Psychiatr. Pol. 2025; 59(2): 267–280
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/OnlineFirst/174471

Polish mental and sexual health specialists working with transgender and gender diverse persons – who are they and what is their background?

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Summary

Aim. This study aimed to present the demographic and professional characteristics of Polish mental and sexual health specialists (MSHS) and their experience in clinical work with transgender and gender diverse (TGD) people.

Method. This cross-sectional study was conducted using the LimeSurvey platform. A total of 239 MSHS with a diverse professional background, at different stages of their careers, with experience of working with TGD patients, completed the survey. Participants were asked to provide demographic (e.g., gender and sexual identity) and professional (e.g., knowledge of leading standards and guidelines of care) data. Descriptive statistics were used.

Results. The mean age of participants was 39.5 years (*SD* 7.92) and the majority were assigned female at birth (73.2%). The sample was composed predominantly of psychotherapists (70%), then psychologists (53%), medical doctors (31%) and certified sexologists (5.9%). The majority (72%) practised in large cities (>500,000); 68.6% reported female gender identity, 24.7% a male identity and 6.3% were TGD; 63.2% were heterosexual, 12.1% homosexual, 12.6% bisexual, and 12.1% reported other sexual identity. Both the significance of religion and religious practice were significantly decreased compared to general Polish population. Most participants declared that they either do not know the basic guidelines of care for TGD people at all or know them very little. The majority of MSHS rated their professional training as insufficient.

Conclusions. People providing clinical services to TGD patients are a professionally diverse group. There is an urgent need to expand and intensify professional training directed at MSHS on topics related to the health care dedicated to TGD people.

Key words: gender incongruence, gender dysphoria, mental health professionals

Introduction

In Poland, as in the rest of the Western world, the visibility of transgender and gender diverse (TGD) persons is increasing. At the same time, it is not clear whether, similar to other countries [1], the number of referrals to mental and sexual health specialists (MSHS) is also on the rise, as no reliable statistics are kept in Poland in this respect. Taking a closer look at the domestic market of clinical services, it may be observed that increased number of MSHS present themselves as clinicians supporting TGD persons. We still, however, lack sufficient knowledge about those MSHS.

Studies that aimed to characterise specialists who offer services to TGD persons, including their need and competence, are scarce and were mostly conducted abroad. The aspects that were explored so far include, among others: knowledge of standards and guidelines of care for TGD individuals [2, 3], self-assessed sense of competence in providing gender-affirming medical interventions [2, 4], familiarity with those interventions [4, 5], readiness to introduce and continue said services [4], beliefs and emotions regarding talking about this subject with patients [2, 3], as well as perceived barriers in providing such care [6].

However, the topic of MSHS providing care to TGD people is almost absent in the state-of-the-art literature, despite their significant participation not only in the process of medical transition, but also in caring for their psychological well-being in a holistic sense, such as dealing with the negative consequences of experiencing minority stress.

Exploration of personal and professional characteristic of Polish MSHS is additionally interesting due to two sets of factors. The first one is related to the dynamically developing understanding of transgender phenomenon and gender incongruence over the last decade, along with a rapid evolution of standards of care and clinical guidelines [7]. The changes that were introduced in the DSM-5 classification and especially in the ICD-11 are paradigmatic and have been discussed in detail in the Polish literature [7, 8]. At the same time, further editions of the *Standards of Care WPATH* (*Standards of Care World Professional Association for Transgender Health*; SOC WPATH) – have been published (the seventh version [9], which was the first to receive an official Polish translation [10], and the eighth edition published just last year [11]). Other international organisations have also issued their recommendations: the American Psychological Association (APA) – *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA GPPTGNP) [12] and the Endocrine Society (ES) – *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (ES CPG) [13]. 2020 also saw the publication of the first official Recommendations of the Polish Sexological Society (PTS) on medical care in transgender adults – position statement of the expert panel (PTS Recommendations) [14]. The essence of the above-mentioned changes can be described as a shift from perceiving gender diversity and/or gender non-conformity as psychopathological phenomena, and a shift from a model of care based on in-depth

psychiatric assessment of TGD people to new, affirmative models of care – the SOC WPATH model and informed consent models (ICMs) [15].

