Situation of LGBTA Persons in Poland

2015-2016 REPORT

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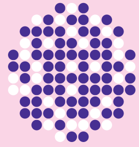
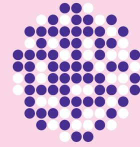


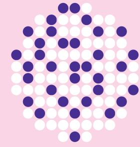
68,9%

encountered at least one type of violence,



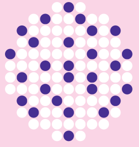
63,72%

of LGBTA people experienced verbal abuse,



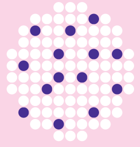
33,96%

– threats,



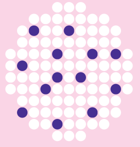
27,27%

– vandalism and refusal,



14,11%

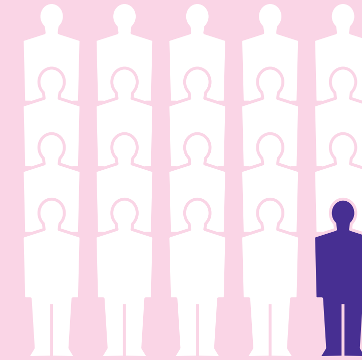
– sexual violence,



12,84%

– physical violence.

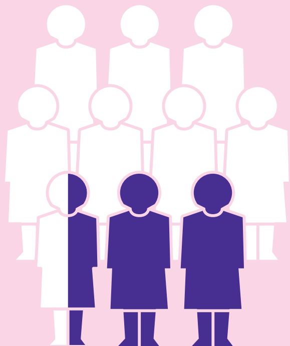
N = 6348



Less than 4%

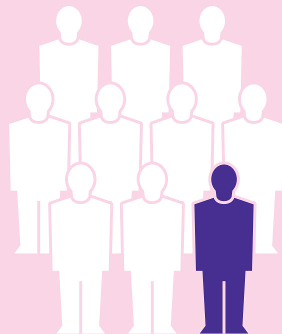
of LGBTA people who experienced violence motivated by homophobia and/or transphobia reported it to the police.

N = 6348



25%

of mothers

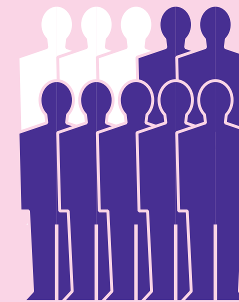


12%

of fathers

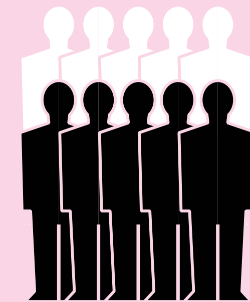
fully accepts the orientation of LGBTA persons from their family.

N <5853; 8903>



69.4%

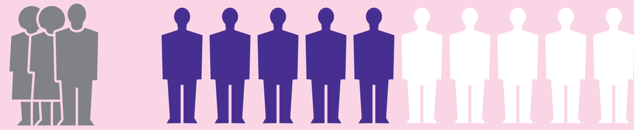
of LGBTA youth has suicidal thoughts.



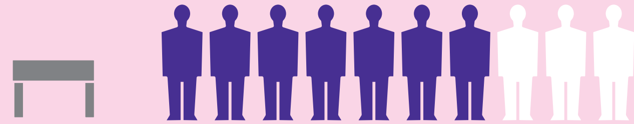
49,6%

of LGBTA youth has symptoms of depression.

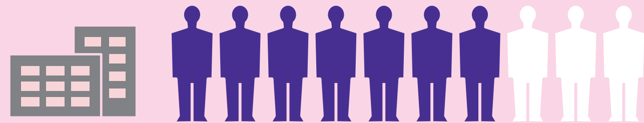
N = 2666



50% of LGBTA people hide their orientation from neighbors and landlords,

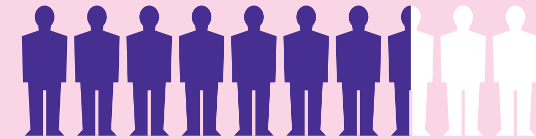


71% at the workplace



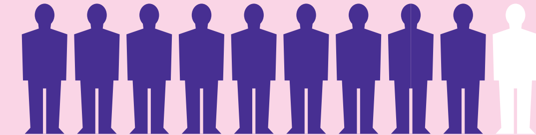
73.3% at school or university.

N <4402; 6765>



75%

2010–2011



87,2%

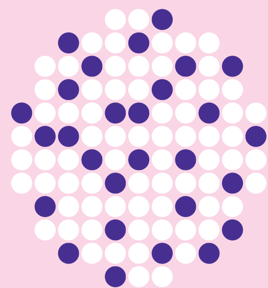
2015–2016

Increasingly more LGBTA people want a registered partnership.

N = 6273

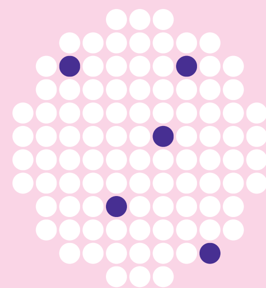
28,4%

of LGBTA people



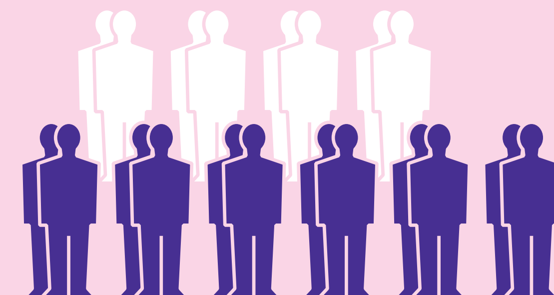
5%

of society



suffers from depression.

