the “discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth”), not everyone who is transgender will experience this discomfort or distress (p. 5). For these individuals who *do* experience gender dysphoria, it is a valid and relevant mental health disorder. However, for a majority of people who are transgender, they are not inherently disordered because they identify as transgender (WPATH, 2011).

On one hand, the existence of a diagnosis allows for a medical validation of one’s identity. This validation comes with a variety of benefits, not least of which include access to medical care to help with the transitioning process, which can be covered by insurance in cases where it is deemed “medically necessary” (Butler, 2004b). These agents of transitioning can include: choosing to live as one’s desired gender, HRT, GCS, declaring a legal name, and securing the legal status of one’s gender. Therefore, the GD diagnosis provides an individual with a pathway to transition and allows them to avoid the “distress, maladaptation, and other forms of suffering” that one might experience if prevented from transitioning (Butler, 2004b, p. 76).

With that said, the process of formally diagnosing an individual pathologizes their existence, thereby implicating that they are “to be found, in some way, to be ill, sick, wrong, out of order, abnormal, and to suffer a certain stigmatization as a consequence of the diagnosis being

given at all,” (Butler, 2004b, p. 76). The diagnosis, then, also gives validity to transphobic rhetoric that frames people who are transgender as needing “fixing” (Butler, 2004b).

In many ways this diagnosis is a parallel to the diagnosis of *homosexuality* in the first iteration of the DSM in 1952, and was seen as a “sociopathic personality disturbance” (The History of Psychiatry and Homosexuality, 2012). Later, in the DSM-II, homosexuality was reclassified as a sexual deviation. After much protest, the APA moved to finally delete the diagnosis of homosexuality in 1973, but replaced it with *Sexual Orientation Disorder*. This diagnosis ultimately transformed into the *Ego Dystonic Homosexuality* in the DSM-III, which was finally removed in 1987 (Butler 2004b; The History of Psychiatry and Homosexuality, 2012). These diagnoses of homosexuality gave credence to anti-gay groups, like the National Association of Research and Therapy of Homosexuality, which wished to implement “conversion therapies” to individuals who are homosexual (Butler, 2004b).

Similarly, the pathologization of transgender identity allows for comparable views of “fixing” a person’s gender identity. Some individuals believe that the diagnosis should be eliminated entirely. The notion of being transgender, consequently, would not be a disorder requiring a diagnosis, but rather a person who is “engaged in a practice of self-determination, [and] an exercise of autonomy” (Butler, 2004b, p. 76). However, abandoning the formal diagnosis in favor of recognizing and respecting a person’s autonomy creates tension. A formal diagnosis facilitates an economically easier path to transitioning that individual self-conceptualization does not. Yet, this same diagnosis produces stigmatization and labels individuals as disordered (Butler, 2004b). As controversial as the diagnosis may be, its resulting benefits from insurance providers should not be taken for granted. Benefits to the transitioning process can result in much needed services, including voice therapy.

Ideally, one should be able to secure the benefits that facilitate transitioning, without the consequences of pathologizing one's existence. However, for the time being, this is not the case. Going forward, one can only hope that as society changes, so too will its perspective on the transgender experience.

CHAPTER VI

SIGNIFICANCE OF VOICE

The human voice is extremely unique. It is the auditory fingerprint that is used to navigate one's daily life. This intricate system of pipes and sinuses turns a simple sinusoidal wave into a complex wave layered with harmonics, and is unlike anything else that humans experience. Every person's voice depends on the physiological make up of their body, but it does not end there. One's voice is also impacted by factors such as: health, language, dialect, and yes - gender.

A person's voice is the unique medium with which they interact with the people in their environment. People can recognize someone by their voice almost instantaneously when the person begins to speak (Hamilton, 2000). A person's identity, inevitably, involves one's voice. Whether it is a singer, a radio host, a teacher, or even a person that claims to "hate" their voice - each of these individuals has a relationship, conscious or otherwise, with their voice that has been incorporated into their identity. A person's voice has been said to act "as a mirror of the inner self" (Colton, Casper, & Leonard, 2006, p. 2). It is no surprise then, that people who have vocal pathologies undergo intense psychological and emotional stress when their voice does not function as it previously did (Colton et al., 2006). Similarly, people who are trans can experience trouble when/if their voice is not congruent with their gender identity (Davies & Goldberg, 2006). This trouble can be a direct result of their voice not matching their gender identity and/or presentation, which can cause discomfort. Additionally, an incongruent voice can cause other

people to misgender them, which may result in feelings of distress and dysphoria (Davies et al., 2015; Davies & Goldberg, 2006; Hancock, Krissinger, & Owen, 2010; Neumann & Welzel, 2003).

A gender-congruent voice is important as it has an “impact on [one’s] psychosocial and financial wellbeing, and personal safety” (Oates & Dacakis, 2015, p. 49). Furthermore, voice feminization is considered an important aspect of transgender care, as studies have shown that voice feminization is rated “extremely important” by individuals in the transgender community (Hancock et al., 2010). Speech masculinization is an area that needs to be researched further. Many FtM individuals obtain a satisfactory speaking fundamental frequency (SFF) by taking testosterone. However, Van Borsel, Cuypere, de Rubens, and Destaerke (2000) found that 25% of trans men were sometimes perceived as female on the phone. Much more research needs to be done, but all evidence suggests that an incongruent voice is harmful to an individual, while a congruent voice supports and affirms one’s identity. For more details about human physiology and voice, please see Colton et al. (2006).

CHAPTER VII

TRANSITIONING

Transitioning is the process by which one begins to match their gender identity with their gender expression. Transitioning is a long, multifaceted, and individualized journey. There is no “one way,” nor is there a “correct” or “incorrect” way to transition. Transitioning may take many years for some, while others will transition in a relatively short amount of time. Some individuals choose to undergo HRT and GCS, while others do not. None of these choices make a person any “more” or “less” transgender. Gender, and how a person identifies and conceptualizes their gender, is a personal experience that may or may not be congruent with society’s standards. This section will broadly describe the transitioning process and an SLP’s role as a client transitions. It is extremely important for professionals to understand that these experiences should not be generalized to all people who are transgender.

Process

Because transitioning is person-specific, only general themes will be discussed here. For more in-depth information about transitioning, the reader should refer to Atnas, Milton, and Archer (2015), Bilodeau and Renn (2005), Cass (1979), Devor (2004), Hiestand and Levitt (2005), and Levitt and Ippolito (2014). Generally, evidence shows that children as young as three to nine years of age discover that they are different from their peers. These feelings of being different come up again around the time of puberty when the body begins to physically change, and can frequently result in feelings of shame, isolation, and depression (Shaefer & Wheeler,

2004; Adler & Christianson, 2012). It is noteworthy to include that children who are supported in their transition by their families and social networks at the younger stages have no more depression and only minimally more anxiety than their non-transgender peers (Olson et al., 2015).

Once a person goes through the process of self-discovery, understanding, and acceptance that they are transgender, the “transitioning” process begins to take physical manifestations. It is important to note that these initial stages of transitioning can extend over many years for some people. Bodoian, Byrd, and Adler (2014) found that the average trans woman who sought out voice therapy was 36-years-old. Furthermore, Bodoian et al. (2014) found that 71% of their respondents had been married at least once, and 56% reported that they had at least one child. Disclosure of one’s gender identity is usually the next step after a person realizes their true gender identity. People will begin to tell their close friends, family, and/or colleagues. At this point, a person’s gender expression may not match their gender identity, or the person has begun to make small changes (e.g., growing or cutting their hair). As time goes on, a person will continue to change their outward gender expression to match their gender identity. These changes may be done gradually, or not, and will continue until they are presenting their gender identity in all areas of their life. Gender fluid individuals may continue to have entirely masculine or feminine presentations in some contexts, while blending genders in others. The process of changing one’s outward appearance, which may also include going by a different name or pronouns, is called *social transitioning*.

Frequently, an individual will seek out a mental health professional before or during the transitioning process. After an individual has been presenting for six months, they may begin to look into HRT and/or GCS. Six months is notable, as the DSM-V requires that the individual

present as their desired gender for at least six months to confirm a diagnosis of GD (APA, 2013). Generally, this diagnosis comes from a mental health provider (WPATH, 2011). However, the *WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (7th version)* (2011) does not formally mandate a length of time a client must be seen to receive a diagnosis of GD. The diagnosis of GD usually helps to facilitate medical transitioning and/or care (APA, 2013). However, not all individuals seek to receive the diagnosis, and may choose to vary their gender expression depending on the setting. Additionally, some individuals may present their gender identity full-time for much longer than six months without wanting to be diagnosed with gender dysphoria.

If an individual wishes to undergo HRT and/or GCS, then they will have to work with a licensed counselor, psychologist, psychiatrist, or other medical professional that is able to diagnose GD. Once the professional gives the diagnosis of GD, the individual can obtain a letter to support the diagnosis. With this letter, the individual can take it to an endocrinologist who is knowledgeable with trans health and begin HRT. Trans men are typically given testosterone hormones, and in some situations progestin to “assist with menstrual cessation early in hormone therapy” (WPATH, 2011, p. 50). Trans women are typically given a combination of testosterone suppressants, or anti-androgens, and estrogen (WPATH, 2011). Some individuals choose to stop here and not have any surgery, while others choose to have GCS. A person might also seek to change their name and gender on their birth certificate. Sometimes this will require a diagnosis of GD and a supporting letter from the mental health professional to legally justify these changes, although it will vary between jurisdictions. This can be a straightforward process or not; it largely depends on the state, county, and even individual judges involved.

Everyone has a different concept of what it means to transition. As discussed, gender is very complex and much more than just a binary classification. Some individuals identify as entirely female, while others may identify as both female and male. A person's gender conceptualization will ultimately determine their transitioning process, and this process will continue until a person feels that their gender expression matches their intrinsic gender identity.

A Speech-Language Pathologist's Role as a Client Transitions

While transitioning varies from person to person, the author created this section to discuss the role of the SLP throughout a client's transition. This section is an oversimplification of transitioning, and is intended solely as a guide for clinicians to better conceptualize their role when working with a client who is transgender. It is important to remember that these stages fall along a continuum with no discrete boundaries.

Pre-Discovery

At this point a client does not yet realize they are transgender, although they may or may not experience depression and anxiety. An SLP would only see a client at this stage if they were being seen for a different speech and/or language disorder (e.g., a fluency client). If an SLP sees signs of depression or anxiety, then the appropriate referrals to mental health care providers should be made. A clinician should strive to create a safe and welcoming environment for all clients.

Discovery

At this stage a client may begin to question their gender identity, which may involve experimenting with gender expression privately. At this point a client is continuing to learn more about themselves and the Transgender community. Similarly to *pre-discovery*, a clinician would not see a client at this stage unless they were an existing client for other speech or language

concerns. The clinician should continue to foster a safe and welcoming environment for all clients, and make referrals to the appropriate professionals if signs of depression or anxiety are present.

Acceptance

Now, a client recognizes and accepts themselves as transgender, although has not come out or socially transitioned. Their identity as a person who is transgender begins to emerge. An SLP might see a client this early on in their transition if the person considers their voice to be a large part of their social transition and would like more information before beginning to transition. Additionally, a person who is transgender might seek out an SLP for more information about voice and transitioning in general. An SLP might also have an existing client on their caseload for unrelated speech and/or language concerns, who is in the process of developing their transgender identity and may turn to the SLP for information about transitioning. An SLP should foster a supportive environment and make a client feel safe to bring up questions or concerns about voice and gender. Additionally, the SLP should be culturally competent and knowledgeable on the broad topics of transitioning and the LGBTQ+ community to answer the person's questions, as well as refer out to the appropriate resources and professionals.

Disclosure

As the client begins to come out to their friends and family and begins to socially transition, they may seek out professional services (e.g., voice, counseling). As they come out, their gender expression may begin to change as well. An SLP at this point should be receptive to a client's questions and be knowledgeable about gender identity and voice. Additionally, the SLP would begin working with education, assessment, and therapy as appropriate for a client's

individual needs. An SLP should also contact other professionals that are helping the client throughout their transition to create a comprehensive approach.

