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Voice and Communication Therapy for the Transmasculine Client: Service Delivery and Treatment Options

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Voice and Communication Therapy for the Transmasculine Client:

Service Delivery and Treatment Options: A Literature Review

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GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Introduction

The first reported terminology of 'transsexual/transvestite' was in 1910 by Dr. Mangus Hirschfeld (Proud trust, n.d.). Although these terms are outdated, their existence over a decade ago suggests that transgender/non-conforming individuals have been present and identified for many years. Despite the presence of transgender (TG) individuals throughout history, they are a largely misunderstood and mistreated population (WPATH, 2012). Transgender is an umbrella term used to describe individuals whose gender identities differ from their sex assigned at birth (Adler, Hirsch, & Mordaunt, 2012), while transsexual/transvestite is an outdated term to describe individuals whose gender identities differ from their assigned sex at birth. Terms relating to TG individuals are vastly changing. In particular, person first language is the standard, so identifying an individual with a term they are comfortable with is most appropriate. Further, gender is no longer thought of as binary, but as a spectrum between masculine and feminine. Likewise, while the terms transsexual and transvestite were once appropriate, they no longer used to represent the TG population. TG/transsexual/transvestite was once in the Diagnostic and Statistical Manual of Mental Disorders (DSM), indicating that being TG is a disorder. This term has recently been dismissed from the DSM, and the associated terms are no longer appropriate or representative of the population. Thus, recent terms such as "female-to-male" and the like are no longer considered representative of a person's gender identity. Instead, the term transmasculine (TM) will be used to label individuals that are TG males. This paper focuses mainly on TM individuals, or those who identify towards the male end of the gender spectrum, but who were identified as the female sex at birth. TM individuals may not know about or understand the range of services that speech-language pathologists can provide to them throughout their transition. Thus, the subsequent literature and service manual aims to help clinicians and potential TM

clients more effectively provide services or seek out services for gender-affirming communication services (GACS), respectively.

When reading literature focusing on TG individuals, one will likely find that there is significantly more research relating to transfeminine (TF) individuals than TM individuals. This literature review consolidates relevant research relating to TM communication services. It seeks to close the gap between available research and GACS for TM individuals. Although this paper focuses on TM clients and their need for services, knowledge about the TG experience overall will be provided as well.

TG Individuals and Healthcare

According to the 2015 U.S. Transgender Survey, 1 out of every 3 TG individuals experienced mistreatment from a healthcare provider related to them being TG. This mistreatment includes discrimination such as verbal harassment, refusal of treatment, or ignorance on the part of the health care provider. Understandably because of this discrimination, 23% of TG people surveyed in 2015 did not seek out medical services when they were in need of health care. Because health-related services are a right that many TG individuals do not feel safe or secure seeking, even general health maintenance may be challenging. More specialized services related to TM person's transition, such as speech-language pathology, are not being sought (Sawyer, 2014).

According to a study conducted by Sawyer (2014), 91% of eighty-eight LGBT individuals surveyed have not received services from a SLP. This is due to several factors, including 57% misunderstanding the scope of SLP's practice, while others did not seek out services for other reasons, although they knew that SLPs could help them. Since many TM individuals are not seeking out SLP services to facilitate voice and communication congruent

with their gender identity, they may turn to unhealthy and/or harmful vocal practices increase vocal fold mass (i.e., smoking, vocal overuse) in order to decrease vocal pitch. SLPs can help TM individuals make safe voice and communication changes and avoid potentially harmful self-treatment. In order to do so effectively, SLPs must work to become culturally competent and knowledgeable about partnering with this population.

Cultural Competency and SLP Confidence

The American Speech-Language Hearing Association (ASHA) Code of Ethics (COE) indicates that "cultural competence involves understanding and appropriately responding to the unique combination of cultural variables and the full range of dimensions of diversity that the professional and client/patient/family bring to interactions," (ASHA, 2016). Thus, SLPs are ethically responsible for providing culturally competent speech, language, and hearing services to all patients. Any type of discrimination towards TG clients seeking services is a violation of the COE laid out by ASHA.

Although these guidelines exist, several studies have shown that SLPs do not provide adequate services to TG individuals. According to Turner (2006), cultural competence (CC) is a chain that begins with awareness and sensitivity, growing to competency, then to mastery. If a clinician is not confident about providing TG care, establishing an awareness of the issues facing this population builds a solid foundation for providing services. Building on the foundation of sensitivity towards the needs of this population leads to a greater opportunity for professional growth that leads to CC and ethical treatment for TG individuals.

SLPs are often not confident when working with this population of individuals likely due to lack of awareness or knowledge. Even SLPs that are culturally competent, may not feel as though they have the proper education to serve this population. Several TG individuals have

been turned away because the provider indicates a lack of knowledge/resources to serve them (Sawyer, 2014). While this may be a result of discrimination, studies show that many SLPs do not feel competent working with this population because they might lack the clinical experience and training that is required to facilitate change for TG individuals. Since GACS are newer, many SLPs are not trained in providing delivery of these services. Even if they are, the communication needs of TG individuals are widely variable. While this is true, there are some basic guidelines that SLPs may wish to follow when providing services to TG clients.

Voice and Communication Treatment for TM Individuals

Van Riper (1963) stated that one way of looking at speech and voice output is the identification and exhibition of the "self." For some TG individuals, their current communicative ability and the communication that is consistent with their gender identity does not match. When there is a mismatch with the true self and current self, dysphoria, resulting in significant stress and anxiety, is a common occurrence. Dysphoria is characterized as "distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth," (The World Professional Association for Transgender Health (WPATH), 2012).). which can also cause significant stress and anxiety. Although the rate of gender dysphoria is unknown, it is believed that at most TG individuals will experience some sense of dysphoria at some point in their lives. For many TG individuals, dysphoria is a constant state that can follow them post transition, as well. Knowing the prevalence of TG individuals in the United States (U.S.) may provide some insight into gender dysphoria rates. Specifically, as of 2014, approximately 0.53% of the US population, or 1 in 189 adults, identified as TG. Of this statistic, 0.16% of the population identified as TM (Crissman, Berger, Graham, & Dalton, 2017; WPATH, 2012).

Perception of Gender in Communication

Several studies throughout the years have focused on the differences between "masculine" and "feminine" characteristics of communication. Thus, the general differences between masculine and feminine speakers are outlined in the subsequent sections.

In theory, there is a gap between the way masculine and feminine speakers use articulation. Women tend to use longer vowels during speech in all parts of the word, while more masculine speakers include shorter vowels. Masculine speakers also tend to separate words, where feminine speakers tend to blend words together. By creating more pronounced endings and beginnings to words, articulation will likely be perceived as more masculine. Feminine speakers are more likely to have breathy vocal quality in speech, while masculine speakers are not thought to have breathy vocal quality. Another factor related to gender identity and communication is vocal intensity. The masculine voice is generally louder than the feminine voice. By using a louder voice without air leakage during voiced sounds, the perceptual quality of voice will likely become more masculine.

Speech rate may indicate more perceptually masculine or feminine speech. Masculine speakers generally have a slower rate of speech than women because they are more likely to articulate each part of a word being said. On the other hand, feminine speakers may articulate a word more rapidly by linking each sound in a word or phrase together.

Generally, masculine speakers are also thought to use words in a more assertive manner, using fewer words to describe several concepts. Feminine communicators, on the other hand, are thought to use a larger variety of words to describe a smaller number of concepts.

Although these differences in gendered communication are not appropriate or accurate for every client, they are used as a general overview of the perceived differences in the available

literature. These differences are used as a baseline throughout this literature review to enhance the awareness for the need of services.

