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The male-to-female transgender voice client of the 21st century

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The male-to-female transgender voice client of the 21st century

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Thesis

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Dedication

To my husband – you are my rock and I love you. To my daughter – you are the reason for everything. You two are the center of my universe.

Acknowledgements

I thank my advisor, Courtney Byrd, for her encouragement and enthusiasm. You kept me going! I also thank Richard Adler for sharing his expertise and for his contagious enthusiasm for serving the transgender community. I would also like to thank all of the transgender participants who helped with the development and completion of this survey. It could not have happened without you.

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Abstract

The male-to-female transgender voice client of the 21st century

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The University of Texas at Austin, 2010

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The purpose of the present study was to determine the current characteristics and needs of the male-to-female transgender voice client. Specifically, what are the current characteristics (e.g. age, marital status, number of children) of the male-to-female transgender client? Does participation in therapy affect overall satisfaction with feminine presentation? Do alternative methods for voice feminization (e.g. DVDs, YouTube, peer mentors) result in similar levels of satisfaction? Lastly, do male-to-female transgender avoid community activities in order to prevent being perceived as male, and can therapy help with this? We evaluated the responses of 77 participants who completed an Internet-based survey. Results were compared to Blanchard's 1994 study of characteristics of male-to-female transgender persons. Characteristics of the 1994 study and the MtF

transgender client of 2010 were comparable, with a slightly older age for the present study. The client was likely to have been married at least once, and to have at least one child. Respondents who had participated in speech therapy were more satisfied with their femininity overall when compared to those who had not received speech services. Satisfaction with alternative methods was low. In addition, both groups reported a high level of avoidant activities based on fear of being perceived as male.

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CHAPTER 1: INTRODUCTION

Transgender is an umbrella term used to describe people who express their gender in a way that differs from societal norms ("Glossary of Gender," 2010). Transgender persons who want to live as the gender they identify with have to undergo several physical and emotional transformations, including but not limited to their facial structure, their style of dress, and their verbal and nonverbal communication. A variety of therapy approaches can be used by speech-language pathologists to enhance feminine presentation in addition to voice therapy, including nonverbal communication, vocabulary and use of language. In contrast to the female to male transgender whose use of testosterone contributes to physiological changes in their vocal folds that result in a significant, almost automatic decrease in their pitch, the use of estrogen by the male to female transgender does not alter their pitch leaving this population more vulnerable to being perceived as their natal rather than their true gender (Van Borsel, de Pot, & De Cuypere, 2009). Therefore, the need for speech therapy to help transgender persons to be perceived as their true gender is significantly higher within the male to female community.

Historically, the male to female transgender client who participated in speech therapy was reflective of the lack of acceptance in society coupled with the person's efforts to conceal their desire to be the opposite sex (Brown & Rounsley, 1996). Specifically, the typical client at the time of clinical presentation was on average 35 years old, previously married at least once and had one or more children (Blanchard, 1994).

However, these characteristics may no longer be descriptive of the typical male to female transgender client as several important changes have occurred over the past decade (e.g., the gay, lesbian, bisexual, transgender [GLBT] Civil Rights movement, inclusion of positive portrayals of transgender persons in media, the widespread use of the Internet for communication and information regarding alternative lifestyles, and increased representation of GLBT people in political positions) that have resulted in a society that is more aware and sometimes more tolerant of gender variance.

According to ASHA, the SLP must disregard his or her religious, moral, and ideological issues when working with transgender clients. Furthermore, the Code of Ethics states that "individuals shall not discriminate in the delivery of professional services….on the basis or race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability. (ASHA, Code of Ethics, Principles of Ethics I Rule C). The Knowledge and Skills document describes the need to become culturally competent and culturally sensitive. Therefore, clinicians are obligated to become knowledgeable about transgender clients (Adler, Hirsch, & Mourdant, 2006). In a professional relationship, underexposure and lack of appropriate training in interactions with transgender persons could translate to awkwardness or embarrassment. In addition, the clinician should have a basic understanding of the best evidence-based treatments available to this population. The purpose of the present study is to identify the current characteristics of male to female transgender clients who are likely to seek voice therapy and any changes in their needs and/or desire for seeking such therapy. This information will help the SLP to more effectively understand and address the needs of this unique population.

HISTORY

The existence of transgenderism dates back centuries. In some cultures, the presence of transgender people was celebrated, most significantly in Native American cultures in which the transgender person was considered "two-spirited" (Brown & Rounsley, 1996). However, transgenderism was largely unacknowledged in the United States until the early 1950s when an American GI named Christine Jorgensen embarked on a highly publicized journey to obtain sexual reassignment surgery (SRS) in Denmark. In the early 1960s, Dr. Harry Benjamin, considered the "grandfather" of transgenderism, wrote and published the first book on transgenderism, *The Transsexual Phenomenon.* In 1980, the Harry Benjamin International Gender Dysphoria Association (recently renamed the World Professional Association forTransgender Health, or WPATH) to promote standards of care was founded. The AIDS crisis in the 1980s is frequently considered a catalyst for the politicization of the GLBT movement and further increased visibility of gays and lesbians in the media. During the 1990s, the GLBT movement was primarily focused on changes in legislation, such as anti-discrimination laws which included sexual and gender orientation. The National Center for Transgender Equality (NCTE), a national advocacy group for transgender people, was developed in 2003 to help prevent discrimination. Finally, the unique journey of the transgender person has been highlighted through academy award winning films (e.g., Boys Don't Cry), modern reality shows (e.g., "The Real World") and highly regarded mainstream talk shows such as Oprah. Taken together, the GLBT civil rights movement and the appearance of transgender people in pop culture may have impacted the face of this clinical population.

That is, the transgender person of 2010 who seeks the services of a speech language pathologist may have different characteristics when compared to the transgender client profile described almost over a decade ago by Blanchard (1994).

DEMOGRAPHIC CHANGES

Blanchard researched the files of 194 adult men identified as "gender dysphoric" who were patients at the Gender Identity Clinic of the Clarke Institute of Psychiatry (Toronto, Ontario, Canada) who presented for initial assessments from 1980 to 1991. The participants ranged from individuals with cross-dressing tendencies to patients seeking sex reassignment surgery. Inclusion criteria for the Blanchard study were: (1) indication on application that he had experienced desires to be the opposite sex and (2) clinical diagnosis as sexually attracted to women, to both sexes, or to neither sex. Results revealed that the average age of the transgender person at clinical presentation was around age 35 (Blanchard, 1994). Results further revealed that sixty-eight percent of participants had been married at least once and 45% of participants reported at least one child.

Age

Although Blanchard reported an average age of around 35 for transgender clients, these numbers may have changed based on changing political climates and heightened awareness of both the nature of gender identity and transgender support networks. The recent development of several organizations that support transgender teens and children

may also result in younger clientele. Further, the acceptance of transgender persons as part of a standard representation of today's youth is highlighted through the inclusion of transgender persons on MTV's The Real World and America's Next Top Model. Finally, the introduction of the Internet, in particular, has provided valuable information and support that is both easily and confidentially accessible to many young transgender people. Thus, the transgender person of today may self-identify as being part of the transgender community and may potentially have began the process of clinical intervention (e.g. therapy, hormone therapy, etc) at an earlier age.

Marital Status

In addition to age, the marital status of transgender persons may no longer be in line with Blanchard's findings. The pressure to marry as a primary means to reject or conceal their gender identity may have changed based on the exponential increase in awareness of transgender issues as a direct result of the Gay Civil Rights movement. Specifically, the presence of GLBT persons in the media and politics since the 1990s may have encouraged self-identification for transgender individuals. Thus, the transgender person of today may have the emotional and informational support to come to terms with their true gender identities prior to attempting to hide their gender identification through veiled efforts such as marriage.

Children

Blanchard's results revealed a relationship between number of children and age of clinical intervention, which he hypothesized, might be attributed to denial of true gender identity (Blanchard, 1994). However, transgender parents have appeared in popular media, with the most recent example being the female-to-male transgender person who became pregnant in 2008 and who has since had an additional child. In addition there are several online resources that are currently available to transgender parents, including listservs and organizations, such as National Center for Transgender Equality (NCTE). There are also several online resources available to children of transgender parents (e.g. Kids of Trans). This increased awareness and acceptance of transgender parenting and also the significant amount of support for both transgender parents and their children may have changed the likelihood that these persons will have children to reject their identity as the act of having a child is no longer considered exclusive to families in which parents are biologically male and female.

Gender identity and sexual orientation

Male to female transgender persons may identify as female, transgender, or genderqueer, among others (See Appendix G for glossary of terms that are applicable to the transgender culture). Because many transgender persons refute the existence of binary gender expression, it is not unusual for a male to female transgender person to use terms that would likely be unfamiliar to the SLP. Blanchard's study focused exclusively on male-to-female transgender persons who identified as female and who reported that

they were attracted mainly or solely to women. However, an analysis of gender identity and sexual orientation could reveal specific differences in terms of participation in therapy. For example, a transgender person who does not subscribe to the binary construct of "male" and "female" may not have as much interest in being perceived as female to others. Similarly, sexual orientation may influence the degree to which the transgender person desires to appear feminine. Perceptions of femininity in lesbian communities may differ from perceptions of femininity relative to heterosexual males (Laird, 2000; Weston, 1996), although obviously variation would exist among individuals in the groups. It is also possible that lesbians, who have already challenged sexual stereotypes as a consequence of being a sexual minority, may be more tolerant of a wider spectrum of gender expressions/identities in a romantic partner than a heterosexual male.

TREATMENT

Feminine Presentation

In order to present as female, the transgender person may choose to alter her appearance (e.g. through hairstyle and makeup, facial reconstructive surgery, hormone therapy, etc.) and/or non-physical presentation (e.g. voice, mannerisms, and gait). In comparison to other interventions which may require surgery or hormones, changing pitch and increasing use of gender-oriented nonverbal communication are non-invasive techniques that can increase the likelihood of the transgender person being perceived as female. Transgender people may seek therapy to approach all or some of these facets of feminine presentation.

Participation in Therapy

For transgender people who seek the services of a speech-language pathologist to increase feminine presentation, a total program for speech therapy can include altering pitch, with supplementary strategies such as nonverbal communication (e.g., maintenance of eye contact during conversation, nodding while listening to communication partner, etc.) and strategies for using speech and word choice more likely to be used by women (e.g., using interjections, fewer interruptions of communication partner, etc) (Tannen, 1990; Adler, Hirsch, & Mourdant, 2006; Neumann & Welzel, 2004). Because of heightened awareness of transgender issues as well as recent changes in public policy that protect transgender people from discrimination based on gender identity or expression, it is possible that the need for speech therapy to increase feminine presentation has lessened over time. Previous literature has based success in speech therapy with a documented increase in the transgender person's fundamental frequency and has also used the perceptions of voice professionals and naïve observers as a means of measuring the client's success in therapy. To date, to this author's knowledge, there has been only one published study that has examined the relationship between participation in voice therapy and the client's level of satisfaction (McNeil, Wilson, Clark, & Deakin, 2008). However, although uniquely informative, the study was limited to only 12 transgender individuals and assessed satisfaction after speech therapy exclusively. The present study explores perceived importance of femininity and satisfaction with speech therapy and also a variety of other therapies as well as the perceived importance of speech therapy in the transition process.

Alternative Methods

A number of resources are available on the Internet that may be considered by transgender persons to be more affordable and more accessible than working with a speech-language pathologist. These resources can be found by using Google search using words such as “transgender voice lessons” and “transgender voice therapy” and “voice feminization.” They are relatively inexpensive, ranging from $25-$60 for CD or DVD sets. However, the majority of these are not offered by certified speech-language pathologists and all methods by nature are unidirectional and as such do not include feedback from the instructor. In addition, although the YouTube programs are free, they generally consist of techniques that are based on personal experience, but are not based on in-depth knowledge of the vocal tract and laryngeal structures. Thus, these methods often contain techniques that involve poor vocal hygiene (e.g., sustained falsetto) and have potential to cause serious injuries to the vocal folds (e.g., vocal nodules, vocal fold paralysis, etc.). Based on the unskilled nature of the techniques, lack of vocal hygiene protocols, and the absence of in-person feedback from a skilled therapist, alternative methods place the transgender client at risk for harming the vocal structures. Nevertheless, these methods are commonly used; for this reason, we wanted to examine satisfaction levels of the transgender person with these techniques relative to the reported satisfaction reported by those who participate in speech therapy.