Presenting

At this stage, a client begins to express their gender identity full- or part-time and experiment with different things that fit their own sense of gender. The SLP should be supportive of various expressions of gender and conceptualizations of gender identity that a person might have. At this point the SLP will use a client-specific approach to work with the client to develop a voice that fits their sense of gender identity. An SLP should continue with assessment, therapy, and referrals for other services as necessary, while also continuing to work with the other professionals involved in the client's transition.

Post-Transition

At this point, a person presents as their gender identity full-time, and has achieved an internal and external gender balance (i.e., their inner-self matches their outward appearance). An SLP should continue with education, assessment, and therapy, with follow-up sessions as appropriate. Additionally, the SLP should also act as a resource for other professionals on the client's healthcare team.

Summary

With any client, an SLP should create and promote a safe environment for their clients to take risks and improve. An SLP should also use a client-centered, holistic approach to assessing and treating clients. A part of this holistic approach to therapy is understanding a client's internal concept of gender. By having an in-depth knowledge of identity and gender, the culturally competent SLP will be able to create appropriate goal targets based on the client's sense of gender, and not societal norms. Additionally, where a client is in their transition will impact how

therapy is conducted. It is important to remember that these stages are an idealized simplification of the transitioning process, and that an SLP's role in therapy should be adapted to each client's needs.

CHAPTER VIII

VOICE AND COMMUNICATION THERAPY

Voice is intrinsically tied to one's identity and can shape a person's psychological well being by ensuring that a person is not misgendered (Glynn et al., 2016). Because of this, a person who is transgender might wish to seek out voice therapy to help establish congruence between their voice and their identity. The World Professional Association for Transgender Health (WPATH) recognizes this relationship and has outlined in its *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (2011) the role of speech-language pathologists (as well as other voice professionals) and the goals of therapy. The WPATH believes that the purpose of voice and communication therapy is to "help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self" (WPATH, 2011, p. 53). Keeping in mind that gender is a spectrum, the goal of therapy is to not teach an individual to have stereotypically "masculine" or "feminine" speech, but rather to work with the client and help them to develop a voice that reflects their sense of self. Additionally, ASHA has outlined areas appropriate to work on with a client who is transgender. These areas include: pitch, resonance, intonation, rate, volume/intensity, language, speech and sound production, and pragmatics (ASHA, n.d.). These areas are discussed in the *Current Best Practice* section.

The culturally competent SLP should be mindful of potential barriers to accessing therapy for some people who are transgender. For some, voice therapy is cost-prohibitive. The unemployment rate of people who are transgender is triple that of the national average, and of those who are insured, 25% have been denied insurance coverage for transitioning-related services in the last year (James et al., 2016). Additionally, Bodoïn et al. (2014) found that many participants in their survey “stated that they were not aware that speech treatment services existed for transgender persons” (p. 48). Potential solutions include a sliding payment scale or group-therapy sessions to help reduce the cost of voice therapy. However, neither of these would be effective for the client who is unaware that voice services exist. Some individuals turn to the internet or their peer groups for information on changing their voice. However, these individuals, reported less satisfaction with these options, compared to those who had received voice therapy (Bodoïn et al., 2014). It is also important to remember that the client who is transgender brings their “own knowledge and experience to the table and the SLP is not necessarily the sole expert” (Bodoïn et al., 2014, p. 49). It is vital for the SLP to work with the client and their understanding of their gender to determine which areas to address in order to create an authentic, yet safe, voice for the client.

ASHA’s Recommendations

ASHA’s guidelines regarding treatment with clients who are transgender include: pitch, intonation, resonance, rate, volume, language, speech sound production, and pragmatics (Voice and Communication Therapy for Clients Who Are Transgender, n.d.). The goal of working on these areas is to create a voice that is congruent with the clients sense of identity, as well as ensuring that the client does not engage in any practice or habits that might cause damage to the vocal folds (WPATH, 2011). Additionally, ASHA has ethical guidelines that its clinicians must

abide by. These guidelines and their implications for practice with clients who are transgender will be discussed in the section *Ethics*.

Current Best Practice

This section briefly examines gathering case history, baselining information, and each area of therapy to work on so that the reader has a cursory understanding of what voice and communication therapy entails. While a majority of clients who are transgender and seek voice therapy are trans women, this section is written to be applicable to both trans men and trans women. Before delivering therapy, the SLP is encouraged to read Adler, Hirsch, and Mordaunt (2012), Davies et al. (2015), and Davies and Goldberg (2006) for in-depth information and a complete understanding of assessment, therapy, and best practices. It is important to remember all of these behaviors being assessed and treated are intrinsically tied to cultural and linguistic norms that will vary from client to client. The following discussion is derived from the U.S.'s mainstream culture and Standard American English. Clients from other linguistic and cultural backgrounds will require different norms.

Case History

Obtaining a complete case history is an important aspect of any client. This remains true for clients who are transgender. For clients who are transgender, specific information pertaining to vocal: health, habits, use (professionally and recreationally), abuse, and previous attempts at modulating voice (self-guided or otherwise) should be collected. Unlike other voice clients, a client who is transgender and is seeking therapy for voice is not required to see an otolaryngologist before receiving therapy (Davies et al., 2015). However, if the SLP suspects a vocal pathology by observing “roughness, limited range, difficulty projecting, rapid vocal fatigue, or effortful voice production,” then the SLP should not provide therapy and refer the

client to an otolaryngologist (Davies et al., 2015, p.127). Other areas to inquire about include psychosocial history and how one understands and conceptualizes their gender. It is important for the clinician to remember that how one understands their gender may shift over the course of therapy. Specifically for trans men, an SLP should obtain information about binding, as it will have a direct impact on one's respiration ability. Given that individuals who are trans are more likely to have bad experiences with professionals, it may be appropriate to delay obtaining a comprehensive case history until sufficient therapeutic rapport is established (Davies & Goldberg, 2006). It is best to let clinical judgment guide this process, which is one reason why being culturally competent and sensitive is so important when working with the Trans community.

As previously discussed in the *Terminology* section, surgery can be a very sensitive topic. The clinician should only broach this topic if they feel comfortable with the sensitive nature of the topic, or if the client addresses this topic first. Surgery has a potential impact on how therapy will be conducted; therefore, having this information is beneficial, however not mandatory for therapy to proceed. In order to inquire about this sensitive area without being too invasive, it is best to ask a client "What does your transition timeline look like?" This question serves multiple functions. First, it allows for the client to establish where they are in their transition - are they just starting, or do they already present their gender identity in all contexts in their life. By having this understanding, the clinician has better insight to their role within the transition (e.g., will the client need references to other professionals, or do they come with their own team established). Additionally, the client is allowed to bring up what they feel comfortable discussing. If they do not bring up any surgeries, then the clinician can probe further by asking specifically about the person's medical transition timeline, and explain that this information may

impact how therapy proceeds. It is important, however, for the culturally competent clinician to understand the sensitive nature of this topic, and to not risk therapeutic rapport in the process of collecting this information.

All surgeries will require time for the client to heal, which will impact a person's day-to-day life. The surgeries that will have the most direct impact on voice and communication therapy include: a *thyroid chondroplasty* (also known as a tracheal shave or laryngeal shave), a *phonosurgery* to raise the pitch (cricothyroid approximation, anterior commissure advancement, laser-assisted voice adjustment, etcetera), or chest surgery (either an augmentation mammoplasty or subcutaneous mastectomy) (Davies et al., 2015). A thyroid chondroplasty and phonosurgery will directly impact an individual's ability to phonate. A chest surgery will directly affect a person's respiration and breath support for phonation. Additionally, facial feminization surgeries may indirectly impact the therapy process.

Some literature suggests that trans women who undergo bottom surgery do not experience the same amount of worry in regards to their voice, and for that reason, knowledge about plans for GCS is warranted (Davies et al., 2015). That said, if a client has sought out voice services, then it is safe to assume that they wish to undergo voice therapy, and that concerns with bottom surgery are not extremely relevant. If a clinician does not feel comfortable approaching this extremely sensitive and invasive topic, then it is best to avoid it in order to preserve good rapport.

General Considerations

As with any speech or language client, the SLP should continue to use clinical judgment throughout therapy. This includes utilizing broad-base protocols to assess oral motor, speech, language, and voice, and modify as necessary. One of the most important aspects of voice

therapy with a client who is transgender is to ensure that they are able to develop an authentic voice without damaging or straining the voice. If during therapy, atypical vocal patterns and/or habits develop, voice therapy for one's gender identity should cease, and the client should be referred to an otolaryngologist and proper vocal hygiene and health should be the main focus of therapy.

Assessment

The following information relating to assessment is taken from Dacakis (2012). In order to obtain a baseline, an SLP should collect a speech and language sample of natural conversation, a picture description task, and a verbal reading task to analyze speaking fundamental frequency (SFF). The SLP should also obtain the client's speaking F_0 range, total maximum phonation range, average speaking rate, intonation, and average speaking intensity across different speaking situations. Some evidence shows that formants impact a listener's perception of gender. If this will be targeted in therapy, the SLP should also measure the formants of the corner vowels (i.e., /a/, /i/, and /u/) by having the client sustain the vowels. Additionally, the SLP should analyze the language used by the client, both verbal and nonverbal behaviors. Video recording equipment is ideal. But if the client is uncomfortable with video, then audio recordings will suffice, as long as the SLP is observant of nonverbal behaviors.

Collecting data, both quantitative and qualitative, about the client's voice is important. However, a clinician should also collect information regarding the client's perception of their voice. Evidence shows that how an individual perceives their voice has more of a correlation to listener-perceived femininity than actual SFF measurements (Hancock et al., 2010; McNeill, Wilson, Clark, & Deakin, 2008). A clinician can gather this information via informal interviews, or by using assessments such as the Vocal Handicap Index (modified to include trans-specific

concerns) or the Transsexual Voice Questionnaire – Male to Female (TVQ^{MtF}), formerly known as the Transgender Self-Evaluation Questionnaire (Dacakis, Davies, Oates, Douglas, & Johnston, 2013; Dacakis, Oates, & Douglas, 2016; Davies & Goldberg, 2006; Davies et al., 2015). Both the Vocal Handicap Index and the TVQ^{MtF} are available online. A link to the TVQ^{MtF} is listed in the Appendix.

Treatment

The subsequent sections below discuss the various aspects of speech and communication that can be targeted in therapy. These areas are provided so that the reader has a cursory understanding of what therapy might entail for a client. This section is not an exhaustive resource. The reader should use the topics below to deepen their understanding of how one's gender identity might affect these areas in therapy. It is important to create a client-centered approach to therapy that is congruent with a client's internal sense of gender.

Pitch. The following information relating to pitch is taken from Gelfer and Mordaunt (2012), and Davies et al. (2015). The mean speaking fundamental frequency, or SFF, in conversational speech for men is 100 to 150 Hz, and for women it is 180 to 250 Hz (Colton et al., 2006). It is important to understand that changing pitch alone does not change listeners' perception of the speaker's gender. Other factors (e.g., second formant frequency, breathiness) also play a big role in identifying a speaker as male or female, despite reaching a gender-neutral or feminine SFF (Gorham-Rowan & Morris, 2006; Gelfer & Schofield, 2000 cited in Gelfer & Mordaunt, 2012). However, the importance of pitch should not be played down, as a speaker's SFF is the primary indicator of their gender (Byrne, Dacakis, & Douglas, 2003; Davies & Goldberg, 2006).

The target pitch for each client will vary depending on their physiology, as a target SFF that deviates too far from one's physiological fundamental frequency (F_0) increases the risk of developing a vocal fold pathology. The SLP should choose a target pitch that is three to four semitones above an individual's physiological F_0 . The ultimate goal is to find a target frequency that is perceptually in-line with the client's sense of gender that does not damage one's vocal folds. Additionally, a target frequency should allow for natural variation in pitch and intonation in connected speech.