Need for Services

Many TM individuals do not seek services because they believe testosterone therapy or other surgical interventions should adequately provide lower vocal pitch, leading to more masculine communication. However, TM individuals may be dissatisfied with hormone-induced pitch change alone. Azul (2018), studied the presence of voice problems in the TM client. Of twelve participants self-reports, nine (64%) desired or expected lowered pitch after testosterone therapy. Fifty percent of these participants also indicated that they experienced trouble with controlling their vocal gender presentation. Although for many other TM individual testosterone does decrease pitch by increasing vocal fold mass, this alone is often not sufficient for TM individuals to achieve his/their desired communication. Markers of communication are composed of more than just pitch, which may be the reason many of these individuals are dissatisfied with testosterone treatment alone. There are many other aspects of communication that should be taken into consideration when observing and identifying a TG individuals vocal and communicative situation. Azul (2015) stated that it is a generally held belief that many voice specialists feel that TF individuals are in greater need of communication services because estrogen does not typically result in increased vocal pitch. Although this may be true, Azul points out the fact that these voice specialists are missing key factors of gendered communication. One overarching factor is that, “the effect of testosterone on the voice of transmasculine people is not always the same” (Azul, 2015, p. 33). Such practice patterns do not account for the individual needs of and effects of hormone treatment of the client. Azul (2015) also describes how TM clients' satisfaction with their voice might vary due to differing goals and

objectives. For example, a client may not be concerned about their vocal pitch but have other communication concerns. Similarly, the way the voice is perceived will vary from listener to listener.

In a study conducted by Nygren (2016), the fundamental frequency of 28 TM individuals decreased continuously across 24 months. Although the fundamental frequency and perceived pitch dropped, 24% of these individuals reported vocal fatigue and instability. This study also revealed that although fundamental frequency dropped significantly, sound pressure levels did not change significantly, indicating that although hormones did affect change in pitch, vocal intensity and resonance did not change significantly. Although pitch is one factor in gendered communication, resonance and intensity are also significant influences. Masculine speakers tend to use more chest-focused resonance, while feminine speakers use more head-focused resonance (Adler, 2012). The difference in resonatory patterns is not achieved with testosterone treatment but can be a potential goal for GACS. In a study conducted by Hancock and associates (2017), seven TM individuals were surveyed after 3, 4, 5, and 12 months of testosterone therapy. The researchers found that there were mixed effects of hormone therapy on vocal quality. Although fundamental frequency dropped after testosterone therapy, specific participants found that their fundamental frequency increased. Further, two participants' fundamental frequency dropped, but not satisfactorily. One of these participants described his voice as "very male" by the year mark, while the other participant did not note a change in his voice. Thus, these results indicate that even if fundamental frequency does not drop, the client might be satisfied, but the opposite may also be true.

Since vocal pitch alone cannot be the sole determinant of masculine communication, other factors need to be addressed. Other categories of communication related to gender may

include articulation, resonance, rate and volume, syntax, semantics, pragmatics, and non-verbal communication (Adler, Hirsch, & Mordaunt, 2012). Adler and associates (2012) provide a comprehensive overview of the different subcomponents that are associated with TG communication and that are addressed in gender affirming voice and communication services for TM clients. Adler and associates, (2012), focuses on masculine versus feminine components of communication. Although gender is on a spectrum, this information on binary components of communication is useful and can help guide treatment but need to be tailored for each client. Clinicians should use these tools in relation to the needs and goals of the client but should not hold to them strictly.

Azul (2016) laid out a more comprehensive overview of TM vocal situations based on self-reports from fourteen TM clients: gender-related voice features, vocal gender presentation, gender self-attribution to voice, gender attribution received from others, and listener response to voice. These guidelines are listed below:

- Gender-related voice features with subcategories of pitch, loudness, and voice quality.
    - Pitch: for many TM individuals, pitch lowers as a result of testosterone therapy, but this alone does not sufficiently masculinize communication.
    - Loudness and quality.: Testosterone treatment may decrease pitch, but also increase instability in the voice that affects vocal loudness and quality that may benefit from GACS. Other individuals simply find that a drop in pitch does not affect their overall vocal quality. For example, in a study conducted by Azul (2018), some TM individuals might experience desire for a change in vocal quality. One participant in particular noted they wished for a “smoky” voice

quality, while others might experience a desire for a more “rich” or “full” voice quality, which could indicate the need for resonance therapy.

- Vocal gender presentations of self-perception and control of vocal gender presentation. Gender self-attribution to voice: match with desired vocal gender.
    - Self-perception is a key part of GACS but can be challenging as a result of gender dysphoria. A TM individual experiences difficulty self-identifying progress or goal areas for change, but a questionnaire could be useful in this situation.
- Gender attribution received from others: match with desired gender attribution, predictability of gender attributions received from others and listener response to voice: quality of anticipated listener response to voice.
    - A key part of GACS for TM clients might revolve around the desired gender perception of others. For example, a client might be concerned about how they present on the phone.

All of these factors influence the TM individual’s vocal situation and should be accounted for in the treatment plan. Each area represents a part of communication that the TM individual encounters in everyday life and could cause dysphoria. Goals will likely not be based around these exact subcategories, but could be referred to when thinking of the subcategories of communication the goals are based around (articulation, pitch, resonance, etc.) Because there are so many areas of communication that cannot solely be altered through surgical intervention, GACS is an option that may be beneficial to the quality of life of TM individuals.

Considerations - Lack of Research for Assessment and Therapy Assessment

For many TM clients, there is a gap between his/their current communicative ability and his/their congruent communicative ability. If the client is coming to therapy with hopes to

change their communicative ability to be congruent to their identity, the treating clinician should start the clinical process with assessment. For example, Adler and associates (2012) created a beneficial outline for therapy that begins with the assessment process. One of the first steps in assessment might be a laryngeal examination completed by a laryngologist. Although an evaluation from a laryngologist would provide information about the structure and function of the vocal folds and larynx, this practice is not done in all situations for several reasons. Of the many reasons, one might be due to the invasive nature of the nasal or oral endoscopy. Many TM individuals may feel some degree of dysphoria, so completing a laryngeal exam might create unnecessary discomfort. As stated above, there is a large level of distrust among the TG population and the medical field as a result of years of mistreatment. Because of this mistreatment, going to a medical center and having an invasive procedure such as a laryngeal examination can induce unnecessary anxious feelings. Since GACS services are aimed to provide change for communication differences and not disorders, an evaluation of the larynx may not be necessary. Aside from this, the clinician should collect a case history, conduct a patient interview, provide a psychosocial questionnaire for the client to complete, and conduct a vocal inventory of the client's baseline ability.

Although there are standard practices for assessment and treatment procedures, there is a large gap between research regarding TM and TF individuals relating to GACS. Many of the questionnaires and procedures outlined in texts are normed on TF individuals and focused on their experience with communication. This should be taken into consideration when working with a TM individual so that the information and tasks used in GACS can be modified if necessary.

Case history and patient interview: Collecting a case history and interview for TG individuals on any aspect of the spectrum can be challenging. There are many factors to consider, such as stage of transition as well as emotional, psychological, financial, and motivational state. Because of this, a case history interview should be modified before each initial interview to be consistent with the patient's needs. Identifying information is required, but the clinician should be conscious about the client's congruent name. Respect is a large part of any therapy process and is demonstrated when the client's congruent name and gender (even if it is not legally changed), are honored by the professional. It is also important to identify what the patient prefers to be called outside of the clinic and on documents that might be sent to his or her home. Confidentiality of the client's transition is essential, so the clinician and staff should be aware of the needs of the client in regard to his or her name. When collecting medical information, questions should focus around the patient's vocal health history. Questions regarding respiratory disease, laryngeal disease, past surgery or trauma to head/neck area, neurological disorder, hearing loss, and history of smoking/recreational drug use will help the clinician better understand the patient's vocal history and current situation. The case history should also include a list of current medications, as thy may affect the course of services by impacting the client's physically (i.e., voice changes) and emotionally.

