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Characteristics and expectations of patients seeking help for gender dysphoria in one of the sexological outpatient clinics in Poland

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Summary

Aim. The aim of the study was to present the characteristics of the convenience sample of the transgender people who registered in one of the sexological outpatient clinics, with particular emphasis on the needs of those seeking assistance. The division into persons with binary and non-binary identities was included.

Method. A statistical analysis of the data obtained from the medical records of a group of 49 patients, including 35 patients declaring binary identity and 14 patients declaring non-binary identity, was conducted. The data included, among others, the reported gender identity, the process of its emergence and the range of expectations towards the outpatient clinic (hormone therapy, qualification for gender confirmation procedures, support in obtaining legal recognition of gender reassignment, assistance in the coming-out process, treatment of co-occurring psychiatric problems or psychological assistance).

Results. The results indicate a great diversity of the examined group in terms of the declared gender identity. In the group of non-binary persons, a different than in binary persons course of the emergence and consolidation of gender identity is noticeable. The expectations reported in terms of hormone therapy, surgical treatment, legal recognition, assistance in the coming-out process and mental health indicate that there are differences and heterogeneous needs in the study group. The results indicate that expectations for hormone therapy, gender confirmation surgeries and legal recognition are more common in binary patients.

Conclusions. Despite the frequent perception of transgender people as a homogeneous group with similar experiences and expectations, the results indicate considerable diversity in the given range.

Key words: transgenderism, gender dysphoria, non-binary

Introduction

The origins of the modern health care standards for transgender people were not an easy process. On the one hand, various attempts were made to conceptualize transgenderism itself; on the other hand, the scope of medical interventions requested by patients was disputed. However, the treatment of the people considered to be somatically healthy and mentally ill with somatic agents, i.e., hormonal and surgical procedures, met with reluctance of the medical community. In these circumstances, one of the pioneers of transgender health care, endocrinologist Harry Benjamin, developed rules for the qualification of patients for medical gender confirmation treatment (GCT). These circumstances have led to the fact that, despite being aware of the great diversity of transgender people and their health needs, Benjamin has extremely narrowly and conservatively defined the category of 'transsexualism', which has survived to our times in the still valid form in ICD-10 classification [1, 2].

A person eligible for medical interventions was expected to experience his or her gender binary, through unambiguous male or female identification, and to expect a full range of affirmative interventions to embody the experienced gender as fully as possible. The picture was accompanied by the assessment of heterosexuality from the point of view of the experienced gender identity and a typical developmental trajectory in which transgender features were present from the childhood. The aversion to one's own genitals was to be common and being in relationships and engaging in sexual activity were to be unusual [3].

Nowadays, transgenderism loses the status of a clinical entity and the diagnostic focus is shifted to the state of chronic distress resulting from the discrepancy between the experienced and assigned gender (DSM-5) [4] or even to the state of the discrepancy itself and the resulting aspirations (ICD-11) [5]. The principles of clinical treatment are also evolving, such as the ones expressed in the Standards of Care issued by the World Professional Association for Transgender Health (WPATH) [6].

The diagnostic aim is no longer to identify 'true transsexualism', and the therapeutic approach is characterized by considerable and patient-centered flexibility. A large diversity of the population of transgender people is also taken into account, including the hitherto invisible group of non-binary people [7].

Meanwhile, both the experiences of transgender people seeking assistance and the scientific publications appearing in Poland point to rather conservative view of this issue in Poland [8, 9].

The aim of the analysis is to present the characteristics of the sample of transgender persons registering to one of the sexological outpatient clinics, with a division into persons with binary and non-binary identities and with particular emphasis on the needs of patients seeking help.

Material

The analysis of the available medical records of adult transgender patients who registered in the Sexological Outpatient Clinic of University Hospital in Krakow in

the years 2014–2019 (N = 49). 2014 is the year of the actual beginning of providing services to patients experiencing gender dysphoria in our facility. The records were prepared by the employees of the clinic: a medical doctor, specialist in psychiatry and sexology, and a psychologist, certified clinical sexologist. It was based on patients' interviews during routine clinic visits and analysis of patients' standard biographies. The study was approved by the Jagiellonian University Bioethical Committee (No 1072.6120.148.2020).

