EUROPEAN PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

Ghent, Belgium, 29 September 2015

Dear Madam, Sir,

The European Professional Association for Transgender Health (EPATH) has read with great interest the proposals developed by the Working Group regarding the implementation of the L.v. Lithuania judgment of 11 September 2007.

EPATH was founded in 2013, because of a widespread felt need for an exchange of knowledge, skills and scholarship in transgender health at European level. EPATH wishes to promote mental, physical and social health of transgender people in Europe, to increase the quality of life among transgender people in Europe and to ensure transgender people's rights for healthy development and well-being. A first EPATH conference on transgender health care was held in Ghent, Belgium, last year, with 350 participants from 31 different countries. Some post-Soviet countries were also present, with participants from Kyrgyzstan, Ukraine and Russia. This was a first step in exchanging knowledge and clinical practice, and was highly valued from all sides. It is in this light that we take the opportunity to give our professional advice and input for the proposals, with the hope to support the important task set out by the Working Group to provide guidelines for setting up health care provisions for transgender persons. EPATH fully realizes the complexity of this task, and wishes nothing more than to share our experiences and provide clinicians with a platform for mentoring, training and an exchange of knowledge and skills.

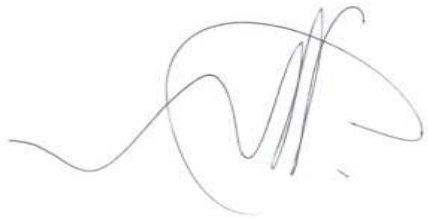
The present assessment is based on the *Standards of Care 7 for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (SOC 7) of the World Professional Association for Transgender Health (WPATH, 2012). WPATH is the international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy and respect in transsexual and transgender health. The goal of the *Standards of Care* is to provide clinical guidance for health professionals to assist transsexual, transgender and gender-nonconforming people with safe and effective pathways to achieve lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological wellbeing and self-fulfilment. EPATH functions as the European chapter of the WPATH, and as such endorses the Standards of Care of WPATH. The SOC is available for download at http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655.

Furthermore, the assessment cites data stemming from the report *Being Trans in the EU*, published by the European Union Agency for Fundamental Rights (FRA) in 2014. The EU LGBT survey results provide valuable evidence of how transgender persons in the EU

experience bias-motivated discrimination, violence and harassment in different areas of life, including employment, education, healthcare, housing and other services. The evidence collected and analysed from this survey can serve politicians and policy makers as they strive to craft legislation, policies and strategies that better safeguard the fundamental rights of transgender persons. The report is available for download at http://fra.europa.eu/en/publication/2014/being-trans-eu-comparative-analysis-eu-lgbt-survey-data.

We are aware of the existing differences between the West-European and the post-Soviet regions in health care provision for people with Gender Dysphoria and discourses regarding Gender Dysphoria (Karagapolova, 2015). Nevertheless, we truly believe that the proposals of the governmental Working Group could benefit from this assessment, based on evidenced-based science. Therefore, in what follows, the board of EPATH has taken the liberty to formulate some general remarks for the Working Group to take into consideration. We hope to positively contribute to the important task set out by the working group to provide health care services for transgender persons, and invite all interested parties to join our professional association.

Your sincerely,



For the Board of EPATH,

Prof. dr. Guy T'Sjoen,

President & Director of the Scientific Division

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# EPATH's assessment of the working groups

## "OUTLINE OF REQUIREMENTS FOR PROVISION OF HEALTH CARE SERVICES FOR PERSONS WITH GENDER IDENTITY DISORDERS"

### 1. Transgender health care and legal gender recognition

EPATH follows *WPATH's Identity Recognition Statement (2010)*, which opposes surgery or sterilization as requirements to change legal gender. Furthermore, we also follow *WPATH Statement on Identity Recognition (2015)* that states that other legal barriers preventing trans people having congruent identity documents should be avoided, especially those which might involve health professionals directly, e.g. examining people and filling out paperwork for court proceedings. These legal barriers are harmful to trans people's health because they make social transition more difficult, put congruent identity documents out of the reach of many, and even contribute to trans people's vulnerability to discrimination and violence. These laws are at odds with the perspectives expressed in the Standards of Care of WPATH (SOC 7).

Furthermore, EPATH would like to recommend to take into account the Recommendation 2010(5) formulated by the Council of Europe that calls on member states to ensure that the highest attainable standard of health can be effectively enjoyed without discrimination on the grounds of sexual orientation or gender identity. It also specifies, that *"transgender persons [should] have effective access to appropriate gender reassignment services"*. Moreover, according to this Recommendation, *"any decisions limiting the costs covered by health insurance for gender reassignment procedures should be lawful, objective and proportionate"* (FRA, 2014).

### 2. Differences in gender identities

Whereas gender identity for a long time has been understood in a dualistic way, in which only two categories of gender exist: men and women, extensive research in the past decades have showed that this constructed binary does not reflect reality (Bockting, 2007; FRA, 2014; Kuyper & Wijsen, 2014; Van Caenegem, 2015). This canon of research both from medical as well as sociological disciplines shows that many people find themselves somewhere between the two categories of male or female.