Intonation. The following information relating to intonation is taken from Gelfer and Mordaunt (2012), and Davies et al. (2015). The intonation or inflection that a speaker uses is especially important for individuals whose F_0 is in the gender-neutral range. English-speaking women generally use more varied intonation patterns than men. Additionally, English-speaking women, especially younger women (but also younger men), generally use more upward inflections, similar to when asking a question - i.e., what is commonly now termed “upspeak” or high rising terminal in the academic literature (Levon, 2016). English-speaking men tend to use a more level and/or downward glides on utterances.

Intonation functions as a suprasegmental aspect of language and can convey additional meaning in one's speech. When raising one's pitch, the SFF must be at a comfortable target where one is still able to vary their pitch sufficiently in connected speech. A comfortable conversational range for transgender clients to target in therapy is about 12 semitones. This means that an individual will be able to vary their pitch six semitones above and below their SFF to convey paralinguistic aspects of speech. For complete information on pitch and intonation, see Gelfer and Mordaunt (2012).

Resonance. The following information on resonance is taken from Hirsch and Gelfer (2012). The term resonance actually refers to three distinct features of speech: the formant frequencies produced by the vocal tract, the vocal quality due to perceptions of vibrations in different parts of the body, and using the nose as a resonator. Additionally, some evidence shows that vowel formant frequencies play a big role in gender perception for English-speakers (Coleman, 1983; Mikos & Pausewang-Gelfer, 2001; Pausewang-Gelfer & Mikos, 2005 cited in Davies & Goldberg, 2006). Vowel formant frequencies are approximately 20% lower in adult men than adult women, which is heavily influenced by language – the same does not hold true for other languages studied. Resonance can also be talked about in terms of “head resonance” and “chest resonance.” *Head resonance* is described as a “brighter, forward sound that accompanies sensations of the voice ringing or resonating in the mouth, nose, sinuses, or upper part of the head” (Davies & Goldberg, 2006, p. 174). *Chest resonance* is described as a “full, rich sound that is produced in lower notes and accompanied by a feeling of voice vibrating in the chest” (Davies & Goldberg, 2006, p. 174). There are currently no scientific reliable ways to measure head or chest resonance. Additionally, there is no empirical evidence to show that the feeling of head resonance increases the perception of trans women as women. However, Hirsch and Gelfer (2012) discuss how understanding this resonance pattern is “crucial” to establish consistently feminine speech patterns “without dark undertones,” and have anecdotal evidence that resonance plays a big role in being perceived as a woman (p. 227).

Rate. The following information on rate and volume is from Boonin (2012b). There has been very little research on rate and gender, although the research that has been done shows that men generally speak more quickly than women. Rate is a highly contextualized aspect of speech that will vary for each individual from setting to setting. If necessary to target at all, individuals

should practice various rates of speech for various settings. Verhoeven, de Pauw, and Kloots (2004) shows that men spoke an average of 6% faster than women in the Dutch spoken by people in Belgium and the Netherlands. Additionally, Boonin (2012b) reported studies by Terrango (1966) and Addington (1968) that also showed individuals (cis men and women) were perceived more feminine when speaking with a slower rate.

Volume. A speaker's volume is largely influenced by the context, and involves a variety of other factors. It is generally agreed that men speak louder than women, despite the multitude of confounding factors to parse out any specific difference. Conversational speech takes place at about 50-65dBs, and whispered speech at 30dBs. Natural variations of volume in speech tend to be within 2-3 dBs for both genders. Given that one's speaking volume largely depends on context, Boonin (2012b) discusses how reviewing the subject of volume can also be an easy segue into pragmatics and proper use of volume in different settings. Not all clients will have a trouble using a pragmatically appropriate volume. However, maintaining a proper pitch while increasing volume is a common concern, and should be addressed if necessary.

Language. It is important to remember that language largely depends on culture, context, and with whom one is speaking. The umbrella of language involves more than just the words that we produce. Language includes pragmatics - how people use language, both verbal and nonverbal. A discussion of verbal and nonverbal pragmatics will be discussed in the section *Pragmatics*.

Over the years, there have been many studies that look into the difference between language and gender. However, the findings from these various studies are frequently contradictory with no clear or concise difference between the genders of the speakers. Because of these inconsistencies, including language as a part of therapy is a debated topic that will vary

from individual to individual. This discussion will be looked at more in-depth in the *Language and its role in therapy* section.

Speech sound production. The following discussion on articulation is taken from Boonin (2012a). Literature in this area suggests that women tend to speak a “more correct” or standardized speech than men. Oates and Dacakis (1983) found that women are more likely to use the standardized “ing” ending, rather than “in” that men might use. Other studies show that women are more likely to correctly produce the postvocalic /ɪ/ and not drop it, making “car” become /ka/. Edwards (2009) postulates that women might use these more standard forms to offset their “less secure” social standing, or because of a their maternal role which makes them more conscious of passing on the standardized form of the language to their children. However, Edwards (2009) also points out the contradictory findings that women are typically catalyst for language change. Recent research has focused more on the physiological differences between men and women that look at how tongue movements and vocal tract dimensions have an impact on speech sound production between genders (Boonin, 2012a).

Boonin (2012a) establishes the following sections to work on for women who are transgender in therapy. For vowels, the client should practice easy onset to prevent hard glottal attacks and reducing tension in the neck, shoulders, and chest. Clients should also work on vowel prolongations, since women tend to elongate their vowels more than men. For consonants, Boonin (2012a) suggests practicing precise phonemes and “light” contacts or articulation. For the area of speech sound production, having insight to the phonological patterns of the client’s dialect of English would prove to be beneficial, as practicing a “light” pattern of speech that does not reflect the true realization of the client’s dialect may draw more attention to them. Boonin (2012a) also recommends practicing linking words together to produce a more legato speech

pattern. While the above discussion focuses on women who are trans, more research needs to be completed about articulation and which areas would need to be worked on for trans men.

Pragmatics. Frazier and Hooper (2012) define pragmatics as “the knowledge, or rules, of language in a particular setting or level of formality, including language comprehension and language formulation (spoken or unspoken),” and includes rules of conversations between and amongst genders, as well as confounding variables like race and class (p. 279). The area of pragmatics is broad and will vary wildly depending on the social setting one finds themselves in. Gender stereotypes are engrained into children from a very young age, meaning that children grow up subconsciously learning the rules of gender and how to speak and interact with the same or different gender (Edwards, 2009; Frazier & Hooper, 2012; Carter, 2014). Historically, research into pragmatic differences between the genders has perpetuated stereotypes about gender since biblical times. These findings are now attributed to poor research designs and methods, which were often influenced by the researchers’ own biases (Jordan-Young, 2010; Fine 2010, cited in Frazier and Hooper, 2012). The best recommendation to prevent from perpetuating these antiquated notions of gender in therapy is to continually “study the emerging literature on language and gender, particularly as researchers discover that the binary categories of man and woman in conversation are more fluid than previously thought” (Frazier & Hooper, 2012, p. 283).

There are stereotypical ideas of gender differences that the clinician may present to the client. However, it is best to work with the client to understand their own sense of gender and develop an approach that supports their intrinsic identity, rather than prescribing stereotypically “masculine” or “feminine” behaviors. Given that pragmatics is a part of language, language as a whole will be discussed with more detail in the section *Language and Its Role in Therapy*. There

are older stereotypes about gender that the clinician should be knowledgeable about, in the event that the client wishes to incorporate these behaviors into their therapy sessions. Behaviors such as increased eye contact and smiling, nodding one's head during conversation, increased use of gesturing while speaking, and occasional touching of the listener are stereotypically associated with feminine non-verbal communication (Andrews, 1999; Gold, 1999 cited in Davies & Goldberg, 2006). Additionally, other ideas about communication differences between genders are that men use language to establish themselves and to acquire information, while women use communication to share thoughts and feelings and to build consensus. However, there is other empirical evidence to show that these beliefs are not true, and are only perpetuated by society's belief that these stereotypes exist (Cameron, 1992; Edwards, 2009; Frazier & Hooper, 2012; Carter, 2014; Hancock et al., 2015; Park et al., 2016).

Follow-Up

Currently, there are no standard guidelines for the length of therapy. However, the amount of time that an individual will require will vary from person to person (Davies & Goldberg, 2006; Mordaunt & Hirsch, 2012; Davies et al., 2015). Some studies report a correlation between length of therapy and mean pitch achieved, while another study reported that client satisfaction was not related to the number of sessions of therapy (Davies & Goldberg, 2006). In general, SLPs report that "treatment may take anywhere from 6 to 9 months to achieve desired results" (Mordaunt & Hirsch, 2012, p. 474).

After the initial therapy sessions have been completed, follow-up sessions are recommended to ensure maintenance and transference of skills, as well as allowing for clients to bring up any questions that they have encountered while using their new voice in their day-to-day lives. Ideally, follow-up sessions should be able to re-assess the parameters measured at the

beginning of therapy to assess maintenance and to “evaluate the effectiveness of refresher sessions” (Davies & Goldberg, 2006, p. 183). Additionally, the follow-up sessions should include a discussion of both successes and breakdowns in communication, and strategies to use when the client experiences difficulty after the initial therapy sessions have ended. Follow-up sessions can be one-on-one, or in a group setting. A group setting is valuable as it allows for the client to develop a sense of community and hear the triumphs and tribulations of other individuals in the Transgender community (Davies & Goldberg, 2006).

Summary

In conclusion, there are many areas for the SLP to address with a client who is transgender. It is important to remember to work with the individual to develop a client-centered approach that closely aligns with their intrinsic sense of gender, rather than prescribing “feminine” or “masculine” speech patterns. The SLP should assess areas that are relevant to the client’s intrinsic gender, allowing the client to guide what they see as necessary to work on in therapy. Some clients will need to work on almost all of these areas, while other clients will only need to work on one or two areas. Additionally, some clients will wish to develop a bimodal speech pattern. Again, understanding the client’s gender identity will be essential to constructing a therapy plan that is both beneficial and conducive to aligning the client’s sense of gender to their voice. Furthermore, while most of the clients seen by SLPs for voice are women, there is still much research that needs to be done to look at speech and language therapy implications for trans men (Bodoin et al., 2014; Davies et al., 2015).

Current Issues in Speech-Language Pathology

Given the societal spotlight currently placed on gender identity, the U.S.’s understanding of gender and gender identity are rapidly changing. With all of these changes comes a better and

deeper insight to the transgender experience. These deeper understandings lead to changes in perspectives. This paper is not meant to be the be-all and end-all stance or view of gender identity. Rather, the aim of this paper is to capture the current understanding of these topics and how they relate to contemporary speech-language pathology. The next sections include issues that are debated and highly contested with no clear answer. There are logical arguments for both sides of these issues. Here more questions will be asked than answered. The reader is encouraged to investigate these areas further, and form their own opinions, especially as the understandings of these topics continue to shift over time.

Disorder v. Difference

When discussing transgender voice exclusively, is this an area of voice disorder or voice difference? There are no vocal fold pathologies, per se - no polyps or edema that exist that are causing this. However, a voice disorder is defined as a “voice quality, pitch, and loudness [that is] inappropriate for an individual's age, gender, cultural background, or geographic location” (Voice Disorders, n.d., paragraph 1). If a 30 year-old trans woman’s voice does not match a 30 year-old cis woman’s voice from the same city, then is the first woman’s voice disordered? Arguably, the trans woman comes from a different culture (i.e., the LGBTQ+ subculture). That begs the question - does one compare the same woman’s voice to another trans woman who has received therapy and who has a higher SFF, or to a trans woman who has not undergone therapy and who has a lower SFF? Which would be the correct comparison to determine a disorder? If one chooses the higher SFF, then it could be argued that those women with a lower SFF have a voice disorder; yet, if one chooses the lower SFF to compare the initial woman to, then does one implicate trans women with a higher voice as having a voice disorder? Or does a clinician say that a low to high SFF for trans women is acceptable, and thus there is no disorder at all? But one

must keep in mind that if a trans woman's speech interferes with her attempts at communication, then "it is 'defective,' if defined by the very criteria established by communication clinicians and researchers" (Boonin, 2012a, p. 250).