Avoidance of Community Interaction

The binary construct of gender can force transgender people to conform to perceptions of what is considered male or female in order to gain support and acceptance from the community (Gagne & Tewksbury, 1998). This emphasis on conformity to gender roles can create a hostile environment in which transgender people understandably experience anxiety about a variety of social situations. Transgender people have an awareness of when they are perceived as male (e.g. are clocked or read) by others, and their anxiety can increase when in an unfamiliar situation (Eyre, Guzman, Donovan, & Boissiere, 2004). As a result, MtF transgender people may avoid everyday social situations based on the fear of being perceived as male, thereby reducing quality of life and participation in activities of daily living. This avoidance behavior may be mitigated by participation in speech therapy, during which strategies may be provided to avoid undesirable outcomes (e.g., introducing herself by name to avoid being "sir'ed" in public or on the phone). Because of the variety of approaches used with the transgender client, the term speech therapy will be used instead of voice therapy, which focuses only on pitch alteration. Participation in speech therapy may also increase the transgender person's awareness of avoiding situations in different social contexts, particularly with unfamiliar people, as a precursor to implementing new strategies.

PRESENT STUDY

Although there are a number of studies evaluating the efficacy of speech and voice therapy for transgender clients, to our knowledge there are few studies examining the most current characteristics of the transgender client and the interests of this

population in terms of being perceived as female. Within this context, the present study posed the following questions: (1) Are the characteristics regarding age, marital status, and number of children cited by Blanchard (1994) applicable to the MtF client of 2010? (2) Is there a relationship between these characteristics, gender identity, and sexual orientation and whether or not transgender clients have participated in speech therapy? (3) Is there a relationship between participation in speech therapy and overall satisfaction with feminine presentation, and if so, do voice-only goals in therapy compared to voice and language-based goals affect overall satisfaction? (4) Does satisfaction with services differ in terms of participation in speech therapy compared to alternative methods of voice feminization (e.g. online resources such as DVDs, YouTube, and/or peer mentors)? (5) Is there a relationship between avoidance of community activities (e.g. talking on the phone, socializing with men) and participation in speech therapy?

It was expected that characteristics of the transgender client at clinical presentation had changed to reflect a younger client who has never been married, with fewer or no children. Because we expected that the younger generation of transgender people would be less concerned with passing as female, we further hypothesized that participation in speech therapy would be particularly affected by age, and that older participants would be more likely to have participated in therapy, and those participants who had received speech services would likely have been married at least once and would have had more children. We expected gender identity and sexual orientation to be diverse, and participants who used unconventional terms to describe gender identity and sexual orientation were expected to be less likely to have participated in speech therapy. Satisfaction for speech therapy was expected to be rated higher than satisfaction for

alternative methods, the quality of which are variable and nonspecific to individual client needs. Finally, it was expected that speech therapy would result in lower overall avoidance of community activities.

CHAPTER 2: METHOD

Collecting data that identifies demographics and interests of transgender people is challenging. One of the most significant challenges is the typically secretive (i.e. closeted) nature that is characteristic of transgender life in that many transgender people do not want to reveal themselves as transgender once they successfully "pass" as the opposite sex. Thus, previous research appears to have only been able to explore subgroups of transgender people who have shared traits: transgender people who have sought sexual reassignment surgery (SRS), transgender people who were HIV positive and could be contacted via the clinic through which they sought services, or politically active transgender people who are more visible to mainstream society (Rosser, Oakes, Bockting, & Miner, 2007). The internet seems to provide a method for accessing demographic information across the wide range of persons who define the transgender population as it is far-reaching and allows for anonymity. Thus, for the present study, a Web-based survey was conducted from February to March 2010 using the survey-hosting Web site SurveyMonkey (http://www.surveymonkey.com).

Participant recruitment and informed consent

The participants for this survey were recruited by contacting the directors of transgender-oriented organizations such as support groups, listservs, GLBT organizations at universities, and clinical staff and/or professors at ASHA accredited universities who specialize in voice and/or transgender clients (See Appendix C for list of contacts). The

participants who completed the survey were also requested to forward the URL for the survey to other male-to-female transgender people they know.

Voluntary enrollment was ensured by using an Informed Consent preamble that contained the University of Texas at Austin Institutional Review Board approved text, including the question "Do you consent to take the survey?" with the option of answering "yes" or "no" or exiting the survey by closing the browser (See Appendix F for consent form and Appendix A for survey questions). Users who did not select "yes" could not advance to the survey.

Pilot Survey

Initially, a focus group of male-to-female transgender persons (N=3) took the survey before it was released to actual participants. The focus group was asked to complete the survey online and encouraged to make suggestions for changing the survey. This was done to ensure that the survey was clear and comprehensible to the target group, and that the questions were not considered offensive to the transgender community. As a result of the pilot, changes made to the survey included larger text boxes on a number of open questions (more than 50 characters were allowed), as well as minor word changes for the sake of clarity. The survey was also refined to correct a forced ranking error for the rating questions. One question regarding age of clinical presentation was added after the 7th participant had completed the survey in order to gain more specific information regarding age. In addition, review of responses to the pilot survey revealed terminology specific to the transgender community. See Appendix G for a review of these

terminology and related definitions. See Appendix E for email correspondence from one of the persons who completed the pilot and two other participants who completed the revised survey and were included in the final data corpus (the content of these emails are enclosed with basic information [e.g. name, email address, place of employment, etc.] withheld to protect anonymity).

Participant characteristics

Between February and March 2010, 98 individuals answered the survey hosted on the study website. Of these surveys, 77 were deemed sufficiently complete. Table 1 presents the characteristics of all participants (See Appendix H). Because the survey was written in English, all participants were English-speaking. 61% of participants (n=55) indicated membership in one or more transgender or GLBT political or support groups. This was not surprising because participants were targeted through many group organizations. Participants were also generally located in the Northwest, Southwest, Northeastern regions of the United States, with few or no participants from the Midwest or Southern regions (See Appendix I for identification of locations of specific respondents).

Inclusionary criteria. Because this survey targeted male to female transgender people, participants must have reported an assigned sex of "male" at birth. In addition, the participants must have reported "female," "transgender," or "other" answers which

reflected a gender other than that of their assigned sex (e.g. genderqueer, other gendered, etc).

Exclusionary criteria. Surveys were distributed to transgender organizations and listservs as well as GLBT organizations. Therefore, the survey was available to people who did not automatically meet inclusionary criteria. Participants were excluded based on any one of the following: they indicated their assigned sex was female, they identified as male, if they did not provide an answer for their assigned sex or gender identity, or if they failed to respond to multiple questions. A total of 4 respondents indicated their assigned sex at birth was female and they identified as male. A total of 5 respondents indicated their assigned sex was male but they identified as male. Because "consent to participate" was the only required field for advancement of the survey, not all participants answered every question on the survey. In fact, a total of 8 respondents did not advance beyond the initial consent question. A total of 4 respondents did not complete the final page, and although answering questions was optional, it was assumed that the surveys were abandoned due to fatigue, boredom, or web server/computer difficulties. One respondent did not mark her assigned sex, but based on her responses for the remainder of the survey, it was concluded that this was an error and her responses were included in the final data corpus. Thus, in total, 21 respondents were excluded from participation.

Final participant pool

To review, between February and March 2010, 98 individuals answered the survey hosted on the study website. Of these surveys, 77 were deemed complete and included in the final data corpus. Table 1 presents the characteristics of all participants (See Appendix H). Because the survey was written in English, all participants were English-speaking. 61% of participants (n=55) indicated membership in one or more transgender or GLBT political or support groups. This was not surprising because participants were targeted through many group organizations. Participants were also generally located in the Northwest, Southwest, Northeastern regions of the United States, with few or no participants from the Midwest or Southern regions (See Appendix I for identification of geographical locations of specific respondents).

Response rate per question

Although 77 participants completed the study, there were not 77 responses for each question. One "skip logic" (an automatic redirection to another page based on answer to specific item) was added in order to direct participants to relevant questions based on whether or not the participant had received speech therapy. See Appendix B for number of responses per item.

CHAPTER 3: RESULTS

The purpose of the present study was to explore whether or not the profile of the transgender person has changed given the increased awareness and tolerance in today's society. Specifically, we explored demographic shifts, the influence of gender identity and orientation on seeking speech therapy services, the relationship between speech therapy and feminine presentation, perceived benefit of speech therapy versus alternative methods, and the nature of avoidance behaviors in this population. As stated in the methodology section and reviewed in Table 2, the number of respondents varied per question. Thus, the proportions reported for each question were based on the respondent number not the total participant number. These pilot proportion data will serve as a basis for future statistical analysis with a larger group of respondents.

DEMOGRAPHICS

For comparison to the demographic results to those reported Blanchard (1994), see Figure 1.

Age

The average age of clinical presentation based on reported age when first seeking therapy was approximately 36.2 years of age. The mean age of participants who entered their birthdates (n=73) was 48 years, with a range of 18 years and 5 months to 75 years and 5 months of age.

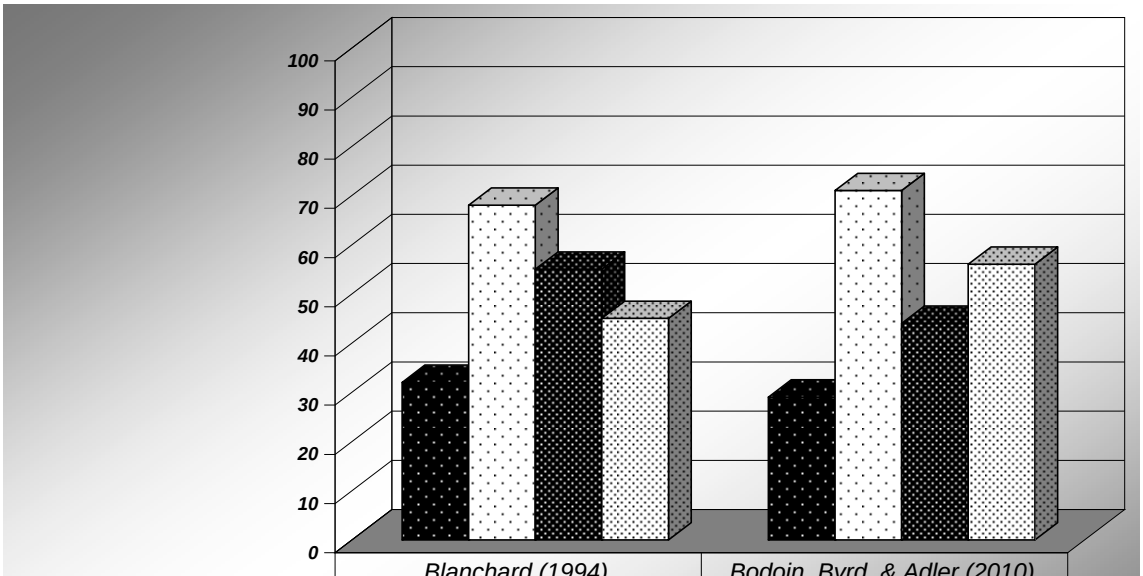
Marital Status

Approximately 71% (54 of 76 who responded to question) participants indicated they had been married at least once. The majority of the respondents (43%) had been married only once (n=33), 18% had been married twice (n=14) and 9% had been married more than twice (n=7).

Children

Forty-three out of 77 (56%) participants reported having at least one child. The remaining 34 participants (44%) indicated they had no children.