Method

The analysis of medical records was conducted with questionnaire, with the help of which a systematic registration of the studied variables was made, including: reported gender identity (binary vs. non-binary), age at the time of registration at the outpatient clinic, size of place of residence, name used (gender neutrality, reference to the assigned name), relationship status, presence of gender nonconformity in the childhood, age at which gender identity began to emerge and clarity about gender identity is achieved, coming-out about gender identity, expectations towards the outpatient clinic (hormone therapy, qualifications for gender confirmation surgical procedures, support in obtaining legal recognition of gender reassignment, assistance in the coming-out process, treatment of co-occurring psychiatric problems or psychological assistance).

The extraction and registration of data from medical records using a questionnaire was carried out by two medical doctors, co-authors of the research (M.P., S.Ż.).

Patient identities marked in the documentation as male or female were classified as binary, and the rest as non-binary. In the latter group, the category of trans-masculine, trans-feminine and agender identity was additionally distinguished. The conversion of the data on gender identities used in the records into the above-mentioned categories is presented in the appendix. The researchers did not have access to the terms used by the patients themselves.

The sexual orientation of the patients was categorized based on the recorded gender of the people to whom the patient was attracted or had sexual contact with. The bisexual/pansexual orientation category included people in which both sexes, as well as different gender identities, were recorded regarding the sex of desired and actual sexual partners or the patient's declaration that the sex or gender identity of sexual partners was not important for the patient.

Statistical analysis

The descriptive statistics are presented with reference to the whole group as well as with a division into binary and non-binary identities. Due to the small size of the studied sample, the chi^2 test was replaced with the more conservative Fisher's Exact Test. For the effect size measures Cramer's V and the polychoric correlation coefficient (rho) were employed. All the calculations were performed in STATA 14.

Results

Demography

The basic demographic data are discussed from the perspective of reported gender identity and presented in Table 1.

Table 1. **Sociodemographic characteristics of participants**

		Gender identity		
		Total	Binary	Non-binary
Age at the time of registration at the outpatient clinic	M	24.5	24.3	25.0
	MED	21.0	20.0	21.5
	MIN	18	18	18
	MAX	52	52	43
	N	49	35	14
	N missing	-	-	-
Size of the place of residence (%)	< 10k.	26.5	28.6	21.4
	10–99k.	20.4	20.0	21.4
	100k or more	51.0	51.4	50.0
	N	48	35	13
	N missing	1	-	1
Education (%)	Secondary school student	35.9	40.0	22.2
	Vocational	5.1	3.3	11.1
	Secondary	51.3	53.3	44.4
	Higher	7.7	3.3	22.2
	N	39	30	9
	N missing	10	5	5

The patients visiting the outpatient clinic were young, on average at the age of 24.5, with a median of 21 years. 35.9% of the group were secondary school students, and the majority (51.3%) had secondary education. The patients originated from places of different sizes, half of them (51%) lived in cities with population over 100k.

The majority of the respondents used names unambiguously assigned to the gender, other than their given names. Gender neutrality of the names was reported in 33.3% of non-binary individuals, while it was not found in binary individuals. The difference was statistically significant ($p < 0.001$, $V = – 0.52$). The situation in which the chosen name referred to the assigned name (e.g., Kamil – Kamila) occurred in 11.9% of the entire study group. In this respect, non-binary and binary persons did not differ from each other ($p = 1.000$, $V = 0.01$).

Nearly half (47.1%) of the studied group was in a romantic relationship. There were no significant or marked differences between binary and non-binary persons ($p = 0.703$, $V = 0.01$).

The declared gender and sexual identity and the age of the emergence and consolidation of gender identity

Table 2. **Gender identity, assigned gender and sexual orientation of the sample of transgender people**

		Gender identity			
		Total	Binary	Non-binary	
Gender identity – detailed	M	46.9	65.7	0.0	
	F	24.5	34.3	0.0	
	A/G	8.2	0.0	28.6	
	M > F	12.2	0.0	42.9	
	F > M	8.2	0.0	28.6	
	N	49	35	14	
	N missing	-	-	-	
Assigned gender	M	36.7	37.1	35.7	$p_F = 0.597$, V = 0.01
	F	63.3	62.9	64.3	
	N	49	35	14	
	N missing	-	-	-	
Sexual orientation (declared behavior)	ANDRO	16.7	14.3	25.0	$p_F = 0.723$, V= 0.18
	GYNE	50.0	53.6	37.5	
	PAN/BI	30.6	28.6	37.5	
	NONE	2.8	3.6	0.0	
	N	36	28	8	
	N missing	13	7	6	
Sexual orientation (declared attraction)	ANDRO	6.5	8.7	0.0	$p_F = 0.056$, V = 0.53
	GYNE	41.9	52.2	12.5	
	PAN/BI	38.7	34.8	50.0	
	ASEX	9.7	4.3	25.0	
	other	3.2	0.0	12.5	
	N	31	23	8	
	N missing	18	12	6	

