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Crafting the Dialogue: Meta-Therapy in Transgender Voice and Communication Training

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For years, I heard Master's-level students emerge from Voice Disorders courses saying things along the lines of "I know what to do in therapy, but how do I *do therapy*?" In fact, I said the same thing as a new voice clinician. Responses, including those I have given my own graduate students, were along the lines of "with time, you will grow." Yet I always had a nagging sense that skilled clinicians could better impart the experiential wisdom that renders them expert voice clinicians.

Though time and experience are certainly valuable in transitioning from novice to expert, I propose that graduate instruction pertaining to what I call "meta-therapy"—a distinct category of clinical care that is relevant to therapy efficacy and efficiency—is also vital to hastening clinical expertise. The remainder of this article will address what meta-therapy is and is not, where the construct of meta-therapy fits with various models of clinical instruction, and ways it might be taught in graduate education. Not only will this content be addressed in the context of training graduate clinicians, but also specifically in the context of voice and communication training with clients who identify as transgender.

What is Meta-Therapy?

What experienced clinicians learn—often for themselves, over time—is that the conversation shapes the therapeutic response. Expert clinicians develop go-to dialogues that serve to focus and guide their patients' perspective, and to build a conceptual framework for *what we are doing here*. These dialogues are honed and distilled over time, and skilled clinicians ultimately employ these dialogues in a manner that conserves both time and energy while optimizing therapeutic outcome. Meta-therapy, broadly, is the dialogues, schemas, and reflective tasks that clinicians employ to achieve their clinical aims. The meta-therapy construct is meant to be seen as a fourth categorical element of voice therapy, a dialogue-based thread that weaves together the classical elements of voice therapy such as direct therapy, indirect therapy, and counseling. It is onto the framework built by meta-therapy that direct and indirect therapy techniques are pinned, allowing those traditional voice therapy elements to be maximally effective and efficient.

Iwarsson (2015) discusses skills relevant to meta-therapy using the terms "silent know how" and "clinical expertise," and stresses that these skills must be taught instead of relying on acquisition over time. The present article seeks to view these skills not as a feature of some clinicians, but as a fourth categorical element of voice therapy. Thus, to the extent that "meta-therapy" is related to "silent know how," meta-therapy is perhaps more of a *tool* instead of a *skill*. In concurrence with Ivarrson, meta-therapy is meant to be seen as something a novice should learn, rather than an innate feature of the practitioner or a skill that only develops with time and experience.

As part of this first pass at articulating the concept of meta-therapy as a fourth category of voice training specifically for clients who are transgender, Table 1 presents a sampling of ways

that I apply it in my own clinical practice when working with clients. The Sample Discussion Points (Column 2) are center-points of individual "spiels" that I have formulated over time, as I was never explicitly taught these dialogues. Within my own practice, I have automated the accompanying dialogue to varying degrees, and that dialogue helps me to build and reinforce various parts of a client's conceptual framework for what we are doing in training. Everything in Table 1 is truncated for practicality and brevity, but the main points are represented.

Table 1. Meta-Therapy Exemplars: Sample Discussion Points With Rationale

Aim	Sample discussion points and tasks	Rationale
Understanding the endeavor (often introduced prior to and during the first session)	- "For all intents and purposes, you are a professional voice user now, so I will expect you to prioritize your vocal health, as will I." - "My job is to make you your own clinician, so if/when you run into problems with your voice in the future, you can solve them without me." - "As you build your skills as your own clinician, I will not decide what we work on; sometimes I won't even decide on how we get there."	These points help clients to take ownership of the process of voice and communication change. Ownership by the client is critical in this population, because clients naturally come to clinicians expecting to be told *what to do* in order to present in a more gender-congruent manner. In doing so, the client is effectively giving the clinician the power to transform their communication in the image of a woman or man (or other) that *the clinician* judges to be appropriate. A more appropriate approach is to create the expectation that the client will learn to articulate what it means for them to present with gender congruence, and to empower the client to lead at every turn in the process.
	"Success is not linear."	A priori, this discussion helps to mitigate frustration with the natural one-step forward and two-steps back experience.
	- "The experience of voice and communication change can feel very pubertal." - "Some social risks cannot be avoided."	Many clients hope for a chrysalis-like voice process wherein they emerge into society only when their voice is beautiful and as they desire. In reality, clients need to know that they must work through some awkwardness in order to reach their goals. Unlike during puberty, most people are "transitioning" without a peer group, so they are alone in the awkwardness of their process of change. This can make people feel embarrassed, isolated, and reluctant to practice new skills. Anticipating and normalizing the awkward phase helps people to move through it more quickly and with more self-acceptance.