Figure 1: Comparison of marital status and children



	Blanchard (1994)	Bodoin, Byrd, & Adler (2010)
never married	32	29
married/partnered once or more	68	71
no children	55	44
one or more children	45	56

Gender identity and sexual orientation

Fifty-two of the 77 respondents (68%) identified as female. The remainder of the participants identified as either transgender (27%) or other (5%). The participants who indicated their gender identity as "other" used a fill-in text box to specify their gender identity as "genderqueer" or "my gender." Regarding sexual orientation, 49% of participants identified as lesbian or attracted to women. Thirty-one percent identified as bisexual or pansexual (attracted to all genders). Because transgender persons sometimes resist labels or have specific differences from heteronormative culture (Stryker, 2004), the "other" option was offered as a fill-in text box. There were eleven fill-in responses total. One respondent indicated that she is "attracted to that which is feminine," while another participant responded as "questioning." Two respondents reported their sexual orientation as "asexual" and "celibate," respectively. Eleven participants (14%) identified as heterosexual or attracted primarily to men.

TREATMENT

Feminine presentation

Overall, participants rated importance of being perceived as feminine as very important (M=4.23 on a scale of 1 to 5). Satisfaction with their femininity as rated on the following question was also rated on a scale of 1 to 5 (M=3.34). In terms of feminine characteristics, physical appearance averaged the highest in importance (M=4.27 on a scale of 1-5) and feminine voice averaged the second highest (M=4.25). Nonverbal

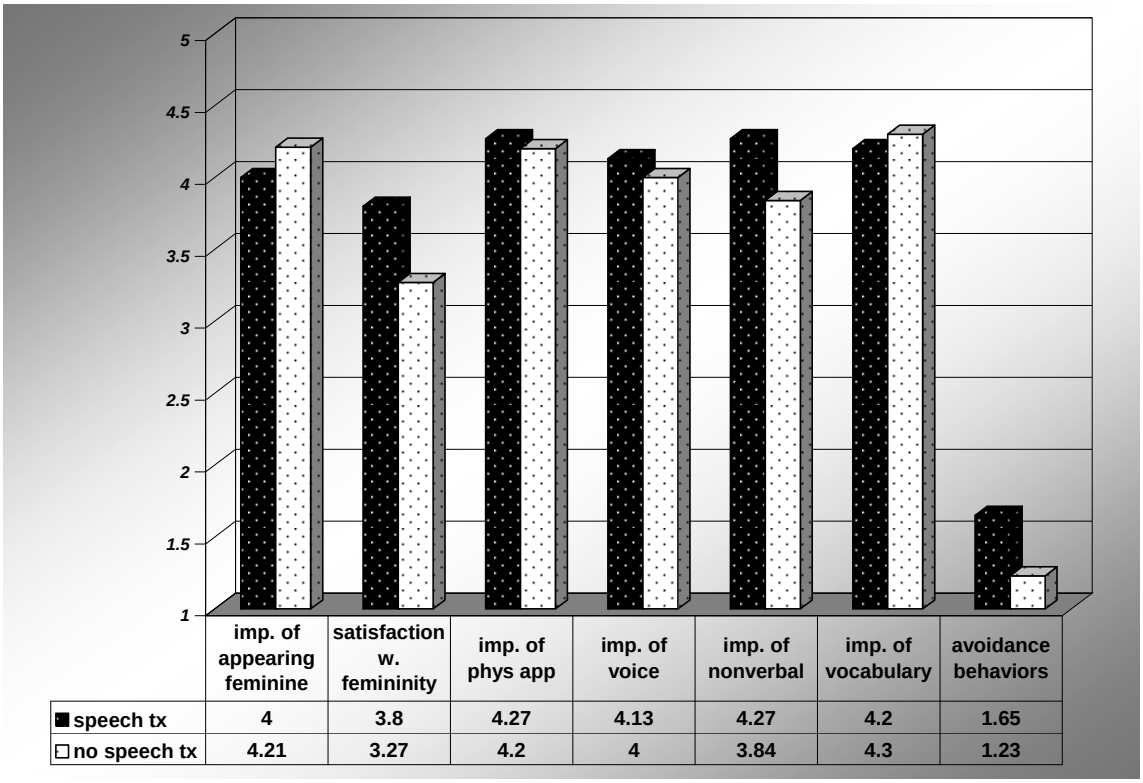
communication (M=4.08) and vocabulary use (M=3.94) averaged slightly lower numbers in terms of importance.

Age was a factor in perceptions of feminine presentation. Overall, younger participants rated the importance of being perceived as female to be slightly higher (4.31 on a scale of 1 – 5) than older participants did (4.26 on a scale of 1-5). In addition, younger participants indicated a higher average level of satisfaction with overall femininity (3.42) when compared to older participants (3.34). Interestingly, the younger pool of participants ranked a feminine voice of higher importance (4.35) than the older participants did (4.13). In contrast, older participants rated nonverbal communication, vocabulary use, and physical appearance higher than younger participants did.

Differences in perceptions and satisfaction of female presentation were also noted in terms of whether or not the participant had participated in speech therapy. Participants who participated in therapy for a speech or language disorder or for aural rehabilitation were excluded from the results. Overall, respondents who did not participate in therapy (n=56) rated the importance of being perceived as female higher (4.21) than respondents who did participate in therapy (n=15) (rated at 4.0). However, those who participated in therapy reported on average a higher rate of satisfaction with femininity (3.8 compared to 3.27). Participants who did not indicate experience with speech therapy also rated the importance of a feminine sounding voice, nonverbal communication and vocabulary use as more important than the participants who had participated in speech therapy. The importance of physical appearance in terms of appearing feminine was approximately equal (4.2 for the therapy group, 4.27 for non-therapy group). Interestingly, the non-therapy group indicated a lower average tendency to avoid per person (1.23 for each of 56 participants) when compared to those who had participated in therapy (1.65 avoidance behaviors per person). See Figure 2 for a comparison of these features.

Figure 1: Comparison of speech therapy and non-speech therapy

Comparison of speech therapy and non-speech therapy groups in terms of importance of femininity, satisfaction with femininity, and factors that are considered to be critical to passing as female. Abbreviations: tx = therapy; imp. = importance; phys app = physical appearance.



	imp. of appearing feminine	satisfaction w. femininity	imp. of phys app	imp. of voice	imp. of nonverbal	imp. of vocabulary	avoidance behaviors
speech tx	4	3.8	4.27	4.13	4.27	4.2	1.65
no speech tx	4.21	3.27	4.2	4	3.84	4.3	1.23

Participation in speech therapy

Because of the variety of speech therapy practices available to MtF transgender people who desire a more feminine presentation (e.g. voice, nonverbal communication, vocabulary, etc) the questions in the survey targeted experience with speech therapy rather than voice therapy exclusively. Twenty-one of 77 (27%) of respondents participated in speech therapy. Of those, 20 responded to questions about the nature of their goals in therapy. Fifteen of the respondents (78%) participated in speech-language

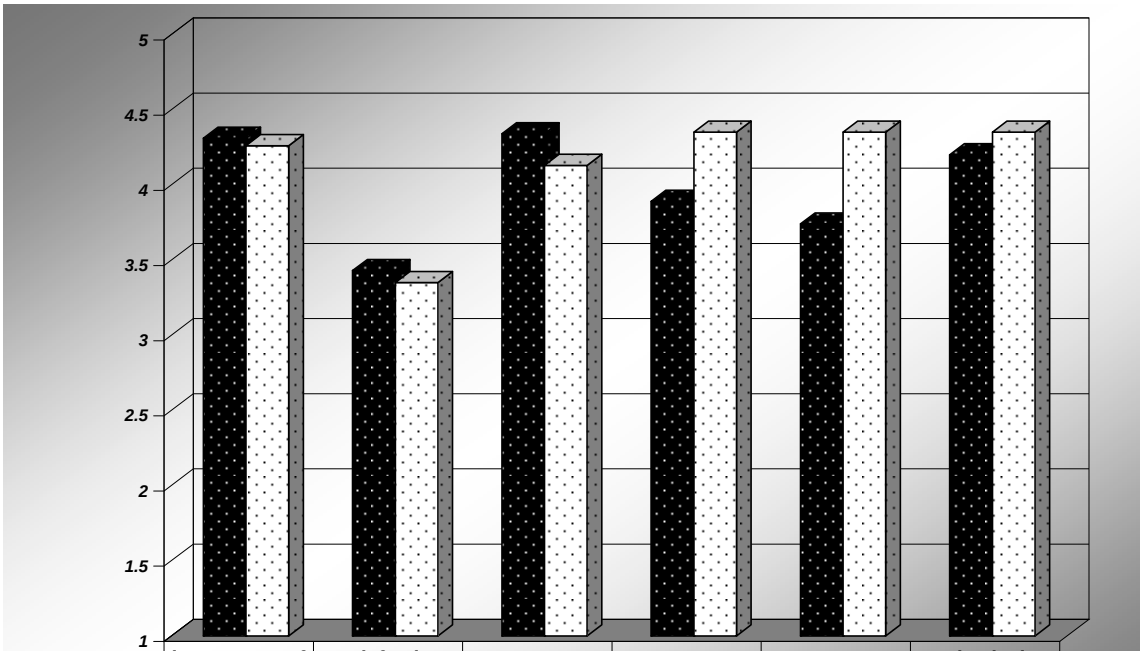
therapy in order to achieve a more feminine presentation, including goals related to voice, nonverbal communication, and vocabulary and word use. The remaining four participants received speech therapy for other speech/language disorders, including child articulation (e.g. “working on /r/”) and aural rehabilitation. Two participants did not answer questions about goals in therapy.

Age at clinical presentation was determined to impact participation in speech therapy. Participants who had not yet sought clinical intervention or did not answer the question were excluded from consideration. Participants who indicated an older age at clinical presentation were generally more likely to have participated in therapy. Specifically, 35% of participants who sought clinical intervention after age 41 (n=23) participated in therapy, whereas only 28% of participants under age 41 (n=35) participated in therapy.

Regarding participation in speech therapy for transgender-related goals, participants who had never married were proportionally higher in number (40%, or 6 out of 14) when compared to participants who had married at least once (60%, or 8 of 14). Nine of 34 participants with no children participated in speech therapy (26%) and 11 of 42 who reported one child or more participated in speech therapy (26%).

In terms of gender identity and participation in therapy, 14 out of 49 participants who identified as female (29%) received speech therapy for transgender-related goals. Three out of 19 participants (15%) who identified as transgender/genderqueer/my gender participated in therapy. Relative to sexual orientation, participants who identified as heterosexual had a higher proportion of respondents who had received speech services for transgender-related goals, with four out of ten participants (40%). Thirteen out of 59

Figure 3. Age based comparisons for factors of feminine presentation.
Factors include importance of femininity, satisfaction with femininity, voice, nonverbal communication, vocabulary and physical appearance in terms of feminine presentation.



	importance of femininity	satisfaction with femininity	voice	nonverbal	vocabulary	physical appearance
younger	4.31	3.43	4.34	3.89	3.74	4.2
older	4.26	3.35	4.13	4.35	4.35	4.35

participants (22%) who identified as lesbian, bisexual, or pansexual received speech services, and the remaining four participants, who identified as asexual, celibate, questioning, or attracted to that which is feminine, did not participate in speech therapy.

The remaining 56 participants (73%) reported that they had not participated in speech therapy. A variety of answers were given as to why the participants had not sought speech therapy as a method to increase feminine presentation. Affordability was the primary reason overall for not seeking services, with 15 of 56 of participants (26%) reporting cost of services as a factor. No prior knowledge of services was another factor for not seeking speech therapy for 12 out of 56 (21%) participants. Eleven participants

(20%) indicated satisfaction with feminine presentation or alternative methods such as CDs or online programs for increasing femininity. Seven participants (12%) reported doubts about results, six participants (11%) indicated that services were not available in the area, and four participants (7%) indicated they had simply not had the chance to pursue therapy yet or were planning to at a later date. One participant reported being denied service by a speech therapist because the therapist was not familiar with therapy approaches for transgender persons.

