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The Clinical Profile of the Male-to-Female Transgender Person of the 21st Century

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Transgender is an umbrella term that is used to describe people who express their gender in a way that differs from societal norms (Fenway Health, 2010). Transgender persons who want to live as the gender they identify with endure several physical and emotional transformations, including, but not limited to, their facial structure, style of dress, and verbal and nonverbal communication. Speech-language pathologists (SLPs) can help transgender persons shift their communicative profile in specific ways in order to enhance their presentation as their *true* gender (i.e., the gender the person identifies with but does not physically present as). However, in contrast to the female-to-male transgender person whose use of testosterone contributes to physiological changes in the vocal folds that result in a significant decrease in pitch, the use of estrogen by male-to-female transgender persons does not alter pitch, leaving this population more vulnerable to being perceived as their natal, rather than true, gender. Thus, the need for speech treatment to facilitate perception as their true gender is likely significantly higher within the male-to-female transgender community.

ABSTRACT: **Purpose**: The purpose of the present study was twofold: (a) to investigate whether the demographic characteristics of the male-to-female transgender person have changed over the past 2 decades given the increased awareness and tolerance of transgender persons in today's society and (b) to determine if there are additional characteristics that may be unique to the transgender clinical profile of today.
Method: A 28-question survey (N = 77 respondents in final data corpus) that was developed to address the authors' research questions was distributed via e-mail to various listservs and organizations for transgender persons.
Results: Male-to-female persons of today, at least in terms of basic demographics, are markedly similar to the profile described almost 2 decades ago relative to age, marriage, and children. They also continue to be highly motivated to attain a feminine presentation, with many reporting that they avoid communicative interactions and everyday activities for fear of being perceived as male. In addition, many are not aware that speech therapy for transgender-related goals exists. However, for those who have had speech therapy, the satisfaction reported is higher than with alternative methods of achieving feminine presentation such as watching YouTube videos.
Conclusion: Preliminary results revealed some similarities and also novel insights that will further enhance our ability to meet the needs of the male-to-female transgender client.

KEY WORDS: transgender, feminine presentation, gender identity, male to female

According to the American Speech-Language-Hearing Association (ASHA) Code of Ethics (Principles of Ethics I Rule C), "Individuals shall not discriminate in the delivery of professional services… on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability" (ASHA, 2010). The Knowledge and Skills document describes the need for SLPs to become culturally competent and culturally sensitive. Therefore, SLPs are ethically obligated to be educated about the needs of transgender clients (Adler, Hirsch, & Mordaunt, 2006).

The purpose of the present study was twofold: (a) to investigate whether the demographic profile of the male-to-female transgender person has changed over the past two decades given the apparent shift in both awareness and acceptance of transgender persons and (b) to determine if there are additional characteristics (i.e., gender identity, sexual orientation, feminine presentation, and their knowledge of and satisfaction with therapeutic options) that are unique to the clinical profile of the transgender client of today.

Past Versus Present Demographic Profile

Over the past 50 years, there has been a surge in the awareness of and support for transgender persons. In the early 1960s, Dr. Harry Benjamin, considered the "grandfather" of transgenderism, wrote and published the first book on transgenderism, *The Transsexual Phenomenon* (1966). Two decades later, he founded the Harry Benjamin International Gender Dysphoria Association (recently renamed the World Professional Association for Transgender Health [WPATH]) to promote standards of care for transgender persons. Within that same time frame, the gay lesbian bisexual transgender (GLBT) movement was initiated to enact antidiscrimination laws regarding gender and sexual orientation. Additionally, the National Center for Transgender Equality, a national advocacy group for transgender people, was developed to further 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; "America's Next Top Model"), and highly regarded mainstream talk shows such as "The Oprah Winfrey Show." Taken together, the development of WPATH, the GLBT civil rights movement, and the appearance of transgender people in popular culture may have changed the face of this clinical population. That is, the transgender person of today may differ from the transgender person of yesteryear.

Almost two decades ago, Blanchard (1994) examined 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. Results revealed that the average age of the transgender person at clinical presentation was 35 (Blanchard, 1994). Results further revealed that 68% of the participants had been married at least once, and 45% of the participants reported having at least one child.