The second group of factors is a specific and complex Polish cultural, social and legal context, crucial for lives and experiences of TGD persons, and the work of MSHS. TGD individuals face discrimination both in their everyday private and social life, as well as in contact with healthcare personnel [16]. In turn, MSHS providing state-of-art care based on the newest standards are currently experiencing increased pressure and attacks from media disinclined to accept trans-affirmative care (e.g., [17]) or from some of the representatives of TGD community (e.g., [18]) advocating for replacing the SOC WPATH model with so-called strong ICM [15].

Above-mentioned factors explain posing the following fundamental research questions:

(1) What is the personal and professional characteristic of MSHS providing services and care to TGD persons in Poland?
(2) How do MSHS providing services and care to TGD individuals in Poland assess their knowledge of publications outlining current diagnostic and clinical standards?

Additional research questions concern the scope of care provided by MSHS to TGD persons, and an assessment of the sufficiency of the courses regarding TGD-focused care completed by the specialists.

Providing answers to the outlined questions will allow for more adequate planning of the courses dedicated to MSHS providing health care to TGD persons.

Materials and method

A study was conducted with a survey constructed by the authors of this paper[1], which was first assessed for comprehensibility by a group of specialists (psychologists, medical doctors and psychotherapists). The study received a positive opinion from the Bioethics Committee, Jagiellonian University[2]. Data were collected from November 2022 to March 2023 via the online platform LimeSurvey. Invitations to participate in the study were addressed to medical doctors, psychologists, psychotherapists, and sexologists at different stages of postgraduate professional education via social media, the snowball method, and through official correspondence addressed to scientific societies, psychiatric departments and clinics, psychology departments, psychotherapy schools, non-governmental organizations, and postgraduate training centres. Participation in the study was anonymous and voluntary. There was also no remuneration associated with it.

[1] Detailed phrases used in the survey can be accessed by request from the authors of the study.

[2] Opinion no: 1072.6120.230.2022

The survey consisted of four separate thematic modules, three of which were utilised as a data source for current analysis. The first one regarded demographic questions: year of birth, gender assigned at birth, gender and sexual identity, denomination, frequency of religious practice, as well as a significance of religion in one's life. The second part referred to the professional profile of participants: professional qualifications, current place of practice, size of the city where the practice in which a specialists works with TGD persons is located, being certified by PTS as a clinical sexologist, and experience of working with TGD adults (length of practice, percentage of patient(s) who are TGD, along with the number of such patients in the last year and month). The final questions in this part of the survey asked about the areas of support provided to TGD people and an assessment of the extent to which previous professional training was sufficient to work with TGD people, on a scale from 1 ("definitely insufficient") to 5 ("definitely sufficient"). The third part of the questionnaire concerned declared knowledge of the WPATH Standards of Care, the PTS Recommendations, the APA GPPTGNP, the ES CPG and the ICD-11, DSM-5 and ICD-10 classifications, assessed on a six-point scale from 0 ("not knowledgeable at all") to 5 ("very knowledgeable").

Statistical analysis

Data from 239 individuals – MSHS with experience of clinical work with TGD individuals – were included in the analysis. Missing data were not systematic and were therefore omitted from the descriptive statistics. The mean (*M*) and/or median (Med) were used to describe measures of central tendency for continuous variables, along with information on the standard deviation (*SD*) and/or quartile range (IQR). Qualitative variables were presented using counts (*N*) and percentages (%). The 95% lower and upper confidence intervals (CI) are also provided for the calculated percentages.

Results

Research participants

The mean age in the study sample was 39.5 years (*SD* = 7.92; Min-Max: 26–59; Med. 38; Q1 33.5, Q3 45) and the majority were assigned female at birth (73.2%). Full demographic characteristics of the study sample are shown in Table 1 and occupational characteristics in Table 2.