Fifteen respondents who received speech therapy for transgender-related goals rated satisfaction on a 1-3 point scale using multiple choice answers indicating satisfaction level as "minimally or not at all," "moderately," or "very" satisfied. Overall, satisfaction ratings averaged 2.53 on a scale of 1 to 3. Sixty-six percent of the 15 participants who received speech therapy for transgender-related goals indicated that they were "very satisfied" with the results of speech therapy. Thirty-three percent indicated moderate levels of satisfaction, for reasons such as newness of program (e.g. "Only 3 of 10 sessions have been completed, so it is too soon to judge"), and lack of practicality of the program related to distance and cost. One participant indicated minimal or no satisfaction with results. When ratings were separated based on whether participants had participated in voice therapy exclusively (n=10) versus voice and other transgender-related goals (i.e. nonverbal communication and use of language) (n=5) those who had voice therapy goals exclusively reported slightly lower satisfaction levels (M=2.4) compared to the participants who had voice in addition to language-based goals or language-based goals alone (M=2.83).

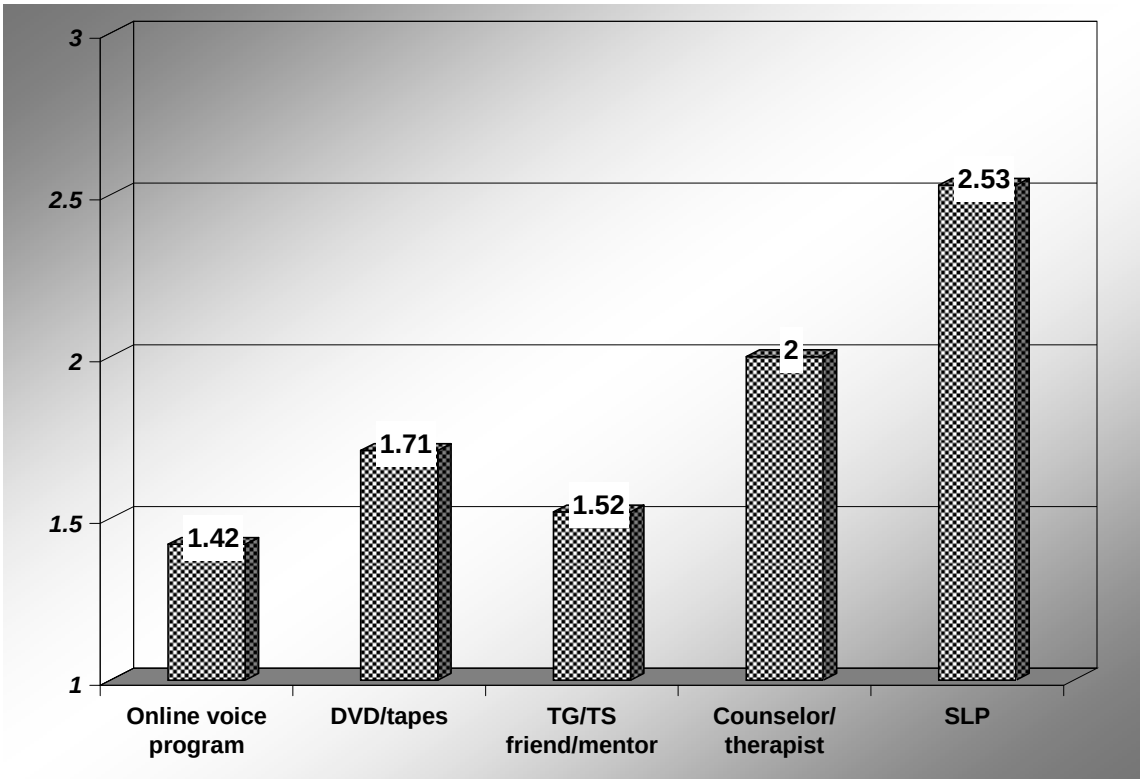
Participants also evaluated the importance of speech therapy relative to transitioning. Forty-eight of the 76 of respondents (63%) who answered the question indicated that speech therapy is important to transition. Twenty-two respondents (29%)

indicated they were not sure, and the remaining 6 participants (8%) reported that speech therapy was not important to transitioning. See Appendix D to review specific comments from participants.

Alternative Methods

On a scale of 1-3, with 1 as "minimally or not at all satisfied," 2 as "moderately satisfied" and 3 as "Very satisfied," satisfaction of participation in an alternative program (e.g. DVDs, YouTube, mentors within the transgender community, and/or counselors and therapists) was rated according to type of alternative methods. Online voice programs, such as YouTube, received an average rating of 1.42 by 19 participants. The average rating for DVDs and tapes for voice feminization was 1.71, as rated by 31 participants. Use of friends or mentors in the transgender community rated an average of 1.52 by 29 participants. Counselors or therapists received a mean rating of 2 by 19 participants. Speech therapy for transgender-related goals was rated an average of 2.53 by 15 participants. See Figure 4 for a comparison of satisfaction ratings for alternative methods and speech therapy.

Figure 4. Satisfaction ratings for therapy and alternative methods.
Participants rated 1 for "minimally or not at all satisfied," 2 for "moderately satisfied" and 3 for "very satisfied." Abbreviations: TG/TS = transgender/transsexual; SLP = speech-language pathologist



Avoidance of Community Interaction

In this survey, participants were asked to indicate which social interactions they avoided out of fear they would be perceived as male. The item options included talking on the phone, socializing with men, meeting new people, going out in public, public speaking, and a fill-in option for "other." There was no non-apply option to this question, but 23 people skipped the question and thus, were presumed to be non-apply, and three other participants indicated "n/a" in the "other" fill-in option. In addition, four participants indicated they did not fear any the above social situations for various reasons,

such as successful passing, being "out" as a transgender person, lower priority with passing (e.g. "I don't care if anyone clocks me, I am me"), and the passage of time since transition mitigating these factors. Overall, 46 of 77 participants (60%) indicated at least one avoidance behavior. Of the 46 participants who confirmed that they engaged in avoidance of activities, 20 marked one choice (43%), 11 marked two choices (23%), 4 marked three choices, 8 marked four choices (17%), and 3 marked five choices (7%). Based on this information, over 50% of participants who avoided activities did so in multiple contexts based on fear of being perceived as male.

The respondents were also asked to check all applicable answers of activities they avoided based on the fear of being perceived as male. Forty-eight percent of the 54 participants avoided public speaking, 38% of the 54 participants indicated they avoided talking on the phone at times based on the fear of being perceived as male, 33% avoided socializing with men, 33% avoided meeting new people, 30% avoided going out in public. Other responses included singing, socializing with young women, and online conversations, presumably with voice/webcam involvement.

UNEXPECTED FINDINGS

Self-taught Methods

Nine participants indicated they achieved a feminine voice by direct observation or other self-taught methods, which included watching different women in a variety of contexts, reading women's magazines, using audio and video feedback of themselves, and by singing. Prior history of vocal training for singing was also noted in the

comments as useful for achieving a feminine voice. Books were also mentioned as resources for obtaining a more feminine presentation.

Female-to-Male Transgender Interest

Four of the excluded respondents to the survey indicated they were female to male transgender persons, and one of those respondents emailed the first author of this study in order to ask about the exclusion of female to male transgender persons (M, personal email to author, 2010). This individual conveyed through this correspondence that he knew of female to male transgender persons who had benefited from voice therapy, and that although hormone therapy does result in a physiological change in the vocal folds that contributes to a lower pitch, the vocal quality is still lacking in terms of sounding like a male whose assigned sex matches his gender (i.e. cisgender male). He further stated that he felt this need for therapy particularly applies to female to male transgender persons who transition later in life. Two of the male to female participants whose survey answers were included in the final data corpus also alluded to the exclusion of female to male transgender persons (e.g. “question assumes all transpersons seeking therapy are male to female”).

CHAPTER 4: DISCUSSION

To review, the purpose of this study was to explore the characteristics and needs of the transgender client of today. The first objective was to determine age, marital status, number of children and compare these findings to those cited by Blanchard (1994). The second objective was to determine if these characteristics, plus gender identity and sexual orientation, had any impact on whether or not the transgender client had received speech therapy. Third, we wanted to determine the levels of satisfaction with speech therapy and to further explore whether or not voice-only goals versus voice and language goals impacted levels of satisfaction. Fourth, we wanted to find out if levels of satisfaction with speech therapy were similar to those of alternative methods such as programs available online (e.g., YouTube, DVDs), peer mentors, and other counselors or therapists. Finally, we wanted to determine if a relationship existed between participation in speech therapy and avoidance behaviors based on fear of being perceived as male.

Question 1: Are the characteristics regarding age, marital status, and number of children cited by Blanchard (1994) applicable to the MtF client of 2010?

Characteristics regarding marital status, age, and number of children cited by Blanchard (1994) appeared to still be applicable to the MtF client of 2010. First, regarding age, we hypothesized that the age of clinical presentation would be younger than Blanchard's study, but it was actually slightly older. The mean age of clinical presentation according to Blanchard's research, which was calculated from the client's

birth date and date of initial consultation, was 34.6 (range= 18.4-63.4). The mean age of initial consultation for the present study was 36.2 (range = 18.4-55.4). Although the maximum age for this study was lower by 8 years, the mean age was within 2 years of the mean age reported by Blanchard. The comparable ages for seeking clinical intervention could be associated with practicalities involved in such a journey. For example, most transgender persons live with their parents before the age of 18 so may need assistance from parents in order to transition before the age of 18 as many aspects of transitioning are expensive and complicated (e.g. locating and paying for a gender therapist, sexual reassignment surgery for those who desire it, breast augmentation, etc.) It is also possible that the age of the transgender client at clinical presentation did not show significant changes from Blanchard's study based on the fact that increased awareness may have influenced older transgender persons to transition based on increased societal tolerance.

The minimum age to complete this survey was age 18, and as a result the range did not include transgender persons who may be in transition but are currently under age 18, which may have lowered the average age. It is also possible that the transition is just as difficult for the transgender person to come to terms with as it was when Blanchard's study was conducted. In other words, the similarity in ages could be based on shame or fear on the part of the transgender person when it comes to self-identifying as transgender and making the decision to formally seek help.

The percentage of transgender persons who reported at least one marriage was also higher in this study when compared to the Blanchard study. However, the Blanchard study examined marital status of heterosexual marriages - our question related to marital status did not specify the sex of the spouse. Marriage between same-sex persons is

currently legal in five states and the District of Columbia, as well as Canada and some European countries. Thus, this question acknowledged the equality of marital spouses regardless of sex. It is important to note that marriage to women by male to female persons is not necessarily uncommon and does not automatically reflect a lack of self-awareness of being transgender or lack of acceptance of her true gender. In addition, issues surrounding sexual orientation are complex for male to female transgender persons, who may suffer social stigmatization or even violence should she be unable to successfully "pass" among potential partners.

Furthermore, based on the question regarding sexual orientation, clinicians may reasonably expect male to female transgender persons to have either a female, male, or transgender spouse. Nevertheless, the question about sexuality likely reflected answers about marriages in which the spouse is female. Because the previous study focused on transgender women who identified as primarily attracted to women, our survey was designed to reflect the diversity of sexual orientation in the male-to-female transgender population. The increased proportion of male to female persons who reported at least one marriage could be because female partners of transgender persons may be more likely to remain in relationships with the transgender person based on changing attitudes toward transgender persons. It is also possible that female partners enter into relationships with transgender persons with an understanding of their gender identity before marriage. Conversely, it could be that there still exists a tendency among the transgender population to marry as a means of rejecting self.

Similar to marital status, the number of children reported in the present study was also higher. The increase in number of children reported could indicate denial of gender

identity, or alternatively, a change in perspective on the part of transgender persons and their partners in terms of starting and raising a family as well as increased acceptance of GLBT families in mainstream society. It is estimated that 6 million to 14 million children under the age of 18 live with a gay or lesbian parent (Singer, 1994). According to recent statistics, an estimated 65,500 adopted children and 14,400 foster children live with a gay or lesbian parent (Gates, Badgett, Macomber, & Chambers, 2007). The National Survey of Family Growth revealed acceptance of gay and lesbian adoptive parents by the majority of respondents, particularly among younger respondents (Vital Health Statistics, 2006). The higher level of acceptance among younger people indicates a shift in attitude that is likely to continue toward increased tolerance of nontraditional families.