In contrast to past research, at present, the average age of the transgender person at clinical presentation may be much younger than 35 given the aforementioned changing political climates and heightened awareness of both the nature of gender identity and transgenderism. Thus, the transgender person of today may self-identify as being part of the transgender community and may have begun the process of clinical intervention (e.g., counseling, hormone treatment, etc.) at an earlier age and, subsequently, may also seek speech treatment services at a much younger age.

In addition to age, the marital status of transgender persons may no longer be in line with previous findings. The pressure to marry as a primary means to reject or conceal 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 his or her true gender identity rather than attempt to hide his or her gender identification through veiled efforts such as marriage.

The number of children that was documented in past research and attributed to the denial of true gender identity may also no longer exist. Transgender parents are now more commonly seen 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. There are also several online resources that are currently available to transgender parents, including listservs and organizations such as 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 prior to transition. Thus, the typical transgender client who seeks treatment services may either have never had children with a person of the opposite sex or may have had children, but may have done so with a person who was/is accepting of their transgenderism.

Additional Factors That May be Characteristic of the Transgender Clinical Profile

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). However, because of heightened awareness of transgender issues, as well as recent changes in public policy that protect transgender persons from discrimination based on gender identity or expression, it is possible that the need for speech treatment to increase feminine presentation has lessened over time. Nevertheless, for those who, at present, would desire to seek speech treatment, there are additional factors that may influence that choice. These factors include but are not limited to gender identity, sexual orientation, self-perception of feminine appearance, and knowledge of and satisfaction with therapeutic options.

Gender identity. Male-to-female transgender persons may identify as female, transgender, or genderqueer, among others. An analysis of gender identity could reveal specific differences in terms of a transgender person's participation in speech treatment. 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 and, consequently, may be less likely to seek speech treatment. We aim to extend past research regarding the clinical profile of transgender persons by examining whether the person's gender identity uniquely influences his or her decision to seek speech treatment.

Sexual orientation. Similarly, sexual orientation may influence the degree to which the transgender person desires to appear feminine and, subsequently, her motivation/perceived need for treatment. Perceptions of femininity in lesbian communities may differ from perceptions of femininity among heterosexual males (Laird, 2000; Weston, 1996), although obviously, variation would also exist within groups. For example, 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 identities in a romantic partner than a heterosexual male would. In other words, if the transgender person is in a lesbian relationship, she may be less likely to seek treatment to increase her feminine presentation.

Feminine presentation. A person's feminine presentation may also uniquely influence whether she will seek treatment. Perhaps the more vulnerable the person feels about being clocked (i.e., exposed as the biological sex), the more the person will be motivated to alter aspects of self in order to successfully pass as a female. On the other hand, it is also possible that if society is in fact more accepting, it may be that the increased ability to "pass" as a female is no longer a motivating factor for seeking treatment.

Knowledge of therapeutic options. Finally, the person's awareness of the existence of speech treatment would undoubtedly contribute to participation. Speech treatment for transgender persons can include voice treatment such as altering pitch, with supplementary strategies such as nonverbal communication (e.g., maintaining eye contact during conversation, nodding while listening to communication partner, etc.) and strategies for using speech and word choices that are more likely to be used by women (e.g., using interjections, fewer interruptions of communication partner, etc.) (Adler et al., 2006; Tannen, 1990). Currently, however, there are a number of alternative resources available on the Internet that may be considered by transgender persons to be more affordable and more accessible than working with an SLP. These resources can be found by using Google search using words such as "transgender voice lessons," "transgender voice therapy," and "voice feminization." Some of these resources are free (YouTube) and others are relatively inexpensive, ranging from $25 to $60 for CD or DVD sets.

To our knowledge, there has been only one published study that has examined the relationship between participation in voice treatment and the transgender client's level of satisfaction (McNeil, Wilson, Clark, & Deakin, 2008). Although uniquely informative, the study was limited to only 12 transgender persons and assessed their satisfaction after speech treatment exclusively. Further, there has been no published study regarding the transgender person's awareness of the possibility of speech treatment. For the present study, we wanted to explore both the person's awareness of and satisfaction with speech treatment in comparison to alternative resources.

Collecting data that identify the demographics and interests of transgender persons is challenging. One of the most significant challenges is the typically secretive (i.e., closeted) nature that is characteristic of transgender life: 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 persons who have shared traits: transgender persons who have sought sexual reassignment surgery, transgender persons who were HIV positive and could be contacted via the clinic through which they sought services, or politically active transgender persons who are more visible to mainstream society (Rosser, Oakes, Bockting, & Miner, 2007). Thus, we chose a web-based survey for

our methodological approach as the Internet seems to provide the ideal 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.