Understanding the client	At intake, a homework task that I give all new clients is to draw a line through the center of a sheet of paper; the left side of the paper is titled "Who [their preferred Name] is" and the right side of the paper "Who [their preferred Name] is not." The client populates each side with adjectives, real and/or fictional characters, and any other manner of description appealing to them.	This exercise compels the client to begin articulating points of identity that they wish to cultivate and communicate outwardly. Some transgender clients are still very much closeted, and have not yet had the opportunity to "meet" their most congruent self. Truly, they are cultivating much of their outward identity in the course of their voice and communication training. This exercise gives them an opportunity to reflect, helps the clinician begin to understand the client in front of them, and serves as a springboard for discussion as you make a plan for training together.
	- "Internal conflict associated with voice and communication change is common and normal." - "Voice and communication changes can be both formative and disruptive to sense of self."	Case in point: A 64-year-old transwoman achieved a beautifully feminine "therapy voice," but was lingering in training because she could not generalize outside of sessions. When asked to reflect on why she could not generalize, she concluded that although this voice was her target voice (i.e., it was read as female 100% of the time), it "just isn't me." Specifically, she was an athletic, energetic, stylish older woman, but felt that the trained voice sounded "maternal, like a granny," which she did not identify with. One option was to shift course, hoping to cultivate a different but equally authentic feminine voice. The second option was to talk to the client about "leaving some fraction of yourself/your identity open to who your most authentic-sounding voice says that you are." In this particular case, the person had come out of the closet as a transwoman only 3 years earlier, and thus had never had the opportunity to have maternal or grandmotherly experiences. In the course of this discussion, she came to appreciate the "gift that this new voice brought [her]." She was discharged two sessions later and embraced and maintained that voice.
	"Confidence is key."	For some clients, there is a massive element of "fake it until you make it" to successful application of training techniques. Clinicians have a role in fostering clients' sense of confidence, but also in reminding clients that the appearance of confidence is a tool to be applied.