Question 2: **Is there a relationship between these characteristics, gender identity, and sexual orientation and whether or not transgender clients have participated in speech therapy?**

Overall, there appeared to be a relationship between age and whether or not transgender clients have participated in speech therapy. On average, respondents were more likely to have participated in speech therapy if they sought clinical intervention at an older age (age 42 or older). This could be because of attempts to use first use alternative methods initially and then pursuing speech therapy at a later age. It could also be related to a lack of awareness among the younger transgender community of the SLP

services that are available to them, as well as the likelihood of a relationship between income and age in order to afford such services.

Perceptions of the importance of femininity also differed between the two age groups. Younger participants rated the importance of being perceived as female to be slightly higher than older participants. It is possible that concerns about passing change as the transgender person becomes older or further along in her transition. This was reported by some of the individual responses in the survey. For example, one older respondent, aged 60, indicated, "I don't care if anyone clocks [perceives me as male] me, I am me." Another participant, aged 70, indicated that she avoided activities based on fear of being perceived as male during early transition, but "with time (~18 months) overcame this obstacle."

Based on survey results, participants who reported at least one marriage were slightly less likely to have participated in speech therapy. This could be because, as Blanchard hypothesized, transgender people marry in an attempt to deny their true gender identity. This could affect speech therapy as well because of the necessity of coming to terms with one's gender identity in order to seek help to develop a more feminine presentation. However, it could also be that participation therapy is based primarily on age in that people who have been married are likely to be older.

Participants who reported one or more children were equally likely to participate in therapy as those who reported no children. This could be the result of increased awareness about transgender parents as well as a higher availability of support networks for children of transgender parents. It is also possible that transgender people are having

children after seeking clinical intervention based on changing attitudes about GLBT families.

Results revealed that transgender clients who identified as female comprised a higher proportion of participants who had received speech therapy for transgender-related goals. Participants who identified as transgender or genderqueer appeared slightly less likely to have participated in speech therapy. This term genderqueer is generally used as a distinction from binary gender identity (Stryker 2008). Sexual orientation appeared to be a factor in participation, with the highest proportion of individuals who had received services identifying as heterosexual (attracted to men). Although the majority of respondents reported that their sexual orientation was lesbian, bisexual, or pansexual, the proportion of participants who received therapy was lower for this group compared to participants who identified as heterosexual. However, it should be noted that participants who identified as heterosexual were much fewer (n=11) compared to remaining participants (n=66) and therefore may not be a good measure for this subpopulation of transgender persons. Individuals who identified as asexual or celibate did not report prior experience with speech therapy.

Reasons for the higher proportion of heterosexual-identified participants who have received speech therapy could be attributed to the relative importance of being perceived as female particularly if the male to female person socializes with biological males (J, email to author, 2010). However, there were some male to female transgender persons who did not identify as heterosexual who indicated comparable interest in being perceived as female. One participant who identified as bisexual explained: "Even if I were to become a butch lesbian, I would want as full as possible ability to speak with a

female voice." In essence, the results show that gender identity and sexual orientation do not exclude interest in feminine presentation and/or interest in receiving speech services for transgender-related goals.

Question 3: Is there a relationship between participation in speech therapy and overall satisfaction with feminine presentation?

Overall, respondents who had participated in speech therapy reported higher levels of satisfaction with feminine presentation. Participants rated physical appearance and voice as more important than nonverbal and social language communication. This may be because physical appearance and voice are characteristics that are common identifiers of gender (i.e., high clocking areas) and are more likely to result in the transgender person being perceived as male (i.e., being read) (Eyre, de Guzman, Donovan, & Boissiere, 2004). Higher levels of satisfaction could reflect more realistic standards based on working with a speech therapist or increased success and/or confidence levels based on intervention. It could also be related to level of investment or being proactive about achieving a more feminine presentation.

In addition, there is a wide range of physical appearance and other factors related to feminine presentation that the transgender person may or may not possess prior to transitioning. For example, there are transgender persons who have more feminine physical characteristics (e.g. shorter stature, more feminine facial features) with a voice that is naturally higher in pitch and also transgender persons with a lower voice who are taller and are more likely to be perceived as male. Thus, it is a possible that male to

female transgender persons who already present as more female are more satisfied with their feminine presentation prior to participating in therapy. However, it could also be that working with a speech therapist increases levels of satisfaction with femininity only among those groups of transgender persons who have less of a physical presentation as a female. Finally, it could be that regardless of physical appearance, speech therapy results in increased overall satisfaction with femininity. Future research should consider exploring the transgender person's perception of physical self with the likelihood to both seek speech therapy and to report satisfactory results.

Question 4: Does satisfaction with services differ in terms of participation in speech therapy compared to alternative methods of voice feminization (e.g. online resources such as DVDs, YouTube, and/or mentors in the transgender community)?

Participation in speech therapy resulted in higher levels of satisfaction than alternative methods for increasing feminization such as the Internet or peer mentors. This could be because speech therapy yields better results for male to female transgender persons who desire a more feminine presentation; however it could also stem from the difference in priorities between the two therapies. Speech therapy for the transgender person usually focuses on a combination of voice, nonverbal communication, and use of vocabulary, whereas many of the methods found through audio/video alternatives focus mainly on the voice alone. Indeed, participants reported a lower average satisfaction level for speech therapy in which voice alteration was the only goal. Voice therapy by itself does not necessarily result in a voice that is likely to be perceived as feminine

(Dacakis, 2002); therefore, results may be less satisfactory than for holistic therapy in which other language-based facets of feminine communication are addressed (Adler. Hirsch, & Mordaunt, 2006; Gelfer, 1999: Van Borsel, De Cuypere, & Van den Berghe, 2001).

In addition, although results from the present study demonstrate satisfaction with the relatively inexpensive to free online programs is low; many transgender people reported that the alternative methods seemed to be the only options available. What is particularly disconcerting for the field of speech-language pathology is that many participants stated that they were not aware speech therapy services existed for transgender persons. In fact, most participants indicated they would seek speech therapy services if they were available and/or affordable. Further, the overwhelming majority of participants indicated that speech therapy is important to transitioning. It must be noted that there are other expensive services (e.g. hormone therapy, facial reconstructive surgery, etc.) that may be utilized more frequently by the transgender client. It is possible that the lack of awareness of services taken together with doubts about results influences the perception among potential clients that the cost of therapy may exceed the benefits of participation in therapy. Outreach to other professionals, such as gender therapists, who are typically responsible for referring transgender people, could increase awareness in the transgender community about SLP services. Inclusion of services at the university clinic level, where therapy is frequently more affordable, could also make therapy more accessible to the transgender community, as well as providing outreach to the community in terms of what SLPs can do for the transgender client. ASHA currently has a special interest division for voice disorders and although this technically includes specialized

focus for transgender persons, given the unique nature of their communication needs, it would be prudent to (at least) develop a task force to explore the benefits of establishing a special interest division that is specific to this population. This development could serve to help increase the SLPs knowledge of the transgenderism which would in turn increase the efficacy of the assessment and treatment provided to these persons. Furthermore, these actions would undoubtedly also serve to increase the number of transgender persons who seek speech therapy due to the higher availability and improved quality of those services.

Question 5: Is there a relationship between avoidance of community activities (e.g. talking on the phone, socializing with men) and participation in speech therapy?

The chief concern for many SLPs relative to therapy goals is participation in activities of daily living, including community or social outlets. Results from the survey revealed a high degree of avoidance of community and daily activities on the part of male to female transgender persons based on the fear of being perceived as male. The majority of participants indicated concerns about talking on the phone, and one participant indicated "my voice on the phone has been a true disappointment." Interestingly, transgender persons who participated in therapy to enhance feminine presentation reported more avoidance behaviors based on fear of being perceived as male when compared to the non-speech therapy group. This difference in frequency of avoidance behaviors could be related to the transgender person's increased awareness of avoidance behaviors as a result of working with a speech therapist, who may include recognition of

avoidance behaviors in treatment. It could also be that those transgender persons who more frequently avoid communicative situations are those who are more likely to seek speech therapy in order to present as female. Finally, it is also possible that those persons who seek therapy are in fact seeking it so that they can reduce their avoidance of specific speaking situations. Future research should consider the effectiveness of strategies to assist the transgender individual in overcoming fears about being perceived as male (i.e. clocked or read) and satisfaction with results in implementing those strategies.

Unexpected Findings

Although the SLP can assist the transgender client in terms of vocal hygiene, pitch modulation, and feminine presentation using nonverbal communication and language, the transgender individual appears to be independently confident about her presentation and likely to report autonomous use of sophisticated self-taught techniques (e.g. observing women's mannerisms, behaviors, and presentation, analyzing her own voice via audio and video, as well as feedback from others on the phone). Therefore, therapy should be transactional and with the understanding that the transgender person brings her own knowledge and experience to the table and the SLP is not necessarily the sole expert. Indeed, the transgender person can likely inform the therapist about techniques she would like to refine that the SLP may not have considered due to lack of experience as a transgender person.

Female-to-male transgender persons expressed interest in voice therapy through correspondence with the first author and through excluded responses on the survey. Just

as a higher pitch is not the only voice feature that allows someone to be perceived as female (Dacakis, 2002), it follows that a lower pitch is not the only voice feature that will allow someone to be perceived as male. Further research into the needs of the female to male person could provide direction for the SLP and guide the nature of outreach to this frequently overlooked population.

Limitations

Internet research, although helpful in studying groups which are not as visible in mainstream society, has several limitations. First, the person taking the survey must have access to a computer and know how to navigate on the Internet successfully (e.g., clicking on links, recognizing formats). Second, the venue through which we collected data, although designed to get a reasonably varied sample, do not provide a random sample, rather it provides a self-selected sample. Participants in the present study also had a high likelihood of belonging to a group that was supportive in nature (e.g. transgender groups or university clinics), and therefore were likely to have initiated seeking help or support. However, because transgender persons are often ostracized in mainstream society, we considered support groups and other trans-oriented organizations to be uniquely attractive to transgender persons and thus more likely to have members of varying ages and backgrounds. Nevertheless, membership to such groups may have influenced participant responses. For example, transgender persons who do not belong to such groups may be older, may be more isolated, or may have decreased interest in group identification on the basis of gender identity and may therefore be less likely to seek

speech therapy. Future research should research should target across the age range and also those persons who do not belong to any formalized group in order to attain a more representative sample of the transgender community.

Another limitation of this study is that focused only on English-speaking participants in the United States. Future research should explore different cultural attitudes toward transgender issues in order to further enhance the SLP's understanding of transgender issues from a multicultural perspective. Perceptions of gender roles can differ across cultures, so an understanding of influences in the transgender person's perception of femininity would assist in determining appropriate goals in therapy relative to the client's cultural background.

Finally, regarding participation in therapy, the participants in the present study may not be representative of the proportion of transgender persons who receive and do not receive therapy because the surveys were sent to contacts who are professors or directors of voice therapy for transgender clientele. However, the purpose was to compare priorities for therapy and satisfaction with therapy among transgender persons who participated in therapy and those who did not. Thus, the representation of transgender clients who had received therapy was necessary in order ensure available data regarding experience with therapy.

Conclusions

The male to female person of today at least in terms of basic demographics seems to be markedly similar to the profile described almost two decades ago relative to age,

marriage, and children. Male to female transgender persons also continue to be highly motivated to attain a feminine presentation. In fact, many transgender persons avoid communicative interactions (e.g. talking on the phone, public speaking, socializing with new people) and everyday activities (e.g. going out in public) based on the fear that they will be perceived as male (i.e. clocked or read). Results further revealed that although many transgender people are not aware that speech therapy for transgender-related goals exists, for those who have had speech therapy the satisfaction reported is much higher than with alternative methods. Thus, SLPs appear to be uniquely qualified in helping the transgender person to enhance and feel confident about their feminine presentation. Based on these factors, it is the ethical responsibility of the SLP to continue to reach out to the transgender community and affiliated professionals in order to increase awareness and provision of speech therapy services for this population.