A clinician can circumvent this by saying that there is no disorder, but rather a difference. And at the client's request, a difference can be treated (analogous to accent reduction). Differences, however, are cosmetic and typically not covered by insurance. However, the WPATH (2011) includes voice as a medically necessary aspect of transitioning in their *Standards of Care*. One may wish to treat a difference (e.g., voice/dialect modification) for a variety of reasons, including the possibility of more job opportunities. However, to say that a woman who is transgender is working on her voice for more job opportunities, or other physical rewards, does not fully capture her lived experience. When a person who is transgender is misgendered, it can cause extreme psychological distress and panic (APA, 2013; Dacakis et al., 2013). The aim of voice therapy, then, is to help find and develop a genuine, and safe, voice that fits the client's identity to assuage any potential misgendering from strangers.

The author has spoken to several other health professionals who frequently work with clients who are transgender about the pathologization of people who are transgender and relating the formal diagnosis of gender dysphoria to clients. It was the general consensus that pathologizing people who are transgender is not ideal. However, given the current paradigm that health professionals work under, a diagnosis of gender dysphoria is a necessity to provide these individuals with the care that they need (e.g., HRT, legal standing). These professionals discussed how the best approach is to have a straightforward conversation with a client about a formal diagnosis of gender dysphoria and its implications. While it is outside of the scope of practice for a speech-language pathologist to diagnose gender dysphoria, when working with a

client who is transgender, if they have an existing diagnosis of GD from another professional, then it is ideal to use that diagnosis when billing third party payers to cover services.

Due to the potential psychological distress that may come from being misgendered, and in congruence with the WPATH's stance and companion document about voice, it is the author's opinion that voice services should be readily available for *all* individuals transitioning. This means that voice services should not be limited to only those who have the means to cover services out of pocket. In order to ensure this access to care and resources, then the author believes that the term of voice *disorder* is appropriate to ensure this access to care, instead of voice *difference*, which would not necessarily entitle one to the same benefits. Although the author agrees that pathologizing individuals who are transgender is not ideal or correct, this is the system that one must utilize. One must come to their own conclusion on whether or not the ends justify the means. The reader is encouraged to consider both sides of the arguments, weigh out their merits, and form their own opinion on this matter. Time will, hopefully, settle this matter in a way that allows one to access the care needed, while also not pathologizing people who are transgender.

Therapy v. Training

Similar to the aforementioned discussion about a voice *disorder* or voice *difference*, there is much debate about the subject of voice *therapy* versus voice *training*. Many individuals who feel that being transgender should not be pathologized also have the view that there is no voice disorder, and thus, voice services would not fall under voice therapy. Instead, a person who is transgender and receives voice services is having voice training. Conversely, those who would argue that obtaining a healthy voice congruent with one's gender identity should be covered as a part of comprehensive transitioning care might argue that this is voice therapy, and thus should

be covered and included in the transitioning process. Some voice professionals believe that one can obtain therapy without pathologizing the individual, similar to how a person can go to a mental healthcare provider for therapy but not be diagnosed with any formal mental health issues. These valid, yet differing, views highlight the lack of a clear consensus on these matters.

The author derives his stance on this matter from two considerations. First, are the internationally accepted *Standards of Care* put out by WPATH (2011). The WPATH uses the term *therapy* throughout its *Standards of Care* document to describe voice and communication services. It is also worth noting that the WPATH does not mandate any one set of terminology, as long as the professional remains respectful. Therefore, to say voice *training*, is not incorrect. However, for the sake of consistency, the author sides with the WPATH's use of the word therapy. The second reason the author uses therapy over training is because voice training connotes a vocal coach or singing instructor. As a speech-language pathologist, many individuals have never studied vocal pedagogy and how to use the voice outside of occupational communication. The understanding of voice and vocal use as an SLP pertains to the day-to-day aspects of speech and language, and not the theatrical abilities of the voice. While vocal coaches and singer instructors are an important resource for both individuals who are transgender and SLPs, the author believes it is important to distinguish between the services provided by a vocal coach and an SLP.

Language and Its Role in Therapy

Language is a complicated and debated issue, with varied amounts of evidence. Lakoff's (1975) landmark work set the stage for sociolinguistics and gender. Lakoff argues that women use more: hedges/fillers (*you know, sort of*), tag questions (*it's raining, right?*), emotional and expressive adjectives, precise color terms, intensifiers (*so*), politeness and indirect requests,

euphemisms, diminutive forms, collaborative conversational style, and other “softer” forms of language that make up the female register (Lakoff, 1975). This publication is still frequently cited when discussing the difference between gender and language. However, Lakoff’s work has been highly criticized for its methodology, the author’s analysis, and for viewing the “male” speech pattern as the norm (Edwards, 2009). Other studies have looked into Lakoff’s claims, and found inconsistent and contradictory findings to the claims made in Lakoff’s (1975) work (Crosby & Nyquist, 1977; Hirschman, 1994; Hancock, Stutts, & Bass, 2015; Schwartz & LaSalle, 2008).

When a model is developed to predict the gender of a speaker, it is accurate for that specific setting or study. However, when that model becomes generalized to other situations, it is no longer able to predict the gender of the speaker (Mulac & Lundell, 1986; Mulac Wiemann, Widenmann, & Gibson, 1988 cited in Hancock et al. 2015). These findings show how varied and context-dependent speech and language is to a situation. Hirschman (1994) hypothesized that the difference between men and women’s language may be a result of the perceived power dichotomy between two people, and O’Barr and Atkins (1980, cited in Cameron, 1992) claim that it is a difference in one’s status that marks one’s speech (i.e., high-status women did not speak in the “female register” proposed by Lakoff). Studies that have further investigated these potential differences have since shown that neither status nor perceived role fully explain the difference between the language used by the different genders (Cameron, 1992; Edwards, 2009). Additionally, findings show that how a woman speaks in same-sex dyads will differ from how she speaks in a mixed-sex dyad (Crosby & Nyquist, 1977). It is important to remember that language is constantly evolving and what is perceived to be the norm will change over time. Hooper, Crutchley, and McCready (2012) review sociolinguistic literature and provide a list of

options for the SLP to target in therapy with a client who is transgender. However, it is important for the clinician to remember that many of the findings cited “are of limited value because generalization is restricted to highly specific communicative contexts or particular age groups,” (Hancock et al., 2015, p. 318).

Based on all of the contradictory findings, the SLP may hesitate to approach assessing language and targeting linguistic goals in therapy. However, despite the inconsistencies found in various studies, it is important to remember that some studies *do* find differences, even if they are minute. The SLP should be cautious, however, to extrapolate findings from any one study as “the” difference between genders and language. It is also vital for the culturally competent SLP to remember that every person’s sense of gender will vary. Some individuals may have no desire to work on their language, while others may see it as a crucial part of therapy. Some clients may wish to learn about the differences between language use and genders for different contexts in their life.

Rather than prescribing that the client work on a set of linguistic features, the SLP should rely on their client-centered therapy approach and clinical judgment. Davies and Goldberg (2006) recommend that language modification be based “on the client’s own observations of gender markers in the specific environmental context[s] of concern to the client” (p. 176). Working with the client to select a few role models who embody or match the client’s sense of gender, the SLP can assign the client to listen to and/or watch the selected role models speaking. Once the client observes the language that their role models are using, the SLP can then guide the client to come up with their own goals in therapy for what they perceive to be the difference between genders. Additionally, for contrast, the SLP can assign the client to look at a role model of a different gender, and compare the differences between the language used. The SLP should

possess a sufficient grasp on the sociolinguistic research published about the differences between the genders, to ensure that the client is not misguided in their analysis. By allowing the client to discover the differences on their own, the SLP is letting them choose to work on goals that more closely align to their sense of gender, rather than mandating how one gender speaks.

Multiple Vocal Profiles

Some SLPs believe that they should not engage in voice therapy with a client who is transgender that does not present as their desired gender 100% of the time or with a client who is gender fluid (Davies et al., 2015). As it stands, most resources available do not have multiple vocal profiles as a supported goal (Davies et al., 2015). Some clinicians believe that switching between two styles of speech would lead to inconsistent practice of the target voice, thus impeding the progress in therapy. While these concerns are valid and warranted, it would not be ethical to deny an individual access to a “vital component of care” for transitioning (Davies et al., 2015, p. 121).

All people naturally have the ability to code switch between dialects and registers of speech and language. The ability to learn novel vocal profiles is demonstrated in actors, voice actors, and other professionals. As gender and gender identity have become better understood, a culturally competent clinician will understand that gender identity is not a fixed or binary entity, and that how a person identifies will shift over time and contexts. Therefore, with practice, it is possible to develop a bimodal/bigender speech and communication pattern. Furthermore, it is the WPATH’s stance that clinicians should not “routinely exclude clients who have two speech/voice patterns as their treatment goal” (Davies et al., 2015, p. 121). Therefore, clients should be informed that behaviors are difficult to change without dedicated practice and that a

significant amount of time will have to be spent to develop a novel vocal profile if they wish to achieve satisfactory results.

Person-First Language

As mentioned previously, the author utilizes person-first language (i.e., a person who is transgender) throughout this paper, with some minute exceptions. While this decision is not entirely controversial, there are differences of opinion that are important to recognize and respect. The author's justification for using person-first language is to put the focus on an individual's humanity and agency, and not limit their existence to one aspect of their identity. This is a common practice within the field of speech-language pathology, just as it would not be appropriate to refer to a person with aphasia as "an aphasic."

However, some individuals use one aspect of their identity as sources of pride. This is notably seen in some people with disabilities (e.g., "I am a Deaf person") and in people's sexual orientation (e.g., "I am a gay man"). These aspects of one's identity are considered central to that person's identity and not a negative thing. Some individuals in the Transgender community take pride in being a trans woman or trans man, and view being transgender as central to their identity. In direct contrast to this, there are other individuals who do not like to be labeled transgender, and feel that they have been their gender since birth, despite how society has gendered them. For instance, a woman who feel this way may say, "I am not a trans woman; I am a woman, and I have been a woman since birth."

There is no correct or incorrect way to conceptualize one's identity. However, it is possible to be disrespectful and not recognize and respect a person's autonomy. Therefore, after sufficient rapport has been established, a clinician should inquire how a person conceptualizes their gender identity to avoid accidentally undermining a client's autonomy.

The Name of the Field

Voice professionals (e.g., SLPs, vocal coaches), who work with clients who are transgender, have questioned what to call this field. Previously, working with clients who are transgender on voice has been labeled “transgender voice,” “transsexual voice,” “voice feminization,” or “voice masculinization” in the literature. However, as the social understanding of gender and gender diversity has grown, the label of “transsexual voice” is no longer appropriate or accurate. Additionally, the label “transgender voice” does not fully encapsulate what a speech-language pathologist or voice professional would cover, as voice is only one portion of what therapy would entail. Furthermore, to refer to these areas as either “masculinization” or “feminization” does a disservice to gender-variant individuals, as it perpetuates the social construct of a gender binary.

Although the term *transgender* is an umbrella term to describe individuals who are not cisgender, to use the label “transgender” would not do justice to the many different conceptualizations of gender identity that exist. Because gender is not a binary option, like the terms *speech feminization* or *speech masculinization* would entail, the professionals in this area examine communication across a gender spectrum. Additionally, an SLP works on areas including, but not limited to: pitch, resonance, intonation, rate, volume, language (including phonemes, semantics, and pragmatics), articulation, breathiness, as well as nonverbal communication. These many areas are best described as “voice and communication,” since there are so many components to target. Therefore, the author suggests that this field should be described more inclusively, and accurately, as *Gender Spectrum Voice and Communication*, or GSVC, rather than “transgender voice.” This label encompasses the nature of the field, while

also allowing for an individual to decide whether or not they view these services as “therapy” or “training.”