In summary, the clinical profile of the male-to-female transgender person two decades ago may have been reflective of the lack of societal acceptance. Specifically, the typical client was reportedly 35 years old at the time of clinical presentation, had been married at least once, and had one or more children (Blanchard, 1994). However, these demographic characteristics may no longer be descriptive of the typical male-to-female transgender client as several important changes have occurred over the past decade that have resulted in a society that is more aware and increasingly more tolerant of gender variance. Thus, in addition to identifying current demographics of the transgender person, we aimed to further our understanding of factors that might uniquely influence the transgender person's desire to participate in speech treatment. Within this context, we posed the following questions:

- Are the previously cited demographic characteristics regarding age, marital status, and number of children applicable to the male-to-female transgender client of today?
- What is the current profile of the transgender client of today with regard to gender identity, sexual orientation, feminine presentation, and knowledge of and satisfaction with therapeutic options?

METHOD

The questions on the survey were generated by the authors in order to allow for an understanding of how the past demographic characteristics compare to the transgender client of today and to allow for exploration of whether these characteristics as well as additional ones are unique to the transgender person who seeks speech treatment. A focus group of male-to-female transgender persons (N = 3; ages = 37, 58, 61) was asked to complete the survey online and was encouraged to make suggestions for changing the survey. This pilot was completed to ensure that the survey was clear and comprehensible to the target group and that the questions were not likely to be 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. In addition, a review of responses to the pilot survey revealed terminology specific to the transgender community that we decided would be important to include in the final survey. The final survey that was administered to participants in the present study is provided as Appendix A.

Participants

Participants 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. (Appendix B provides the 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 knew.

The survey was hosted via the SurveyMonkey website (www.surveymonkey.com). Voluntary enrollment was facilitated by using an informed consent preamble that contained text approved by the University of Texas at Austin Institutional Review Board, 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. Users who did not select yes could not advance to the survey. In total, 98 individuals advanced to the survey. However, there were specific criteria that had to be met in order for an individual to be included in the final participant pool for this study.

Participants were excluded based on any one of the following: They indicated that their assigned sex was female, they identified as male, they did not provide an answer for their assigned sex or gender identity, or they failed to respond to multiple questions at the end of the survey. Four respondents indicated that their assigned sex at birth was female and they identified as male, five respondents indicated that their assigned sex was male and they identified as male, eight respondents did not advance to questions beyond the initial consent question, and four respondents did not complete the final page. Thus, in total, 21 of the 98 respondents were excluded from participation.

Seventy-seven of the 98 respondents (M_{age} = 33; age range = 18–75) met the criteria for inclusion in the study. Table 1 presents the demographic characteristics of these 77 participants. The majority (n = 55) of participants indicated membership in one or more transgender or GLBT political or support groups, which was not surprising because participants were recruited through these organizations. Participants

Table 1 (p. 1 of 2). List of study participants and their demographic characteristics.