Understanding and shaping expectations	- At the outset of training, have an open conversation with the client to ensure that they have the time, money, environment, and emotional and cognitive reserves to embark on this training now. - Set an *a priori* goal for "graduating" from weekly sessions	These conversations serve to remind clients that they are embarking on a challenging process that should be prioritized in order to be successful. If they need to wait until after graduation, or after their divorce, etc., it will ultimately take less time and money if they have as a high a level of "readiness" as possible. Setting a goal for ending weekly sessions and transitioning to biweekly, monthly, or PRN sessions—in my practice, 2–3 months—helps maintain clients' motivation and keeps the process from dragging on in an open-ended fashion.
	- "You might need to redefine your vocal boundaries as you develop your new voice." - "How will your social life need to adjust if you decide to adopt these vocal behaviors? Are you willing to make those changes?"	Clients need to recognize that there might be tradeoffs as they move toward a more desirable vocal quality (e.g., inability to speak as loudly, loss of vocal durability, etc.).
Understanding the process	- "Voice therapy is not like physical therapy. Lip trills won't make your vocal folds stronger. Rather, they give you an access point (also, "a thread to pull") for a new way of voicing." - "Today, everything we are working on relates to either forward resonance or airflow. If it's not clear how a task relates to one or both of those, let me know." - "Let's not be prescriptive (e.g., do 20 lip trills twice a day). Rather, we are explorative. You possess a vocal instrument, and lip trills and hums lead us to new ways of playing your instrument. So the ball is in your court this week—use those lip trills/hums that we practiced to find new ways of using your instrument." - "I'm not sure what you can do with your vocal instrument—we are finding that out together. If you hear something you don't like when you play your instrument, let it be—you aren't married to that sound. But you'll only find out what you can do with your instrument if you explore it—the good, the bad, and the ugly."	New clinicians often flounder with the mechanisms of voice therapy. Perhaps that is because it is quite challenging to make an abstract and complex product—voice production—accessible to a layperson. To do this, we rely on "easy" and concrete tasks such as lip trills and hums, which, in turn, lends the false impression that the process is simple or even silly. So, then, both new clinicians and patients are easily frustrated when a better voice cannot be easily accessed. Thus, a framework for the process is mutually valuable. Further, a good voice therapist pulls tricks out of their sleeve, seeking moments of stimulability until something works and sticks. In their mind, they may be trying multiple strategies to achieve just two goals: (1) bring resonance forward, and (2) elicit adequate airflow. But if they try 15 different things to get there, the patient has no way of knowing that those 15 tasks all converge on two main goals. So the patient goes home thinking that lip trills are intrinsically helpful, similar to how range-of-motor exercises are useful for a shoulder injury, and practices lip trills as though there is something innately healing or prophylactic about them. But in truth, doing lip trills three times a day will do nothing to minimize hyperfunctional vocal behaviors or make a voice sound more feminine. Rather, lip trills and hums provide an *access point* for a better voice, a thread that the patient can pull to discover an easier way of using her voice. The clinician must somehow create a framework that emphasizes this distinction if training will be effective.

	"We have worked on elevating your pitch, bringing your resonance forward, increasing inflection, lengthening and connecting phrases, and minimizing laryngeal tension. You are putting all of this together beautifully in our sessions, but I don't want you to have a laundry list of all these things in your head in order to achieve this voice. Can we give this collection of behaviors one name? What would you call it?"	Most people have multiple pre-programmed speech "modes." For instance, many people can fairly effortlessly produce a Stern Mom voice, a Kindergarten Teacher at Naptime voice, a Southern Belle voice, and an Old Italian Guy voice. Notably, they generate these character voices without needing to think of the multiple voice, speech, physical kinematic, and even linguistic parameters that shift automatically to achieve each mode of production. If clinicians do take the approach of talking about target parameters (e.g., forward resonance, legato speech patterns) in the course of training, then as soon as the client can synthesize and implement those parameters, it is useful to wrap them all up in one tidy package, and send the client home with a "mode" instead of a to-do list.

How is Meta-Therapy Unique From Other Therapy Modalities?

Based on past conversations I have had with several clinicians on this topic, it seems that many skilled voice therapists independently developed similar dialogues long ago, each in their own unique way. Hopefully, then, some readers found Table 1 to feel very familiar. On the other hand, some readers might remain unconvinced that meta-therapy should be seen as a distinct construct, because several of the examples given might seemingly align with a classic category of therapy approaches. Most of the apparent overlap seems to be between meta-therapy and counseling. As an example, one of the bullets in Table 1 refers to "internal conflict associated with voice and communication change." In the present system of categorizing therapy approaches, this can only fall into the Counseling category. But I would argue that *dealing with* internal conflict is counseling, whereas *alerting clients to the possibility and normalcy of* internal conflict is meta-therapy.

Meta-Therapy Versus Counseling

The distinction between counseling and meta-therapy is important. Clinicians, particularly novices, often seem conditioned to be so wary of scope-of-practice issues that they avoid diving into arenas that feel too much like counseling. In doing so, we risk disempowering ourselves as practitioners in our field. For voice-specialized speech-language pathologists, the emotion-voice link is part of the meat of our trade, and it cannot always be carved away from an effective therapeutic approach and outsourced. Talking about feelings, psychology, self, emotion, and identity is not automatically counseling—that would be like saying that talking about beauty is tantamount to giving a makeover. Corollary to this point, helping a client understand that "emotions play out in voice" is not direct therapy, indirect therapy, or counseling—it is valuable framework-building information that serves to normalize and destigmatize the very real and sometimes fraught interplay of voice, state of mind, and personality. In sum, clinicians and patients can have a valuable discussion about these emotions without unpacking clients' psychological issues and thus diving into the realm of counseling.