Appendix A: Survey Questions

1. Do you agree to participate in the survey?
   - □ Yes
   - □ No
2. What was your assigned sex at birth?
   - □ Male
   - □ Female
   - □ Intersex
3. Which gender do you MOST identify with now?
   - □ Male
   - □ Female
   - □ Transgender
   - □ Other (please specify)
4. Which answer best describes your sexual orientation?
   - □ Lesbian – primarily attracted to women
   - □ Bisexual – attracted to both men and women
   - □ Heterosexual – primarily attracted to men
   - □ Other (please specify)
5. At approximately what age did you become aware of having a gender identity other than that of your assigned sex?
   - □ Before age 15
   - □ 16-30
   - □ 31-45
   - □ 46-60
   - □ 60+
6. When did you start actively making the transition to female?
   - □ Before age 15
   - □ 16-30
   - □ 31-45
   - □ 46-60
   - □ 60+
   - □ I have not yet started transitioning.
   - □ I do not plan on transitioning
7. At what age did you first seek clinical services (e.g. counseling, hormone therapy, etc) in order to explore/begin the transition process? <p>(If you have not received clinical services, please write n/a)
8. What is your current occupation?
9. In which of the following ways has your choice of career been influenced by your gender?
   - □ I chose careers that are generally considered masculine
   - □ I avoided stereotypically female jobs
   - □ I chose careers that are generally considered feminine

- □ I avoided stereotypically male jobs
- □ My career choice was not influenced by my gender
- □ Other (please specify)

10. Which of the following groups are you affiliated with? (please check all that apply)
    - □ Transgender Law Organization
    - □ Transgender Support Group
    - □ Transgender listserv
    - □ University of Texas
    - □ Other (please specify)
11. Please rate the following (scale of 1-5):
    - □ How important is it to you that you are perceived as female?
    - □ Describe your overall satisfaction with your femininity.
12. Please rate the importance of each of the following characteristics in terms of being perceived as female. (Scale of 1-5)
    - □ A feminine-sounding voice
    - □ Nonverbal communication (e.g. body language)
    - □ Physical appearance (e.g. hair, dress, etc)
    - □ Other (please specify)
13. Do you ever avoid the following interactions because you are worried that you will be perceived as male? SCALE OF IMPORTANCE
    - □ Talking on the phone
    - □ Socializing with men
    - □ Meeting new people
    - □ Going out in public
    - □ Public speaking
    - □ Other (please specify)
14. Have you ever received speech therapy from a speech therapist?
    - □ Yes [if participants marked “yes,” they skipped Items 18 thru 20]
    - □ No [if participants marked “no,” they were redirected to Item 18]
15. What was the purpose of speech therapy? Please check all that apply.
    - □ To make my voice sound more feminine
    - □ To make my body language (e.g. gestures, mannerisms) appear more feminine.
    - □ To make my social use of language more feminine
    - □ I received speech therapy because of a speech/language disorder.
    - □ Other (please specify)
16. Where did you receive speech therapy
    - □ At a private practice
    - □ At a university
    - □ Other, please describe
17. How satisfied were you with the services?
    - □ Very satisfied
    - □ Somewhat satisfied
    - □ Minimally or not at all satisfied

- □ Please explain your answer.

18. You indicated that you have not received speech therapy. What is the main reason you have not participated in speech therapy?
    - □ I didn't know services were available.
    - □ I don't think I would feel comfortable receiving speech therapy.
    - □ I don't think speech therapy would be useful for me.
    - □ I am satisfied with my femininity.
    - □ I can't afford speech therapy.
    - □ I was refused service by a speech therapist.
    - □ Other (please specify)
19. Speech therapists are ethically required to serve transgender clients. If you were refused service, why do you think this happened?
    - □ I was refused service based on my gender identity.
    - □ The speech-language pathologist was not knowledgeable about TG/TS clients.
    - □ I was refused service based on financial or insurance reasons.
    - □ Other (please specify)
20. If you were to participate in speech therapy, how important would each of the following goals be for you? (Please rate the importance of each)
    - □ To make my voice sound more feminine
    - □ To make my body language (e.g. gestures, mannerisms) appear more feminine.
    - □ To make my social use of language more feminine
21. If you have used any other services besides speech therapy <b>to increase your femininity, please rate your satisfaction with the results.
    - □ Online voice programs
    - □ DVD or tapes for voice feminization
    - □ Friend or mentor in the transgender community
    - □ Counselor or psychotherapist
22. Do you think speech therapy is an important part of transitioning to female?
    - □ Yes
    - □ No
    - □ I'm not sure
    - □ Please explain your answer.
23. What is your date of birth?
24. What is your zip code?
25. Which of the following best describes your marital status?
    - □ Single
    - □ Married/Partnered
    - □ Separated
    - □ Divorced
    - □ Widowed
26. How many times have you been married?
    - □ Never
    - □ Once

- □ Twice
- □ More than twice

27. How many children do you have?
    - □ None
    - □ One
    - □ Two
    - □ Three
    - □ Four or more
28. What is the highest level of education you have completed?
    - □ High school
    - □ College
    - □ Graduate or professional school
    - □ Other (please specify)

Appendix B: Rate of Response

Table 1: Number of responses per item.

Item Number	Total Respondents
1	77
2	77
3	77
4	77
5	77
6	77
7	69
8	74
9	77
10	64
11	77
12	77
13	54**
14	77
15	19*
16	20*
17	20*
18	57
19	14
20	53
21	64
22	76
23	73
24	71
25	76
26	76
27	77
28	77

*skip logic question resulted in fewer participants

**question developed after 7th participant

Appendix C: Contacts

List of listservs and Trans organizations and contacts

TransOhio www.transohio.org

Richard Adler, Moorhead University adlerri@mnstate.edu

Trans DC Coalition http://dctranscoalition.wordpress.com/

Ingersoll Gender Center (Seattle Washington) ingersoll@ingersollcenter.org

University of Iowa Speech Center ann-fennell@uiowa.edu

University of North Carolina at Greensboro

Transgender Education Network of Texas www.tentex.org

National Center of Transgender Equality (Declined)

University of Texas Gender and Sexuality Center rosal@austin.utexas.edu

Utah Pride Center jenny@utahpridecenter.org

TransOhio TransOhio@gmail.com

L'GASP faix@yahoo.com

Transgender Law Organization query@transgenderlaw.org

A. Cleghorn (personal contact)

B. Nagel (personal contact)

J. Blackwell (personal contact)

Appendix D: Comments about importance of speech therapy

Voice related, positive:

1 = Voice is usually the most important feminine "marker" to the general public. Many MtF transexuals often are very feminine looking but their voice is the handicap
17 - I feel having a gender appropriate voice is VERY importnat. Learning that speech therary can help mkaes it an important part.
20 - My voice "can" be "adjusted" but it takes time and an understanding of HOW to do it. That knowladge is NOT readiely avalible. I do not believe that just "reading books or watching dvd's will give me the nessary information and feed back to move forward.
28 - I think voice is a key gender indicator. If you look gorgeous but your voice sounds male, you will be read. If you have a great voice and only an average appearance, you will probably pass. Voice is a main indicator and crucial to fitting in.
39 - Yes, I think speech therapy *can* be an important part of transitioning. It really depends on the individual and the situation. My voice was already relatively feminine, and I had no problem training myself without paying for speech therapy. For trans women who have deeper voices, though, I think it would be a very important part of transition and I know a lot of people who use it.
46 - To me being able to sound like a female is important because our voice is one of the first things that people will key in on in their perception of our gender. Women can have a deep feminine voice but having a deep bass sounding voice does make people confused when interacting with us, so having a feminine voice, even a deep feminine voice helps us in our every day life.
64 - Next to GRS sounding and acting female is very important to me. Its a shock to me to hear a gruff voiced woman
71 - Even if I were to become a butch lesbian, I would want a full as possible ability to speak with a female voice. Also, my voice on the phone has been a true disappointment.

Overall communication skills/passing, positive

P2 = Just this evening, I watched a recently recorded Oprah show featuring a Transsexual story line. The transsexual had excellent female cmmunication skills. I literally was thinking, just before coming in to work on the computer and spotting this message, that I should start working on my skills again. Being female, not transsexual is what I want from my life. Speech and comunication skills are an important part of life.
12 - Not essential but nice to have. I hate being "sir'd" on the phone at work, but it rarely happens in person. I simply do what I can to do as a woman earning double minimum wage. Social interaction is never a problem. I tell my newer TG sisters that experience brings confidence and that perfection can be the enemy of excellence.
11 - Voice can often make or break your image.
2 - Relates to congruency of the whole transition
3- I believe speech therapy to be very important in developing the skills necessary to pass.

14 - It's all part of having a female appearance
21 - communicating in a feminine matter is crucial to passing
24 - For those who identify as transsexual it is critical
36 - It is a great help in passing
58 - It's necessary to retrain one's speech in order to be perceived by others as a woman. Although some can attain this on their own, even those people can still use some help in this matter.
69 - It's one of the most important things one can do in order to successfully live as a female.

Neutral, unsure, individual choice

1 - I believe that although it is an individual choice, many if not all would be happier if they could achieve a more feminine voice to where they sound female on the phone or in a drive-thru.
6 - I'm not sure how critical it is. I think it might be, but I'm not sure.
22 - For some, it is very important; for others, not important at all. Transition (evolution) is a Life long process of introspective self-analysis, external feedback, and subsequent adjustment.
23 - if it works it would be very important
33 - It's important if it's important to the transitioning person. It was to me, but doesn't have to be for everyone
35- If one needs it, it may be. But not all need it / benefit from it.
41 - I think it would be helpful, but I wouldn't want to blurt out someting in the wrong voice when someting happend, like droping a book on my foot.
47 - for me it is moderatly important, but less important than many other things, and will be low on my priority list.
51 - I would say being perceived as female , or at least not being heard as male, is important,(for an mtf) ,but this should not _require_ intense speech therapy.
60 - Yes, but not really important.
70 - I feel that speech depends on the individual. For some they can use friends, others it comes naturaly, and while others there is no hope with out speech therapy. However, I feel that all transgended people (both mtf and ftm) can benefit from the assitance.

Other methods work better, negative

27 - I think speech therapy can be useful, but I also know, based on my experience and observations of others, that femine intonations, speach patterns, and body language can be learned with little financial cost just by observing and mimicing the world around you.
4 - I transitioned many years ago. Back then it seemed that the best results were from people inside the community, rather than outside.
7 - I'm not sure because some people may already be speaking in such a manner that all it takes is a twist here and there, and you're done. On the other hand, I know of people getting read left and right because they don't even try to change their voice and absolutely don't care what other people think.

Doubts about effectiveness, availability, neutral

54 - I doubt that I'll be able alter my voice.
66 - I think it should be a very important part, but many of us simply cannot afford it. Frankly, I don't even know of a speech therapist in this area who works with TG clients.

Not trying to pass/ difference in perceptions of femininity, neutral

55 - I think a speech therapist can help, but it is possible to attain a natural sounding female voice without voice therapy. The question diachotomizes voices to male and female without considering the naturally occurring range of both gender's voices. Additionally it begs the question, is being more feminine actually being more female. Any cisgendered woman would find the statement preposterous, yet somehow it is constantly applied to trans women.
9 - I think it can be very important but from my own experience I have found that voice correction or not people normally accept me as my female self because I totally accept me as my female self. I am not trying to "pass" - I am.

Appendix E: Emails from participants

Emails are represented in exact form as received. No corrections were made in terms of spelling or grammar.

T.
In regard to your original survey question:
"6. At what age did you self-identify as transgender/transsexual

Not every one is/was aware of the term transgendered when they were growing up.

Many, my self in this group, were confused of their feeling of their physical sex and had no terminology, just maybe "I feel like a girl, not a boy" or maybe just "I don't feel like a boy" which may have been the physical sex. Until the terminology of transgender is encountered which may not be until a teenager or later, a transgendered person may have ambiguities in self identification, basically "none of the above (male or female)". Perhaps transgendered is a common term now but I think a lot of kids may or have been shielded from this "forbidden" term by parents or guardian.