note: M = male; F = female; A/G = agender; M>F = trans-male; F>M = trans-female; ANDRO = male identity of partners, i.e., cis male or trans-male sexual partners; GYNE = female identity of partners,

i.e., cis female or trans-female sexual partners; PAN/BI = people of different genders and identities; NONE = lack of sexual behavior with persons of any gender; ASEX = asexual orientation; p_F = Fisher's Exact Test p value

In the sample, 71.4% of patients declared binary identity, either the male (65.7%) or female (34.4%). The non-binary people comprise 28.6% of the sample, within 42.9% declared trans-male identity, 28.6% trans-female identity and 28.6% agender identity. Generally, the male identity prevailed (46.9%), followed by the female identity (24.5%), trans-male identity (12.2%), agender identity (8.2%), and the trans-female identity (8.2%).

The group showed great diversity in sexual behavior with the domination of contacts only with women (50.0%), followed by all genders (30.6%), less frequently only with men (16.7%). A minority of the studied group declared the lack of any sexual behavior with persons of any gender (2.8%). No difference was observed between the binary and non-binary persons. The results close to statistically significant difference were found in the declared sexual desire ($p = 0.056$, $V = 0.53$). Half of the examined non-binary and 34.8% of binary persons declared pan – or bisexual orientation, while as much as 25% of the non-binary patients declared asexual orientation, which was declared by 4.3% of the binary patients.

Table 3. **Gender identity development**

		Gender identity			
		Total	Binary	Non-binary	
Presence of gender nonconformity in the childhood	% Yes	97.0	96.3	100.0	$p_F = 1.000$, V = 0.08
	N	33	27	6	
	N missing	16	8	8	
Age at which gender identity began to emerge	<7	34.2	39.3	20.0	$p_F = 0.066$, rt = – 0.51
	7–12	34.2	39.3	20.0	
	13–18	26.3	21.4	40.0	
	19–24	5.3	0.0	20.0	
	N	38	28	10	
	N missing	11	7	4	
Age at which clarity about gender identity was achieved	Teenage period	63.6	78.3	30.0	$p_F = 0.004$, V = 0.60
	20–29	15.2	13.0	20.0	
	>30	9.1	8.7	10.0	
	No clarity	12.1	0.0	40.0	
	N	33	23	10	
	N missing	16	12	4	

p_F = Fisher's Exact Test p value

The majority of the studied group reported the existence of the features of gender nonconformity in their childhood (97.0%), with no significant difference between the binary and non-binary patients.

The beginning of the emergence of gender identity appeared before the age of 7 in 34.2% of the patients, between 7 and 12 in the same proportion, between 13 and 18 in 26.3%, and between 19 and 24 in the remaining 5.3%.

Patients with non-binary identities indicated a later onset of identity emergence (in 60% of people after 13 years of age) than patients with binary identities (in 79% of people under 12 years of age). Although the observed effect size was average (rt = – 0.51), this difference did not exceed the required level of statistical significance ($p = 0.066$), however, the observed trend deserves attention. Similarly, at the time of examination 40% of the non-binary patients were not clear about their identity, unlike the binary patients, for whom it was already clear. For the majority of the study group (63.6%) and binary patients (78.3%), it became clear during the adolescence, which was the case only in 30.0% of the non-binary patients. The observed difference is statistically significant ($p = 0.004$, $V = 0.60$).

The data are presented in Tables 2 and 3 respectively.