Notably, the policy on counseling set forth by the American Speech-Language-Hearing Association (ASHA) is written in a manner that could easily be interpreted as inclusive of meta-therapy (ASHA, 2004). Nonetheless, counseling's popular reputation—as a realm pertaining to coping, emotional and psychological discord, and generally all things touchy-feely—seems to supercede written policy when it comes to practice. Even if the policy on counseling technically *could* encompass all elements of meta-therapy, this article aims to present logical evidence that it should not. To recapitulate, lumping elements of meta-therapy into the counseling bin effectively

throws a veil on meta-therapy, because (a) the plain-speak of counseling is often not explicitly taught to student clinicians, and (b) while clinicians might think about "clinical dialogue" when they think of counseling, most do not think of it as a tool for "building the conceptual framework," which is indeed a crux of meta-therapy. Finally, the ASHA policy on counseling must not only contend with popular convention, but also actual definitions. Merriam-Webster Dictionary defines counseling as "professional guidance of the individual by utilizing psychological methods especially in collecting case history data, using various techniques of the personal interview, and testing interests and aptitudes," ("Counseling," n.d.). Taking this definition, the meta-therapy examples highlighted in Table 1 are *not* firmly rooted in counseling.

This murkiness surrounding counseling is part of the impetus for discussing this fourth category of therapy modalities, meta-therapy. In lumping so much of clinical "silent know-how" into the often black-box category of counseling, we do no favors to our clients, our students, or our field. We can gain clarity through a focused attempt to actually outline what is *that special something* that experienced clinicians and those with naturally good therapeutic intuition bring to the table. Clinicians, clients, and the broader field will be well-served by describing, de-mystifying, and operationalizing that expertise or "silent know-how" that is herein referred to as meta-therapy.

Meta-Therapy Reveals Therapeutic Style

In addition to the aforementioned reasons for embracing meta-therapy, one could argue that it is in meta-therapy that the uniqueness of a therapist is revealed. Most contributors to this Part of *Perspectives,* including myself, worked with the transgender population well before a textbook existed on the topic, and we did so largely in clinical isolation. Nonetheless, we all arrived at largely the same types of dialogue with our transgender clients. Yet, despite the astounding degree of inter-clinician agreement on the meta-therapeutic approach to transgender voice care, there is just as much nuance and idiosyncracy in the details of our approach. Meta-therapy is the area in which clinicians and students can develop their own unique voice, allowing us all to arrive at the same clinical outcomes through a myriad of approaches. Thus, just as is true for our clients, it is through meta-therapy that we empower our students to take control and ownership of their own clinical process.

Meta-Therapy by Other Names

DPR Model

Perhaps it will hearten the reader to learn that the field of psychotherapy is grappling with very similar issues. For instance, Bennett-Levy (2006) discusses a complementary construct to meta-therapy in his model of clinical expertise learning, the DPR model (an acronym for the Declarative-Procedural-Reflective processes involved). Table 2 provides a cursory overview of the DPR model; some examples in the list were modified for clarity and relevance to the current topic. Within the Procedural stage of this model, "when-then rules, plans, procedures and skills" are discussed in a way that renders them quite similar to what is proposed herein in the context of meta-therapy. Bennett-Levy proposes that active, mindful Reflection by the clinician (a specific stage in the model, represented by "R" in the acronym) is central to the development of when-then rules. The author refers to the Reflection system of learning as a "metacognitive skill" that is a key element of expertise. Stated in these terms, *meta-therapy essentially utilizes reflection by master clinicians to generate an oral and written history of when-then rules for practice*. That history can serve as an early guide for, and then be re-written by, each new clinician as they come to *appreciate the ways in which they are uniquely effective as therapists.*

Table 2. When-Then Rules, Plans, Procedures, and Skills.