ID	*GI*	*SO*	*Spc Tx*	*Age of CP*	*Times married*	*# of children*	*Ed. level*
1	F	L	No	—	Once	2	College
2	F	B	No	—	Twice	1	HS
3	F	B	No	—	≥3	1	College
4	F	L	No	—	≥3	1	College
5	F	L	No	—	Twice	4+	Grad/Pro
6	F	L	No	—	Never	0	College
7	F	L	Yes	—	Never	0	Grad/Pro
8	F	Asexual	No	—	≥3	2	Grad/Pro
9	F	L	No	54	Twice	0	College
10	F	L	No	49	Once	0	College
11	F	L	No	30	Never	0	College
12	F	B	No	50	Once	0	College
13	F	B	Yes	55	Once	2	College
14	TG	L	Yes	42	Once	3	College
15	F	L	Yes	40	Twice	0	Grad/Pro
16	TG	B	No	—	Once	2	HS
17	F	L	No	47	Once	2	Grad/Pro
18	TG	L	No	48	Twice	2	College
19	TG	B	No	—	≥3	3	Grad/Pro
20	F	L	No	—	Twice	3	College
21	TG	H	No	42	Once	1	Grad/Pro
22	TG	B	No	35	Once	3	College
23	TG	B	No	—	Once	0	Grad/Pro
24	TG	Pan/Fem	No	—	Once	2	College
25	F	L	No	40	≥3	2	HS
26	GQ	B	No	47	Once	0	Grad/Pro
27	F	L	No	27	Once	0	Grad/Pro
28	TG	B	No	—	≥3	3	College
29	F	H	No	37	Once	3	College
30	F	L	No	53	Once	2	College
31	F	L	No	43	Once	0	College
32	F	L	No	31	Never	0	HS
33	F	Pan	No	20	Never	0	HS
34	TG	L (NI)	No	53	Once	0	Grad/Pro
35	F	L	No	26	Never	0	HS
36	F	H	Yes	69	Once	3	College
37	F	L	Yes	27	Never	0	Grad/Pro
38	F	H	Yes	12	Twice	0	Grad/Pro
39	My gender	L	No	20	Never	0	HS
40	GQ	Q	No	—	Never	0	College
41	F	L	Yes	54	Never	0	HS
42	TG	L	No	—	Once	2	College
43	TG	L	No	32	Never	0	College
44	F	H	Yes	55	Once	3	College
45	TG	B	No	39	Once	0	College
46	TG	Pan/Fem	No	40	Twice	1	College
47	TG	Celibate	No	52	Twice	2	HS
48	TG	L	Yes	55	≥3	4+	College
49	F	L	No	21	Once	2	College
50	F	B	No	34	Never	0	College
51	F	H	Yes	16	—	1	HS - DNC
52	TG	B	Yes	—	Twice	4+	College
53	F	B	Yes	47	Twice	3	Grad/Pro
54	TG	B	No	28	Twice	2	Grad/Pro
55	F	Pan	No	25	Never	0	Grad/Pro
56	F	L	Yes	—	Never	2	

Table 1 (p. 2 of 2). List of study participants and their demographic characteristics.

ID	*GI*	*SO*	*Spc Tx*	*Age of CP*	*Times married*	*# of children*	*Ed. level*
57	F	H	No	31	Once	2	Grad/Pro
58	TG	L (NI)	No	45	Once	2	College
59	F	H	No	19	Once	1	Grad/Pro
60	F	L	Yes	18	Never	0	HS
61	TG	B	No	—	Once	3	HS
62	F	Pan	No	50	Once	0	College
63	F	L	Yes	20	Once	0	College
64	F	L	No	53	Twice	2	HS
65	F	L	Yes	50	Twice	4+	Grad/Pro
66	F	L	No	44	Once	2	College
67	F	B	No	28	Never	0	Grad/Pro
68	F	L	No	35	Once	2	College
69	F	B	No	24	Never	0	College
70	F	L	No	28	Once	1	HS
71	F	B	Yes	26	Once	2	HS
72	F	H	No	19	Once	1	HS
73	TG	L	Yes	27	Never	0	College
74	F	L	Yes	26	Never	0	HS
75	F	H	Yes	25	Never	0	Grad/Pro
76	F	H	No	19	Never	0	HS
77	GQ	B	No	20	Never	0	College

Note. ID = participant number; GI = gender identity (F = female; TG = transgender; GQ = genderqueer); SO = sexual orientation (L = lesbian; B = bisexual; Pan/Fem = pansexual with a preference for feminine; Pan = pansexual; H = heterosexual; NI = non-identified); Spc tx = speech treatment; CP = clinical presentation; Ed. = education (HS = high school; Grad/Pro = graduate or professional school; DNC = did not complete level of schooling). A line for the answer indicates that the respondent did not answer the question because he or she had not sought clinical treatment.

were also generally located in the northwest, southwest, and northeast regions of the United States, with few or no participants from the midwest or southern regions. (See Figure 1 for identification of geographic locations of specific respondents.)