Knowledge of documents

Declared familiarity with basic documents related to diagnosis and clinical management ranged widely. Only 1.5 to 2.0% of the survey participants were not at all familiar with the ICD-10, ICD-11 and DSM-5 classifications, with 31.2% to 57.1% being very familiar with them. Between 26.3% and 68% of MSHS were not at all familiar with one of the core standards/recommendations for TGD care (SOC 7 WPATH, PTS

Recommendations, APA GPPTGNP, ES CPG), with between 4.9% and 30.7% being very familiar. As many as 30 study participants (12.5%) were not familiar with any of the mentioned documents. Good or very good familiarity with all four documents was indicated by 10 participants (4.1%). Detailed results for individual documents are summarised in Figure.

Area of support

The most common form of care provided to TGD people was psychotherapy – both related to the process of medical transition (psychotherapy before transition – 38.08%; psychotherapy during transition – 35.15%) and unrelated to this process (56.49%). Detailed data related to the extent of care are summarised in Table 2.

Sufficiency of training

2.9% of respondents found the healthcare training for TGD completely sufficient and 17.6% found it sufficient. In contrast, 21.9% and 37.6% felt that they were completely insufficient or insufficient, respectively.

Table 1. **Demographic characteristics of the study sample**

Characteristic	N	%	Lower CI for %	Upper CI for %
Sexuality				
Gender identity				
Woman	164	68.6	62.7	74.5
Man	59	24.7	19.2	30.2
Transgender/Other	15	6.3	3.2	9.4
No answer	1	0.4		
Pronouns				
Female	164	68.6	62.7	74.5
Male	64	26.8	21.2	32.4
Gender neutral	11	4.6	1.9	7.3
Sexual identity				
Heterosexual	151	63.2	57.1	69.3
Homosexual	29	12.1	8.0	16.3
Bisexual	30	12.6	8.4	16.8
Other	29	12.1	8.0	16.3
Religion				
Denomination				
Roman Catholic	70	29.3	23.5	35.1

table continued on the next page

Atheist	137	57.3	51.1	63.6
Other	10	4.2	1.6	6.7
Do not know	12	5	2.3	7.8

*Data gaps below 5% were not included in the table

Table 2. **Professional characteristics of the study sample**

Professional characteristic	N	%	Lower CI for %	Upper CI for %
Profession				
Medical doctor (not psychotherapist)	54	22.6	17.3	27.9
Psychologist (not psychotherapist)	17	7.1	3.9	10.4
Medical doctor and psychotherapist	20	8.4	4.9	11.9
Psychologist and psychotherapist	110	46.0	39.7	52.3
Psychotherapist (neither medical doctor, nor psychologist)	38	15.9	11.3	20.5
Psychotherapy training				
No training	54	32.1	17.3	27.9
In-training	58	34.5	18.8	29.7
Certified	56	33.3	18.1	28.8
Approaches				
Psychodynamic	50	31.3	15.8	26.1
CBT	69	43.2	23.1	34.6
Systemic	18	11.3	4.2	10.9
Other	23	14.4	5.9	13.4
Specialization in psychology				
None	85	66.9	58.7	75.1
Clinical psychology	18	14.2	8.1	20.3
Psychosexology	7	5.5	1.5	9.5
Other	18	14.2	8.1	20.3
Number of specialists certified by PTS	14	5.9	2.9	8.8
Length of practice with TGD patients				
<1 year	30	14	8.4	16.8
1 year	185	86	72.1	82.7