The proposal now only refers to 'transsexual' persons, defined by WPATH as *"individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role"* (SOC 7, p97), which is only one form of a gender identity.

However, transgender persons are *"a diverse group of individuals who cross or transcend culturally defined categories of gender, and their gender identity differs to varying degrees from the sex they were assigned at birth"* (Bockting, 1999, in: SOC 7, p97). A trans man or FtM is an individual assigned female at birth, who is changing (or has changed) his body and/or gender role from female to a more masculine body or role. A trans woman or MtF is an individual assigned male at birth, who is changing (or has changed) her body and/or gender role from male to a more feminine body or role. It is also recommended to use the pronouns belonging to the gender identity (not the sex assigned at birth) of the person. More terminology and definitions can be found in SOC 7, p95-97.

In the EU LGBT Survey of the European Union Agency for Fundamental Rights (FRA, 2014), 11% of all European transgender people identify as 'gender variant' and 39% identify as 'queer' or 'other'. Only 17% of all European transgender people identify as 'trans woman' and only 9% identify as 'trans man'. This study also contained 38 Lithuanian respondents, of which 6 identify as 'trans woman', 2 identify as 'trans man' and 5 identify as 'transgender', whereas 7 respondents identify as 'gender variant' and 9 identify as 'queer/other'. These results show the diversity in trans identities among a self-identified trans respondent group.

A representative study in the Belgian general population indicated that 0,7% of all natal males and 0,6% of all natal females in Flanders are gender incongruent, meaning they feel more like the opposite gender than the sex they were assigned at birth, whereas 2,2% of all natal males and 1,9% of all natal females in Flanders are gender ambivalent, meaning they feel as much male as female, or none of both (Van Caenegem et al., 2015). These findings confirm the earlier findings of a large population-based survey in the Netherlands (Kuyper & Wijsen, 2014).

## 3. The difference between gender dysphoria and being a trans person

Health care professionals generally use classification systems such as the Diagnostic Manual of Mental Disorders (DSM; APA, 2013) or International Classification of Diseases (ICD; WHO, 1992) to diagnose people, and although opinions vary about the classification of gender dysphoria as a mental disorder, the existence of a diagnosis often facilitates access to health care and can guide further research into effective treatments (SOC 7, p6). However, terms are changing in both of these classification systems and it is advised that health professionals refer to the most current diagnostic criteria and appropriate codes. As such, in 2013 the term 'Gender Identity Disorder (GID)' was changed into 'Gender Dysphoria' in the DSM-5 to reduce stigma associated with transgender persons (Drescher, 2014). A revised version of the ICD-10 (which was published in 1992), with an anticipation date of 2018, will probably also hold some important changes with regard to the

terminology and classification of gender identity issues (Drescher et al., 2012). Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas (SOC 7, p6).

Not all transgender persons necessarily want medical treatment, nor experience discomfort about their gender identity, frequently referred to as 'gender dysphoria'. Regarding gender dysphoria WPATH states: *"Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and the person's sex at birth (and the associated gender role and/or primary and secondary sex characteristics)"* (Fisk, 1974; Knudson et al, 2010). Only *some* gender-nonconforming people experience gender dysphoria at *some* point in their lives.

Using the term 'gender dysphoria' includes all persons who experience distress because of the discrepancy between their gender identity and their sex assigned at birth, and who might need health care to explore their gender identity and find a gender role and expression that is more comfortable for them (SOC 7, p5). Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). *"Treatment is individualized: what helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. […] Gender identities and expressions are diverse, and hormones and surgery are just two of the many options available to assist people with achieving comfort with self and identity"* (SOC 7, p5).

The EU LGBT survey (FRA, 2014) shows that only 35% of the transgender people in Lithuania have ever sought medical or psychological help for being a transgender person. Most cited reasons for Lithuanian transgender persons not to seek help were that it is not available in their country (19%), that it is not covered by health insurances in their country (19%), that they did not dare to seek help (31%), that they had no confidence in the services provided (35%), that they were afraid of prejudice from care providers (31%), or that they did not know where to go (35%). Also, more than half of the Lithuanian transgender persons (54%) that never sought help for being a transgender person stated they did not need or want help. This again shows that not all transgender persons experience gender dysphoria or want medical treatment.

## 4. Sexual orientation and gender dysphoria

Although transgender persons might have a difficult relationship with their body because it does not reflect their gender identity, which sometimes leads to avoidance of sexual relationships, most transgender persons would like to have a healthy sex life. Treatment with cross-sex hormones can have an influence on sexual desire (some trans women experience a decrease, while some trans men experience an increase in sexual desire) (Elaut, 2014), but someone's gender identity does not reveal anything about one's sex life or sexual desire, nor about one's sexual orientation. A person's sexual orientation is not listed as a criterion for the diagnosis of gender dysphoria.