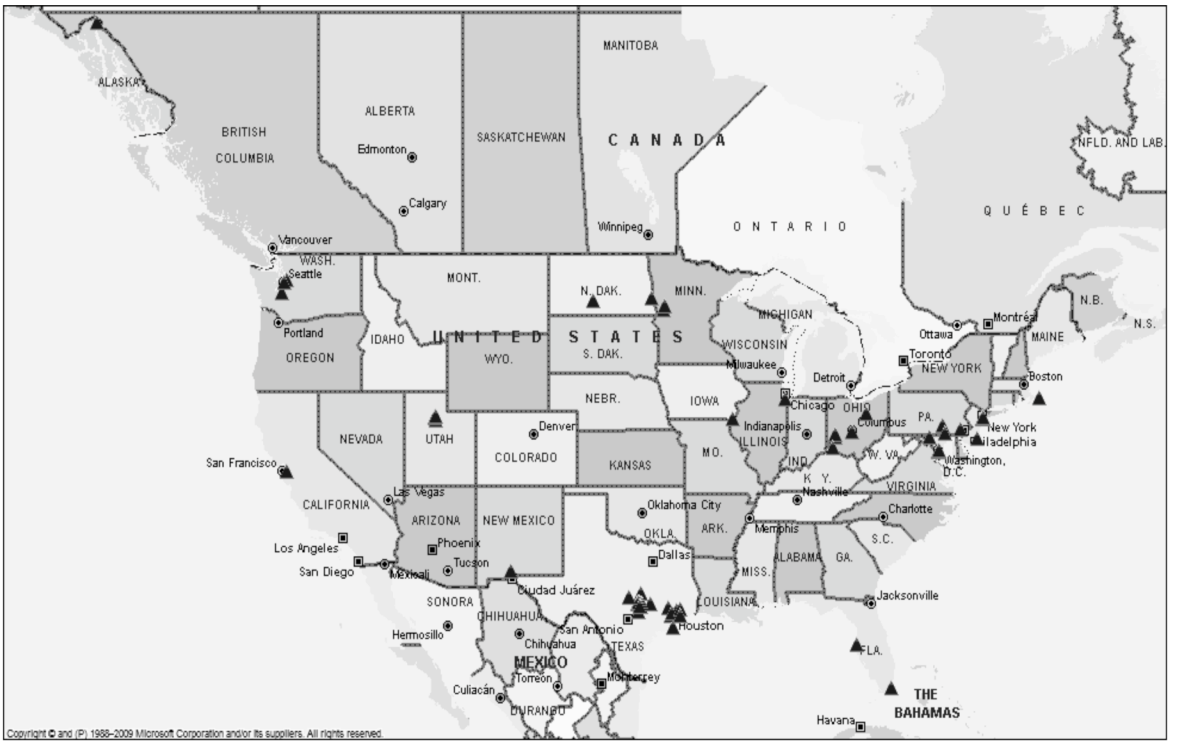
RESULTS

The purpose of the present study was to complete a preliminary exploration into whether or not the profile of the transgender person has changed given the increased awareness and tolerance of transgenderism in today's society. Specifically, we explored demographic characteristics and other factors that might uniquely influence the transgender person's desire to seek speech treatment, including gender identity, sexual orientation, feminine presentation, and knowledge of and satisfaction with therapeutic options. Although there were data from 77 respondents, 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 treatment. See Table 2 for number of responses per item. Thus, the proportions reported in the results for each question are based on the respondent number, not on the total participant number.

Comparison of Male-to-Female Transgender Persons Over Time

The first thing we wanted to know was whether the previously cited characteristics regarding age, marital status, and number of children were applicable to the male-to-female transgender client of today. Fifty-eight of our study's participants reported the age at which they first sought speech treatment. The reported mean age at clinical presentation was approximately 36 years (age range = 18–55). Age at clinical presentation appeared to impact the transgender person's participation in speech treatment. Participants who indicated an older age at clinical presentation were generally more likely to have participated in speech treatment. Specifically, 35% of participants sought clinical intervention after age 41 (n = 23) (mean age at completion of survey = 60; age range = 43–75), whereas only 28% of participants under age 41 (n = 35) (mean age at completion of survey = 34; age

Figure 1. Participant location by zip code (as represented by a triangle).



range = 18–64) reported that they participated in speech treatment.

Approximately 71% (54/76) of the participants indicated that 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). Regarding participation in speech treatment, participants who had never been married were proportionally lower in number (40%, or 6/14) when compared to participants who had been married at least once (60%, or 8/14).

Forty-three out of 77 (56%) participants reported having at least one child. The remaining 34 participants (44%) indicated that they had no children. Nine of the 34 participants with no children participated in speech treatment (26%), and 11 of 42 who reported one child or more participated in speech treatment (26%).

Additional Characteristics Unique to Today's Transgender Client

The second thing we wanted to know was whether there were additional characteristics such as gender identity, sexual orientation, feminine presentation, or knowledge of and satisfaction with therapeutic options that are unique to the clinical profile of the transgender client of today.