The patients' needs and expectations

Table 4. **The patients' expectations directed to the clinic and the information on the measures already taken by them**

Gender identity	Expectations				Already taken			Total			
	% Yes	% Maybe	% No	N	% Yes	% No	N	% Yes	% Maybe	% No	N
Hormone therapy											
Total	71.1	4.4	24.5	45	18.7	81.3	48	91.0	4.5	4.5	44
Binary	79.4	0.0	20.6	34	20.6	79.4	34	100.0	0.0	0.0	34
Non-binary	45.4	18.2	36.4	11	14.3	85.7	14	63.6	18.2	18.2	14
N missing	-	-	-	4	-	-	1	-	-	-	1
	$P_F = 0.016$, V= 0.43				$p_F = 1.000$, V = 0.07			$p_F = 0.002$, V = 0.55			
Surgery											
Total	68.9	13.3	17.8	45	4.2	95.8	48	73.4	13.3	13.3	45
Binary	81.8	3.0	15.2	33	5.9	94.1	34	87.9	3.0	9.1	33
Non-binary	33.3	41.7	25.0	12	0.0	100.0	14	33.3	41.7	25.0	12
N missing	-	-	-	4	-	-	1	-	-	-	4
	$p_F = 0.001$, V = 0.54				$p_F = 1.000$, V = 0.13			$p_F = 0.001$, V = 0.58			
Legal recognition of gender reassignment											
Total	75.6	7.3	17.1	41	6.3	93.7	48	82.9	7.3	9.8	41
Binary	87.5	3.1	9.4	32	5.9	94.1	34	93.8	3.1	3.1	32

table continued on the next page

Non-binary	33.3	22.2	44.4	9	7.1	92.9	14	44.4	22.2	33.3	9
N missing	-	-	-	8	-	-	1	-	-	-	8
	p_F = 0.003, V = 0.52				p_F = 1.000, V = 0.03			p_F = 0.004, V = 0.54			
Coming-out											
Total	4.4	8.7	87.0	23	93.6	6.4	47	91.6	4.2	4.2	48
Binary	5.9	0.0	94.1	17	94.3	5.7	35	94.3	0.0	5.7	35
Non-binary	0.0	33.3	66.7	6	91.7	8.3	12	84.6	15.4	0.4	13
N missing	-	-	-	26	-	-	2	-	-	-	1
	p_F = 0.059, V = – 0.53				p_F = 1.000, V = 0.05			p_F = 0.135, V= 0.36			
Help with mental problems											
Total	58.3	2.8	38.9	36	76.1	23.9	46	88.1	2.4	9.5	42
Binary	56.0	0.0	44.0	25	75.8	24.2	33	89.3	0.0	10.7	28
Non-binary	63.6	9.1	27.3	11	76.9	23.1	13	85.7	7.1	7.1	14
N missing	-	-	-	13	-	-	3	-	-	-	7
	p_F = 0.310, V = 0.28				p_F = 1.000, V = 0.01			p_F = 0.520, V = 0.23			

p_F = Fisher's Exact Test p value

The available medical records include data on the patients' expectations directed to the outpatient clinic and the information on the measures already taken by the patients.

These expectations concerned both strictly the transition process, as well as obtaining assistance with coming-out or experienced mental problems. These data are summarized in Table 4.

With regard to hormone therapy, 71.1% of the total number of the transgender patients expected support in this respect, among those who identified themselves binary, this percentage constituted 79.4%, and non-binary 45.5%, showing a statistically significant difference (p = 0.016, V = 0.43). Also, a considerable percentage of the people from both groups had already started hormone therapy at the time of registration, but neither a convincing effect size was observed here nor the difference between the binary (20.6%) and non-binary (14.3%) people was statistically significant. Including the people requiring hormone therapy and those who had already started it, the percentage of the people in the whole study group was 91.0%, with all the binary and 63.6% of non-binary people in this group. The difference proved to be statistically significant (p = 0.002, V = 0.55).

A slightly smaller percentage of the total number of the patients expected (68.9%) and had already performed (4.2%) some kind of gender confirming surgery, while a higher percentage than in the case of hormone therapy had not yet had specified their expectations, although they allowed such a possibility (13.3%). The binary patients more frequently than non-binary patients required surgical actions (81.8% vs. 33.3%; p = 0.001, V = 0.54), as well as they expected or had already undergone such actions (87.9% vs. 33.3%; p = 0.001, V = 0.58) – the differences were statistically significant.

Comparable, as in the case of hormone therapy and surgery, a proportion of all transgender persons (75.6%) as well as a proportion of the binary (87.5%) and non-binary (33.3%) persons expected support in terms of a legal recognition of gender reassignment ($p = 0.003$, $V = 0.52$) or expected and had already been granted with such a recognition (respectively: 82.9%, 93.8%, 44.4%; $p = 0.004$, $V = 0.54$.). In both discussed cases, the differences between the binary and non-binary individuals were statistically significant with a considerable effect size.