When-then rules, plans, procedures, and skills (Bennett-Levy, 2006) include:
• Specific types of intervention (e.g., schedule of activities)
• Procedures for the introduction of intervention types (e.g., description of rationale, practice within session, potential challenges to be anticipated)
• Optimal times of introduction (e.g., during the first session)
• Clients best served (e.g., those seeking to work on more masculine voice characteristics, those at certain stages of transition)
• Consideration of potential influence of behavioral or cognitive patterns (e.g., concrete versus abstract thinkers)

Adult Learning and Supervision Models

Within the realm of speech-language pathology, the topic of meta-therapy sits at the intersection of small but eloquent bodies of literature pertaining to adult experiential learning, reflective teaching approaches, supervisory effectiveness, and the development and measurement of clinical expertise. Andrews and Schmidt (1999) propose that awareness of the psychosocial elements of therapy must be cultivated and cannot be assumed. In their view, the more abstract aspects of interaction are cultivated through direct learning experiences *after* procedural knowledge has been solidified. This model slightly differs from that of meta-therapy in that *meta-therapy should be taught as procedural knowledge,* with the relevant course content being borne out of reflections by experienced practitioners.

Core concepts of meta-therapy overlap those of reflective and relationship-based supervision approaches. It is broadly agreed upon that the best supervisor-supervisee relationships occur when the supervisor reflects upon his or her own experiences and then shares them with the supervisee in an open, allied context (Bordin, 1983; Geller, 2013; Shahmoon-Shanok & Geller, 2009). For instance, Walden and Gordon-Pershey (2013) stress that not only should supervisors understand how students learn but also how they themselves acquire new information and skills. In the context of their work, meta-therapy seems conceptually a combination of Conceptual and Metacognitive knowledge. Relatedly, Geller (2013) laments the limited training to prepare clinicians for supervisory roles in speech-language pathology, noting that the field traditionally reinforces educational models of learning over relationship-based reflective models, the latter of which is crucial for optimal supervision-based learning. Bordin (1983) emphasized that both *the person seeking change* and *the change agent* (in their work, the supervisee and the supervisor, respectively) must have a shared understanding of goals and tasks that are central to their working alliance. Indeed, these notions presented by Geller and Bordin are lynchpins of the argument in favor of meta-therapy.

Rehabilitation Treatment Taxonomy

Most recently, Turkstra, Norman, Whyte, Dijkers, and Hart (2016) presented a framework for specifying treatment methods called the Rehabilitation Treatment Taxonomy (RTT). In RTT, three main treatment components are described: *targets, ingredients,* and *mechanisms of action. Targets* are essentially the behaviors to be changed with treatment; *ingredients* are the clinician's behaviors or actions that lead to target-specific changes; and *mechanisms of action* are the evidence-based or theoretical means by which targets are influenced by ingredients. According to this model, "any time a therapist explains a task […] that therapist is administering ingredients," (p. 165). Further, the authors claim that ingredients must be measurable. To conform to the RTT model, all meta-therapeutic elements in Table 1 must somehow be made measurable, which would be challenging, but philosophically aligned with the main thrust of this article. To muddy the waters, though, in explaining *mechanisms of action,* the authors broadly refer to "learning and information processing," as well as psychological "theories that explain changes in behavior or cognition" (p. 165). Such nomenclature seems highly relevant to the discussion of meta-therapy,

and since meta-therapy is innately more challenging to measure than other *ingredients* (e.g., circumlaryngeal massage, stretch-and-flow phonation) it is tempting to place meta-therapy into Turkstra et al.'s *mechanisms of action* category at some level lower than "the neural processes of memory consolidation," to use their example. Indeed, Turkstra et al. acknowledge that *mechanisms of action* are notoriously difficult to characterize, which also holds true for meta-therapy. At any rate, the definition of *mechanisms of action* in RTT does lead us back to the DPR model of clinical learning, which also has meta-therapy straddling two intertwined categories.

Regardless of the terminology, it is evident that various clinicians, researchers, and thought-leaders are working to triangulate a definition for *that special something* that skilled speech-language pathologists apply in therapy. As a field, we are overdue in prioritizing such efforts. Until we define it, we can neither operationalize nor teach it.