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Percentage of TGD patients				
≤20	172	80.00	74.65	85.35
30–40	19	8.84	5.04	12.63
50–60	9	4.19	1.51	6.86
70–80	12	5.58	2.51	8.65
≥80	3	1.40	-0.17	2.96
Average number of TGD patients	Med (IQR)		M (SD; Min-Max)	
In a year	4 (8)		22.2 (105; 0–1000)	
In a month	2 (4)		4.5 (10.7; 0–120)	
Area of specialist support				
Psychological diagnosis for medical transition	44	18.41	13.5	23.3
Assessment for legal transition	8	3.35	1.1	5.6
Psychotherapy before transition	91	38.08	31.9	44.2
Psychotherapy during transition	84	35.15	29.1	41.2
Psychotherapy, independent from transition	135	56.49	50.2	62.8
Psychiatric diagnosis for medial transition	24	10.04	6.2	13.9
Psychiatric diagnosis, independent from medial transition	56	23.43	18.1	28.8
Practice location (size of the area where the practice is located)				
<10,000–100,000	31	13.0	8.5	17.5
100,000–500,000	34	14.2	9.8	18.7
500,000 –1 m	89	37.2	31.1	43.4
>1 m	85	35.6	29.5	41.6
Practice location (type of practice)				
Private practice	162	67.78	61.9	73.7
Specialist public outpatient clinic	48	20.08	15.0	25.2
Specialist non-public outpatient clinic	50	20.92	15.8	26.1
Multispeciality public hospital	59	24.69	19.2	30.2
Non-governmental organisation	30	12.55	8.4	16.8
School	11	4.60	1.9	7.3
Other	14	5.86	2.9	8.8

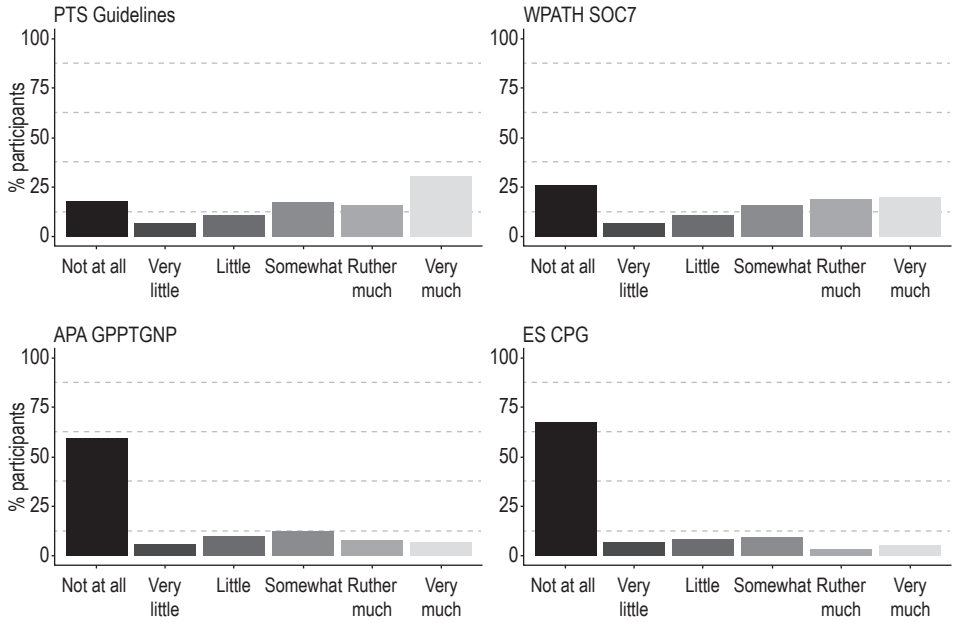

Figure. **Degree of knowledge of the basic guidelines and standards of care as declared by MSHS.**

Discussion

The aim of this study was to explore the personal and professional characteristics of MSHS working with TGD persons and their declared knowledge of leading recommendations and standards for working with this group of patients.