A relatively small percentage of all patients expected assistance in the coming-out process (4.4%), and most of them (93.6%) had done it, at least to some extent.

More than half of the study sample (58.3%) expected that the outpatient clinic could provide assistance in coping with accompanying mental problems, with no significant differences observed between the binary and non-binary groups.

Discussion

Historically, as it was described in the introduction, Benjamin's diagnostic and therapeutic model assumed that the only suitable candidates for the admission to the gender confirmation medical treatment included those who met the strict diagnostic criteria described in ICD-10 classification [2].

Although this approach has proven to be extremely effective in eliminating the risk of misclassifying patients for gender confirmation interventions, it has left a significant group of transgender people experiencing gender dysphoria without adequate support. The consequence of such a situation was the imitation of 'typical transgender narratives' by transgender people seeking help, who would like to find it and who would most probably be denied it otherwise. Another result was a growing lack of mutual trust, in the form of the tendency of some professionals to perceive transgender persons as disturbed and manipulative, and specialists in turn as unhelpful and 'gatekeepers' (i.e., making access to gender confirmation interventions difficult or impossible) [3, 10].

In this context, and at the same time in the context of evolving standards of care, there is a reason for concern that still, transgender persons are sometimes perceived as a group with homogeneous characteristics, and 'typical transgender narrative' is a guarantee for some specialists to initiate the treatment [11, 12].

However, the results obtained in this study, albeit coming from an unrepresentative convenience sample, draw a completely different picture, showing the remarkable diversity of the examined group.

Although the majority of the persons declared binary identity, as in other studies [13–15], almost one third of the respondents were non-binary. Moreover, a deeper exploration of the identities of the examined persons indicates even greater internal differentiation, closer to the concept of gender identity spectrum [16] than the dichotomous division into male and female identities. There was also a considerable variation in the developmental trajectory. Although some features of atypicality related to the sense and/or expression of gender in the childhood were declared by the majority of the respondents (97.0%), the age at which transgender identity manifests itself and

becomes clear as to its nature varied. Admittedly, a significant percentage of all the surveyed people started to question their identity in the childhood or early adolescence but for 32% of the people this process started later, i.e., after 12 years of age. Similarly, although 63.6% of the respondents gained clarity about their own identity during their adolescence, still over 20% of the people reached it after 20 years of age, and over 10% did not have such clarity when contacting the outpatient clinic. These results are consistent with the conclusions from the previous studies, which indicate the diversity of the population of transgender people in this respect [17].

In relation to the issue discussed above, we also observed a noteworthy statistical trend ($p = 0.066$, rt = – 0.51) regarding the difference between binary and non-binary persons. The non-binary people more often than the binary people started to question their identity at a later age. The required significance was achieved in the case of gaining clarity about one's own gender identity, where the non-binary persons clearly declared the lack of it more often when contacting the outpatient clinic. This may suggest that the process of the emergence and consolidation of the non-binary identity is somewhat different, extended over time and potentially more difficult.

There are various interpretations of this state of affairs. The non-binary identity is not an obvious developmental possibility and the knowledge about it is still limited. Some non-binary people struggle for a long time with the ambiguity concerning their own identity, seeking satisfactory explanations for the atypicality of their experiences. The attempts to fit into commonly available categories appear unsatisfactory. It can also be different. A non-binary identity, although it does not have to be so, is at a certain stage, an identification that is less threatening, on the way to binary identification as a trans-man or a trans-woman [18, 19].

Including the above facts, as well as the possible greater social misunderstandings faced by non-binary persons, they may constitute a group requiring particular clinical attention in the form of psycho-educational, supportive and psychotherapeutic actions. However, it should be emphasized, that according to the current standards the aim is not to achieve the final and perceived as the only proper binary identification [20].