N = 5947

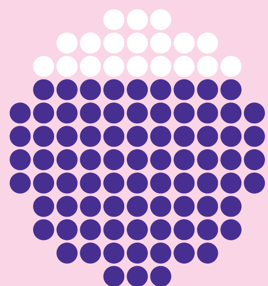


61,76%

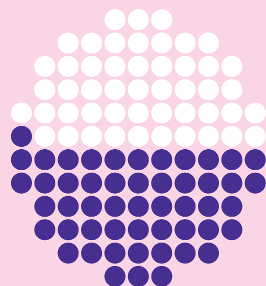
of transgender people want to remain in their marriages. Court requirements concerning legal gender reassignment do not allow it.

N = 33

80,4%
of LGBTA people



50,92%
of general population



voted in the 2015
parliamentary elections.

N = 5291

ASEXUAL PERSON – a person without an attraction and capability for deeply emotional and sexual relations with persons of the same gender, opposite gender, or of more than one gender
BISEXUAL PERSON – a person attracted to both women and men.
CISGENDER PERSON – a person whose gender assigned at birth corresponds with their gender identity.
GAY MAN – a male person attracted to other men.
GENDER IDENTITY – a deeply felt, internal sense, and personal experience of gender. Gender identity may or may not correspond with gender assigned a birth.
HOMOPHOBIA – prejudice against homosexual people/homosexuality and bisexual people/bisexuality, based on stereotypes.
INTERSEX PERSON – a person born with male and female primary and secondary sex characteristics.
LESBIAN – a female person attracted to other women.
LGBTAQI PERSONS – lesbians, gays, bisexual, transgender, asexual, queer, and intersex persons.
NON-HETERONORMATIVE PERSON – a person who is non-heterosexual and/or rejects traditional gender roles.
OUT – adjective to describe a person who is open about their sexual orientation.
QUEER PERSON – a person who does not fit into traditional gender and sexual orientation categories; in practice crossing/contesting existing norms regarding sexuality, appearance, and gender and strategic refusal to clearly define oneself within these categories.
SEXUAL ORIENTATION – attraction and capability for deeply emotional and sexual relations with persons of the same gender, opposite gender, or of more than one gender, as well as lack of such attraction.
TRANSGENDER PERSON - a person whose gender assigned at birth does not correspond with their gender identity.
TRANSPHOBIA – prejudice against transgender people/transgenderism based on stereotypes.
TRANSSEXUAL PERSON – a transgender person undergoing sex reassignment (for example surgical procedures or hormone therapy etc.) in order to adjust physical appearance to their gender identity.

Introduction and research goals

Campaign Against Homophobia, Lambda Warsaw Association, and Trans-Fuzja Foundation, three Polish organizations for LGBTAQI rights, conduct the largest study in Poland concerned with the situation of non-heteronormative persons (lesbians, gays, bisexual and transgender people), every five years. The latest edition also includes asexual persons.

The aim of the study was to carry out an in-depth sociological and psychological analysis of the living conditions of LGBTA persons in Poland. The first report about the situation of LGBT persons was published in 1994. Since then the study is conducted regularly. The result of the last edition was a report for the years 2010-2011. This edition is dedicated to analysing living conditions of LGBTA persons (including asexual persons) in the years 2015-2016.

We hope that the report prepared by Campaign Against Homophobia, Lambda Warsaw, and Trans-Fuzja reaches people responsible for making national and local laws, and its reading will lead to taking actions resulting in positive change in the areas of i.a. education, job market conditions as well as social, health, and public safety policy.

Methodology and procedures

Studies on the situation of LGBTA persons were conducted using an online questionnaire. Data was collected through a survey published on the website www.kph.org.pl/badanielgbt from November 24th, 2016 until the end of February 2017. The study was

promoted via mailing to Polish LGBTAQI organizations, asking them to share the survey on their websites and social media, external mailing to users of dating websites for gay people, and sharing the link to the study on various internet forums and LGBTAQI groups on social media.

Respondents were asked about their experiences and social situation from January 2015 until the end of 2016. The questionnaire consisted of about 85 questions, with an additional set of questions for transgender persons, and an added set for lesbians and gays about hate speech, depending on the person's identity and experiences (e.g. of violence). Filling out the survey took between 15 and 45 minutes.

This questionnaire was different from the one five years ago. Since the research tool for the 2010-2011 study did not allow for broader comparisons between particular groups (transgender persons got a completely different set of questions than homo- and bisexual persons), this time we decided to change the questionnaire in a way that enabled comparisons between these groups. Additionally, some questions were asked in a way that allowed us to compare the results to the general population of Polish people. The current structure of the research tool also made it possible to study asexual persons.

The survey included questions about areas of life such as education, work, health, and family life. It touched upon issues concerning violence, discrimination and unequal treatment, mental wellbeing of respondents, sociopolitical beliefs, and attitudes towards relationships.

Limitations due to sample selection and data comparability

When drawing conclusions from empirical studies, one has to consider a number of factors which limit the possibility of generalizations. These factors may come from different sources; some of the potential errors may be related to the subject matter of the study (e.g. issues difficult for respondents), nature of the studied population (e.g. problems with defining the population and reaching an appropriate sample), as well as the study itself (methodological imperfections). Additionally, there are specific contextual elements of the study (e.g. the current political or social

climate) which can affect its validity.

Before we describe all the limitations, we want to highlight two very important issues. Firstly, it is one of the largest and most systematic attempts to analyse issues regarding the social situation of LGBTA persons. Secondly, in studies on these types of issues (particular populations and hard samples to reach) the methodological problems discussed later on are unavoidable. Therefore, the decision to conduct the study comes with the question whether, knowing about the methodological imperfections, one should attempt to study the problem anyway and have some, even approximate, data or one should give up any attempts and have no information.