Gender identity. Fifty-two of the 77 respondents (68%) identified as female. The remainder 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."

In terms of gender identity and participation in treatment, 14 out of 49 participants who identified as female (29%) received speech treatment for transgender-related goals. Three out of 19 participants (16%) who identified as transgender/genderqueer/my gender participated in speech treatment.

Sexual orientation. Regarding sexual orientation, 49% of the participants identified as lesbian or as attracted to women, and 31% identified as bisexual or pansexual (attracted to all genders). Transgender persons may resist labels or have specific differences from the hetero-normative culture (Stryker, 2008). Thus, an "other" option was offered as a fill-in text box. There were 11 fill-in responses. One respondent indicated that she is "attracted to that which is feminine," one responded as "questioning," one as "asexual," and one as "celibate." Eleven participants (14%) identified as heterosexual or attracted primarily to men.

Table 2. Number of respondents per item.

Item number	*Total # of 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[a]
14	77
15	19[a]
16	20[a]
17	20[a]
18	57
19	14
20	53
21	64
22	76
23	73
24	71
25	76
26	76
27	77
28	77

[a]Skip logic question resulted in fewer respondents.

Participants who identified as heterosexual had a higher proportion of respondents who had received speech treatment for transgender-related goals (40%, or 4/10). Thirteen out of 59 participants (22%) who identified as lesbian, bisexual, or pansexual received speech services, and the remaining four participants, who identified as attracted to that which is feminine, questioning, asexual, or celibate, had not participated in speech treatment.

Feminine presentation. Participants rated being perceived as feminine as very important (M = 4.23 on a scale of 1 to 5). In terms of feminine characteristics, physical appearance received the highest rank in importance (M = 4.27 on a scale of 1 to 5) and feminine voice the second highest (M = 4.25). Nonverbal communication (M = 4.08) and vocabulary use (M = 3.94) were ranked slightly lower in importance. The large majority of persons who reported that they had received treatment (15/21; 78%) reported that they had done so in order to improve their feminine presentation.

Knowledge of therapeutic options. Fifty-six of the 77 participants reported that they had not sought speech treatment as a method to increase feminine presentation. A variety of answers were given as to why the participants had not sought speech treatment. Affordability was the primary reason overall for not seeking speech treatment, with 15 of 56 participants (27%) reporting cost of services as a factor. No prior knowledge of availability was another factor for not seeking speech treatment for 12 of 56 (21%) participants. Eleven participants (20%) indicated the use of alternative methods such as CDs or online programs for increasing femininity. Seven participants (13%) reported doubts about speech treatment results, six participants (11%) indicated that speech services were not available in the area, and four participants (7%) indicated that they had simply not had the chance to pursue speech treatment yet. One participant reported being denied services because the SLP was not familiar with treatment approaches for transgender persons.

Satisfaction with treatment. Fifteen respondents who received speech treatment for transgender-related goals rated their satisfaction on a 1–3 point scale using multiple choice answers indicating their satisfaction level as *minimally or not at all, moderately,* or *very satisfied*. Overall, the 15 respondents' satisfaction ratings averaged 2.53 on a scale of 1 to 3. Sixty-six percent of the 15 participants who received speech treatment for transgender-related goals indicated that they were very satisfied with their results. 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 impracticality of the program related to distance and cost. One participant indicated minimal or no satisfaction with results. Participants also evaluated the importance of speech treatment relative to transitioning. Forty-eight of the 76 respondents (63%) who answered the question indicated that speech treatment is important to transition. Twenty-two respondents (29%) indicated they were not sure, and the remaining six participants (8%) reported that speech treatment was not important to transitioning.

By comparison, 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 the specific method: Online voice programs such as YouTube received an average rating of 1.42 by 19 participants, DVDs and tapes for voice feminization received an average rating of 1.71 by 31 participants, use of friends or mentors in the transgender community received a rating of 1.52 by 29 participants, and counselors received a rating of 2.00 by 19 participants.

DISCUSSION

The present awareness and acceptance of transgenderism appears to be much higher than what it was in the recent past. Thus, we hypothesized that the clinical profile of the transgender client of today would markedly differ from the transgender client in Blanchard's (1994) study. The first objective was to explore whether the demographic profile is comparable to what has been reported previously by Blanchard. The second objective was to determine if there are additional characteristics such as gender identity, sexual orientation, feminine presentation, and/or knowledge and satisfaction with therapeutic options that are also unique to the clinical profile of the transgender client of today.