Similar diversity and uniqueness have been observed with regard to sexual orientation, both in terms of the pursued sexual contacts and the declared sexual attraction. It should be noted that contrary to the 'classical narrative' and according to contemporary studies [21] and clinical experience, only a small percentage of the transgender persons (2.8%) did not declare any partnered sexual behavior. Slightly more of the surveyed persons (9.7%) did not feel any sexual attraction, with the characteristics potentially significantly different between the non-binary (25.0%) and binary (4.3%) persons. A significant percentage of the sample was bi – or pansexual, both from the point of view of the declared behavior and the attraction they felt. This is another argument in favor of the recently postulated understanding of sexuality (largo sense) of transgender persons as a unique and not only a cliché of the experience of cisgender persons [13, 14, 22]. This fact needs to be incorporated into clinical practice by avoiding forceful attempts to match the experience of transgender patients with what is considered a normative framework.

Another very important element for the clinical practice is the awareness of the health needs of the transgender persons registering at the outpatient clinic. Our results

confirm the literature data [13], which show a great diversity of transgender persons in this respect. Although the majority of the respondents declared the intention to initiate hormone therapy or had already received it, there were significant differences between the binary and non-binary people in this regard. As many as 79.4% of the binary patients and only 45.5% of the non-binary patients were expecting to include hormones, whereas 100% of the binary patients and 63.6% of the non-binary patients wished or had already had these hormones included. Only non-binary patients (18.2%) were included in the group of the people who did not have and did not expect to have hormone therapy to confirm gender. The data demonstrating that a non-binary identity may be related to the scope of the expected clinical action have already been published [23, 24].

The motivation to resign from hormone treatment may vary. The patients give reasons such as the fear of being rejected by the social environment, the fear of adverse effects on physical health, medical contraindications or doubts as to whether this intervention is appropriate for them. In the case of the non-binary persons, an additional role is played by the request to change some aspects/body parts, in the absence of such requests in relation to other parts of the body or even the desire to keep them unchanged. This can lead to uncertainty (more common in this sample in the non-binary people; 0% vs. 18%) as to whether they should undertake such actions. Especially since it is not always possible to achieve the desired configuration of features due to the specificity of hormones activity [25].

In the case of gender-confirming surgery, binary individuals expected it clearly more often than non-binary individuals (81.8% vs. 33.3%). The non-binary people, more often than in relation to hormone therapy (41.7%), were uncertain about the performance of the surgical intervention. The clinical experience shows that the non-binary transmale persons very often consider or report the need to perform a mastectomy, without expecting other gender-confirming medical interventions, which may be responsible for the observed results. The reasons found in our clinical practice for resigning from surgical interventions are the absence of gender dysphoria affecting certain bodily aspects, more often than not the so-called bottom body part, or such dominance of the top body part and voice dysphoria (due to its role in social identification and societal aspect of gender dysphoria) that the assessment of other aspects of gender dysphoria becomes secondary or not even fully possible. In addition, the patients raise concerns about the quality of the results of surgical procedures and the fear of the procedure itself or financial constraints.

Summarizing the results in relation to gender confirming medical interventions (GCMI) and at the same time the motivations for choosing or resigning from a given intervention that were observed in our clinical practice are consistent with the literature data.

Also, a relatively common need (75.6%) of the persons consulted in our outpatient clinic was the assistance in obtaining legal recognition of gender reassignment, although some people (6.3%) had already obtained such recognition. Taking into account both the people who requested such assistance and those after the legal recognition, the people who aimed at obtaining the recognition accounted for 82.9%

of the sample, with a clear (V = 0.54) difference between the binary (93.8%) and non-binary patients (44.4%).

Based on our clinical experience, it is not a satisfactory solution for many non-binary people to be able to confirm their gender as the 'opposite' category in the dichotomous system of possibilities, so they simply resign from the possibility of confirmation. At the same time, the patients often state that they would be interested in it if the legal system allowed for neutral or other gender assignment. It can be suspected that this state of affairs contributes to the results.

In addition, our clinical experience suggests that there are other reasons for not taking legal action. According to this, for some transgender persons, the possibility of adjusting the name itself in the Civil Registry Office to a gender-neutral name is satisfactory, for other patients, on the other hand, the resignation from this process is an act of protest against dehumanizing legal procedures, and for some others, the reason for the resignation is the fear associated with the unclear, perhaps hostile attitudes and behavior of parents, who, due to the legal state of affairs, are a party in civil proceedings.

The available studies show that transgender people are more likely to suffer from mental disorders in the depressive-anxiety spectrum or experience suicidal thoughts, attempt suicide, as well as other non-suicidal self-harm actions [26, 27]. In this context, it is not unusual that more than half of the sample group required assistance in the mental disorders they were experiencing, and most people either had such expectations or had already been using such assistance (88.1%). The clinicians should therefore be aware of this and should not concentrate on the limited diagnostic (the assessment and opinion for legal recognition) or therapeutic activities (initiating hormones).