Defining the population and sample selection

In order to talk about a sample being representative, one needs very detailed knowledge about the population the sample is supposed to represent. In the case of LGBTAQI people, an operational definition like this is impossible to construct. It is mostly due to the fact that part of the LGBTAQI population is not out and/or does not identify with these social categories. For example, a woman who has romantic or sexual relationships with women, and who does not identify as a lesbian, will be of interest to the authors of this study, however, people who do not identify with the agreed upon categories are unlikely to become part of the sample, and therefore will not be properly represented. Thus, this publication describes the situation of mostly people who identify as lesbian, gay, bisexual, asexual, and transgender. The second problem regarding proper representation of the population in the sample comes from the method. The data gathering method employed for this study allows for reaching a large number of people but also means that portions of the population will be underrepresented. Online studies via websites and LGBTAQI organizations' networks result in more young people and those who identify with and are more engaged in the LGBTAQI community ending up in the sample.

Sociodemographic profile – sample characteristics

The 2015-2016 study on the situation of LGBTAQI persons had 10704 respondents. This portion of the report will describe demographic characteristics of the studied sample, such as age, gender, sexual orientation, education, income, subjective financial situation, as well as place of residence and migration.

Researched groups

Based on answers to the questions about sexual orientation and gender identity, the target group (LGBTA persons) was divided into six subgroups[1] - lesbians, gays, bisexual women, bisexual men, transgender persons, and asexual persons. Among the respondents, gay men were the largest group (45,9%), followed by bisexual women (20,8%), and lesbians (17,2%). Few of the respondents were transgender persons (7,2%), bisexual men (6,4%), and asexual persons (2,5%). Moreover, some of the respondents were non-binary; they identified neither as transgender, nor as men or women (N=268). This group was excluded from analysis of subgroups (as it was not homogenous), however these respondents were included in all general analyses.

Age

Participants of the study were mostly young – the average age was M = 25,28 (SD = 9,43 ranging from 8 to 97 years old[2]), while median[3] age was 23, which shows that the sample consisted mostly of young adults. This information allows us to draw important conclusions about the study sample. It shows that the results presented in this report concern mostly young representatives of the LGBTAQI community in Poland and one should be careful when relating them to the entire Polish LGBTAQI community[4].

Nearly half of the respondents[5] (42,2%) were aged 18-25. A quarter of them (25%) were between the ages of 26 and 35 while one fifth (19,3%) were underage. Least represented were people aged 36-45 (9,8%) and above 45 (3,7%).

1 N = 9660.
2 The question about age was compulsory. It is likely that respondents, who did not want to answer this question chose one of the extremes. Further analysis (e.g. looking at links between other parameters and age) does not include answers from those extremes (<13 and >95).
3 Median divides a set in half – the number of answers below and above it is the same.
4 See *Limitations*.
5 N = 9262.

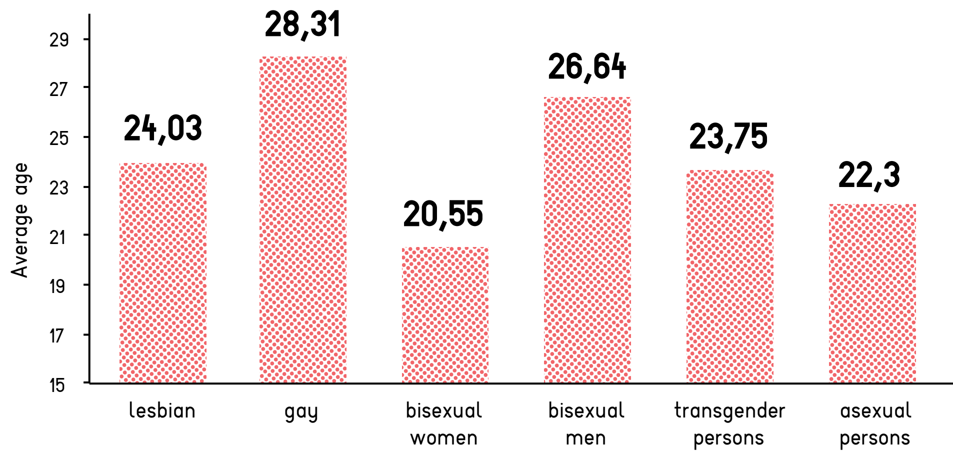


FIG. 1. Average age of respondents divided into subgroups based on sexual orientation and gender identity (N = 9262)

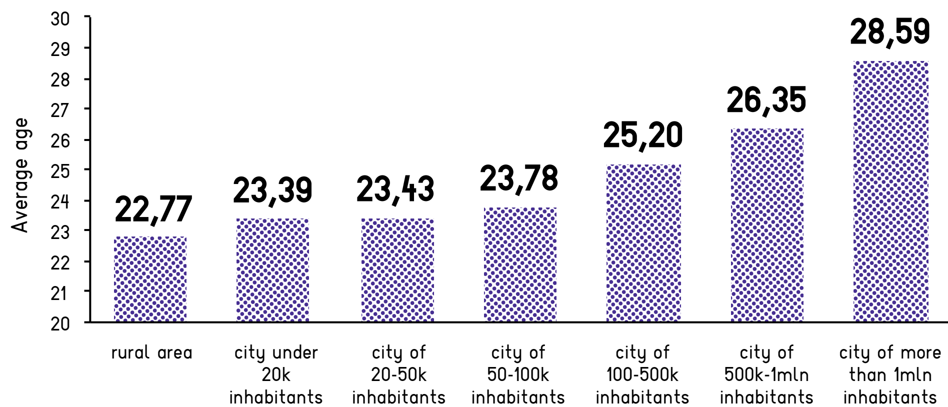


FIG. 2. Average age of respondents by size of place of residence (N=7877)

Subgroups of respondents, based on sexual orientation and gender identity, differed by age[6] (fig.1). Gay men were the oldest, while bisexual women – the youngest.

