

Giving voice to our transgender clients

Matthew Mills and Gillie Stoneham
on developing competency and
co-working with extraordinary and,
ultimately, ordinary clients

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Last year was a significant year in bringing gender identity and gender variance firmly into the spotlight. The media featured personal narratives: Caitlin Jenner's public transition, Louis

Theroux's thought-provoking 'Transgender Kids' and the death of Vikki Thompson, who committed suicide after being sent to a male prison.

As academics and professionals working in the field of gender dysphoria (GD), 2015 was also a key year for us too. The first conference of the European Professional Association for Transgender Health (EPATH) took place in Ghent in March. Although the group of international SLTs attending the conference was relatively small, the passion for developing an evidence base for transgender voice and communication was palpable. Presentations included post-surgical pitch change, motor learning theory and the essential role of speech and language therapy within multidisciplinary team working. However, our highlight was discovering the commonality in our group therapy and its outcomes, and the particular skill mix we share across speech pathology, vocal pedagogy and psychological approaches.

So began a real commitment to dialogue and co-working to discover how we could share these ideas with specialist colleagues around the UK. Actions have already resulted in the launch of a new clinical excellence network (CEN) and the ongoing process of developing a RCSLT competency framework.

Challenges ahead

Service provision is patchy geographically and there is a need for coordinating the training and clinical experience of SLTs across the UK to work effectively with trans and non-binary clients. The 'Interim NHS England Gender Dysphoria Protocol and Guidelines 2013-2014' tried to address the inequality of patient access and promote nationally-consistent commissioning of specialist services across the UK. 'Speech therapy' is listed as a 'core procedure' and the specification states that everyone diagnosed with GD who requests it should receive it either at their gender identity clinic (GIC) or within a local network speech and language therapy service.

The uneven provision of therapy provision is partly due to the location of GICs and because there are relatively few clinically skilled and experienced therapists. There are local services with senior voice therapists who have developed a great deal of clinical

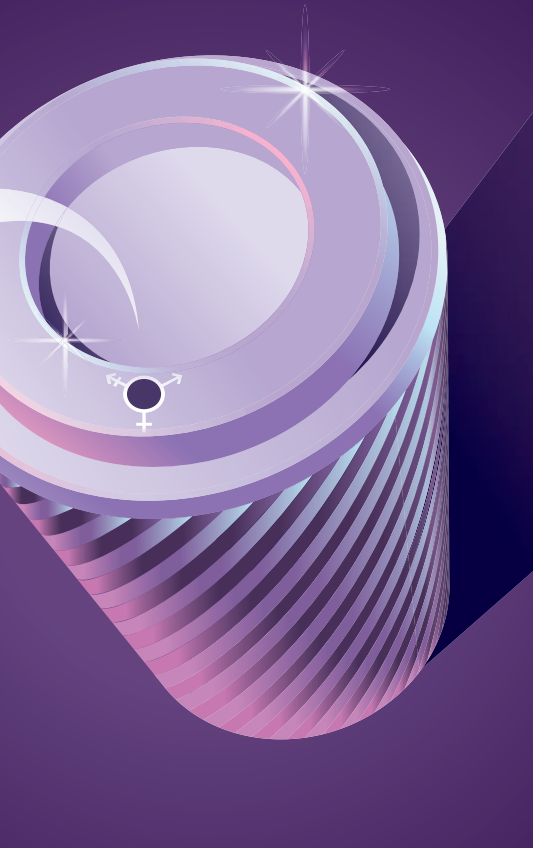
experience working with trans clients. These SLTs may not have regular access or input into a GIC, yet SLTs working with trans clients are recommended to be part of such a specialist multidisciplinary team (Wylie et al, 2014).

Charting new ground

In June 2014, the RCSLT facilitated a working party from which the 'Gender Dysphoria Action Plan' emerged. In December 2015, the British Association of Gender Identity Specialists (BAGIS) celebrated its first birthday. This unique organisation was formed in recognition that multidisciplinary gender specialist clinicians share a cross-fertilisation of knowledge and can unite to define competency, shape care pathways, contribute to the evidence base and be at the forefront of current debate. At its first scientific meeting in September 2015, our 'Voice and Communication' presentation was at the heart of the conference and delivered to an international audience of multi-specialists.