Patient interviews are used to build rapport, and better understand the needs of the individual, desired gender attribution, and level of gender dysphoria to guide the assessment process. Although treatment relating to gender dysphoria is not directly in the scope of practice for SLPs, it is important to note that the level of gender dysphoria that a client may experience creates a need for communication change that an SLP can address. Asking clients about their daily life will help the clinician gain a holistic understanding of the client. One important

question to ask in either the patient interview or the case history form is how much time is spent in the patient's congruent gender.

During the patient interview process, many of the topics are useful for the clinician to know but can be triggering and difficult for the patient to talk about. Clinician sensitivity and awareness is essential when asking questions relating to transition, family support, employment, vocal history, social interaction, and many more. By using caution and communicating the purpose of the questions asked, the clinician can facilitate a successful client interview. Information regarding a patient's history of voice use and potential phonotrauma can help guide the evaluation process. Since many clients come to therapy after attempting to lower pitch on their own, understanding the patient's history of vocal misuse is essential. Patient interviews will help shape the goals writing and therapy processes moving forward.

During the intake portion, a baseline of the client's fundamental frequency and vocal range might be included based on the needs of the client. This would aide in giving the clinician an idea of where to start the therapy process and if the need for voice therapy for pitch lowering is necessary, or to focus on other aspects of communication. However, if the client does not seek pitch lowering as a goal towards congruence, the clinician should consider not obtaining baseline data regarding fundamental frequency as it is non-essential to the assessment process in this case.

Psychosocial questionnaire. A psychosocial questionnaire should be administered for the clinician to further assess the impact the patient's current communicative ability has on the patient's everyday life. Questionnaires help the SLP to understand patient preferences and needs, creating a holistic approach to therapy. One of these is the Vocal Handicap Index (VHI), which presents questions in a rating scale format (Jacobsson, Johnson, Grywalkski, & Silbergleit, 1997). The VHI would likely provide the general, necessary information about the patient's

current vocal situation. Many of the questions involve the patient's own perception of their voice to others, their perception of voice use, and how they react to their vocal ability. This could give the clinician a general overview of the patient's feelings about their voice while avoiding any outdated or offensive terms Some questionnaires alone will not provide reliable results, as there has not been extensive research specifically on how accurate or relatable these questionnaires are for TM individuals (Adler, 2012). Most of the assessments are focused towards TF individuals, potentially because they seek services more readily than TM individuals (Adler, 2012). Questionnaires should be used to gain a deeper understanding of vocal gender presentation and desired outcomes for the client seeking services. The current state of the patient can greatly impact on the therapy process. If a patient is struggling, he may have a harder time working on self-awareness practices that are essential to the therapy process.

To further assess the patient's state and how their communicative ability affects them, there are questionnaires that are available. Although these questionnaires are aimed towards both TM and TF clients, many of them are only norm-referenced on TF persons. Not only are these questionnaires geared towards the TF population, but many of them use outdated terms that are likely offensive today. Though this is true, many of the questions on these evaluations are still relevant and beneficial to the therapy process. Another common questionnaire is the Transgender Self-Evaluation Questionnaire. The TSEQ was created by Davies (2006) to provide an overview of the TG patient's perceptions and feelings about his or her vocal situation. Although the TSEQ is a useful tool to use in therapy, it was never formally normed or published (Hancock, Kissinger, and Owen, 2011); however, the TSEQ may be used because it poses questions about the patient's experience with voice and communication as a TG person. Many of the questions address the experience of both TF and TM individuals, using "I feel" language to reference how

the patient's attitude towards their vocal situation affects quality of life. A third vocal health questionnaire aimed towards the TG population is the Transgender Voice Questionnaire (TVQ). The most recent version of the TVQ is specifically aimed at TF communication, so caution should be used when assessing the validity when used with the TM population. Table 1 outlines information regarding the normed population, terminology used, and how voice is assessed for the three questionnaires discussed in this review.

Table 1
Voice Questionnaires for TM GACS Assessment

	Normed Population	Terminology Used	Voice Assessment
VHI	Anyone with voice disorders	General terminology - not gender specific	The experience of the client and their experiences with the perception of others
TSEQ	Not formally normed	Provides choices for masculine or feminine gender population	The experience of the TG client in terms of their gendered communication and with their experience with the perception of others
TVQ	TF individuals	Feminine gendered terminology	The experience of the TF client in terms of their gendered communication and with their experience with the perception of others

Holistic approach - client centered approach

A holistic approach for the TG individual is defined by Fairchild & Stronach (2018) as therapy where the clinician and client are both engaged in therapy and the process. The focus of therapy is a collaboration between the client and clinician. Collaboration is the most efficient way to provide speech-language voice therapy for TM individuals because of the broad range of potential needs and unique individuality of each patient. A TM client may come into a diagnostic not knowing what his/their congruent voice entails, so it is the SLP's job to continually adjust the treatment plan based on feedback from the client.

Conclusion

Resources for TM GACS services are limited and may not be well understood by all SLP practitioners. Providing culturally competent services is a requirement from the ethical guidelines from ASHA. If an SLP provider is unsure of their ability to treat this population, a referral to another more knowledgeable and experienced provider is required when appropriate. The treatment process begins with an assessment of the client's current vocal ability, case history, and psychosocial views so that the treating clinician can set up an appropriate and holistic plan of care for the client. Once a plan is in place, treatment typically begins with education of the different aspects of communication. Then, the SLP may start introducing techniques that are appropriate for the client, such as breathing exercises, relaxation techniques to enhance relaxed muscles of the larynx, and other communicative masculinization tasks.

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A Handbook for Clinicians on Gender Affirming Communication Services (GACS) for the Transmasculine Client:

Voice and Communication Therapy and Treatment

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GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

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GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Introduction

It is widely believed that testosterone treatment will be solely responsible for lowering pitch and masculinizing communication for transmasculine (TM) individuals. Yet, even if testosterone treatment decreases vocal pitch, the extent of this pitch decline may not be satisfactory to the client or, even more likely, there may be other aspects of their community that are misaligned with gender identity.

Terminology relating to TG individuals:

Terminology relating to transgender (TG) individuals is wide and changes often. While the terms in this manual are currently accepted, they might soon be outdated and unacceptable in future works. A review of the current appropriate terminology is required prior to initiation of therapy and learning. A general list of the terminology is reviewed below, but a more comprehensive list of terms can be found on this Human Rights Campaign website: https://www.hrc.org/resources/glossary-of-terms

Transgender (TG):

- umbrella term used to describe individuals whose gender identity/expression differs from their sex assigned at birth (Human Rights Campaign, 2019)

Gender Spectrum:

- Gender is typically thought of as the binary male and female. In reality, the gender spectrum includes a multitude of different genders between male and female. A few of the many different genders along the spectrum can include transgender, non-binary, non-conforming, gender-fluid, etc. Sensitivity to an individual's place on the gender spectrum is important for service delivery to ensure that the client feels safe and acknowledged. Although there is a wide variety of genders on the continuum of possibilities, it is

important to note that the research consolidated in this manual is aimed to focus on the differences from masculine and feminine communicators. The information provided focuses on the binary of gendered communication (masculine and feminine trends from research) but given the vast variety of potential individuality of clients, these trends may not apply directly. If a client is not comfortable with services that emphasize or focus on specific masculine or feminine communication trends, it is important to alter the goals to fit that exact client. (GenderSpectrum, 2019).