Age of respondents differed by size of their place of residence (fig. 2). The oldest respondents lived in Warsaw[7], the youngest – in rural areas.

6 F(5, 9256) = 226,41; p < 0,001; hp2 = 0,11.

Gender

Among respondents who did not indicate that they are transgender (or have a transgender past), most were men – they made up 56,8% of the group. Among transgender persons, people declaring themselves as men were also the biggest group – almost 50%. Detailed information about the gender of respondents can be found on the chart below (fig. 3), separately for cisgender and transgender people.

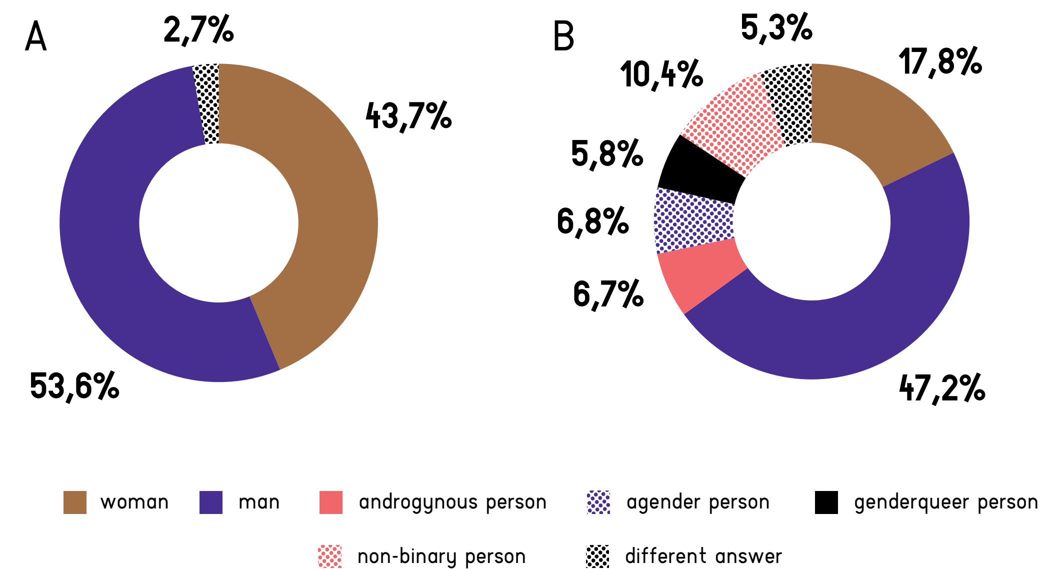


FIG. 3. A: Cisgender respondents by gender (N = 9879), B: transgender persons by gender (N =674)

7 Since there is only one city with a population of more than 1 million (Warsaw), we assume that respondents who chose this option live in the capital: F(6,7870) = 64,76; p <0,001; hp2 = 0,05.

Sexual orientation

When it comes to sexual orientation, in this edition of the study most respondents were homosexual persons – they made up 65% of the studied group. Figure 4 shows detailed information about the sexual orientation of respondents.

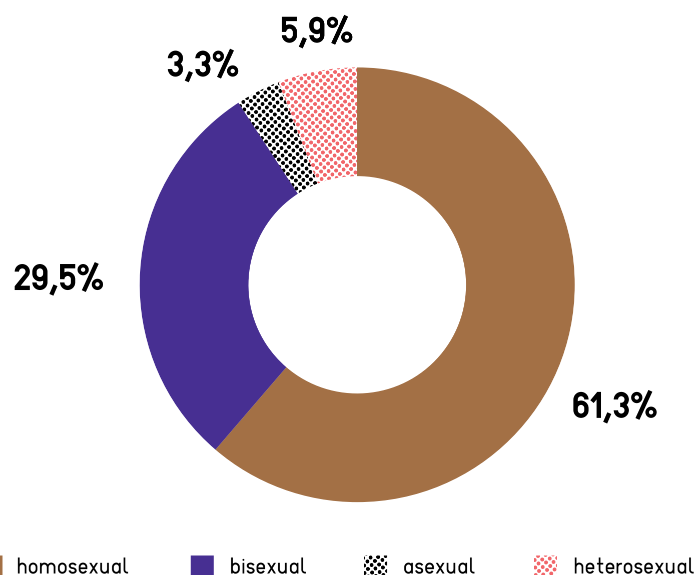


FIG. 4. Respondents by sexual orientation (N = 10384)

Education

People with higher education[8] dominated among the respondents (41,8%), followed by people with secondary (38,8%) and primary (17%) education. People with vocational education were least represented (2,4%).

Respondents were also asked about the number of completed years of education. Figure 5 shows the breakdown of answers to this question. The average number was M = 14,21 (SD = 3,54).

8 N = 7877.

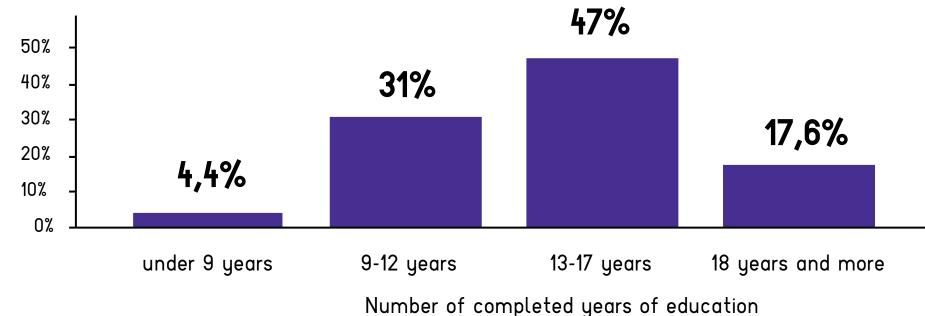


FIG. 5. Breakdown of completed years of education (N = 7831)

Length of education was broken down by subgroups of respondents[9] (fig. 6). Gay men were the most educated, while transgender persons – the least. Differences in length of education decreased (although did not completely disappear) when age of the respondents was considered. This shows that better or worse education of particular subgroups divided by sexual orientation, is not only a result of the age difference between these groups.