Selected personal characteristic of MSHS

The study group was composed predominantly of young people. This can be interpreted both as a consequence of the increased representation of these individuals in the online space [19] where the study was conducted (and partly advertised) and/or as a growing interest in the TGD patients' population among the younger segment of MSHS. It is also possible that TGD individuals themselves are more likely to seek help from younger MSHS, expecting more openness, acceptance and up-to-date modern knowledge in this group. Older MSHS, educated in times of a different paradigm, may be associated with psychiatry and sexology's oppressive and pathologising attitude towards transgender people and gender diversity. These phenomena have historically been framed in psychopathological terms as consequences of disorders of an individual's psychosocial development. Furthermore, the classic model of qualification for medical gender-affirming interventions required a prolonged and extensive diagnostic

and therapeutic process, now recognised as a manifestation of so-called gatekeeping [7, 8]. Previous research conducted abroad shows that younger, recently trained MSHS feel more comfortable working with gender diversity and talking about pronouns in the office, while older, reluctant or prejudiced towards these topics and psychoanalytically oriented MSHS report the greatest difficulties in this area [20].

In terms of numbers, people with both assigned and self-identified female gender predominated in the study group. This may reflect the sizeable representation of women in the helping professions [21]. Moreover, previous foreign studies show that MSHS women, especially those who are acquainted with transgender people or have received training with a multicultural component, tend to declare a more positive attitude towards TGD persons [22–24]. Another interesting result of our study is the high representation of LGBTQ+ people in the sample. Available data reveal that at least a few percent of the population identify as LGBTQ+ [25]. From this perspective, in the MSHS sample, in which more than one-third declared a sexual identity other than heterosexual and/or a gender identity other than cisgender, there may have been up to several times as many such individuals as in the general population. Such a large difference may be due to the underestimation of the size of this subpopulation in population-based studies (closeted life and not revealing one's identity in surveys) [25], and simultaneously due to the MSHS' greater sense of security in disclosing it. In addition, individuals belonging to a stigmatised minority may also have a particular type of motivation to be involved in health care for TGD people. These may include, for instance, traits such as empathy and knowledge stemming from one's own experience of minority stress and supporting other LGBTQ+ people can be seen as both an effect and a source of development and integration of one's own minority identity [26, 27].

It is important to mention, however, that being both MSHS and LGBTQ+, can result in at least two types of risks. First, one's own minority stress experiences that has not yet been processed, i.e., traumas resulting from discrimination and internalised oppression, pose the risk of over-identifying with a patient and therefore not distinguishing between one's own mental processes and those of that person. Secondly, one's own minority experiences unsupported by adequate knowledge (e.g., in the scope of inclusive health care for TGD persons) and training, pose the risk of succumbing to the illusion of sufficient substantive preparation to work with this population, and therefore neglecting the obligation to continuously expand one's professional competence [28, 29].

Another significant characteristic of the study sample was religiosity. Compared to the general Polish population, the majority of which is described as belonging to the community of Roman Catholic Church (RCC) [30], more than half of the respondents identified as atheists. As the mainstream narrative in the dominant Polish RCC tends to be extremely conservative or even averse to LGBTQ+ people, this characterisation of the sample is not surprising. Believers and practitioners were also present among the respondents, which leads to the question of whether affirming clinical practice

may be challenging for them. The object of our analysis, however, was not to assess the relationship of MSHS' religiosity with the quality of care they offered to TGD individuals or the clinical decisions they made.

Knowledge of recommendations, guidelines, and standards

Results concerning the declared familiarity with the basic recommendations and standards related to the health care for TGD patients should be considered concerning. This is particularly relevant in the context of the increasing demand for trans-affirmative clinical care and the proliferation of institutions and individuals (mainly in the private market) advertising themselves as specialised in this field.

The most important and the only national document that describes and frames the principles of health care for TGD adults in Poland is the PTS Recommendations [14], published in the autumn of 2020, two years before our study began. This makes it all the more worrying, concerning that nearly one-fifth of MSHS were not familiar with this document at all, and several percent knew it very little. Information about its existence was posted on the PTS website, and it was published in a well-known and respected open access journal.