- More information about the gender spectrum can be found at the following link: https://www.genderspectrum.org/quick-links/understanding-gender/

Transmasculine:

- an individual, assigned the sex of female at birth, who identifies towards the male side of the gender spectrum

Female-to-male:

- an outdated term previously used to describe transmasculine individuals

Transsexual:

- another outdated term to describe individuals whose gender identities differ from their assigned sex at birth

Cisgender:

- an individual whose gender identity and expression matches their sex assigned at birth

Non-binary:

- gender expression that does not conform to the male or female binary

Gender dysphoria:

- *"*discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth," (The World Professional Association for Transgender Health, 2012, p.5).

Gender Identity:

- a person's sense of gender as female, male, or somewhere along the gender spectrum

Gender Expression:

- characteristics of a person's gender expressed through personality, appearance, and behavior that is culturally labeled as masculine, feminine, or androgynous

Sex:

- assigned at birth as either male or female based on genitalia

Transition:

- "Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role," (The World Professional Association for Transgender Health, 2012, p. 97). Transition can look vastly different from person to person.

GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Need for services: Pitch is Not the Only Factor

There is a paucity of literature addressing the efficacy and components of Gender Affirming Communication Services (GACS) for the transmasculine client because of the widely held belief that the drop in vocal pitch, typical with testosterone therapy, sufficiently masculinizes communication. Androgen therapy may not sufficiently alter a TM person's communication because communication is so much more than vocal pitch. Many aspects of communication contribute to gendered communication perceptions. The following information outlines the ways that perceptual gendered qualities are embedded into communication sub-types.

Articulation:

- In theory, there is a gap between the way masculine and feminine speakers use articulation. Since the 1950s, studies have been conducted to look at the differences in articulatory patterns between men and women. Articulatory differences between men and women can be broken up into two categories: vowels and consonants.
    - Vowels: For both men and women, it is healthier to produce easy onsets of vowels. Vowel onsets are the way that one produces a vowel at the beginning of the word. A hard glottal attack or onset requires quick approximation of the vocal folds, and creates a louder voice and sudden onset of phonation. Consistent use of harsh glottal attacks is often associated with phonotrauma or damage to the thin tissues of the vocal folds. Another factor of vowel masculinization is vowel duration. Women tend to use longer vowels during speech in all parts of the word, so masculinization of articulation might include shortening vowels.

- Consonants: In terms of consonants, speakers closer to the feminine side of the continuum may use more precise articulation than masculine speakers. Feminine speakers may also use “Lighter” articulatory contacts than male speakers. For example, more exact articulation of consonants may create a more authoritative, or “masculine” mode of communication. Masculine speakers tend to also separate words, where feminine speakers tend to blend words together. By creating more pronounced endings and beginnings to words, articulation will likely be perceived as more masculine. Further, women are more likely to have breathy vocal quality during voiced phonemes. By using a louder voice without air leakage during voiced sounds, the perceptual quality of voice will likely become more masculine (Boonin, 2012).

Intensity:

- Loudness occurs as a result of increased subglottic pressure below the vocal folds which, results in an increased amplitude (displacement) of vocal fold vibration during phonation. Overall speaking intensity during conversation is typically 50-65 dB, but studies have shown that there is a perceptual difference in intensity for masculine and feminine speakers. Male vocal intensity is generally higher than female vocal intensity. Generally, masculine speakers use 2-3 dB higher intensity than their feminine counterparts across speaking situations, (Boonin, 2012).

Prosody:

- Prosody is one of the greatest contributors as to whether communication is perceived to be more masculine or feminine. Prosody includes speech rate, stress, and intonation. These three factors contribute to the overall emotion, meaning, and rhythm of the speaker. Speech rate is a component of prosody that may indicate more perceptually

masculine or feminine speech. Men generally have a slower rate of speech than women because they are more likely to articulate each part of a word being said while women may articulate a word more rapidly by condensing articulation. Feminine speakers generally use more changes in pitch and loudness as they talk speech than masculine speakers do. Therefore, more masculine speakers will use less rapid speech rate, and less intonation and rhythm in given speech than feminine speakers will, (Leung, Oates & Pang, 2018).

Syntax and semantics:

- Although syntactic and semantic use can depend on a multitude of factors (culture, socio-economic, age, social-setting, etc.), differences may also be seen across the genders. Wood (2009) reported that men generally use language to establish assertiveness, to maintain status and control, and for problem-solving. They may be more likely to use general and abstract terminology, and express little emotion. Recognizing general trends in language use may help the clinician shape language to a specific client's needs (Wood, 2009).

Pragmatics:

- Pragmatics is the way one uses language depending on the different situations or social settings they are in. Pragmatic differences in feminine and masculine speakers are often stereotypical, so caution regarding the use of these ideals is advised. Often, TG individuals may find it beneficial to be flexible with gender pragmatics in different settings. It may be important to "pass" in one setting, while beneficial to not "pass" as their congruent gender in another setting. Other clients may wish to "pass" in all

pragmatic settings. A comprehensive holistic approach with each client will further guide the clinician through this sub-component of speech (Frazier & Hooper, 2012).

Non-verbal behaviors:

- A large part of an intended message is displayed non-verbally. This can include movement of the body, facial expression, eye-contact, physical appearance, proxemics, physical appearance, smell, etc. All of these perceptual factors can affect how a listener judges or perceives the message and the communicative ability of the conversational partner. Generally, these factors can play a role in the way a listener perceives the communication of their conversational partner as feminine or masculine. Although non-verbal behaviors are widely variable across cultures, the summary below details trends in gendered non-verbal communication (Hirsch & Van Borsel, 2012).

Body language:

- Also called kinesics, body language is the way one uses body movement in conversation to aid in communicating a message. Generally, masculine speakers keep their head, hips, and trunk static throughout a conversation, whereas women move their head, hips, and trunk more often to convey messages. Men may also take up more space, using larger arm movements to emphasize their point (often using grander gestures). Although men make larger gestures, women tend to make gestures more often than men (Hirsch & Van Borsel, 2012).

Resonance:

- Resonance is a multi-faceted process of the vocal tract filtering phonation, emphasizing certain harmonics and creating different vocal qualities. Generally, for more masculine speakers, a chest-focused resonance is the goal. Women tend to have higher-focused

resonance (i.e., head versus chest). When resonance is re-focused to the chest, the vocal tract opens and lengthens, creating a larger space for the phonation to be resonated such that lower-frequency harmonics are a stronger component of the voice signal. This creates a "richer" vocal quality, perceptually correlated to male speakers (Hirsch & Pausewang, 2012).

Considerations

Self-guided attempts at changing the voice:

- In an attempt to lower fundamental frequency when hormone therapy does not produce sufficient results, TM individuals might engage in behaviors that result in swollen vocal folds thereby lowering pitch. Common behaviors might include screaming and excessive coughing. Knowledge of a patient's behaviors upon intake is important. If a client is engaging in behaviors that may harm the vocal folds, education about these potential effects and what can be done instead is an important starting point.

Change to outward appearance might have a positive effect on TM client:

- Gender dysphoria is defined as "distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)," (WPATH, 2019, p. 96). Gender dysphoria is a common occurrence for individuals across the TG spectrum. When a person feels more confident or congruent with their outward appearance and communication or is able to pass in society, they are likely to be more motivated to participate in therapy. Although this is true, many individuals that come in for services may not feel comfortable altering their appearance to match their congruent self, so

creating a safe environment for them to do so can also correlate with increased motivation for therapy.