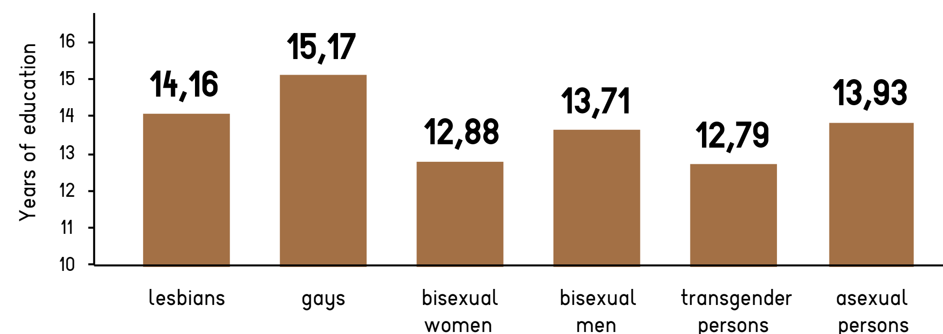


FIG. 6. Average number of years by subgroups based on sexual orientation and gender identity (N = 7624)

Number of years of education was related to the size of the city in which the respondents lived[10] (fig. 7). The most educated lived in Warsaw, the least – in rural areas and cities under 20k inhabitants. Importantly, these differences remained when controlled for age of respondents.

9 $F(5, 7618) = 125{,}61$; $p < 0{,}001$; $hp2 = 0{,}08$.
10 $F(6, 7824) = 166{,}44$, $p < 0{,}001$; $hp2 = 0{,}11$.

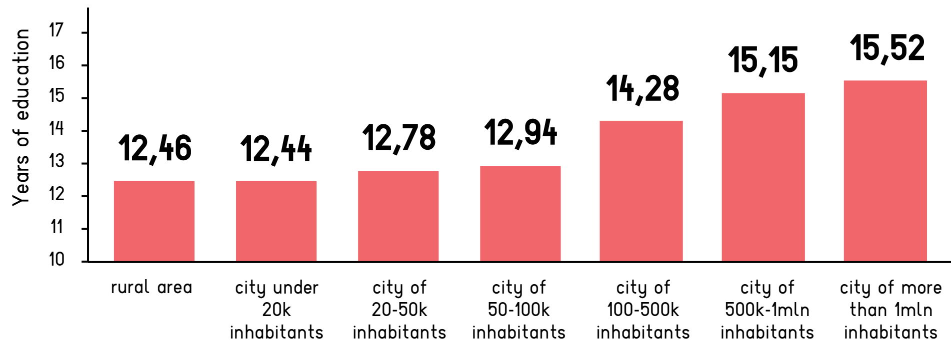


FIG. 7. Average number of years by size of place of residence (N = 7831)

Moreover, unemployment rates in the county where the respondents lived, negatively predicted their level of education, understood as completed number of years of education[11]. This means that the higher the unemployment rate in a county, the worse educated the respondents were.

Income

Respondents were asked to disclose their monthly net income range[12]. The largest group of respondents declared that their income was between 1001PLN and 2000PLN (28,3%). The second largest group were people with an income ranging between 2001PLN and 3000PLN (24,7%). One in five people declared an income of less than 1000PLN a month (22,4%). People with incomes between 3001PLN and 4000PLN (15,3%) and above 4000PLN were least represented. The median answer was between 1501PLN and 2000PLN (9,2%).

The studied subgroups differed from each other based on average monthly net income[13]. Gay men were the most well-off; 57,8% of them declared an income of at least 2000PLN. 29,1% of transgender people declared the same range, making their declared financial situation the worst among the groups. It should be noted that while the differences between the subgroups (created based on sexual orientation and gender identity) decreased when controlled for age and number of completed years of education, they remained statistically significant. In other words, differences in income of all subgroups included in the analysis did not depend only on age or level of education.