CHAPTER IX

COUNSELING

Counseling one's clients is a very important role that many clinicians may purposefully or inadvertently avoid. Although this is not ideal, this can be understood because so few programs in Communication Science and Disorders in the U.S. offer training for this aspect of the field (Luterman, 2008). However, good counseling skills are crucial to help clients realize their potential. While the overall process might take a little longer than it would if the clinician just gave the client all of the answers, ultimately the answers that the client finds on their own will be more rewarding, meaningful, and have a greater impact (Luterman, 2008).

Role of the Speech-Language Pathologist in Counseling

It is important for an SLP to understand their role in counseling. It is within the scope of practice for an SLP to counsel clients "regarding acceptance, adaptation, and decision making about communication, feeding and swallowing, and related disorders" (ASHA, 2016b). It is important to remember that an SLP is not a mental health counselor, and should recognize the boundaries of what falls outside of the scope of practice of an SLP.

Tellis and Barone (2016) detail more specific examples that are within and outside of an SLP's scope of practice in regards to counseling. Issues relating to speech, language, swallowing, or hearing disorders, as well as "nonclinical depression, resistance, reluctance, grief, avoidance, embarrassment," anything that "has a negative impact on [a] client's quality of life," as well as issues with caregivers, family members, or friends that relate to a client's speech,

language, swallowing, or hearing difficulty (Tellis & Barone, 2016, p. 32). Examples of things that fall outside of the SLP's scope of practice include: diagnosed emotional or psychiatric condition (e.g., panic or anxiety disorders, clinical depression, bipolar disorder), financial problems, marital problems, or job issues that do not relate to one's communication disorder, as well as drug or alcohol issues, child custody matters, and suicidal tendencies or thoughts (Tellis & Barone, 2016). In the event that the client broaches these latter topics not relating to their speech, language, swallowing, or hearing disorder, then they should be referred to the appropriate mental health provider.

The SLP should be familiar with common emotions that are involved with coping, loss, and communication disorders, including but not limited to: anger, guilt, vulnerability, confusion, and denial. These emotions are complex and can come from many different factors. Additionally, emotions rarely exist in isolation from each other. Often a person can experience multiple emotions that shape their actions and beliefs. Having a nuanced understanding of these emotions as well as the different processes involved in developing and resolving these emotions are crucial to counseling clients.

Goals of Counseling

Counseling is an important part of practice, especially for clients who are transgender. The transitioning process itself can be a long and difficult journey of self-discovery. Voice is so inherently tied to one's intrinsic sense of identity and emotions that intense feelings are likely to come up at some point when discussing voice. Counseling may involve discussing emotions when using certain vocal profiles, and whether or not they match the client's sense of self. Because evidence shows that a trans woman's perceived femininity is based more on her own satisfaction with her voice than by quantitative metrics, (McNeill et al., 2008; Hancock et al.,

2010) counseling should revolve around helping individuals accept and embrace a voice that matches the client's sense of gender identity, rather than what a culturally idealized "feminine voice" sounds like.

Strategies

It is outside the scope of this paper to go in depth regarding specific counseling strategies. However, broadly speaking, pulling from Luterman's (2008) *Counseling Persons with Communication Disorders and their Families*, strategy recommendations include: *content response* (e.g., telling the client about services available in the area), *counterquestion* (e.g., "How did you come to that conclusion?"), *affect response* (i.e., commenting on the client's emotions), *reframing* (i.e., validating the client's response, and then recasting it in a different perspective), *sharing-self* (e.g., "I had a hard time experiencing loss, too"), *affirmation* (i.e., validating the client's feelings by agreeing), *language changing* (e.g., saying "want to" instead of "have to"), *silence* (i.e., a tool to show that the client must take responsibility for themselves in the session), and *contracting* (i.e., explicitly discussing the contract of what the relationship between the professional and client will entail, what the client will or will not do for the client).

Counseling can be a difficult skill to master, but clinicians should not shy away from developing these skills. Counseling skills can be critical to maximizing the success of the client and allowing them to take responsibility for the progress of their therapy. While there are many techniques to choose from, "if the clients know they are being counseled, the counselor is probably doing it poorly" (Luterman, 2008, p. 93). Additionally, while an SLP has so many skills to offer a client in terms of speech, language, and communication in general, one must remember that "one of the most powerful tools available is listening to the clients and genuinely caring about their plight" (Adler & Christianson, 2012, p. 92). For a better understanding of the

counseling process as it relates to speech-language pathology and audiology, strategies to use, and theories of counseling, see Luterman (2008) and Tellis and Barone (2016).

CHAPTER X

CREATING A SAFE SPACE

By now, the reader should have an understanding of the prejudice and discrimination that so many people who are trans face, both in public and in the healthcare setting. Because of these high rates of discrimination, many people who are transgender might not feel comfortable in a clinical setting at first, especially if there are things to signal that a person is not in a safe space. A safe space is defined as a place that is “free of bias, conflict, criticism, or potentially threatening actions, ideas, or conversations” (Safe Space, n.d.). In one’s day-to-day life, there are conscious and unconscious signs that signal whether a person is in a welcoming space or not. For many people who live in the mainstream culture, these signals are not readily apparent. However, for those that belong to minority groups and experience discrimination, these signs are easily noticed, and can tell a person whether or not they are unwelcomed, tolerated, or embraced. These signs are not always obvious, and they are not always physical objects. They can take the form of the language or actions performed by individuals in a space. It is important for a clinician to understand that an individual can be extremely vigilant about these signals, especially if they have experienced discrimination in the past. Therefore, a clinician must consciously create a safe space for clients who are transgender, to show that the environment they have entered is free from prejudice and discrimination. By making a client feel welcomed and safe, the SLP is able to allow for the client to be vulnerable and facilitate personal growth and change. The author suggests the following practices to help cultivate a safe space that allows

for a gender-diverse individual to feel safe and welcomed in a space. These suggestions are by no means an exhaustive list.

Operationally

Examples of ways to create a safe space operationally are discussed here. This is not an exhaustive list, and ways to create a safe space will continue to grow and change. While it may not be possible to implement all of these changes depending on one's facility, it is best to include as many as possible.

One of the easiest ways to create a welcoming environment is via the case history forms that clients fill out on their first visit. Frequently, under the section sex or gender, the client is given two options: male or female. As previously discussed, these categories do not exist in a binary, and to have a case history form that asks this shows insensitivity on the part of the clinician. The best option is to have a blank space that allows a client to speak for themselves. Additionally, the case history form should ask which pronouns they use, again with a blank space. To do this shows that the clinician and facility is knowledgeable about gender identity, and cares about not misgendering someone. If the client is paying for services using insurance, then this can provide another obstacle. Insurances frequently require the use of legally documented information, which the client may not have had a chance to update (i.e., name, sex at birth). If this is the case, then a separate area/form should be provided to differentiate how a client identifies, and what information the clinician will render to the insurance provider.

Once this information is obtained, a system should be put in place to ensure that clients are properly addressed and not misgendered or deadnamed, especially when answering the phone. People who answer the phones should use and be knowledgeable of the system that is in place to prevent mistakes from happening. Additionally, even if someone's pronouns are on their

case history form, all staff should feel comfortable asking someone their pronouns. Two seconds to ask someone their pronouns (remember to not use “preferred pronouns”) is much better than accidentally misgendering someone. Additionally, the practice of stating one’s pronouns should be normalized and made routine for all of the staff. The simple line of, “Hello, my name is ___, and I use ___ pronouns; what about you?” when meeting someone goes a long way to show that the person is in a safe and accepting place.

Restrooms, ideally, would be gender-neutral. A single-occupancy restroom provides the most safety and privacy. If there are single-occupancy restrooms available to use, then this is preferable. There are no tangible reasons that a single-occupancy restroom needs to be gendered at all. If single-occupancy restrooms are available, then signs that simply say “restroom” are all that is needed. It is unnecessary to label one restroom “male” and one “female,” which can be daunting for people who are trans, especially if they are non-binary. If the restrooms in the facility are not single-occupancy, then provide signage that explicitly states that discrimination based on gender identity is not allowed. In addition to signage around the restrooms, non-discrimination signage should be clear and visible to everyone in public spaces. Having, and enforcing, a zero-tolerance policy on discrimination based on sex, gender identity, and sexual orientation is essential to cultivating a safe space for everyone to feel welcomed and at ease.

Education

While there are certain things that can be done in a physical space, these alone are not enough to make sure an individual feels welcomed. Just as clinicians and other professionals are required to engage in continuing education for their area of expertise, the ever-changing subject of LGBTQ+ culture is no different. A culturally competent clinician must continually deepen and broaden their knowledge on issues that face the community, as well as the terminology

individuals use to define their existence. It is not about knowing everything all of the time, but being willing to listen and learn more when one encounters something not previously known.

Additionally, it is the role and responsibility of the culturally competent clinician to continue to educate peers and other professionals about LGBTQ+ issues. This may include teachers in a school, nurses and doctors at a hospital, staff within an office, or anyone else involved on a person's transition team. As a culturally competent professional, it is one's duty to stay informed about information pertaining to the Queer community (ASHA, n.d.). Staying informed and educated is an important aspect about creating a safe space for clients. Simply by the choice of words one uses, a client who is trans will be able to tell how well informed the clinician is, which will have a direct impact on how safe the client feels in that environment.

CHAPTER XI

ETHICS

Professionals who are ASHA members must abide by ASHA's Code of Ethics. These ethics guide the practice of the members and ensure the highest quality service delivery and professionalism. ASHA's Code of Ethics mandates that all of its members be culturally competent when working with clients. For additional guidelines on ethics and best practices when working with the transgender community, a clinician can refer to WPATH's *Standards of Care* (2011), currently in its seventh edition, as well as the Ethical Guidelines for Members of the World Professional Association of Transgender Health, Inc. (2016). Both of these resources are listed in the Appendix for the reader.

Cultural Competency

In order to respond to the culturally diverse needs of one's clients, a professional should adjust the services rendered to accommodate the cultural and linguistic diversity that exists in clients to ensure efficacy of the services (ASHA, n.d.). To do this, a clinician must be aware of their own cultural background and influences, as well as be knowledgeable in the culture that the clinician is serving. While the LGBTQ+ community is its own subculture, a person from the Queer community may also have other cultural influences that the clinician must be aware of. Therefore, a culturally competent clinician should be knowledgeable about the Queer community, as well as any concomitant cultural influences that a client may possess.

The LGBTQ+ subculture in the United States has a long and complex history, composed of many separate yet overlapping identities, whose various intricacies and details are beyond the scope of this paper. However, by understanding identity, gender, gender identity, and the terminology detailed earlier in this paper, the reader should possess a working knowledge to utilize when working with the Transgender community and gender diverse individuals. The author cannot stress enough the importance of understanding that each individual is different and that no generalizations can be made about the entire Queer or Transgender community.

The culturally competent clinician should remain receptive to the individual needs of clients, while also ensuring that their own biases do not impact their practice. Before working with any client from a different cultural background, a clinician should complete ASHA's Cultural Competency Checklist: Service Delivery (2010) and Cultural Competency Checklist: Personal Reflection worksheets (2010) to examine and reflect on any personal biases that the clinician may have. Both resources are listed in the Appendix. This period of self-reflection should also be done before beginning to work with clients who are transgender, as well as periodically to ensure that the professional's own beliefs do not affect service delivery.

Respecting An Individual's Autonomy

As the reader has learned, cultural competency is an important aspect of providing therapy for individuals who are transgender. Additionally, the reader should possess the understanding that the Transgender community is a diverse and heterogeneous population of individuals. A part of being a culturally competent clinician when working with people who are transgender is understanding and respecting their autonomy, as long as it is ethically appropriate. Not all people who are trans have surgery or begin hormone therapy. The client's choices will directly impact how therapy is provided, and a clinician needs to respect, honor, and

accommodate the client's decisions when it comes to their identity and/or transition, as long as it is ethical and appropriate, as defined by ASHA.