Chest binding:

- Chest binding is when an individual (who has not had top surgery) uses binding to flatten their chest. Chest binding may make respiration techniques during therapy a challenge by compressing the ribcage. Although there are many alternatives or ways to work around binding in therapy, one way to do so is to engage the client in diaphragmatic breathing. Diaphragmatic breathing techniques can help with appropriate and healthy respiration to support phonation that will consequently circumvent the challenges that occur from chest binding. Diaphragmatic breathing will also allow for expansion below the ribcage, where the binding is, allowing for more productive inspiration. Binding can also create challenges for chest-focused resonance. If you are working with a client that has chest binding and the goal is chest resonance, he/they might have difficulties detecting the sensation of chest resonance that might allow them to replicate such resonance outside the therapy room.

Posture:

- A TM client might slouch in an attempt to conceal his/their breasts. The treating clinician needs to be aware that the client is not slouching out of habit, but it might be that he is slouching as a way to hide binding. Education about posture and breath support in therapy is suggested to indicate why a more elongated posture might be encouraged.

Mastectomy/top surgery:

- Mastectomy is the removal of breast tissue. Many TM clients, although not all, elect to have a mastectomy. Mastectomy is more commonly referred to as “top surgery” and will

be referred to as such for the remainder of this manual. There are many considerations regarding top surgery. Intubation, level of healing, and restriction of range are just a few of these considerations. Intubation during top surgery might cause vocal fold damage because of the force used to insert the tube through the glottis and the soft tissue of the vocal folds. If the client is planning to have top surgery (or any kind of surgery with general anesthesia), intubation is a factor that might affect the vocal mechanism and progress made in therapy. Another consideration for top surgery is restriction of range of motion of the thorax, specifically arm and chest restrictions. Recovery for top surgery typically takes several weeks or months. The clinician should take the client's level of healing and range restriction into consideration during therapy.

Laryngeal surgery:

- Laryngeal surgery may be a consideration for several TM clients who are dissatisfied with the extent of pitch decline provided by testosterone therapy. During an initial case history intake, the clinician should make sure to ask the client if they have had laryngeal surgeries or if they plan to. If they plan to, educating the client on the potential risks of surgery and how they could hinder GACS services would be beneficial. If the client indicates plans for laryngeal surgery, the clinician should also inquire about when the client plans to get a surgery.

Psychosocial situation

- TM clients might come to the clinic with heightened anxieties relating to their dysphoria and incongruence between their communication and gender identity. Such anxiety can hinder therapy in a multitude of ways. If a person experiences dysphoria regarding their voice, they might speak with a lower intensity, thus limiting the patient's ability to fully

engage with vocal practice exercises in therapy. A TM client might also be less inclined to experiment with their voice and communication in therapy, which could slow progress. Psychosocial situations often play a role in communication therapy progress, so awareness of the individual's psychosocial situation, ahead of time, and how to circumvent or work through these issues is essential to progress.

Assessment Considerations

Because there is typically a gap between GACS clients' baseline and congruent communicative abilities, the treating clinician should start the clinical process with assessment. Adler and colleagues (2012) created a beneficial outline for therapy that begins with the assessment process. First and foremost, it is often advised that the treating clinician receive the results of an evaluation by an otolaryngologist (ENT). Such results will provide a better idea of the structure and function of the client's larynx, while also helping to identify vocal pathologies, if any. Although an evaluation from an ENT or laryngologist (ENT with more specialized training in the larynx) would provide information about the structure and function of the vocal folds and larynx, this practice is not done in all situations for several reasons. Of the many reasons, one might be the invasive nature of the nasal or oral endoscopy. Many TM individuals may feel some degree of dysphoria, so completing a laryngeal exam might create unnecessary discomfort. As stated in the attached literature review above, there is a large level of distrust among the TG population and the medical field as a result of years of mistreatment. Because of this mistreatment, going to a medical center and having an invasive procedure such as a laryngeal examination can induce unnecessary anxious feelings. Since GACS services are aimed to provide change for communication differences and not disorders, an evaluation of the larynx may not be necessary. Aside from this, the clinician should collect a case history, conduct a

patient interview, provide a psychosocial questionnaire for the client to complete, and conduct a vocal inventory of the client's baseline ability.

Case history & Patient Interview:

Collecting a case history and interview with TG clients requires sensitivity and empathy. The stage of transition as well as the client's emotional, psychological, financial, and motivational state should be considered. Because of this, a case history interview should be modified before each initial interview to be consistent with the patient's needs. Identifying information is required, but the clinician should be conscious about the client's current name. Respect is a large part of any therapy process and is demonstrated when the client's congruent name and gender (even if it is not legally changed), are honored by the professional. It is also important to identify what clients prefer to be called outside of the clinic and on documents that might be sent to their home. Confidentiality of the client's transition is essential, so the clinician and staff should be aware of the needs of the client in regard to their name. When collecting medical information, questions should focus on the patient's vocal health history. Questions regarding respiratory disease, laryngeal disease, past surgery or trauma to head/neck area, neurological disorder, hearing loss, and history of smoking/recreational drug use will help the clinician better understand the patient's vocal history and current situation. The case history should also include a list of current medications, as thy may affect the course of services by impacting the client's physically (i.e., voice changes) and emotionally.

Patient interviews are used to build rapport, and better understand the needs of the individual, desired gender attribution, and level of gender dysphoria to guide the assessment process. Asking clients about their daily life will help the clinician gain a holistic understanding of the client. One important question to ask in either the patient interview or the case history

form is how much time is spent in the patient's congruent gender. During the patient interview process, some questions may be useful, but be triggering and difficult for the client to talk about. Clinician sensitivity and awareness is essential when asking questions relating to transition, family support, employment, vocal history, social interaction, etc. By using caution and communicating the purpose of the questions asked, the clinician can facilitate a successful client interview.

A topic that helps guide the evaluation process is the patient's history of phonotrauma. Since many clients come to therapy after attempting to lower pitch on their own, understanding the patient's history of vocal use or self-treatment is essential. Patient interviews will help shape goal writing and therapy processes moving forward.

During assessment, the client's average fundamental frequency and vocal range might be determined based on the needs and goals of the client. Such information may give the clinician an idea of where to start the therapy process and if the need for voice therapy for pitch lowering is necessary, or if other aspects of communication may be the primary focus.

Psychosocial questionnaire

A psychosocial questionnaire should be administered for the clinician to assess how the client feels their communication is impacting their day-to-day life. Questionnaires help the SLP to understand patient preferences and needs; creating a holistic approach to therapy. Some questionnaires were developed specifically for TG clients while other are more general. For example, the Vocal Handicap Index (VHI), ask respondents to rate their agreement on a number of statements about their current voice. The VHI may provide the necessary information about the one's current vocal situation. Many of the questions ask for the client's own perception of how their voice is perceived by others, their perception of voice use, and how they react to their

current vocal function. Unfortunately, questionnaires designed specifically for TG clients are primarily designed for those who are transfeminine (TF), potentially because they seek services more readily than TM individuals. Not only are these questionnaires geared towards the TF population, but many of them use outdated terms that may be perceived as offensive today. Clinicians should ensure that any measure provided to the client yields relevant and beneficial information for the therapy process while avoiding any outdated or offensive terms. Another common questionnaire is the Transgender Self-Evaluation Questionnaire (TSEQ). The TSEQ was created by Davies (2006) to provide an overview of the TG patient's perceptions and feelings about his or her vocal situation. Many of the questions address the experience of the client, using "I feel" language to reference how the patient's attitude towards their vocal situation affects quality of life. Although it seems as though it would be appropriate for a TM client, the TSEQ was designed to assess the TF vocal situation, with no research done on the communicative experiences of the TM population. Because of this, caution should be used. A revised version of the TSEQ was created by Davies, now called the TVQ. Although the TVQ can be used for both transmasculine and feminine individuals, it uses gendered terminology that solely relates to the transfeminine population. The most recent version of the TVQ was developed for and uses language specific to the TF population. Thus, it may not be an appropriate measure to use with TM clients.