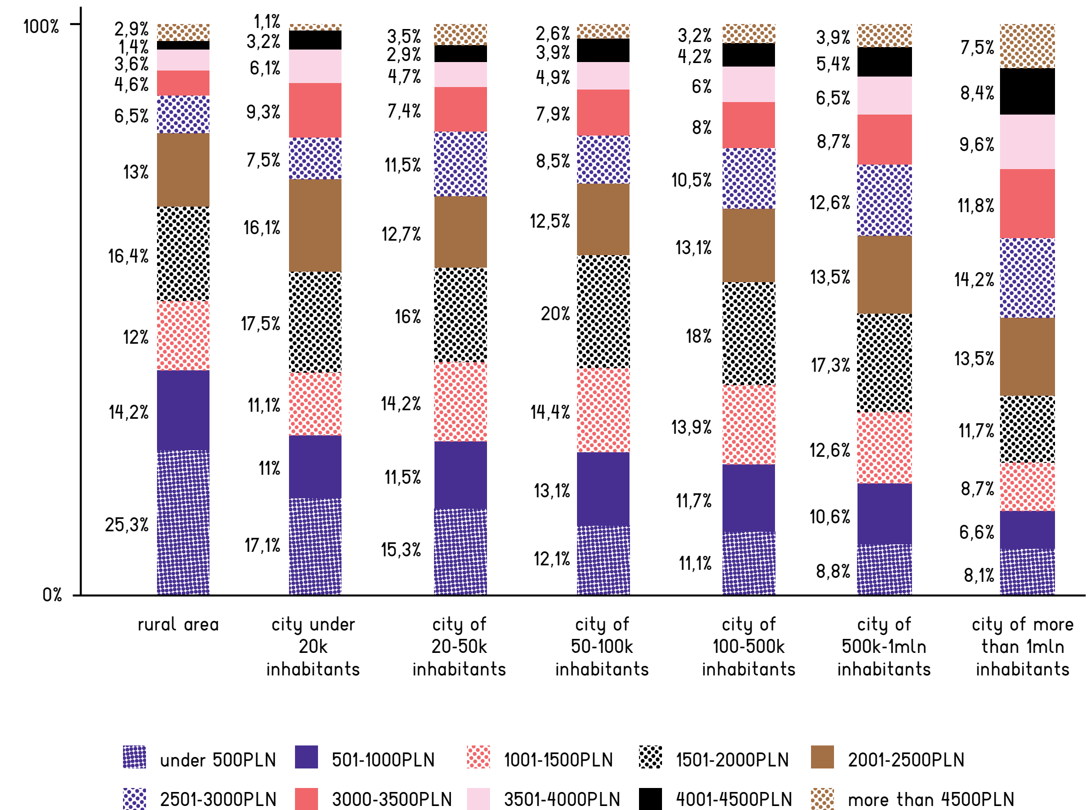


FIG. 8. Distribution of monthly net income by size of place of residence (N = 4555)

11 B = -0,07; SE = 0,02; p = 0,001. This effect is unique, and thus independent of other county characteristics included in the model (average pay in 2015, number of inhabitants in 2015, and percentage of believers). Other county level effects mentioned in this chapter are also unique.

12 N = 4555.

13 $F(5, 4469) = 51,53$; $p < 0,001$; hp2 = 0,06.

The size of respondents' place of residence influenced their incomes[14] (fig.8). The financial situation of Warsaw residents was the best, 65% of them declared an income of at least 2000PLN. The smallest income was declared by people living in rural areas – 32% of them declared an income of 2000PLN or more.

Moreover, the average pay for general population in a specific county, drawn from data collected by the Central Statistical Office of Poland (GUS), positively predicted the respondents' incomes[15]. This means that respondents' incomes mirrored the average income for their place of residence – the higher the average income in a county, the higher the respondents' income.

Subjective financial situation

Foreseeing that the number of answers to the question about monthly income level will be relatively low, we included less invasive questions in the survey, measuring subjective feelings about respondents' own financial situation. Figure 9 presents the distribution of answers.

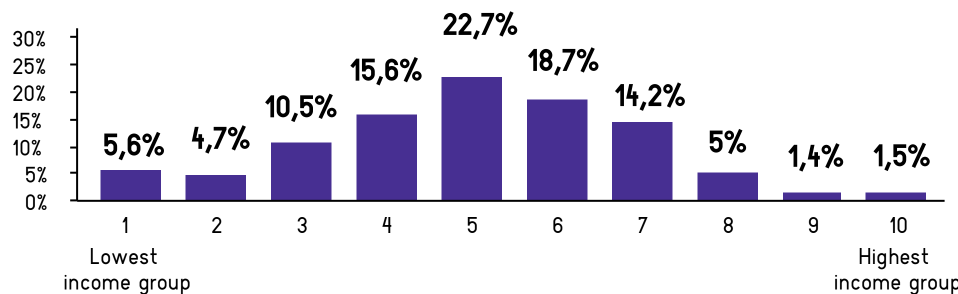


FIG. 9. Distribution of answers to the question about subjective financial situation (N = 7877)

Respondents thought that their financial situation is average – on a 10-point scale, where 1 was the lowest income group and 10 the highest income group, the average answer was M= 5,02 (SD = 1,92). However, subjective financial situation did differ by

14 F(6, 4548) = 40,70; p < 0,001; hp2 = 0,05.
15 B = 0,02; SE = 0,01; p < 0,001.

demographic factors, including sexual orientation and gender identity[16]. ay men were relatively in the best situation, while transgender people in the worst[17]. Similarly to questions about income level, the differences between subgroups within the LGBTA community disappeared when controlled for age and completed years of education. Subjective financial situation was related to the respondents' place of residence[18]. Inhabitants of Warsaw considered their situation to be the best, while inhabitants of rural areas – the worst[19].

Place of residence and migration

Respondents were asked questions about their place of residence until the age of 18 and presently. Besides a standard question about the size of the place, respondents were also asked to specify their voivodeship and county. The answers allowed us to indicate where the LGBTAQI community is the largest and determine patterns of migration of LGBTA people.