Conclusions

Before drawing the conclusions, it is important to note the strengths and weaknesses of our study. The undoubted strength of the study is relying on the data from one of the few public sexological outpatient clinics in Poland specializing in the health of transgender persons. At the same time, the outpatient clinic aims at ensuring that the actions are consistent, as much as possible, with the general guidelines included in the WPATH Standards of Care [6]. This fact seems to be recognized by transgender patients and may promote greater openness and sincerity of the patients who register, which makes the picture of the experiences and needs of the people who register in the clinic more realistic. The strength of the research is also the regionally, legally and culturally specific Polish context.

The undoubted weaknesses and limitations of the study include: the convenient nature of the sample, its limited size, deficiencies and non-systematic data collection, including the lack of consideration for the measurement of the severity of gender dysphoria (different ways of evaluating it were used during the work of the outpatient clinic). The reliance on the analysis of the medical records may constitute both a strength of the study (the description of a unique clinical group) and a weakness (the lack of systematic data collection within the research project with the objectives formulated in this analysis). A significant limitation of the study is also the lack of ac-

cess to unique terms used by the surveyed patients to define their gender identity, and therefore assigning to a given identity category is subject to a potential error resulting from the arbitrary decision of the persons making the records.

Therefore, the conclusions formulated on the basis of our analysis, although corresponding to the results of the research to date, should be treated with caution. They require confirmation in studies of larger samples of patients from different centers, taking into account the patients' original gender self-identification.

In conclusion, our study shows:

1. The great heterogeneity of transgender people seeking specialist support which include gender identities and their development, sexual orientations and clinical needs.
2. A significant share of the non-binary persons in the group seeking assistance.
3. The unique nature of the experiences and clinical needs of transgender persons, especially those with non-binary gender identities.

Therefore, clinicians should be encouraged to take these facts into account in clinical practice and to abandon the already anachronistic perception of transgender persons and their needs.

References

1. Mijas M, Koziara K. *Klasyfikacja i ewolucja rozumienia zjawiska transpłciowości w seksuologii oraz współczesnych systemach diagnostycznych*. In: Grabski B, Mijas M, Dora M, Iniewicz G, editors. *Dysforia i niezgodność płciowa. Kompendium dla praktyków*, 1st ed. Warsaw: PZWL Medical Publishing; 2020. p. 3 –40.
2. *WHO*. *Klasyfikacja zaburzeń psychicznych i zaburzeń zachowania w ICD-10. Opisy kliniczne i wskazówki diagnostyczne*. Krakow–Warsaw: University Medical Publishing House "Vesalius"; 1997.
3. Grabski B. *Modele opieki i standardy postępowania*. In: Grabski B, Mijas M, Dora M, Iniewicz G, editors. *Dysforia i niezgodność płciowa. Kompendium dla praktyków*, 1st ed. Warsaw: PZWL Medical Publishing; 2020, p. 43–64.
4. *APA. Diagnostic and statistical manual of mental disorders,* 5th ed. Arlington, VA: American Psychiatric Association; 2013.
5. *WHO. International classification of diseases for mortality and morbidity statistics*, 11th ed.; 2018. https://icd.who.int/browse11/l-m/en. [retrieved: 1.07.2020].
6. *WPATH. Standards of care for the health of transsexual, transgender, and gender nonconforming people*, 7th ed.; 2012. https://www.wpath.org. [retrieved: 1.07.2020].
7. Nieder TO, Briken P, Richter-Appelt H. *Transgender, Transsexualität und Geschlechts-dysphorie: Aktuelle Entwicklungen in Diagnostic und Therapie*. Psychotherapie, Psychosomatik, Medizinische Psychologie, 2014; 64: 232–245.
8. Kowalczyk R, Rodzinka M, Krzystanek M. *Zdrowie LGBT. Przewodnik dla kadry medycznej*. Warsaw: KPH; 2016.
9. Robacha A. *Transseksualizm*. In: Lew-Starowicz M, Lew-Starowicz Z, Skrzypulec-Plinta V, editors. *Seksuologia*, 1st ed. Warsaw: PZWL Medical Publishing; 2017, p. 287–299.