Client-centered approach

Each TM person is unique, thus GACS for TM individuals should be client-centered, with goals and treatment methods that work for that specific client and his/their congruent communication. This is achieved through listening to the person's communicative goals, their background, and what they react to or find helpful. As a clinician, you should try to understand

who the client is as a person and their history as a TM individual to effectively tailor therapy to their needs. In order to do this, cultural competency is required. The American Speech-Language Hearing Association outlines the required skills for GACS. If you do not feel culturally competent to conduct therapy with this population (as outlined in the following link), please refer out to another SLP or clinic with both experience and competency in doing so: https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589944119&section=Key_Issues

Creating Goals

The goal writing process should be highly individualized to each person. Goals may change often. At the beginning, the clinician should ask what the patient's desired overall goal is (in the case history/patient interview). Each patient will likely have different ideas about their end goal(s). Starting with a patient's goal and branching out into how to change the sub-components that pertain to that main goal will help create a comprehensive service plan. Another way to incorporate the client's needs into the goals is to integrate information from the self-report questionnaire with the creation of communication goals.

Talking with the client when creating goals will also help the clinician understand the patient's wants and needs, while facilitating open communication in the client-clinician relationship. A more holistic approach to the goal writing process includes the client being aware of and giving input about each goal formulated. This input can also help change the therapy process moving forward, making it more specific for the client's needs.

Treatment Options

Not all treatment options will be useful for the TM client. Instead, the treatment plan should be designed with the client's specific needs in mind. In many cases, education about vocal hygiene, and the sub-components of communication (i.e., articulation, phonation,

resonance, and respiration, prosody, language, and non-verbal communication) will be useful. By providing education, the patient is able to better identify their own communication goals and will also be better able to identify differences in his/their own communication parameters throughout therapy. Education and understanding can also help the TM client progress through the process.

A consideration in all phases is self-awareness. The client's self-awareness is required for advances and progress throughout therapy. Providing the client with opportunities to reflect on the self as well as constructive criticism and positive feedback will facilitate progress.

Vocal health is an essential part of all TG communication. Teaching the client healthy vocal practice facilitates progress moving forward. One critical element of vocal hygiene for the TG client is the idea of progressive relaxation (Adler, 2012). Progressive relaxation includes relaxation of muscles, especially those relating to the larynx and vocal tract. Progressive relaxation may decrease anxiety during therapy and prevent muscle tension that inhibits phonation or communication. Practicing abdominal breathing, stretching, and easy onsets may further support vocal health. Abdominal breathing will be more supportive of phonation than clavicular breathing because abdominal breathing can create respiratory support and a strong base for phonation. Stretching of the neck and shoulders, and easy onset also facilitate relaxation throughout the therapy process and healthy vocal productions.

After education and relaxation exercises are facilitated, the clinician can include the speech subcomponents appropriate for the client. As previously outlined, these could include articulation, rate, volume, resonance, syntax and semantics, pragmatics, and non-verbal behaviors.

Possible Therapy Materials/Methods

Education:

For the client to be an active participant in therapy, education regarding the goals and the specific communication patterns they address, is required. Education helps the client become an active participant in therapy, understand the plan for services and its purpose, and how services will target each area/goal.

Warm-ups

Warm-ups are a useful component that can be included in each therapy session. Warming up can include breathing, stretching, relaxation, voice, articulation, and resonance practices that can help the client bring awareness to the body focus the client focus on the major tasks that will be focused on within the therapy session that day (Mills & Stoneham, 2017).

Relaxation Techniques

Relaxation techniques can involve breathing, stretching, posture adjustment, meditation, and body awareness exercises that will help focus mind-body awareness while also helping relax the muscles of the shoulders, face, and larynx to improve resonance and tone focus. Relaxation and body awareness can be challenging for individuals who experience heightened dysphoria and anxiety. Education about the purpose of relaxation techniques can be helpful. The clinician can introduce relaxation techniques into therapy one step at a time while paying attention to what techniques help the client most (Mills & Stoneham, 2017).

Other Therapy Techniques:

Other therapy techniques employed by the clinician will be dependent on the goals of the client. Two useful resources include, but are not limited to, *The Voice Book for Trans and Non-Binary People* by Matthew Mills and Gillie Stoneham, and *Voice and Communication Therapy*

for the Transgender/Transsexual Client, written by Richard K. Adler, Sandy Hirsch, and Michelle Mordaunt. *The Voice Book for Trans and Non-Binary People* is a great resource to use directly in therapy. Therapy techniques that are appropriate for TM individuals are denoted with a "M" to represent masculine, or "All" to note that this technique could be beneficial to all clients. This book provides different therapy techniques, and an educational section about the larynx, vocal tract, and communication parameters. There are several visuals that will be useful throughout therapy as well.

Voice and Communication Therapy for the Transgender/Transsexual Client is a useful text for the clinician but might not be as directly useful in therapy. The authors provide an overview of GACS from assessment to discharge. The main concern with this text is that the focus in all chapters except one is TF clients. The clinician utilizing this resource will need to be cautious of the TF perspective throughout.

Counseling

Counseling is often a large part of GACS and within the SLP's scope of practice. A GACS clinician must have skill in counseling, as dysphoria might create feelings of shame, anxiety, frustration, etc. for TM individuals. SLPs need to have empathy, genuineness, respect, concreteness, confrontation, self-disclosure, warmth, immediacy, potency, and self-actualization among other characteristics. Creating a safe space for your client is a huge first step in making the client feel comfortable. Although progress can be made without rapport and comfort, progress is likely to occur more quickly when there is a solid relationship between the client and clinician. Being an active listener and allowing for the client to confide in you will help build a client-clinician relationship, thus elevating therapy potential. ASHA lays out several useful strategies for counseling, linked below:

https://www.asha.org/Practice-Portal/Professional-Issues/Counseling-For-Professional-Service-Delivery/

Conclusion

Providing GACS for TM individuals can be challenging, yet extremely rewarding. Since there is so much misunderstanding surrounding the TM person's communicative situation, staying educated and culturally competent will be immensely helpful in aiding your TM client find their congruent communication style. Although there is not a set way to conduct therapy, listening to the clients' needs is always an element of successful GACs.

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A Handbook for the Transmasculine Client:

Considerations when Seeking Gender Affirming Communication Services (GACS)

Considerations

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GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Table of Contents

GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Introduction

This manual aims to assist transmasculine (TM) individuals in learning about the services provided by speech-language pathologists (SLPs). TM individuals may find this manual especially beneficial if they are transitioning (in some form) from their female sex assigned at birth to their non-binary or masculine identity. In particular, this manual is an effort to increase the readers' awareness about gender affirming communication services (GACS), these services' components, and GACS service providers.

It is widely believed that testosterone treatment is sufficient for lowering pitch and masculinizing communication, but for many TM individuals, this is not the case. Although pitch is a widely held determiner of masculine-sounding communication, there are many other parameters and components of communication that influence the perception of voice and speech. Because pitch lowering is so commonly thought to be the central factor in developing, GACS are consequently underutilized and self-treatment, more harmful than helpful, may be attempted.