Comparison of Male-to-Female Transgender Persons Over Time

First, regarding age, we hypothesized that the age of clinical presentation would be younger than that in past research, but the age was comparable (even slightly older in nature). The mean age of initial consultation for the present study was 36 (range = 18–55), which is comparable to the past report of 34 (Blanchard, 1994). 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 and may need assistance from them 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 based on the fact that increased awareness/tolerance may have influenced an even larger number of older transgender persons to transition. On the other hand, the minimum age to complete this survey was 18 years, and as a result, the range did not include transgender persons who may be in transition at a younger age. That being said, the transition process may be as difficult now as it was over almost 2 decades ago. 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.

The percentage of transgender persons who reported at least one marriage was also comparable to that of past research (Blanchard, 1994). However, our question related to marital status did not specify the sex of the spouse. At the time that this study was completed, marriage between same-sex persons was legal in five states and the District of Columbia as well as Canada and some European countries. Marriage to women by male-to-female transgender persons is not necessarily uncommon and does not automatically reflect a lack of self-awareness of being transgender or a lack of acceptance of her true gender.

The proportion of male-to-female persons who reported at least one marriage may reflect the fact that some 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, the tendency to marry as a means of rejecting self may also still be prevalent among the transgender population. Future research should provide more specificity to the marriage question such that these considerations can be taken into account.

Similar to age and marital status, the number of children reported in the present study was also comparable to that reported previously (Blanchard, 1994). This could (as was hypothesized in past research) indicate a denial of gender identity. 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, may also be the reason why these participants reported having children.

Researchers have estimated that there are 2–8 million gay or lesbian parents in the United States (Falk, 1989). 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). In addition, the National Survey of Family Growth revealed acceptance of gay and lesbian adoptive parents by the majority of respondents, particularly among younger respondents (Martinez, Chandra, Abma, Jones, & Mosher, 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. In other words, the number of children in the transgender clinical profile of yesteryear compared to that of today is comparable in number but may differ in nature because in the past, transgender persons may have had children as a means to reject self, whereas in the present, they may be having children because as a transgender person, this is no longer an act that would be considered taboo.

Additional Characteristics Unique to Today's Transgender Client

Gender identity and sexual orientation. Our study results revealed that more transgender clients who identified as female had received speech treatment for transgender-related goals as compared to other types of transgender clients. Participants who identified as transgender or genderqueer appeared slightly less likely to have participated in speech treatment. The term genderqueer is generally used as a distinction from binary gender identity (Stryker, 2008).

Sexual orientation also appeared to be a factor in speech treatment 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 treatment 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 treatment.

Reasons for the higher proportion of heterosexual-identified participants who have received speech treatment 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, March 2, 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 showed that gender identity and sexual orientation do not exclude interest in feminine presentation and/or interest in receiving speech services for transgender-related goals.

Feminine presentation. Overall, respondents who had participated in speech treatment reported higher levels of satisfaction with their feminine presentation than those who had not participated. 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" or rather distinct indicators of gender at birth) 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 the level of investment in or being proactive about achieving a more feminine presentation.

In addition to level of expectation and motivation, the physical appearance and other factors related to feminine presentation that the transgender person may or may not possess prior to transitioning could impact his or her satisfaction with speech treatment. 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 possible that male-to-female transgender persons who already present as more female are more satisfied with their feminine presentation prior to participating in speech treatment. On the other hand, working with a speech therapist may increase a transgender person's level 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 treatment results in increased overall satisfaction with a transgender person's femininity. Future research should consider exploring the transgender person's perception of physical self with the likelihood to both seek speech treatment and report satisfactory results.

Knowledge of therapeutic options. Many participants stated that they were not aware that speech treatment services existed for transgender persons. Further, most participants indicated that they would seek speech treatment services if they were available and/or affordable. In fact, the overwhelming majority of participants indicated that speech treatment is important to transitioning. Nevertheless, participants also reported that there are other expensive services (e.g., hormone treatment, facial reconstructive surgery, etc.) that are more widely available and known to the transgender population. It is possible that the lack of awareness of speech treatment services taken together with doubts about results influences the perception among potential clients that the cost of treatment may exceed the benefits of participation in treatment.