An example of when ethics would override a client's autonomy on transitioning is as follows. Suppose a trans woman presents 100% of the time as male/masculine, and has not come out to anyone except the SLP, whom she is seeing for speech services before she decides to socially transition. If, after a period of trial therapy, the client has not made any progress on her voice goals because she refuses to practice outside of therapy, then it would be best to cease therapeutic services temporarily and refer the client to the appropriate professional. The client's refusal to practice her voice goals outside of the therapy setting due to her current masculine gender expression, creates an ethical conflict for the clinician. ASHA states that a clinician should not bill or deliver services knowing that the client will not make progress. After the client seeks out the appropriate services and becomes more comfortable with practicing a feminine gender expression, the client would be able to resume voice therapy so long as she demonstrates willingness to practice her goals outside of therapy.

However, aside from situations that cause a professional to cross ethical boundaries, a client's autonomy and agency should always be respected. A clinician should understand that how one client chooses to proceed in their transition would not determine the path that another client will take. A clinician should always use evidence-based practice, clinical judgment, and ethical service delivery to fulfill a client's goals in transitioning.

CHAPTER XII

DISCUSSION

The American Speech-Language-Hearing Association (ASHA) requires that all of its clinicians be culturally competent when working with people from different cultural backgrounds. People from the LGBTQ+ community are included, as the Queer community is its own subculture within the broader culture of the U.S. The speech-language pathologist has a special role in working with clients who are transgender in helping them to find a healthy and genuine voice that matches their internal sense of gender. While a person who is transgender may reach out to an SLP for voice, it is also likely that an SLP will have a person who is transgender on their caseload at some point, regardless of the setting. Because of the likelihood that an SLP will encounter a person who is transgender in a professional capacity, an SLP should possess a working understanding of the LGBTQ+ culture, as well as the language to discuss and understand gender identity. Having a basic knowledge about terminology, pronouns, and identity is paramount to ensuring good rapport and being culturally competent. Additionally, having this knowledge allows for the SLP to ask the appropriate questions if and when they are unsure.

Understanding gender identity can be a difficult task, especially for an individual who is cisgender and has never felt uncomfortable in their own body. By first breaking down the complex notion of identity, the reader is able to understand the contradictory and simultaneous private, yet public notion of identity. Additionally, identity is a conglomerate of many aspects of one's unique human experience. A person is neither all of these aspects at once, nor solely any

one singular aspect at any given time. As an individual navigates their life from context to context, they are also negotiating which components of their identity most deeply resonate in that setting. This ongoing back and forth and overlapping sense of self exists in every moment, and defines a person's life. Every individual has agency and autonomy in these negotiations of their identity. How one person identifies will not hold true for an individual with a similar background in a similar setting.

Furthermore, by seeing gender as a byproduct of society and not something that is biologically determined, the reader is able to understand the transactional and constantly evolving nature of gender. Gender is engrained into people from the moment they are born and eventually becomes a part of one's identity. The transactions and decisions a person makes on a daily basis can be heavily influenced by societal constructions of gender, without the person giving it much thought. However, for some people, the gender that they were socialized as does not fit their internal sense of gender. This disconnect can lead to feelings of extreme guilt, shame, and dysphoria if they are not supported, affirmed, and validated. For a majority of people who are cisgender, the gender society assigned to them fits just fine, and eventually becomes integrated into their identity. Once it becomes a part of a person's identity, this functions as a feedback control loop, and serves to perpetuate conformity to one's internal beliefs about how gender works. If, and when, a person comes across something that does not fit into their feedback control loop, it can cause extreme discomfort for that individual.

People who are transgender, and who do not fit into the prescribed gender binary reinforced by society, frequently deal with many negative emotions surrounding their gender identity. Existing outside of cisgendernormative culture is not seen as an option for many people. This lack of awareness and support for gender-variant individuals leads to rampant

discrimination and prejudice. People who are trans can go for decades being in the closet and without being fully happy. Frequently, this is because they just do not possess an awareness that the transgender community exists. Upon finding out about the transgender community, many individuals uncover a whole new aspect of their identity, which they must now explore, understand, and integrate into their current life. This process can be difficult, especially if they do not have the social support from friends and family. Theories about queer identity development are discussed to give the SLP a more complete view and understanding of how transgender identity develops. While the process is different for everyone, there are some experiences that many people may go through, although varying amounts for each person.

Once this new sense of transgender identity has been integrated into all aspects of their life, the person is considered to have transitioned. Transitioning can include both socially transitioning, as well as medically transitioning. Depending on a person's sense of gender and identity, the transitioning process can take many forms. For many people, especially trans women, finding a voice that is congruent with their sense of gender identity is a vital component to transitioning. However, without proper care, one runs the risk of causing damage to their vocal folds.

The speech-language pathologist brings expertise in understanding the anatomy and physiology of the respiration, phonation, resonance, and articulation mechanisms, as well as the speech, linguistic, and paralinguistic differences that may exist between the genders. The SLP is able to work with the client on areas such as: pitch, intonation, resonance, rate, volume, articulation, pragmatics, and language to develop a speech and language profile that is congruent with a person's sense of identity. Although language is a highly contextualized variable, by possessing an in-depth understanding of identity, gender, and gender identity conceptualization,

as well as how language functions, the SLP is able to work with the client to develop their own goals and guide the therapy process using their clinical judgment and evidence based practice, when applicable.

Another important role of the SLP when working with a client who is transgender and seeking voice services is to act as a counselor for all things related to speech, language, and communication. It is important for the SLP to understand what falls under their scope of practice when counseling, and when to refer out to a mental health provider. Identity is intrinsically tied to a person's voice. To work on one's voice without addressing the emotions related to one's identity that are likely to arise would be a disservice to the clients. In order for the counseling to be optimally effective, not only must the SLP possess sufficient skills in counseling, but they must also have an thorough understanding of identity, gender, gender's role in society, as well as transgender identity to help guide the client through the counseling process. Additionally, the SLP must be familiar with terminology and pronouns in order to ensure the counseling being provided is culturally sensitive.

Everything discussed in this paper ultimately comes down to one thing - ethics. As a profession, SLPs are guided in every capacity by the ethical standards put forth by ASHA. When working with a client from a different culture, the SLP must account for and be knowledgeable of cultural differences. For a client who is transgender, the ethical SLP must understand transgender identity. In order to appreciate transgender identity, one must first know how transgender identity develops. In order to understand this development process, one must be aware of gender identity, which begs the question of understanding gender, and ultimately what constitutes identity. These broader themes were first discussed to provide context for the subsequent topics. Each topic discusses a narrower scope of understanding, until reviewing what

it means to be transgender and how transgender identity develops. Additionally, terminology is reviewed to capture its current connotations at this point in time. It is important for the culturally competent clinician to understand this terminology, as well as be aware that the words used to describe the queer and trans experience are always evolving and shifting. Throughout the writing process of this thesis, the words discussed in the terminology have shifted slightly, with new words appearing and others falling out of acceptability. The author has done his best to capture the words, and their connotations, as they exist at the time of publication. But the culturally competent SLP will have to continue to observe these changes going forward.

After possessing this in-depth cultural competence necessary to provide services, ethics continue to guide the SLP's practice by being sensitive to the client's individual needs as well as using evidence-based practice. While there are some areas with robust research and evidence to support practice (e.g., pitch), other areas, such as language, lack statistically significant or inconsistent findings. In these cases, the SLP must use their best clinical judgment that meets the needs of their clients, while developing a linguistic style that is authentic to the person's sense of gender, rather than culturally prescribing that "men" or "women" speak a certain way.

The field of Gender Spectrum Voice and Communication is still a relatively new area of speech-language pathology. As the understanding of gender evolves, so will the implications for seeing clients who come to SLPs to find an authentic voice. In order to provide the most effective therapy, the SLP should possess a comprehensive understanding of the subjects discussed in this paper. Additionally, the SLP should continue to learn about LGBTQ+ topics going forward, as well as staying current on the most recent research about the areas pertaining to Gender Spectrum Voice and Communication. While this thesis provides an extensive and practical discussion in these areas, it is not an exhaustive resource. Rather, it should serve as a

stepping-stone into further developing one's knowledge of the area, whether for the experienced or novice individual.

Table 1: Highlighted findings of discrimination from *Executive Summary of the Report of the 2015 U.S. Transgender Survey* (James et al., 2016)

- Some respondents were living in poverty (29%), compared to the 14% of the U.S. population
- Of those who identified as transgender while in school (grades K-12), 54% were verbally harassed, 24% were physically attacked, and 13% were sexually assaulted
- Harassment was so severe that 17% of individuals left school in a K-12 setting
- Individuals had triple the rate of unemployment rate, 15% compared to the 5% of the general population
- Forty percent (40%) of respondents have tried committing suicide in their lifetime, compared to the 4.6% of the U.S. population, with 7% of respondents reporting they had attempted suicide in the past year
- In the past year, 30% reported having been fired, not hired, or denied a promotion because of their gender identity
- Sixteen percent (16%) reported having lost a job in their lifetime due to being transgender
- Nearly one-quarter (23%) of respondents experienced being evicted or denied a home or apartment because of their gender identity
- In the last year, 12% of respondents experienced homelessness because of their gender identity, while 30% of respondents experienced homelessness at some point in their lives
- Of those who experienced homelessness in the last year, 70% reported being harassed in a shelter
- In the last year, 31% reported being mistreated in a place of public accommodation

(e.g., stores, hotels, government offices), while 20% of respondents avoided one type of public accommodation in the last year for fear of being mistreated

- In the past year, 59% of respondents avoided using a public restroom because they were afraid of being harassed
- In the past year, 9% of respondents reported being denied access to a restroom, while 12% reported being verbally harassed, 1% were physically attacked, and 1% were sexually assaulted when using a public restroom
- More than two-thirds (68%) reported that *none* of their IDs had their updated name or gender, with only 11% of respondents reporting that *all* of their IDs had been updated
- When presenting an ID that did not match their gender presentation, 32% of respondents reported being verbally harassed, denied benefits or service, asked to leave, or assaulted
- Almost one-quarter (23%) of respondents did not see a healthcare provider in the last year for fear of being mistreated, while 33% of respondents reported that they had at least one negative experience with a healthcare provider in the last year

Table 2: Highlighted findings of discrimination from *Harsh Realities: The Experience of Transgender Youth in Our Nation's Schools* (Greytak, Kosciw, & Diaz, 2009)

- Ninety percent (90%) of transgender students heard negative remarks about gender expression sometimes, often, or frequently in school
- A third (39%) of transgender students reported hearing school staff make negative remarks about gender expression
- Transgender students also reported little intervention on the part of school personnel when such language was used
- Sixty-five percent (65%) of transgender students felt unsafe in school because of their gender expression
- Eighty-seven percent (87%) of transgender students reported being verbally harassed in the past year because of their gender expression
- Over half (53%) of the transgender students reported being physically harassed (e.g., pushed or shoved) in the past year because of their gender expression
- More than one-quarter (26%) of the transgender students reported being physically assaulted (e.g., punched, kicked, or injured with a weapon) within the last year because of their gender identity
- Almost half (47%) of the transgender students reported skipping a class in the last month, and 46% reported skipping at least one day of school in the last month because they felt unsafe or uncomfortable
- Transgender students who experienced high levels of harassment had significantly lower grade point averages than those who experienced lower levels of harassment

Table 3: Common Terminology

Category	Word	Definition
Sex		Refers to biological and physical characteristics.
	Male	An individual that has a penis and can produce sperm.
	Female	An individual that has a vagina and can produce eggs.
	Intersex	An individual born with reproductive anatomy that is distinctly neither male or female.
Gender		Refers to a societal construct that can vary by culture.
	Masculine	The gender-equivalent of "male." Behaviors and items deemed masculine are done arbitrarily by a culture.
	Feminine	The gender-equivalent of "female." Behaviors and items deemed feminine are done arbitrarily by a culture.
	Cisgender/ Cis	A person whose gender identity corresponds to their sex. I.e., a male that identifies as a man is cisgender.
	Transgender/ Trans	A person whose gender identity does not correspond to their sex. E.g., a person born with a vagina but identifies as male is transgender.
	Gender non-binary/ Gender non-conforming/ Agender	A person whose gender identity is not limited to the male/female gender dichotomy often prescribed by society.
	Gender expression	The artifacts/societal conventions an individual chooses to use to express their gender identity.
	Gender fluid	A person that does not limit their gender expression to one gender. Sometimes a person might dress feminine one day, and masculine the next.