The EU LGBT survey (FRA, 2014) found that 33% trans women identify as lesbian, and 22% identify as heterosexual whereas 17% of the trans men identify as gay, and 38% identify as heterosexual. Approximately 27% of all transgender people identify as bisexual. Only 44% of people who identify as trans men were sexually attracted to females (FRA, 2014). These results show the diversification of sexual orientation within a transgender population.

## 5. Inclusive access to health care

Transgender persons often (but not always) seek a combination of medical, surgical, mental health, and other related treatments and services. Common treatments include cross-sex hormone therapy; genital reassignment surgery; non-genital surgical procedures of the face, breast, or body; speech and voice therapy; and facial hair removal (Gooren, 2011). The SOC 7 provides an extensive overview of all therapeutic approaches for gender dysphoria. Although the SOC 7 contains an evidence-based discussion of treatment options, adverse effects, and outcomes, specific treatment regimens (e.g., hormone dosing) are published elsewhere (Alegria, 2011; Ettner et al., 2007; Feldman & Safer, 2009; Hembree et al., 2009; Williamson, 2010).

Treatment for gender dysphoria is highly individualized. While many individuals need cross-sex hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options, and some need neither (Bockting & Goldberg, 2006 in SOC 7, p8). Not all transgender persons want a 'full' transformation to be a person of the opposite gender. Some transgender persons do not feel to belong to either of society's binary gender categories. The SOC 7 provides guidelines for transsexual, transgender, and gender non-conforming people, and underlines the difference between gender dysphoria and gender nonconformity (SOC 7, p5, see also above).

Some treatments, such as puberty-suppressing hormones for adolescents, are entirely reversible, while other treatments, such as surgeries, are irreversible. Long-term cross-sex hormone treatments for

example are only partially reversible (e.g., deepening of the voice caused by testosterone, or infertility caused by cross-sex hormone treatment).

Surgical treatment is, like treatment of transgender persons in general, highly individualized. In trans men as well as in trans women, different options are possible with regard to Gender Affirmative Surgery (GAS). For instance, trans men (FtM) can have a vaginectomy, scrotoplasty, hysterectomy, mastectomy, metoidioplasty, phalloplasty, ... Trans women (MtF) can have an orchiectomy, vaginoplasty, mammoplasty, vocal surgery, facial feminization surgery, …

A lot of follow-up studies have shown beneficial effects of GAS on a variety of outcomes, such as sexual function, subjective wellbeing and psychosocial outcomes (De Cuypere et al., 2005; Klein & Gorzalka, 2009). Most transgender persons who have undergone GAS do not regret this choice, even when developing complications (Krege et al., 2001; Lawrence, 2003; Rehman et al, 1999).

## 6. DSD and gender dysphoria

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes et al., 2006). Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioural criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This categorization—which explicitly differentiates between gender dysphoric individuals with and without a DSD—is justified: in people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. The diagnosis of gender dysphoria can coincide with diagnosis of, for instance, Klinefelter syndrome, or polycystic ovary syndrome. There is no evidence to rule out GD if these endocrinal disorders are diagnosed. We refer to the SOC 7 guidelines, pp68-71 for guidelines on 'Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development'.

## 7. Trans health care for minors

Children as young as age two may show features that could indicate gender dysphoria (SOC 7, p12). In many children, this gender dysphoria disappears before or early in puberty. In other children however, these feelings will only intensify as their secondary sex characteristics start developing (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008).

While gender dysphoria in childhood does not necessarily continue into adulthood, gender dysphoria in adolescents is much more likely to persist. Since the early 1990s, adolescents who present to clinical services in Tanner stage 2 (when secondary sex characteristics start to develop) can in some countries, under some circumstances, start a treatment with puberty suppressors (the 'Dutch protocol', now widespread throughout the world). This is a fully reversible treatment that gives adolescents more time to explore their gender identity, and the use of puberty-suppressors may facilitate later transition by preventing the development of sex characteristics that are difficult to reverse if adolescents continue on to pursue sex reassignment (SOC 7, p19). Criteria for treatment with puberty-suppressing hormones, regimens, monitoring and risks can be found in the SOC 7, p19. Usually, adolescents can start with cross-sex hormone therapy at the age of 16.

## 8. Co-existing mental health problems

At the start of gender affirmative therapy, adult persons with gender dysphoria may deal with various forms of psychopathology. Research has shown a marked reduction in psychopathology during the process of gender affirmative therapy, especially after the initiation of hormone therapy, leading to scores in psychopathology resembling those of a general population (Heylens et al., 2013).

Also, in the population of children with gender dysphoria, coexisting internalizing disorders such as anxiety and depression are relatively common (Cohen-Kettenis et al., 2003; Wallien et al., 2007). The prevalence of autism spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries et al., 2010).

The co-occurrence of mental health problems however does not function as a criterion for ruling out the diagnosis of gender dysphoria, and should not prevent the client for gaining appropriate mental health care. Therefore, according the SOC 7, one of the criterion for gender affirmative therapy is: *"If significant medical or mental health concerns are present, they must be well controlled."*

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