Teaching Meta-Therapy

It often seems (with exceptions, of course) that voice therapy gets a reputation for being an easy graduate-level class, but a challenging and intimidating therapy. The invisibility of the construct of meta-therapy might be at the center of that paradox. Graduate clinicians should be guided to develop a clear framework for therapy, above and beyond the declarative and procedural knowledge relevant to disorder types and therapy approaches. In turn, they will be equipped to build a framework for their clients.

If, as proposed earlier, meta-therapy is to be viewed as a form of oral and verbal history that is passed down from experienced to novice clinicians, it might best be taught by prioritizing master clinician models as part of student experience, and creating opportunities for students to see and hear how skilled clinicians address various clinical scenarios. New clinicians crave and treasure such experiences. Unfortunately, in the context of transgender voice and even traditional voice therapy, the need for specialized externship and fellowship opportunities far outstrips the supply. Thus, clinicians with expertise should endeavor to clearly describe, in writing, their own meta-therapeutic approach for students' consumption. As an example task, this written material can be given before or after students watch a video of the master clinician in therapy, and students can try to identify the meta-therapeutic approaches being used.

Meta-therapy skills can also be developed by asking students to describe "what we are doing here" in a therapeutic scenario. Students should be taught that, in turn, helping their clients build their own frameworks for therapy will improve effectiveness and efficiency. To facilitate this, students should have opportunities to practice the dialogue of therapy as much as they practice the application of specific direct therapy techniques.

Finally, I recommend digging more deeply into the topic of counseling such that we disallow it to become a "black box" of clinical practice. Categorically, counseling presently subsumes a proportionally high number of meta-therapy elements relative to direct and indirect therapy techniques. Instead, instructors should shine a light on the elements of counseling that are firmly within our scope of practice, and empower their students to take ownership of those elements. In truly scrutinizing the topic of counseling as we teach and learn it, it is probable that the elements of meta-therapy will also be revealed and more cogently parsed out.

In teaching meta-therapy, we experienced clinicians are effectively giving the new generation the keys to our castle: explicit permission to make use of our most precious, personal, hard-earned therapeutic tools—forever if they wish, or just until they develop their own. In the absence of meta-therapy dialogues being explicitly trained to students of speech pathology, many new clinicians are left (a) placing inappropriately massive emphasis on direct and indirect therapy techniques; (b) wondering why those techniques feel hollow or inadequate in the therapeutic setting; (c) hoping that the tincture of time will give them these "meta" tools; (d) believing that their supervisor's way of doing therapy is the only "right" way; and/or (e) effectively removing themselves from the pool of speech-language pathologists who function as voice practitioners.

Conclusion

To summarize, I argue for meta-therapy to be acknowledged as a distinct category of clinical care that is fundamental to training efficacy and efficiency (i.e., clinical expertise). To provide distinct examples of meta-therapy, I have sketched out how I conceptualize and apply it in the context of transgender voice and communication training. To populate the category of meta-therapy, some of our clinical activities must be reassigned (e.g., from counseling or indirect therapy), whereas other activities that typically go uncharacterized must be brought into the light. In doing so, the broad aim is to demystify and render more accessible *that special something* that expert clinicians possess. In the long run, time and experience will remain as precious as ever, but in the short term, perhaps both students and clients can find their rhythm more completely and more quickly.

Author Biography

Leah Helou saw her first transgender client as a graduate clinician in 2002, and subsequently committed to transgender voice and communication as a key element of her clinical practice. Helou founded (2011) and currently directs the Transgender Voice & Communication Training program at the University of Pittsburgh Voice Center. She co-presents (with Sandy Hirsch and Christie Block) an annual two-day workshop on the topic of Transgender Voice and Communication, moderates an online group ("Gender Diverse Voice & Communication," via Facebook) for speech-language pathologists and professionals in related fields, and is presently developing a subgroup to connect clinicians working with the pediatric and adolescent transgender population.

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