Satisfaction with treatment. Even though there were many participants who were not aware that speech treatment was an option, for those who had participated in treatment, their satisfaction ratings were either moderately satisfied or very satisfied. In contrast, for those participants who had only engaged

in alternative options for increasing feminization, such as the Internet or peer mentors, the satisfactions ratings were either minimal to no satisfaction to moderately satisfied. Unlike with the ratings for speech treatment, no rating of very satisfied was provided by participants for alternative options. This could be because speech treatment 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 treatment 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 treatment in which voice alteration was the only goal. Voice treatment 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 treatment in which other language-based facets of feminine communication are addressed (Adler et al., 2006; Gelfer, 1999; Van Borsel, De Cuypere, & Van den Berghe, 2001). Finally, these ratings were not completed by persons who had both received speech treatment and engaged in alternative methods. Future research wherein such within-subject comparisons could be made would further our understanding of at least the perceived benefit of one approach versus the other.

Unexpected Findings

Nine participants indicated that 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 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 a resource for obtaining a more feminine presentation.

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 may 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; and receiving feedback from others on the phone). Therefore, treatment 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 SLP about techniques she would like to refine that the SLP may not have considered due to a lack of experience as a transgender person.

Female-to-Male Transgender Person Interest

Four of the excluded respondents to the survey indicated that they were female-to-male transgender persons, and one of those respondents e-mailed the first author regarding the exclusion of female-to-male transgender persons. This individual stated that he knew of female-to-male transgender persons who had benefited from voice treatment, and that although hormone treatment 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 that this need for treatment 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 treatment are male to female"). Thus, these comments support the notion that 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 transgender person could provide direction for the SLP and guide the nature of outreach to this frequently overlooked population.

Study Limitations

Internet research, although helpful in studying groups that 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 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, does 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 transoriented organizations to be uniquely attractive to transgender persons and, thus, more likely to have members of varying ages and backgrounds. Nevertheless, membership in such groups may have influenced participant responses. For example, transgender persons who do not belong to such groups may be older, be more isolated, or have decreased interest in group identification on the basis of gender identity and may therefore be less likely to seek speech treatment. Future research should target a wider 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.

Our preliminary exploration of the potential change in the male-to-female profile was limited to comparing our findings to that of Blanchard (1994) because to date, to our knowledge, there have been no similar investigations completed. There were a few limitations with this comparison. Blanchard's study was completed in Canada, and the present study was completed in the United States. Further, the participants in the Blanchard study all sought gender identity services at one clinic. In contrast, the participants in the present study included people who have not presented for services and/or who were from several geographic regions. Therefore, one could argue that any fundamental differences noted may not reflect a valid shift; rather, the differences may instead reflect cultural differences between the United States and Canada. However, the results between the two studies were remarkably similar. Thus, one could more reasonably argue that the male-to-female transgender profile in the United States has not shifted over the past 2 decades, or that the male-to-female transgender profile in the United States is reflective of the profile that was reported in Canada almost 20 years ago. That is, it is possible that we are 20 years behind Canada in our acceptance, or it could be that we are—as present results indicate—markedly similar in our perspective.

Conclusion

These preliminary data suggest that 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. Results further revealed that although many transgender people are not aware that speech treatment for transgender-related goals exists, for those who have had speech treatment, the satisfaction reported is much higher with speech treatment than with alternative methods. Thus, SLPs appear to be uniquely qualified to help the transgender person to enhance and feel confident about her feminine presentation. To increase the awareness and provision of speech treatment services for this population, SLPs should continue to make every effort to reach out to both the male-to-female and the female-to-male transgender community.

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APPENDIX A (p. 1 of 2). TRANSGENDER SURVEY

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? (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) (1 = not important; 2 = minimally important; 3 = moderately important; 4 = important; 5 = very important):
    - ☐ 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 1–6)
    - ☐ 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

APPENDIX A (p. 2 of 2). TRANSGENDER SURVEY

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 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. LIST OF CONTACTS

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Lesbian and Gay Audiologists and Speech Pathologists: faix@yahoo.com

National Center of Transgender Equality (Declined)

Richard Adler: Moorhead University, adlerri@mnstate.edu

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

Transgender Education Network of Texas: www.tentex.org

Transgender Law Organization: query@transgenderlaw.org

TransOhio: www.transohio.org; TransOhio@gmail.com

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

University of North Carolina at Greensboro

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

Utah Pride Center: jenny@utahpridecenter.org