E.
I had been initially interested in voice therapy at a lower per-visit cost, ($250 intake, plus a $125/hr per-visit rate was way too much for me) and the closure of the UW clinic was a blow to my abdomen, in regard to the query: How do I afford all of the necessary elements in my transition?

When I discovered that the voice clinic had closed, literally weeks before my inquiry, I was greatly dismayed. Further inquiry revealed only one source of voice therapy, Sandy Hirsch. Her clinical rate made this an impossibility. I chose to resurrect my old voice training and techniques from my singing career, which helped greatly. Various friends of mine in the trans community here alternately recommended the various voice-training DVDS like Deep Stealth, and recommended throwing it away. Results may vary!

After utilizing some warm-up and stretching techniques, I would raise my voice's pitch considerably, modulating the tonal and resonant qualities based on what I could hear, and utilizing some mimicry of my colleagues at the call center at which I was employed. Before my transition, I would occasionally experiment with modulating my pitch for 20-30 minutes at a time. I would take calls in what I thought was a female voice, and would use my customer's feedback as a guide. If I still got 'Sir' then I wasn't doing it correctly! Now, let me stress that this was pre-transition, done only as an experiment! I was given much training at this job on how to modulate the tone of my voice to sound excited, warm, friendly, even when I wasn't feeling so. This was a much better approach than a monotone voice, which had no life to it at all. I could come to work sick with a cold, and still SOUND like I was doing great!

After years of working on my tonal modulation, simply adding a modulated pitch

(higher) made the transition from perceived-male to perceived female very easy! Now...to do this more than 30 minutes at a time!

I started leaving voicemails on my cell phone with my voice. It was easy to create categories of attributes that I would experiment with, and simply call my voicemail so I could hear my own voice. This was for me easier than carrying a sound-recording device.

I think that, through this whole process, I was able to develop a telephone voice that far surpassed what I was capable of in person at the time. Today, I even employ the simple process of starting off at a higher pitch, then relaxing (down) as necessary. I think it's an easy matter to establish your gender on the phone with a high pitch, modulated inflection and tone, and feminine speech patterns, then relax somewhat as the call progresses. The same is true, I have discovered, with those I work with in-person. Only if they re-focus their mind on my audible presentation would they ever need to reconsider my birth gender.

A good friend of mine, whose vocal process was damaged during a tracheal shave several years ago, has recently asked me questions about Voice Therapy. With only Dr. Hirsch here in the region to provide assistance, her options and her attitude toward reclaiming a more feminine voice are quite limited. It was her, in fact, who inspired me to explore how a MtF can utilize a deeper voice without losing the classical hallmarks of femininity. This is a work in progress.

This survey comes at an amusing moment for me: I screamed my head off at the Bon Jovi concert on Friday, and at a retreat this weekend had a very deep voice. I contracted a cold on Sunday night, and am still stuff up and sore, and my voice is still deep. My challenge today is to be feminine in person and on the phone without the benefit of a higher-pitched voice. I think the word 'over-compensation' comes into play, at least a little.

D:
I am an m2f transsexual myself, in the full-time living experience phase of my transition. Of interest also to you may be the fact that I am a graduate student at University in the Master of Arts in Counseling (MAC) program. I am currently taking the research course and just this week we began the study of surveys, so all of the elements of your survey were of extra interest to me. The transition of my voice, and all of the related elements thereto, are the biggest problem I'm having. Good services are available to me locally for everything else. Online and recorded media are my only resources for help at this time, save for the encouragement of my peers. I would love to see the voice feminization program re-instituted at UT. I have heard that it used to be in existence and widely used, so I do not know why that program died. If you have any suggestions I would love to speak with you. Thank you in advance for any help that you may provide.

J:

One area where I'd like to see a bit of research is the effectiveness of different types of speech therapy. I transitioned back in the 1990's and I've noticed a decline in the "vocal quality" (not sure how else to describe it) of transsexual women from back in the day to the present. I'd be interested in seeing what your survey might reveal about that, and how that can be turned around.

My observation is that anyone who transitions after their late-20's / early-30's isn't as interested in passability / passing as people who transition in their teens to mid-20's. By the late-30's / early-40's passability becomes significantly less important, to the point that I have a hard time who's whom.

J, Email #2
What I'm perplexed by is the reduced emphasis on voice at the same time there is so much more emphasis on facial plastic surgery. Voice is fairly inexpensive and accessible. Skull surgery isn't.

J, Email #3
Age of transition and sexual orientation are very strongly correlated. For example, a 14 year old (age of transition) transsexual woman is very likely, almost to the point of 100% guaranteed, to be attracted to men. A 44 year old transsexual woman is very likely, again almost to the point of 100% guaranteed, to be attracted to women. If a transsexual woman wants to have any chance at all of finding a partner, she has to be able to "fit" within the social circles of her potential partners. So, the young girl who transitions when she starts high school has to be very, very passable so her boyfriends -- assuming they even know of her past -- won't be put on the spot if her past is known by her friends. Most of the women who transition at an older age and date men are dating what we call "tranny chasers" -- men who are sexually attracted to transsexual women, rather than women in general. For women who transition older, they are either dating more "mainstream" lesbians, or else they are dating women who are accepting of "men" who are "different".

In my case, I started transition at 33 (I just turned 48 yesterday) and the issues I had were with women in my social circle disapproving of my female, lesbian-identified, partners because they were dating a "man". Keep in mind -- this is almost 15 years ago, and things were very different in terms of social acceptance. If I'd been in a relationship with a man, it wouldn't just have been finger-wagging, it would have been the end of that relationship, and the end of my involvement in that entire circle of friends. I have dated a small number of men, most of whom had no clue and neither did their friends. But generally I date women who've only had women for sexual partners. That puts me in a sort of "middle" ground between the two groups, so I've gotten to see how both groups of transsexual women exist.

The deal with "voice" is -- as I'm sure you're well aware -- that voice is more than just pitch. If the underlying qualities of a feminine "voice" aren't present, it becomes an exercise in re-learning how to speak from scratch. There's also self- and mutual delusion.

That is, within the trans-community there are self-reinforcing attitudes that "create" a sort of idealized "voice". Within some groups, a "really bad falsetto" is considered to be "good enough" because at one time, some group of people decided that a "really bad falsetto" sounded good enough. Within others, a more "natural" or "genetic female" voice is the standard for the same kinds of reasons -- someone or some group established that as "normal" and all transsexual voices are judged against that. In the first group, someone with a "really bad falsetto" voice is repeatedly going to be told how great they sound, even if they are repeatedly "read" based on sounding like a man. A woman I knew back in '95 used to dismiss her voice -- which was truly horrid -- as "really good", even though it had all the characteristics of a male falsetto. Another woman I knew used to make money as a non-trans phone sex operator (there's extra money to be made as a "trans" phone sex operator, even if the woman isn't trans-anything).

Back to age of transition, the likelihood that a 14 year old transsexual woman is going to have a naturally feminine voice is far greater than the likelihood that a 44 year old transsexual woman will have one. This is very likely related to whatever it is that results in gay men having -- on average -- more feminine voices than heterosexual men, and lesbian women having -- on average -- more masculine voices. Dr. J. Michael Bailey performed some very unpopular research in which people were asked to guess the sexual orientation of males based solely on their voice. It was extremely unpopular, but it did demonstrate that people who are sexually attracted to males are more feminine, vocally, than people who are attracted to females.

I don't know if you're just doing surveys or if you're up for some practical applications of "The Transsexual Voice", but I have pretty decent control over my vocal tract and can demonstrate just about everything you'd ever study in class -- if you need to bring someone in for "Show and Tell" some day.

P, Email #1
First, I found your term "speech therapy" to be misleading. I think of speech therapy as better enunciation, to get rid of a lisp or New York accent. Instead, I underwent "voice therapy" to get a higher pitch and better cadence. I never tell anyone that I underwent speech therapy but I do tell people that I underwent voice therapy. So I wonder how many people didn't even look at your survey because they felt the same way as I first did.

Finally, my voice therapy was money really well spent and as a social worker I tell others that voice therapy should come ahead of any surgeries or hormonal therapy. So I would have liked to seen a survey question where you ask your population to rank voice therapy in importance as compared to hormonal therapy, implants, SRS and electrology. My guess is that it would rank near the bottom. Then ask the same question of the professional community and compare the results. That would really be illuminating!

P, Email #2
Unfortunately you are right that most trans women are hell-bent to start hormones, then implants and then SRS all the while still shaving and talking like men. I don't get it.

I give three and six hour CEU workshops on gender variance and when I talk about the "real life experience" I tell my audiences that it should include the trans woman having a circle of genetic girl friends and being able to stand five minutes in a women's bathroom line and handle this truely unique female experience. You can't do either with a deep voice. But I'm preaching to the choir.

M, Email #1
I received this thru a member of Transgender Education Network of Texas. I was going to take the survey, however when I brought it up realized it is only for MtF transpersons. Is there a reason for this? I know many FtM's who have required or sought voice therapy, especially those who were vocalists. While the journey is different in many aspects the needs in most areas are still similar. I have a feeling the thinking is that female bodied men may not need this particular avenue and rely totally on the effects of testosterone to bring about the changes in the voice that are needed. In reality this is not always true especially for the older person who starts the transition process. I thought I would point this out and perhaps dispel some of the myth of this situation.

While there is a natural deepening of voice with the use of testosterone, most FtM's I have met have the same sort of intonation qualities which do not mimic those of male bodied men. This sometimes is a high clocking (outing) area and there are some of us that do worry about this especially when talking on a telephone.

Good luck with the survey and I do hope it helps to reestablish a service that is very important and especially if it allows grant monies to help provide this needed service to individuals that otherwise would not be able to avail themselves to this service.

Appendix F: Consent Form

IRB APPROVED ON: 02/04/2010 EXPIRES ON: 02/03/2011 Cover Letter for Internet Research

You are invited to participate in a survey, entitled "The Male to Female Transgender Voice Client of the 21st Century." The study is being conducted by Erika Bodoin, B.S. from the Communication Sciences and Disorders department of The University of Texas at Austin, 1 University Station A1100, Austin, Texas 78712-0114, (512) 232-9426, ebodoin@mail.utexas.edu.

The purpose of this study is to examine **the needs of the transgender voice client**. Your participation in the survey will contribute to a better understanding of **how speech-language pathologists can best serve the transgender community.** We estimate that it will take about **ten minutes** of your time to complete the questionnaire. You are free to contact the investigator at the above address and phone number to discuss the survey.

Risks to participants are considered minimal. There will be no costs for participating, nor will you benefit from participating. Identification numbers associated with email addresses will be kept during the data collection phase for tracking purposes only. A limited number of research team members will have access to the data during data collection. This information will be stripped from the final dataset.

Your participation in this survey is voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time without penalty. If you wish to withdraw from the study or have any questions, contact the investigator listed above.
If you have any questions or would like us to email another person for your institution or update your email address, please call **Erika Bodoin** at (512) 232-9426 or send an email to **ebodoin@mail.utexas.edu.** You may also request a hard copy of the survey from the contact information above.

To complete the survey, click on the link below:
https://www.surveymonkey.com/s/5TH77HZ The password for the survey is **voice**
This study has been reviewed and approved by The University of Texas at Austin Institutional Review Board. If you have questions about your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact - anonymously, if you wish - the Institutional Review Board by phone at (512) 471-8871 or email at orsc@uts.cc.utexas.edu.

IRB Approval Number: **2009-12-0083**

If you agree to participate please follow the link above and answer "yes" to the question on the first page, otherwise use the X at the upper right corner to close this window and disconnect.

Thank you.