The situation does not look any better for another important document, the WPATH Standards of Care [9]. The seventh version of the Standards assessed in our study was translated into Polish several years ago and is available free of charge on the Association's website. Despite this, more than 40% of the participants were either not familiar with this document at all or had very low or low familiarity with it. These results are in line with findings from a UK study by Mollitt [20], according to which those participating in the study (i.e., psychotherapists) declared a low level of knowledge of the WPATH Standards of Care [9].

The APA recommendations [12] were not known to nearly 60% of respondents, and the Endocrine Society Recommendations [13] to almost 70% of MSHS. The latter result is consistent with findings of one study, in which half of the endocrinologists had not read the ES CPG at all [2]. Both documents are available in English exclusively, which can only partly explain the results. It may be argued that endocrinology recommendations or guidelines do not need to be known to MSHS, yet it is difficult to sustain such an argument from the PTS Recommendations' point of view [14], which indicate the utmost significance of psychoeducation, also in relation to HIAP. Is it possible to professionally educate others without one's own knowledge of the basic documents? It is, however, strenuous to properly justify the unfamiliarity of a document addressed directly to psychologists [12].

In light of the results presented above, the following questions arise:

(1) What are the circumstances that cause so many MSHS to disclose insufficient familiarity with the documents we have listed?
(2) How can these recommendations be made more accessible, and MSHS encouraged to update their knowledge of them?

(3) Since MSHS do not utilise the standards of practice and recommendations developed by expert bodies, what sources do they obtain expertise of the principles of working with/supporting TGD people from?
(4) Does and how does MSHS' insufficient knowledge of the documents we have identified translate into the management and quality of work with TGD patients/clients?
(5) Does and how does belonging to the LGBTQ+ community translate into a sense of competence and practice in working with TGD individuals?

Answering those questions requires further research. The MSHS assessment above is based on the assumption that it applies to individuals routinely supporting TGD persons, rather than those for whom the encounter with a TGD patient is incidental. Nevertheless, given the nature of the work (providing health care), it is only appropriate to maintain the highest possible standard for assessing professional expertise.

Strengths and limitations of the study

The results of our study should be considered in the context of its limitations. Among the most important are: (1) the non-representative nature of the study sample which makes it impossible to generalise the findings to the entire population of MSHS working with TGD people (in spite of that, knowledge of basic documents is a matter of such paramount significance for the safety and well-being of the patient that the demonstration of deficits in this area among any specialist group should be considered highly disturbing); (2) the online method based on self-report, with all the consequences for the accuracy and representativeness of the samples thus obtained (e.g., increased proportion of younger people), as well as possible distortions of findings (e.g., overly harsh or lenient assessment of one's knowledge) [31]; (3) the inclusion of people who had any prior experience of working with TGD people (this may raise the question of whether this is a group for whom TGD patients/clients represent an area of clinical specialisation; in our sample for most MSHS, TGD persons represented 10–20% of all patients/clients, which, combined with the estimated proportion of TGD people in the general population [32], should be considered a marker of significant involvement in aiding this patient group). In designing further research, it is worthwhile to use alternative sampling methods that result in near-representative samples such as *Respondent Driven Sampling* [31, 33] and to include more elaborate tools to verify self-declared knowledge of the documents.

Notwithstanding, our research possesses strengths: (1) this is the first study which explored both the personal and professional characteristics of MSHS providing care for TGD people in Poland, along with the assessment of familiarity with basic recommendations/standards; (2) significant sample size; (3) wide variation among MSHS in terms of basic education, stage of career, type of postgraduate training and prior experience in working with TGD people.

Conclusions

1. MSHS who provide clinical healthcare services for TGD people are a significantly diverse group – an aspect that would be considered while designing professional training.
2. There is an urgent need to intensify MSHS-directed professional training aimed at strengthening knowledge of existing recommendations/standards developed by scientific and professional societies.
3. In light of the rapidly evolving knowledge and guidelines, MSHS ought to proactively ensure that they keep their competences regarding standards of working with TGD people up to date. Implementation of this ethical obligation is facilitated by the availability of information via the Internet.

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