The differences from one individual to another can make GACS assessment and treatment tricky. Research on gender-affirming communication often focuses on how communication differs between the extremes of the gender spectrum (masculine-feminine). Communication differences for GACS clients are just that, differences. GACS facilitate healthy communication changes that aid an individual in conforming with the congruent self. They are not meant to "fix" a problem. This manual recognizes the full gender spectrum and believes summaries of this research may give you an idea of your potential communication goals and how they may be modified, depending on where you fall on the gender spectrum (Azul 2015; Adler, 2012; Boonin, 2012; Frazier & Hooper, 2012; Hirsch & Van Borsel, 2012; Hirsch &

Pausewang, 2012; Leung, Oates & Pang, 2018; Wood, 2009). If you initiate GACS and disagree about an emphasis on modifying a particular communication component, discussing your expectations and viewpoints with your speech-language pathologist (SLP) will help you tailor services to your needs.

Terminology

Terminology related to GACS is complex and often misused. Thus, the following section will define terminology related to GACS service components and its providers, and the foundations of communication, the voice, and language.

Providers

Speech-language pathologist (SLP)

- Speech-language pathologists are healthcare professionals that work with individuals across the lifespan. They conduct evaluations and treatment for individuals with disorders/differences in the areas of speech, language, voice, swallowing, and cognition. These professionals must obtain a master's degree, complete a nine-month clinical fellowship where they are supervised by a licensed SLP, and pass a national examination before obtaining their certification.

Otolaryngologist

- Physicians that specialize in the management of diseases and disorders related to the ear, nose, and throat (often referred to as ENTs).

GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Foundations of Communication:

Communication

- Use of mutually understood symbols to exchange information (e.g. words, sounds, and signs)

Communication difference/dialect

- Communication is often different based on cultural, regional, and social factors. These differences in communication are not considered disorders.

Speech

- The sounds articulated and strung together to communicate language

Language:

- Use of words, symbols, gestures, etc. to communicate ideas and exchange information

Voice:

- Unique carrier signal for speech provided by the sound that is generated when air facilitates vibration of the vocal folds, and if further modified in the vocal tract

Non-Verbal Communication

- Exchanging information/communicative intent through nonverbal signs, gestures, facial expressions, eye contact, etc.

GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Voice Terminology

Phonation

- Sound produced from the vibration of the vocal folds

Larynx

- The larynx, or voice box, is what houses the vocal folds. This structure is made up of cartilage, muscles, bone, and tissues to protect the trachea (windpipe) from food and drink and allow for voicing.

Vocal Folds

- Two bilateral folds that consist of a muscle and membranous tissue. These folds sit inside the larynx and vibrate together to create sound

Respiration

- Inspiration and expiration of air through the larynx and into the trachea and lungs. Respiration supports vibration of the vocal folds for voice production. In particular, when one is speaking, voicing occurs on exhalation.

Pitch

- How high or low the voice sounds - this is based on how often the vocal folds vibrate (open and close) within one second. The more often they open and close, the higher the pitch and vice versa.

Resonance

- The vocal cords create vibrations, which when unfiltered, sounds like a lawn mower or a bumble bee. The job of the vocal tract is to shape that sound quality. One can shape the vocal tract in many different ways in order to change the quality the voice. Research suggests that a wider and longer vocal tract is associated with a more masculine-sounding voice whereas a narrower and shorter vocal tract is associated with a more feminine-sounding voice. In particular, masculine resonance is often described as full and rich.

Fundamental Frequency

- A physical measure for perceived pitch including a numerical value in the unit Hertz (cycles per second). Research suggests that the average fundamental frequency of adult assigned the male sex at birth is ~120 Hz and average fundamental frequency of adult assigned the female sex at birth is ~200 Hz.

Articulation

- How we use the mouth (tongue, teeth, jaw, and soft palate) to articulate words and make speech sounds

Vocal tract

- The vocal tract includes the area above the vocal folds: the throat, nose, and mouth (tongue, lips, cheeks, teeth, palate). The vocal tract shapes the sound produced from the vocal folds to allow it to sound distinctly human. A visual and auditory representation of how the vocal tract modifies the sound from vocal folds is provided at the following link:
    - https://www.youtube.com/watch?v=wR41CRbIjV4

GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Language terminology

Syntax

- Rules that govern the arrangement and sequence of words in phrases and sentences

Semantics

- The meanings of words and how they are combined in language

Phonology

- The speech sound system in a given language

Morphology

- The study of morphemes used in language. Morphemes are the minimal parts of speech that create meaning. Morphemes can be prefixes, roots, and suffixes. For example, "-ed" is a morpheme that is used to indicate actions performed in the past. There are many more morphemes that are used to provide meaning and specificity in any given language.

Pragmatics

- In essence, pragmatics is social communication. Pragmatics are the rules for using language for social reasons, such as making a request, greeting or informing others about a topic, or taking turns during conversation.

GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Characteristics of Communication relating to TM communication

Prosody

- The melody of the voice, including speech rate, rhythm, and intonation. How quickly we articulate words and the ups and downs of our pitch as we speak can indicate gendered components of speech. For example, slower speech and longer pause times between sentences has been associated with a more masculine perception of the speaker, while faster speech that may blend one sound into the next, may be perceived as more feminine.

Intonation

- How the pitch of one's utterance varies as it is spoken. Intonation can reflect culture, emotion, or intended message. An example of intonation can be if you ask a question, your pitch goes up towards the end of the phrase. If you were to ask a question with a pitch lowering at the end, the listener might not understand that a question is being posed. Intonation can give the listener an idea of the speaker's intended message.

Intensity and Loudness

- Intensity is a physical measure for perceived loudness including a numerical value in the unit Decibels. The higher the number representing the intensity, the louder the voice.

Articulation

- Using the articulators (tongue, teeth, oral cavity, velum) to shape voice into speech sounds.

Strain

- Perceived tension in the voice

Roughness

- Harshness of the voice usually perceived as excessive noise in the voice signal.

Breathiness

- The voice may be described this way when the vocal folds do not come together completely and fully during phonation, such that air escapes.

Hoarseness

- The combination of roughness and breathiness in the voice (extra vocal noise and a lack of vocal fold closure)

Nasality

- Nasality occurs when too much sound escapes through the nose during speech, creating abnormal resonance through the vocal tract. The nasal cavity is typically closed during non-nasal sounds.

Assessment Terminology

Clinicians may employ a variety of assessment methods to facilitate the creation of GACS goals. Although not all of these components are necessary for evaluation, the following terms might come up in the assessment process.

Acoustic analysis

- An evaluation method used to identify physical acoustic properties of the voice (fundamental frequency and intensity). A microphone and computer are used during this evaluation process to record one's voice and determine baseline objective measures of vocal pitch and loudness.

Aerodynamics

- Another evaluation method used to measure how air powers the voice.

Case History/Client Interview

- Typically, a case history is the first component of the assessment collected. Clinicians are looking to gain information about your current communicative abilities, goals, medical history, and psychosocial aspects of your life. Although some questions may feel as though they are not necessary or invasive, all questions serve a purpose in the treatment process. For example, because smoking may have negative effects on the vocal fold structure and function, the clinician may ask you if you smoke in order to gain insight into your baseline vocal functioning. Your responses to questions like these may affect the GACS process and give the clinician an idea of how to personalize GACS services to your unique needs. You are encouraged to ask the clinician the purpose of any question you are not comfortable answering. If you feel uncomfortable answering a question, skipping it or discussing it with the clinician further is just fine.

Oral or nasoendoscopy with videostroboscopy

- A video examination of the larynx and vocal cords. A small tube with a light and camera attachment is placed in either the oral or nasal cavity to view laryngeal structures and the vocal folds as they vibrate.