Appendix G: Review of General Terminology

Variance exists in the use of terms used to describe transgender persons and related issues, both within and outside of the transgender community, and it is best not to make assumptions about the use of such terms in relation to specific transgender persons. In fact, there is a broad spectrum of transgender people who may or may not identify with commonly used labels applied to transgender people. Thus, the following terms and their related definitions should be used as a guide only with acknowledgment that some of the terms and how they are defined are subject to variability. A person's *assigned sex* is defined as the biological sex. *Male* and *female* are terms used to describe a person's sex. *Gender*, on the other hand, refers to socially constructed roles that a given society deems appropriate for men and women (World Health Organization, 2010). In Western cultures, where gender is binary, the terms *masculine* and *feminine* are used. *Gender dysphoria* or *gender identity disorder* are medical diagnostic terms to describe what occurs when a person's *gender identity* (e.g. feeling of being male or female) differs from their assigned sex. *Transgender* is an umbrella term used to describe people who express their gender in a way that differs from societal norms, and can include a vast range of other-gendered identities and behaviors, including drag (dressing as the opposite sex for the purpose of performing) and gender-bending ("borrowing" various aspects of the opposite sex without self-identification as other-gendered). *Transsexual* generally refers to transgender people who have either had sex reassignment surgery or who are living as their desired gender. The term *transsexual* is often used interchangeably with *transgender*, although the gay, lesbian, bisexual and transgender (GLBT) community

most often uses *transgender* to describe people who identify with a gender other than their assigned gender and is considered the preferred term ("Transgender Glossary of Terms," n.d.). *Passing* is a term to describe convincingly appearing as the opposite sex to people who are unaware of the person's assigned sex. Another term that is frequently used specifically for male-to-female transgender persons to describe passing is *being ma'amed*. Being perceived as their assigned sex, in which the male-to-female transgender person is viewed as male is often referred to as *being read, getting sir'ed*, or *getting clocked* (Adler, 2006; Eyre, Guzman, Donovan, & Boissierre, 2004). Getting "clocked" can also result in the transgender person becoming aware that she has been clocked, which is called *reverse clocking* (Eyre, Guzman, Donovan, & Boissierre, 2004). *Cisgender* refers to a non-transgender person, meaning the person's assigned gender at birth and gender identity is aligned ("Glossary of Gender," 2010).

Appendix H: Table of Participants

Table 2. List of participants and characteristics

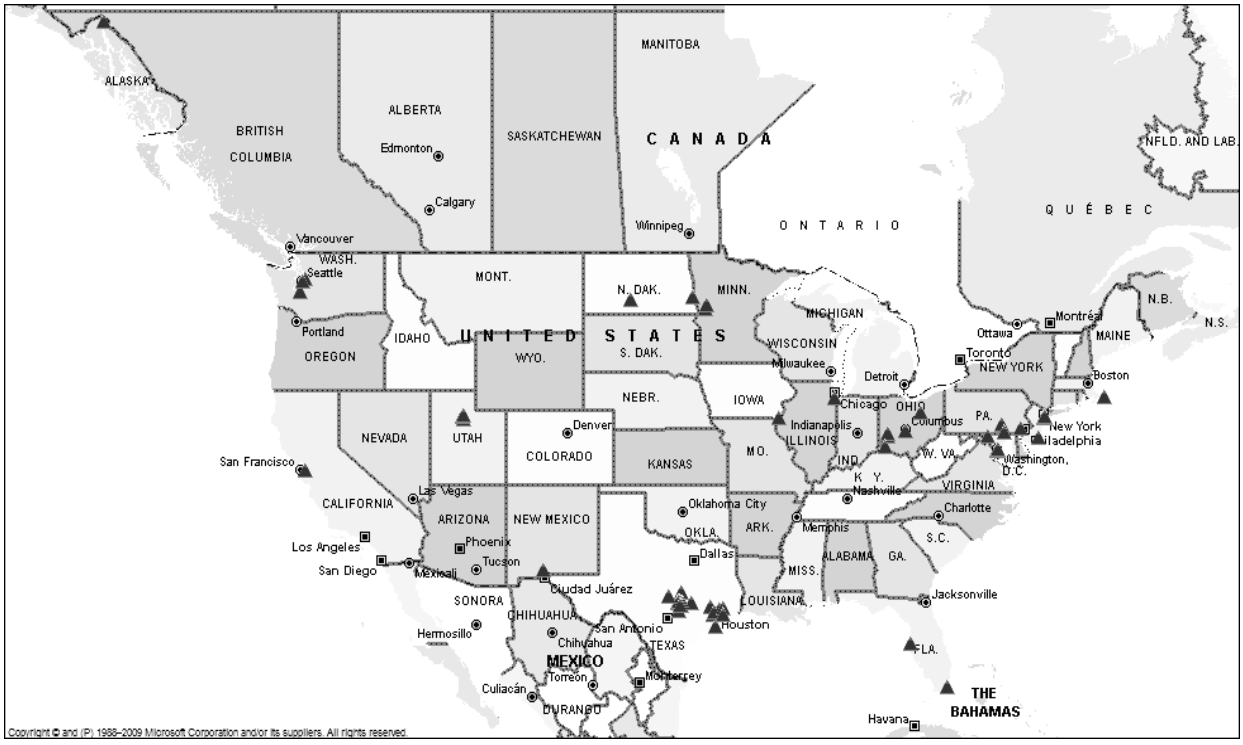
ID	GI	SO	Spch Tx	DOB	Age of CP	Zip Code	Times married	# of children	Level Ed.
1	F	L	No	05/12/1964	--	78758	Once	2	College
2	F	B	No	06/16/1951	--	78947	Twice	1	HS
3	F	B	No	10/02/1949	--	78722	3 or more	1	College
4	F	L	No	03/19/1962	--	78728	3 or more	1	College
5	F	L	No	10/11/1948	--	78660	Twice	4+	Grad/Pro
6	F	L	No	05/18/1962	--	78613	Never	0	College
7	F	L	Yes	01/27/1966	--	77042	Never	0	Grad/Pro
8	F	Asexual	No	10/21/1950	--	77522	3 or more	2	Grad/Pro
9	F	L	No	09/13/1940	54	77086	Twice	0	College
10	F	L	No	10/25/1952	49	77027	Once	0	College
11	F	L	No	07/29/1968	30	77082	Never	0	College
12	F	B	No	07/28/1936	50	77353	Once	0	College
13	F	B	Yes	07/31/1942	55	77098	Once	2	College
14	TG	L	Yes	09/10/1965	42	76548	Once	3	College
15	F	L	Yes	01/11/1959	40	78723	Twice	0	Grad/Pro
16	TG	B	No	02/09/1958	n/a	78640	Once	2	HS
17	F	L	No	05/19/1959	47	34683	Once	2	Grad/Pro
18	TG	L	No	06/18/1946	48	77345	Twice	2	College
19	TG	B	No	08/12/1950	n/a	52627	3 or more	3	Grad/Pro
20	F	L	No	06/10/1955	n/a	17356	Twice	3	College
21	TG	H	No	09/13/1966	42	19460	Once	1	Grad/Pro
22	TG	B	No	11/29/1945	35	60643	Once	3	College
23	TG	B	No	12/06/1972	n/a	77006	Once	0	Grad/Pro
24	TG	Pan/Fem	No	09/07/1939	n/a	77042	Once	2	College
25	F	L	No	12/27/1957	40	77535	3 or more	2	HS
26	GQ	B	No	02/04/1957	47	78703	Once	0	Grad/Pro
27	F	L	No	05/30/1980	27	77566	Once	0	Grad/Pro
28	TG	B	No	11/04/1957	n/a	76548	3 or more	3	College
29	F	H	No	11/29/1968	37	17109	Once	3	College
30	F	L	No	11/07/1942	53	78256	Once	2	College
31	F	L	No	10/06/1965	43	98107	Once	0	College
32	F	L	No	--	31		Never	0	HS
33	F	Pan	No	07/26/1985	20	11232	Never	0	HS
34	TG	L (NI)	No	03/08/1953	53	78609	Once	0	Grad/Pro
35	F	L	No	03/12/1979	26	94610	Never	0	HS
36	F	H	Yes	08/20/1934	69		Once	3	College
37	F	L	Yes	02/07/1979	27	20010	Never	0	Grad/Pro
38	F	H	Yes	12/15/1980	12	98498	Twice	0	Grad/Pro
39	My gender	L	No	09/17/1986	20	20017	Never	0	HS
40	GQ	Q	No	11/17/1950	n/a	10301	Never	0	College

41	F	L	Yes	11/10/1950	54	22201	Never	0	HS
42	TG	L	No	01/02/1948	n/a		Once	2	College
43	TG	L	No	10/04/1967	32	56537	Never	0	College
44	F	H	Yes	03/24/1948	55	58554	Once	3	College
45	TG	B	No	07/10/1947	39	78751	Once	0	College
46	TG	Pan/Fem	No	11/14/1968	40	45405	Twice	1	College
47	TG	celibate	No	05/27/1957	52	--	Twice	2	HS
48	TG	L	Yes	08/14/1947	55	58078	3 or more	4+	College
49	F	L	No	--	21	--	Once	2	College
50	F	B	No	11/15/1975	34	45230	Never	0	College
51	F	H	Yes	07/29/1959	16	78734	--	1	HS - DNC
52	TG	B	Yes	09/21/1958	n/a	--	Twice	4+	College
53	F	B	Yes	--	47	--	Twice	3	Grad/Pro
54	TG	B	No	11/14/1946	28	78703	Twice	2	Grad/Pro
55	F	Pan	No	03/31/1982	25	43215	Never	0	Grad/Pro
56	F	L	Yes	07/01/1955	n/a	44287	Never	2	
57	F	H	No	03/27/1950	31	99840	Once	2	Grad/Pro
58	TG	L (NI)	No	05/27/1951	45	98199	Once	2	College
59	F	H	No	04/22/1951	19	33189	Once	1	Grad/Pro
60	F	L	Yes	08/05/1991	18	84103	Never	0	HS
61	TG	B	No	03/30/1957	n/a	21742	Once	3	HS
62	F	Pan	No	01/31/1956	50	84105	Once	0	College
63	F	L	Yes	05/18/1955	20	10012	Once	0	College
64	F	L	No	02/21/1953	53	84094	Twice	2	HS
65	F	L	Yes	05/21/1959	50	56534	Twice	4+	Grad/Pro
66	F	L	No	10/04/1951	44	45449	Once	2	College
67	F	B	No	--	28	--	Never	0	Grad/Pro
68	F	L	No	04/24/1974	35	78681	Once	2	College
69	F	B	No	10/01/1983	24	88011	Never	0	College
70	F	L	No	09/14/1981	28	71854	Once	1	HS
71	F	B	Yes	03/29/1981	26	84119	Once	2	HS
72	F	H	No	04/12/1983	19	99901	Once	1	HS
73	TG	L	Yes	01/23/1974	27	84123	Never	0	College
74	F	L	Yes	04/08/1982	26	84120	Never	0	HS
75	F	H	Yes	09/17/1972	25	21061	Never	0	Grad/Pro
76	F	H	No	09/28/1988	19	84070	Never	0	HS
77	GQ	B	No	02/09/1989	20	44074	Never	0	College

Abbreviations: ID = participant number; GI = Gender Identity; SO = Sexual Orientation; CP = Clinical Presentation; ; Spch tx = Speech therapy; Ed. = Education; TG = Transgender; F = Female; GQ = Genderqueer; L = Lesbian; NI = Non-identified; B = Bisexual; H = Heterosexual; Pan = Pansexual; HS = High school; Grad/Pro = Graduate or Professional School , n/a = nonapplicable

Appendix I

Illustration 1. Participant location by zip code – triangle represents participants



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Vita

Erika Bodoin was born in Washington State and moved to Austin, Texas in 2000. Once in Texas, she met and married the love of her life and began attending the University of Texas. The GLBT Civil Rights movement is an issue near and dear to her heart, as is the unique journey of the transgender person. She is a published writer of nonfiction as well as fiction. Her most recent work was published in *Learning to Love You More* by Miranda July. She is an avid follower of the Slow Food Movement and has published essays in food blogs and magazines. She loves chasing her two-year-old daughter around and encouraging her to defy binary gender stereotypes.

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This thesis was typed by Erika Melissa Bodoin.