Theory of change modelling with RCSLT colleagues focused us to form the new National Transgender Voice and Communication Therapy CEN in October 2015 and 50 UK-wide SLTs attended its inaugural meeting in February 2016 - 'Sharing skills and developing as a gender





GIC in England. With CEN members we workshopped a competency framework and the RCSLT currently has a draft version which describes three levels (developing, established and highly competent). This will proceed to profession-wide formal consultation. At the March 2016 Gender Symposium in London, commissioners described this growing body of work done by the RCSLT as ‘trail blazing’.

The nature of change

Our aim is to facilitate gender expression through vocal and communicative style changes for trans men, trans women and non-binary clients, since the significant distress related to GD causes psychosocial withdrawal and a lack of participation in communication at all levels. Studies indicate speech and language therapy is effective for trans clients (Gelfer and Tice, 2013). ‘Voice and communication therapy’, our preferred nomenclature, is partly underpinned by the vocal pathology evidence base, but trans people do not have ‘disordered’ voices in and of themselves; they may present with hyperfunction, which needs to be treated before modification (Taylor-Goh, 2005).

Voice change is not an easy process, and not about adopting stereotypes, but as experienced SLTs we see, hear and witness that change is possible. Clients tell us how distressing it is to be mis-gendered on the telephone, to receive the ‘double-takes’ when ordering a coffee or buying a train ticket. Clients often need to work systematically for about a year on aspects of pitch, resonance, intonation and voice quality, and therapy may also focus on voice projection, public speaking, social communication, non-verbal communication, gender linguistics and singing. The starting point is always with the therapeutic questions ‘does change need to happen and, if so, how much?’ The motivation emanates from the client. Therapy works best when individual sessions move to a group and social communication context, focusing on client-led learning, witnessing and support (Mills, 2015; Stoneham, 2015). Trans women are able to raise their speaking fundamental frequencies at the end of group therapy, but more importantly they tell what Michael White and narrative therapy practitioners call ‘thickened’ or self-affirming narratives of self-confidence, advocacy and value (Mills, 2015).

We teach our clients to become mindful, competent and playful with their voices, building in layers of psychological

ownership of the sound they are making and their sense of personal communicative presence, so that voice and communication feels authentic. Importantly, in the process we learn from our clients about their gender comfort and what is appropriate for them individually.

The time is now

We know that to be effective, specialist SLTs require more than their knowledge and skills in voice therapy – we need additional vocal pedagogy and a developed experiential relationship with our own vocal mechanism. We need to be psychologically minded and supervised, and employ a number of psychological and third-wave approaches to facilitate identity exploration. Crucially, we need to sit with gender variance non-judgmentally and in a matter-of-fact way. Referral rates are doubling, and we need a robust workforce supported through the CEN and BAGIS to support our extraordinary and, ultimately, ordinary clients. ■

Matthew Mills, RCSLT National Advisor on Transgender Voice, Lead Specialist SLT and Head of Speech Therapy, Gender Identity Clinic, London. Email: Matthew.Mills@wlmht.nhs.uk; Gillie Stoneham, Senior Lecturer, University of St Mark and St. John, Specialist SLT input West of England Gender Identity Clinic. Email: gstoneham@marjon.ac.uk



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specialist’. We have contributed to the Transgender Equality Enquiry 2015-2016, and have speech and language therapy representation on the clinical reference group (CRG) of the NHS Gender Identity Services.

On the strength of our report on improving national service delivery to commissioners, the CRG voted to recommend a ‘hub and spokes’ model to commissioners where the GIC-based SLT may be a supervisory and multidisciplinary ‘hub’ to local ‘spoke’ SLT colleagues. By the end of 2016, we are on track to have a specialist SLT embedded within every



Matthew and Gillie at the British Association of Gender Identity Specialists Inaugural Scientific Meeting