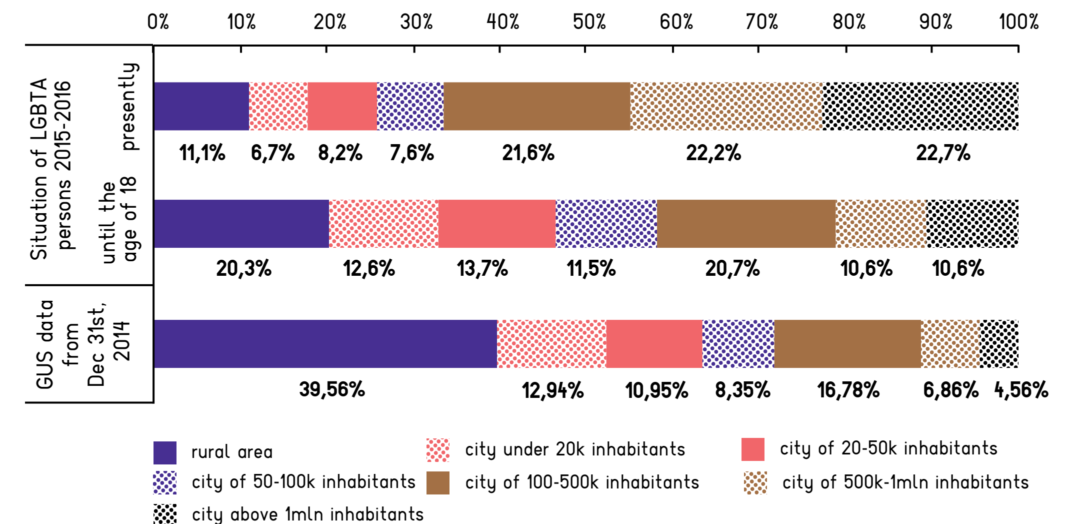


FIG. 10. Distribution of answers to questions about size of the place of residence compared to data for general population (N = 7877).

16 F(5, 7664) = 19,34; p < 0,001; hp2 = 0,01.
17 Gay men: M = 5,21; SD = 1,93. Transgender persons: M = 4,52; SD = 2,08.
18 F(6, 7870) = 40,24; p < 0,001; hp2 = 0,03.
19 Inhabitants of Warsaw: M = 5,55; SD = 1,93. Inhabitants of rural areas: M = 4,57; SD = 2,07.

Figure 10 shows the distribution of answers to question about size of the place of residence compared to results for general population published by the Central Statistical Office of Poland (2015). Figure 11 shows location of respondents until the age of 18 and presently.

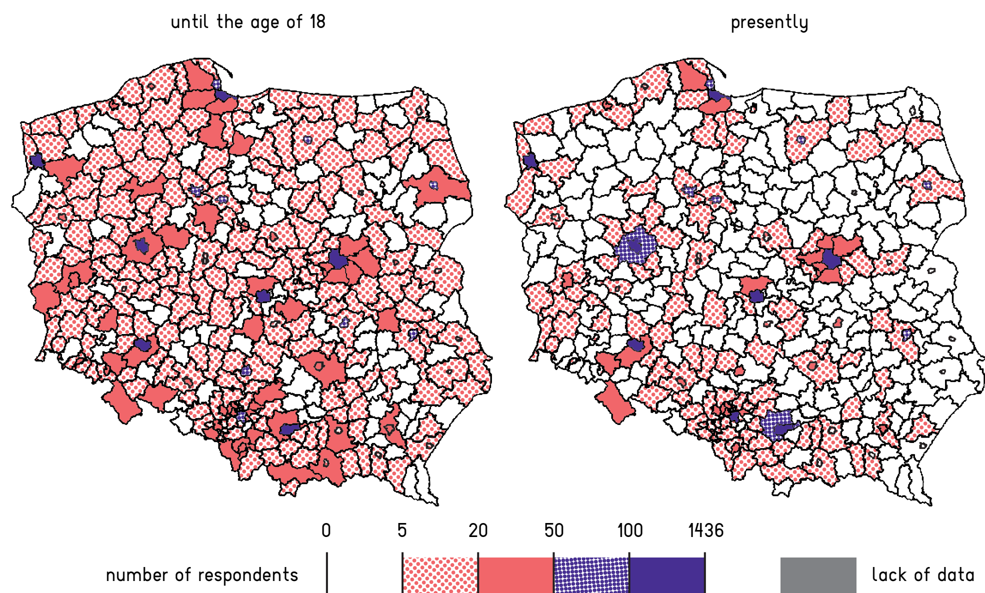


FIG. 11. Respondents' place of residence until the age of 18 and presently (N = 6452 and N = 6841)

Inhabitants of all 380 counties took part in the survey. As expected, among respondents who specified which county they currently live in, the largest group were inhabitants of Warsaw (21%) followed by Cracow (7,4%), Poznań (6,7%) and Wrocław (6,5%). It should be noted that the distribution of inhabitants in cities best represented in the survey is different from the distribution of the general population – according to data by the Central Statistical Office of Poland[20] (2016) the largest Polish cities are Warsaw (4,56%), Cracow (1,99%), Łódź (1,81%), Wrocław (1,66%) and Poznań (1,41%).

20 *GUS Rocznik demograficzny 2016*. Warszawa, GUS, 2016. Downloaded from: http://stat.gov.pl/obszary-tematyczne/roczniki-statystyczne/roczniki-statystyczne/rocznik-demograficzny-2016,3,10.html

Based on this comparison one can come to the conclusion that LGBTAQI persons live in cities of more than 500 000 inhabitants more often than general population. Results presented on fig.10, according to which 44,90% of respondents live in cities of more than 500 000 inhabitants, compared to 11,42% of general Polish population (fig.10), lead to the same conclusion.

Distribution of respondents by current place of residence is less even than that by place of residence until the age of 18. This suggests that many respondents changed their place of residence after adolescence (fig.11) and migrated mostly to large cities, capitals of voivodeships. Analysis of answers to questions about size of the place of residence until 18 and presently, leads to a similar conclusion. During the period between adolescence and the moment of the study, 42,2% of respondents moved to a different-size city; most of them to a larger one (89,34%) and a small portion (10,66%) to a smaller one. Years of education[21] and subjective financial situation[22] positively predicted migration to a larger city – the better off and better educated the respondents were, the more likely it was that they moved to a city with more inhabitants. Migrating to a smaller area was positively predicted by age[23] - the older the respondent, the more likely that they would move to a less populated area. When interpreting these correlations, it should be noted that the cross-sectional nature of this study does not allow for determining casual direction. For example, it is both possible that persons in a better financial situation moved to bigger cities and that their financial situation improved after moving to a bigger city.