	Additionally, a person that is gender fluid might mix and match masculine and feminine at the same time.
Gender bending	A person that is gender bending is usually a cisgender individual choosing to take on attributes of the opposite gender to question society's arbitrarily assigned gender roles.
Drag/ Drag Queen/ Drag King	A form of entertainment, a person dresses up as the opposite gender and usually does a performance of some sort. Frequently people in drag are members of the Queer community, but it is not necessary. When men dress up as women, they are called drag queens, and when women dress up as men, they are called drag kings.
Sexual Orientation	
Straight/ Heterosexual	A male or female that is attracted to a member of the opposite gender.
Gay/ Homosexual	Specifically a male that is sexually attracted to other men. However, "gay" is sometimes used more broadly to refer to individuals that are gay, lesbian, and bisexual, or "not-straight."
Lesbian/ Homosexual	A woman who is sexually attracted to other females.
Bisexual	An individual that is sexually attracted to both men and women.
Pansexual	An individual who is sexually attracted to a person based on factors other than their gender. A person that identifies as pansexual is not attracted solely to "men" or

	"women," but rather individual people.
Asexual	A person who experiences little-to-no sexual attraction to people.
Demi-sexual	A person who does not feel sexually attracted to someone until an emotional bond is established.
Other Terms	
Closeted/ In The Closet	This refers to a person hiding or not expressing who they are, usually for fear of retribution or rejection. Initially used for a gay/lesbian persons, the term has expended to all forms of non-heteronormativity or cishnormativity.
Coming Out	This refers to the process of a person revealing to others their "true-self." Whether it be one's sexuality or gender-identity. It is important to note that coming out is not a singular event, but rather a process.
Gender Dysphoria	This is the technical diagnosis of being transgender, as per the Diagnostic and Statistical Manual of Mental Disorders (DSM – 5). This is a controversial diagnosis.
Presenting	The term used to describe when a person is dressed or "presenting" as their gender identity.
Passing	When a person who is transgender "passes" for their gender, and is able to function within society as their gender without receiving prejudice.
Clocked	When a person is presenting as their gender identity, but is perceived/noticed by other

	individuals as transgender. The opposite of “passing.”
Gender Binary	The notion that there are only two genders: male and female. The gender binary is black and white, and leaves no gray area for gender identity and expression.
Heteronormativity	Is the notion/belief that all men and women are straight and that heterosexuality is the norm. Other sexual orientations are deviations from what is “normal.”
Cisnormativity	Is the notion/belief that there are only two genders and that all men and women are cisgender. Any variation from the gender binary or assigned sex at birth is a deviation from what is “normal.”
Outing	The act of another person drawing attention to the fact that a person is queer- can be in regards to sexual orientation or gender identity.
Sexual Reassignment Surgery (SRS)/ Gender Confirmation Surgery (GCS)	A surgery that one would undergo to have the biological parts of their desired sex. Surgery is not required to be transgender, however some people that are transgender elect to have surgery.
Top/Bottom Surgery	Terminology relating to the two major components of SRS. Top surgery refers to one’s chest area, whether having one’s breasts removed or implants placed. Bottom surgery refers to the sexual genitalia.
Binding	Using a constricting material to flatten one’s breast tissue.
Transitioning	The process one goes through to become transgender. The

	transitioning process is unique to each individual person.
Misgender(ing)	To incorrectly label a person as the wrong gender. Misgendering a person can be done intentionally as a transphobic act, or accidentally with no mal intent. One should always go by a person's gender identity and pronouns.
Deadnaming	To call someone by their name assigned at birth, and not by the name that corresponds to their gender identity.
Transvestite	This term refers to a (frequently straight) male that dresses in women's clothing for sexual pleasure.
Outdated Terms	The following terms have often been previously used in the American vernacular and published literature. However, today they often carry negative connotations and should be avoided.
Hermaphrodite	Previously used to describe individuals with male and female genitalia. The term <i>intersex</i> is more appropriate.
Transsexual	This word was previously used to describe people that are transgender, and is still used, erroneously, in some modern literature. However, it is an antiquated term that limits an individual's identity to biological attributes and should be avoided as it excludes many people who are transgender.
Tranny	A slur derived from transsexual/transgender. It should never be used.
Cross-Dressing	Historically, this term has

	<p>been used to describe a variety of instances for when a person would wear the opposite gender's clothes. However, it now carries a negative connotation with it and should be avoided. A better understanding of a person's motivations should be understood, and the appropriate terminology used (e.g., are they a performer wearing drag as entertainment, or are they transgender and identify with a specific gender?).</p>
Transgendered	<p>While this is still a debated topic, suffice it to say that saying "transgender" will upset very few people, while saying "<u>transgendered</u>" can upset members in the Trans and Queer community. The word "transgender" should never be used as a noun (e.g., "he is a transgender"). However with the "-ed" at the end, it implies that the person who is transgender has something happening to them, rather than validating their autonomy as individuals.</p>

REFERENCES

- Adler, R., & Christianson, A. (2012). Psychosocial issues. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 69-94). San Diego, CA: Plural Publishing Inc.
- Adler, R., Constansis, A. N., & Van Borsel, J. (2012). Female-to-male transgender/transsexual considerations. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 153-185). San Diego, CA: Plural Publishing Inc.
- Adler, R., Hirsch, S., & Mordaunt, M. (2012). *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.). San Diego, CA: Plural Publishing, Inc.
- American Psychiatric Association. (2013). Gender dysphoria. In *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Publishing.
- American Speech-Language-Hearing Association. (2010a). Cultural Competence Checklist: Personal reflection. Available from www.asha.org/uploadedFiles/practice/multicultural/personalreflections.pdf.
- American Speech-Language-Hearing Association. (2010b). Cultural Competence Checklist: Service delivery. Available from <http://www.asha.org/uploadedFiles/Cultural-Competence-Checklist-Service-Delivery.pdf>.
- American Speech-Language-Hearing Association. (2016a). Code of ethics [Ethics]. Available from www.asha.org/Code-of-Ethics/
- American Speech-Language-Hearing Association. (2016b). Scope of Practice in Speech-Language Pathology [Scope of Practice]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (n.d.). *Cultural competence*. Retrieved from <http://www.asha.org/Practice-Portal/Professional-Issues/Cultural-Competence/>
- Atnas, C., Milton, M., & Archer, S. (2015). Making the decision to change – the experience of trans men. *Counselling Psychology Review*, 30(1), 33-42.

- Baron, D. (n.d.). The words that failed: A chronology of early nonbinary pronouns. Retrieved from <http://www.english.illinois.edu/-people-/faculty/debaron/essays/epicene.htm>
- Bilodeau, B., & Renn, K. A. (2005). Analysis of LGBT identity development models and implications for practice. *New Directions for Student Services*, 11, 25-39.
- Bodoin, E. M., Byrd, C. T., & Adler, R. K. (2014). The clinical profile of the male-to-female transgender person of the 21st century. *Contemporary Issues in Communication Science and Disorders*, 41, 39-54. doi:1092-5171/14/4101-0039.
- Boonin, J. (2012a). Articulation. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 249-261). San Diego, CA: Plural Publishing Inc.
- Boonin, J. (2012b). Rate and volume. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 263-278). San Diego, CA: Plural Publishing Inc.
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York, NY: Routledge.
- Butler, J. (2004a). Gender regulations. In *Undoing Gender* (p. 40-56). New York, NY: Routledge.
- Butler, J. (2004b). Undiagnosing gender. In *Undoing Gender* (p. 75-101). New York, NY: Routledge.
- Byrne, L. A., Dacakis, G., & Douglas, J. M. (2003). Self-perceptions of pragmatic communication abilities in male-to-female transsexuals. *Advances in Speech Language Pathology*, 5, 15-25.
- Cameron, D. (1992). Not gender difference but the difference gender makes: explanation in research on sex and language. *International Journal of the Sociology of Language*, 94, 13-26.
- Carter, M. (2014). Gender socialization and identity theory. *Social Sciences*, 3, 242-263. doi: 10.3390/socsci3020242.
- Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, 4(3), 219-235.
- Colton, R., Casper, J., & Leonard, R. (2006). Understanding voice problems: A physiological perspective for diagnosis and treatment. Philadelphia: Lippincott Williams & Wilkins.
- Crosby, F., & Nyquist, L. (1977). The female register: An empirical study of Lakoff's hypothesis. *Language in society*, 6, 313-322.

- Dacakis, G. (2012). Assessment and goal setting: Revisited. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 111-138). San Diego, CA: Plural Publishing Inc.
- Dacakis, G., Davies, S., Oates, J., Douglas, J., Johnston, J. (2013). Development and preliminary evaluation of the transsexual voice questionnaire for male-to-female transsexuals. *Journal of Voice*, 27(3), 312-320.
- Dacakis, G., Oates, J. M., & Douglas, J. M. (2016) Exploring the validity of the Transsexual Voice Questionnaire (male-to-female): Do TVQMtF scores differentiate between MtF women who have had gender reassignment surgery and those who have not?. *International Journal of Transgenderism*, 17:3-4, 124-130, DOI: 10.1080/15532739.2016.1222922
- Davies, S., & Goldberg, J. (2006). Clinical aspects of transgender speech feminization and masculinization. *International Journal of Transgenderism*, 9:3-4, 167-196, doi:10.1300/J485v09n03_08.
- Davies, S., Papp, V., Antoni, C. (2015). Voice and communication change for gender nonconforming individuals: Giving voice to the person inside. *International Journal of Transgenderism*, 16:3, 117-159, doi: 10.1080/15532739.2015.1075931
- DeCuypere, G., Knudson G., & Bockting, W. (2010). Response of the world professional association for transgender health to the proposed DSM 5 criteria for gender incongruence. Retrieved from World Professional Association for Transgender Health https://amo_hub_content.s3.amazonaws.com/Association140/files/WPATH%20Reaction%20to%20the%20proposed%20DSM%20-%20Final.pdf
- Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay and Lesbian Psychotherapy*, 8 (1/2), 41-67.
- Edwards, J. (2009). *Language and identity: An introduction*. Cambridge, United Kingdom: Cambridge University Press.
- Flores, A. R., Herman, J. L., Gates, G. J., & Brown, T. N. T. (2016). *How Many Adults Identify as Transgender in the United States?* Los Angeles, CA: The Williams Institute.
- Frazier, A. M., & Hooper, C. R. (2012). Language: Pragmatics and discourse. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 279-296). San Diego, CA: Plural Publishing Inc.
- Galupo, M. P., Henise, S. B., & Mercer, N. L. (2016) "The labels don't work very well": Transgender individuals' conceptualizations of sexual orientation and sexual identity.

International Journal of Transgenderism, 17:2, 93-104, DOI:
10.1080/15532739.2016.1189373.