Self-report questionnaires

- Typical self-report questionnaires about voice and communication ask you about how your current voice and communication affect you in daily life. Such instruments may ask you about your anxiety related to voice use, behaviors you've engaged in to change your voice, and if your voice affects your motivation to socialize. It is absolutely okay to discuss questions that cause you discomfort with your clinician or skip them. GACS-specific self-report communication questionnaires have typically been normed and validated for the TF population only. Thus, if you feel like question(s) do not apply to you or you are uncomfortable answering them, please talk with your clinician to understand the purpose and make a decision as to whether or not to respond.

Stimulability

- The ability of a person to mimic what might be targeted in therapy. It is used to determine if certain voice and communication tasks may facilitate clients' goals and act as a starting point for therapy.

Relevant Information when Seeking Treatment

How to find Speech-Language Pathologists

Finding an SLP who provides GACS can be challenging for a variety of reasons. The following information will help the reader identify a culturally competent provider.

How speech-language pathology can be beneficial for TM individuals

Where do SLPs generally work?

SLPs work in a variety of settings, including hospitals, schools, nursing homes, private practices, university clinics, and voice clinics, to name just a few. TM individuals seeking to achieve voice/communication congruent with identity would most likely receive service on an outpatient basis. Outpatient GACS would be most common in hospitals, private clinics, or university clinics. Although the professionals in these settings are certified to provide communication services, they may not feel qualified to work with TM individuals, or anyone in the TG population. SLPs are guided by ethical principles and practices through an organization called the American Speech-Language Hearing Association (ASHA). According to the ethical guidelines that SLPs are required to follow, clinicians who do not feel they are competent to provide GACS services, are required to refer out to a professional who can. If you are not sure about the experience of the SLP in regard to GACS, meeting with the SLP and asking questions about their background, knowledge, and past work will help you determine whether you would like to initiate services with that particular professional.

How can SLPs help with TM individuals?

TM communication changes resulting from hormone therapy is widely misunderstood. Although testosterone treatment does result in a pitch drop for many individuals, hormone therapy may not provide changes to other communication parameters. SLPs can help teach TM individuals how to modify other aspects of communication because of their broad knowledge regarding speech, voice, and language. This knowledge can guide you to communication and voice congruent with your identity.

Beginning GACS

What might GACS consist of?

At the initiation of GACS services, a thorough assessment of your individual communicative needs will be conducted. This might include collecting relevant social and medical history, your current goals and perceptions of your communication, and information on any referral sources. Components of your baseline communication will be assessed, as well as psychosocial implications of how your communicative situation impacts your everyday life. Since non-congruent TG communication is considered a communication difference, and NOT a disorder, the goals are highly subjective to the needs of each individual that seeks services. Each clinic collects information and assesses communication differently, but the overall idea of a client-centered approach is consistent. Once assessment is completed, the SLP should consult with you to create goals that will include the necessary voice and communication components that are needed. The clinician may suggest goals for treatment, but the overall goal creation and

tailoring should be collaborative between you and clinician. The following information is an overview of communication components and how specific goals may interface with each.

Voice

- If your goal is to lower your pitch, the SLP will provide information regarding vocal hygiene, vocal quality, and safe techniques to effectively lower pitch. The SLP will also likely facilitate changes in your vocal loudness, resonance, speech rate, and language usage.

Resonance

- Resonance can create a perceptual vocal quality that indicates masculinity versus femininity. Typically, the resonance patterns for males and females differ greatly. While a broad generalization, males' resonance is often described as "lower" or "chest-focused," creating a richer or more full vocal quality. SLPs can help you enhance your natural chest resonance to create a richer and fuller voice.

Breathing and Relaxation Exercises

- Breath support is fundamental to vocal health when changing pitch. SLPs may work with TM clients to establish healthy breathing patterns that support the voice throughout treatment. Along with breathing exercises, relaxation methods are introduced to help reduce tension in the larynx, jaw, tongue, and face. Such relaxation will support communicative change that is safe and comfortable.

Articulation

- Articulation could be included in GACS services to enhance masculine communication in a variety of ways. Articulation for male speakers is often more precise. An SLP can work with you to facilitate an articulatory pattern that is congruent with your gender identity.

Rate

- Faster speech can often relate to more feminine communication, while slower and more deliberate speech can imply more masculine communication. The SLP will likely provide training related to rate, attempting to slow down articulatory rate.

Loudness

- A louder voice is often perceived as more dominant and masculine. This generalization does not refer to excessive loudness, but slight increases in loudness. It might be challenging or difficult to speak louder, especially if you are not used to it. Try to use your time with the SLP to practice and do activities that are uncomfortable. Pushing yourself outside of your comfort zone can lead to a large amount of growth.

Semantics and Syntax

- Although syntactic and semantic use can depend on a lot of different factors, the research details broad differences seen between males and females. Wood (2009) reported that men generally use language to establish assertiveness, to maintain status and control, and for problem-solving. Semantics and syntax, perceived as more masculine, may contain more general and abstract terminology, and express little emotion. On the contrary, feminine speakers might use more terms to describe the same thing (e.g. 5 different terms

for shades of pink, while masculine speakers might categorize them all as the same color). Recognizing general trends in language use may help the clinician shape language to your specific needs. These potential changes may feel inauthentic or incongruent depending on your specific goals and gender identity, but these feelings could help to further specify your goals and make your GACS experience more tailored to your needs.

Pragmatics and Non-Verbal Communication

- A large part of an intended message is expressed without words. We use non-verbal communication in a variety of ways, including but not limited to movement of the body, prosody (rhythm and rate of speech), facial expression, eye-contact, physical appearance, smell, etc. Prosody is included in this column because prosody can help a speaker express emotion and intent of message. Generally, feminine speakers tend to use more variations of prosody in their speech (more ups and downs of pitch and a variety of speech rates), while masculine speakers may vary pitch and rate of speech to a lesser extent. All of these perceptual factors can affect how a listener judges or perceives a message from the speaker. Generally, these factors can play a role in the way a listener perceives the communication of their conversational partner as feminine or masculine. GACS sessions might focus on facilitating new non-verbal communication behaviors to increase the listener's perception of masculinity.

Wrapping up Services

Because timing is dependent on the needs of each client, GACS services will often not have a set timeframe. The number of sessions you complete may instead be dictated by insurance or your own feelings about your progress. Once you and your clinician agree that you feel comfortable in your communicative abilities and progress, dismissal or discharge may be

appropriate. Upon dismissal or discharge, you may be asked to fill out the questionnaire you completed during your initial assessment for a second time. You and your SLP will examine changes in your responses from pre to post-therapy, noting evidence for progress and positive change. The SLP might also provide maintenance tasks or activities for you to complete on your own time in order to facilitate maintenance of your new congruent communication patterns.

Conclusion

Receiving GACS services may be an important step in the transitioning process for TM individuals. It is hoped that this manual will help you get you started with GACS services, should you wish to receive them. Additional resources that may be helpful to you are provided below.

GENDER AFFIRMING COMMUNICATION SERVICES FOR THE TRANSMASCULINE CLIENT

Additional Resources

American Speech-Language Hearing Association (ASHA)

- https://www.asha.org/Practice/multicultural/Providing-Transgender-Transsexual-Voice-Services/

World Professional Association for Transgender Health (WPATH)

- https://www.wpath.org
- https://www.wpath.org/media/cms/Documents/Web%20Transfer/Publications/IJT%20Giving%20Voice%20to%20the%20Person%20Inside.pdf

The voice book for trans and non-binary people: A practical guide to creating and sustaining authentic voice and communication

- Authors: Mills and Stoneham

Brochure of Transgender Communication Services

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

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