10. 10. Lev AI. *Transgender emergence*. New York–London: Routledge; 2004.
11. Wolne Forum Transsowe. http://transpomoc.pl/search.php. [retrieved: 1.07.2020].
12. Transgender Europe.https://tgeu.org/wp-content/uploads/2017/10/Overdiagnosed_ Underserved-TransHealthSurvey.pdf [retrieved: 25.03.2021].
13. Kuper LE, Nussbaum R, Mustanski B. *Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals*. J. Sex. Res. 2012; 49(2–3): 244 –254.
14. Iantaffi A, Bockting WO. *Views from both sides of the bridge? Gender, sexual legitimacy, and transgender people's experiences of relationships*. Cult. Health Sex. 2011; 13(3): 355–370.
15. Cheung AS, Leemaqz SY, Wong JWP, Chew D, Ooi O, Cundill P et al. *Non-Binary and binary gender identity in Australian trans and gender diverse individuals*. Arch. Sex. Behav. 2020. DOI:10.1007/s10508-020-01689-9.
16. Monro S. *Towards a sociology of gender diversity. The Indian and UK cases*. In: Hines S, Sanger T, editors. *Transgender identities. Towards a social analysis of gender diversity*. New York: Routledge; 2010. p. 242–258.
17. Nieder TO, Herff M, Cerwenka S, Preuss WF, Cohen-Kettenis PT, De Cuypere G et al. *Age of onset and sexual orientation in transsexual males and females*. J. Sex. Med. 2011; 8: 783–791.
18. Murjan S, Bouman WP. *Psychiatry*. In: Richards C, Bouman WP, Barker MJ, editors. *Genderqueer and non-binary genders*. London: Palgrave Macmillan; 2017, p. 125–140.
19. Richards C. *Psychology*. In: Richards C, Bouman WP, Barker MJ, editors. *Genderqueer and non-binary genders*. London: Palgrave Macmillan; 2017. p. 141–167.
20. Richards C, Bouman WP, Barker MJ. *Genderqueer and non-binary genders*. London: Palgrave Macmillan; 2017.
21. Cerwenka S, Nieder TO, Cohen-Kettenis PT, De Cuypere G, Haraldsen IRH, Kreukels BPC et al. *Sexual behavior of gender-dysphoric individuals before gender-confirming interventions: a European multicenter study*. J. Sex. Marit, Ther. 2014; 40(5): 457–471.
22. Nieder TO, Becker I. *Transgender and sexual orientation*. In: Bouman WP, Arcelus J, editors. *The transgender handbook. A guide for transgender people, their families and professionals*. New York: Nova Science Publishers; 2018, p. 103–115.
23. Beek TF, Kreuels BPC, Cohen-Kettenis PT, Steensma TD. *Partial treatment request and underlying motives of applicants for gender affirming interventions*. J. Sex. Med. 2015;12: 2201 –2205
24. Nieder TO, Eyssel J, Köhler A. *Being trans without medical transition: exploring characteristics of trans individuals from Germany not seeking gender-affirmative medical interventions* [published online ahead of print, 2019 Nov 11]. Arch. Sex. Behav. 2019. DOI:10.1007/s10508-019-01559-z.
25. Seal L. *Adult endocrinology*. In: Richards C, Bouman WP, Barker MJ, editors. *Genderqueer and non-binary genders*. London: Palgrave Macmillan; 2017, p. 183–224.
26. Dhejne C, Van Vlerken R, Heylens G, Arcelus J. *Mental health and gender dysphoria: a review of the literature*. Int. Rev. Psychiatr. 2016; 28(1): 36–43.
27. Marshall E, Claes L, Bouman WP, Witcomb GL, Arcelus J. *Non-suicidal self-injury and suicidality in trans people: a systematic review of the literature*. Int. Rev. Psychiatr. 2016; 28(1): 58–69.

Appendix

Gender identity coding based on medical records

	Gender identity categories used in the study				
Gender identity categories used in the medical records to indicate gender identity	Female	Male	Agender	Trans-female	Trans-male
F	12	0	0	0	0
M	0	23	0	0	0
NB, F > M	0	0	0	4	0
NB, M > F	0	0	0	0	4
NB, M > F, genderfluid	0	0	0	0	1
NB, agender, M > F	0	0	0	0	1
NorM, NorF	0	0	1	0	0
NB, agender	0	0	3	0	0

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