- Gates, G. J. (2011). *How Many Adults Identify as Transgender in the United States?* Los Angeles, CA: The Williams Institute.
- Gelfer, M. P., & Mordaunt, M. (2012). Pitch and intonation. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 187-223). San Diego, CA: Plural Publishing Inc.
- Gelfer M., Schofield, K. (2000). Comparison of acoustic and perceptual measures of voice in male-to-female transsexuals perceived as female versus those perceived as male. *Journal of Voice*, 14, 22-33.
- Glynn, T., Gamarel, K., Kahler, C., Operario, D., Iwamoto, M., & Nemoto, T. (2016). The role of gender affirmation in psychological well-being among transgender women. *Psychology of Sexual Orientation and Gender Diversity*, 3(3), 336-344.
- Gorham-Rowan, M., Morris, R. (2006). Aerodynamic analysis of male-to-female transgender voice. *Journal of Voice*, 20(2), 251-262.
- Greytak, E. A., Kosciw, J. G., & Diaz, E. M. (2009). Harsh realities: The experience of transgender youth in our nation's schools. Washington, DC: Gay, Lesbian and Straight Education Network. Retrieved from:
<http://www.glsen.org/sites/default/files/Harsh%20Realities.pdf>
- Hamilton, J. (2000). Tuned into the human voice. *CMAJ*, 162(7), 1034-1034a.
- Hancock, A., Krissinger, J., & Owen, K. (2010). Voice perceptions and quality of life of transgender people. *Journal of Voice*, 25(5), 553-558. doi:10.1016/j.jvoice.2010.07.013.
- Hancock, A., Stutts, H., & Bass, A. (2015). Perceptions of gender and femininity based on language: Implications for transgender communication therapy. *Language and Speech*, Vol. 58(3) 315-333.
- Hiestand, K., & Levitt, H. (2005). Butch identity development: The formation of an authentic gender. *Feminism and Psychology* 15(1), 61-85. doi: 10.1177/0959-353505049709.
- Hirsch, S., & Gelfer, M. P. (2012). Resonance. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 225-247). San Diego, CA: Plural Publishing Inc.
- Hirschman, L. (1994). Female-male differences in conversational interaction. *Language in Society*, 23, 427-442.

- Hooper, C. R., Crutchley, S., & McCready, V. (2012). Syntax and semantics: A menu of communicative choices. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 297-317). San Diego, CA: Plural Publishing Inc.
- Intersex Society of North America. (2008). What is intersex? Retrieved from http://www.isna.org/faq/what_is_intersex
- James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). Executive summary of the report of the 2015 U.S. transgender survey. Washington, DC: National Center for Transgender Equality.
- James, K., & Walsh, L. (2017). Finding their voice: The role of the SLP in transgender voice therapy [Powerpoint slides].
- Jones, S., & McEwen, M. K. (2000). A conceptual model of multiple dimensions of identity. *Journal of College Student Development*, 41(4), 405-414.
- Krtiz, B. (2014). The global transgender population and the international criminal court. *Yale Human Rights & Development L.J.*, 17. Retrieved from <http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1120&context=yhrdlj>
- Lakoff, R. (1975). *Language and woman's place*. New York, UK: Harper & Row.
- Levon, E. (2016). Gender, interaction and intonational variation: The discourse functions of high rising terminals in London. *Journal of Sociolinguistics* 20(2), 133-163.
- Levitt, H. M., & Ippolito, M. R. (2014). Being transgender: The experience of transgender identity development. *Journal of Homosexuality*, 61, 1727-1758. doi:10.1080/00918369.2014.951262.
- Luterman, D. (2008). *Counseling persons with communication disorders and their families* (5th ed). Austin, TX: Pro-Ed.
- McNeill, E., Wilson, J., Clark, S., & Deakin, J. (2008). Perception of voice in the transgender client. *Journal of Voice*, 22(6), 727-733.
- Mordaunt, M., & Hirsch, S. (2012). Considerations for discharge and maintenance. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 473-480). San Diego, CA: Plural Publishing Inc.
- Neumann, K., & Welzel, C. (2003). The importance of the voice in male-to-female transsexualism. *Journal of Voice*, 18(1), p. 153-167. doi:10.1016/S0892-1997(03)00084-5.

- Non-discrimination laws. (2017). *Movement Advancement Project*. Retrieved from http://www.lgbtmap.org/equality-maps/non_discrimination_laws
- Nunberg, G. (Contributor). (2016, January 13th). Everyone uses singular 'they,' whether they realize it or not [Commentary]. Retrieved from <http://www.npr.org/2016/01/13/462906419/everyone-uses-singular-they-whether-they-realize-it-or-not>
- Oates, J. (2012). Evidence-based practice in voice therapy for transgender/transsexual clients. In R. K. Adler, S. Hirsch, & M. Mordaunt (Eds.), *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide* (2nd ed.) (p. 45-68). San Diego, CA: Plural Publishing Inc.
- Oates, J., & Dacakis, G. (2015). Transgender voice and communication: Research evidence underpinning voice intervention for male-to-female transsexual women. *Perspectives on Voice and Voice Disorders*, 25.
- Oates, J., & Dacakis, G. (1983). Speech pathology considerations in the management of transsexualism: A review. *British Journal of Disorders of Communication*, 18(3), 139-151.
- Obergefell v. Hodges, 576 U.S. (2015).
- Olson, K., Durwood, L., DeMeules, M., & McLaughlin, K. (2015). Mental health of transgender children who are supported in their identities. *Pediatrics*, 137(3):e20153223.
- Park, G., Yaden, D. B., Schwartz, H. A., Kern, M. L., Eichstaedt, J. C., Kosinski, M., Stillwell, D., Ungar, L. H., & Seligman, M. E. P. (2016). Women are warmer but no less assertive than men: Gender and language on Facebook. *PLoS ONE* 11(5):e0155885. doi:10.1371/journal.pone.0155885.
- Parry, W. (2013, June). Gender dysphoria: DSM-5 reflects shift in perspectives on gender identity. *The Huffington Post*. Retrieved from http://www.huffingtonpost.com/2013/06/04/gender-dysphoria-dsm-5_n_3385287.html
- Pasterski, V., Gilligan, L., & Curtis, R. (2013). Traits of autism spectrum disorder in adults with gender dysphoria. *Archives of Sexual Behavior*, 43, 387-393. doi: 10.1007/s10508-013-0154-5.
- Pullum, G. K. (2006). Shakespeare used they with singular antecedents so there [Blog post]. Retrieved from <http://itre.cis.upenn.edu/~myl/languageblog/archives/002748.html>
- Riley, P. (2006). Self-expression and the negotiation of identity in a foreign language. *International Journal of Applied Linguistics*, 16(3).

- Safe space. (n.d.). Retrieved April 2, 2017, from https://www.merriam-webster.com/dictionary/safe_space.
- Schaefer, L., & Wheeler, C. (2004). Guilt in cross gender identity conditions: Presentations and treatment. *Journal of Gay and Lesbian Psychotherapy*, 8(1-2), 117-127.
- Schilt, K., & Westbrook, L. (2009). Doing gender, doing heteronormativity: 'Gender normals,' transgender people, and the social maintenance of heterosexuality. *Gender & Society*, 23(4), 440-464. Retrieved from http://scholarworks.gvsu.edu/soc_articles/7
- Schmitz, R. M., & Tyler, K. A. (2017). LGBTQ+ young adults on the street and on campus: Identity as a product of social context. *Journal of Homosexuality*. doi:10.1080/00918369.2017.1314162.
- Schwartz, B., & LaSalle, L. (2008). Language choice and gender perceptions: Implications for male-to-female transgender voice therapy [Powerpoint slides]. Retrieved from http://www.asha.org/Events/convention/handouts/2008/1220_Schwartz_Bethany/
- Semmelhack, E. (2008). *Heights of fashion: A history of the elevated shoe*. Pittsburgh: Periscope.
- Sendén, M. G., Bäck, E. A., & Lindqvist, A. (2015). Introducing a gender-neutral pronoun in a natural gender language: The influence of time on attitude and behavior. *Frontiers in Psychology* 6(893). doi: 10.3389/fpsyg.2015.00893 Retrieved from <http://journal.frontiersin.org/article/10.3389/fpsyg.2015.00893>
- Tellis, C., & Barone, O. (2016). Counseling and interviewing in speech-language pathology and audiology: A therapy resource. Burlington, MA: Jones & Bartlett Learning.
- The history of psychiatry and homosexuality. (2012). Group for the Advancement of Psychiatry. Retrieved from http://www.aglp.org/gap/1_history/
- The need for gender-neutral pronouns. (2010). Retrieved from: <https://genderneutralpronoun.wordpress.com/>
- Van Borsel, J., Cuypere, G., de Rubens, R., & Destaerke, B. (2000). Voice problems in female-to-male transsexuals. *International Journal of Language and Communication Disorders*, 35, 427-442.
- VanderLaan, D. P., Leef, J. H., Wood, H., Hughes, S. K., & Zucker, K. J. (2014). Autism spectrum disorder risk factors and autistic traits in gender dysphoric children. *Journal of Autism and Developmental Disorders*, 45, 1742-1750. doi: 10.1007/s10803-014-2331-3
- Verhoeven, J., DePauw, G., & Kloots, H. (2004). Speech rate in a pluricentric language: A comparison between Dutch in Belgium and the Netherlands. *Language and Speech*, 47(3) 297-308.

- Voice and communication therapy for clients who are transgender. (n.d.). American Speech-Language and Hearing Association. Retrieved from <http://www.asha.org/public/speech/disorders/TGTS/>
- Voice disorders. (n.d.). American Speech-Language-Hearing Association. Retrieved from <http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942600§ion=Overview>
- Watson, A. (2009). *Being inappropriate: Queer activism in context* (Master's thesis). Retrieved from Central European University Library database. Available at www.etd.ceu.hu/2009/watson_amy.pdf
- Wade, L., & Ferree, M. M. (2015). *Gender: Ideas, interactions, institutions*. New York, NY: W. W. Norton & Co.
- World Professional Association for Transgender Health. (2011). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7th version). Retrieved from http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926

APPENDIX

APPENDIX

LINKS TO ADDITIONAL RESOURCES

Cultural Competence Checklist: Personal Reflection

American Speech-Language-Hearing Association (2010)

Available from www.asha.org/uploadedFiles/practice/multicultural/personalreflections.pdf

Cultural Competence Checklist: Service Delivery

American Speech-Language-Hearing Association (2010)

Available from <http://www.asha.org/uploadedFiles/Cultural-Competence-Checklist-Service-Delivery.pdf>

Transsexual Voice Questionnaire (Male to Female) (TVQ^{MtF})

Dacakis and Davies (2012)

Available from http://www.shelaghdavies.com/questionnaire/TVQ_Questionnaire.pdf

Ethical Guidelines for Members of the World Professional Association for Transgender Health, Inc.

World Professional Association for Transgender Health (2016)

Available from

https://s3.amazonaws.com/amo_hub_content/Association140/files/WPATH%20Ethics%208-18-16.pdf

Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (7th Version)

World Professional Association for Transgender Health (2011)

Available from

[https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf)

BIOGRAPHICAL SKETCH

Brett Welch attended The University of Texas at Austin from 2010 to 2014, where he received a Bachelors of Arts in Linguistics and a Bachelors of Science in Communication Sciences and Disorders. He later attended The University of Texas Rio Grande Valley from 2015 to 2017, where he obtained his Masters of Science in Communication Sciences and Disorders. Brett is also currently a student member of the World Professional Association for Transgender Health, an international organization dedicated to the wellbeing of transgender individuals worldwide. He is also a member of the National Student Speech Language Hearing Association.

Mr. Welch is a passionate and outspoken activist about queer and trans rights. He has given presentations about speech-language pathology and Gender Spectrum Voice and Communication, as well as cultural competency with the Queer community at the state and local level. He has also presented on language acquisition in individuals with Downs Syndrome at the local level. Additionally, he has an interest in early intervention, linguistics, language acquisition, literacy, Autism Spectrum Disorder, Downs Syndrome, auditory processing, fluency, and Gender Spectrum Voice and Communication. He hopes to continue doing research in the future to further expand the body of knowledge in these areas. His thesis, *The Role of the Speech-Language Pathologist When Working With Clients Who Are Transgender: A Guide of Gender Identity and Cultural Competency*, aims to educate speech-language pathologists and other professionals about gender identity to deepen their understanding and cultural competency when working with the transgender population. He can be contacted at bwelch.slp@gmail.com.