Based on the gathered data, it was possible to measure population outflow and inflow indexes for specific counties (fig.12). Outflow should be understood as the percentage of people who lived in a particular county for the majority of their childhood and adolescence and moved out of it before the study was conducted. We understand inflow to be the percentage of current inhabitants of a particular county, who did not live in it for the majority of their childhood and adolescence.

21 $B = 0,23; SE = 0,02; p < 0,001$
22 $B = 0,10; SE = 0,02; p < 0,001$
23 $B = 0,03; SE = 0,01; p < 0,001$

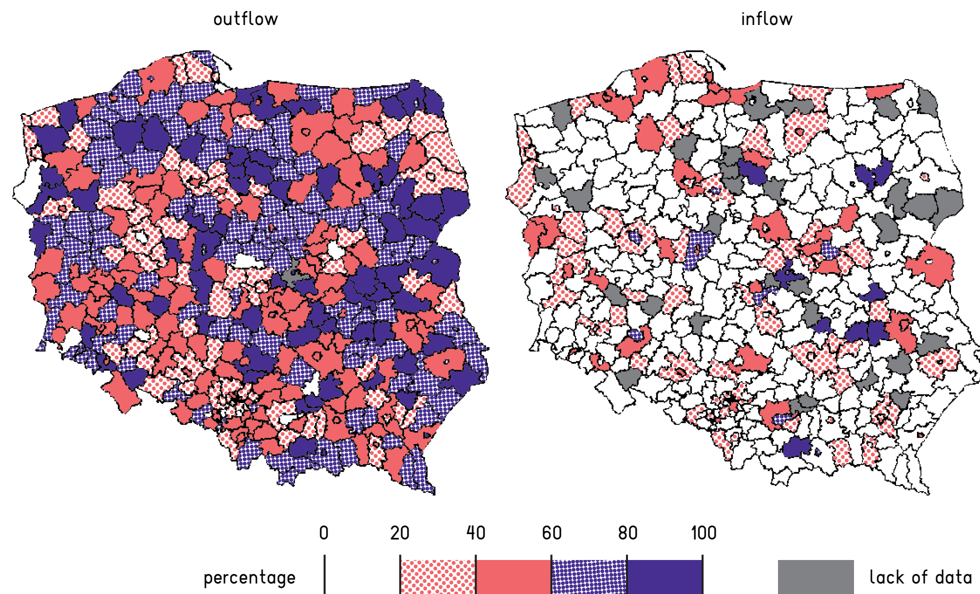


FIG. 12. Outflow and inflow of respondents (N = 6349)

As indicated by fig.12 only in a small number of counties the outflow of respondents was under 20%. The group consisted of the largest voivodeship capitals: Warsaw (12,54%), Cracow (13,98%), Wrocław (16,35%), and Poznań (17,47%). The same cities also had a relatively high inflow of respondents – people who moved were 62,64% of respondents currently living in Warsaw, 66,17% in Cracow, 68,03% in Wrocław, and 68,29% in Poznań. Therefore, one can say that large cities which offer better opportunities (educational, economic, and social) reined in the outflow of LGBTAQI respondents and attracted new inhabitants.

On a county level, inflow of LGBTAQI persons was positively predicted by the number of inhabitants[24], and negatively by the unemployment rate[25] and percentage of people of faith in the county population[26]. This means that counties with the largest number of inhabitants, lowest unemployment rates and lowest percentage of people of faith had the most people who changed their place of residence. Average pay did not affect the rates of incoming residents among the local LGBTAQI population. Therefore, one can say that stable characteristics like population size, religiosity, and structure of the local jobs market were decisive in whether a county attracted LGBTA people or not.

24 B = 3,59; SE = 1,04; p < 0,001. One unit was 100 000 inhabitants.
25 B = -0,53, SE = 0,26; p = 0,041.
26 B = 0,92; SE = 0,42; p = 0,028.

Demographic comparison to the group researched in 2011

Since the previous edition of this study was conducted in a different manner than this one (in differentiating between people with and without a transgender past), comparing respondents by sociodemographic characteristics was only possible on a general level. However, comparing data from this year and from five years ago, one can say that the research groups are similar. Both five years ago and now, the study was dominated by men and people declaring their gender to be male. Five years ago, the group also consisted mostly of educated young adults. The average age for both LGB and trans people was around 26. Moreover, five years ago more than 40% of both groups declared that they had higher education. Percentage of LGBT people living in cities of more than 500 000 inhabitants was also similar to this year.

Level of trust for institutions and participation in parliamentary elections

This chapter will discuss the issue of LGBTA persons' attitudes towards public institutions, namely the government, parliament, police, courts, and LGBTAQI organizations, as well as their participation in the last parliamentary elections (October 2015).

Respondents' answers were compared to the results of studies conducted on a large sample of heterosexual persons (Attitudes towards homosexual persons 2016[27]) and on representative samples of Poles (World Values Survey 2012[28]; Social trust 2016[29]). It allowed us to observe the differences between LGBTA persons and heterosexual persons as well as general population. If we had access to raw data[30] from a comparative study, we controlled for discrepancies in compositions of particular samples to see if the observed differences were a result of them[31].

The results of our analyses are presented based on a pattern. First, we describe the distribution of answers to question(s) measuring a particular characteristic (e.g. trusting the courts). Next, we check for differences between subgroups within the LGBTA community regarding the attribute. Finally, we identify individual factors (the ones considered here are age, education defined as completed years of education, subjective financial situation, religiosity, and size of place of residence) which predict a particular attribute independently of other variables.

Level of trust for institutions

Respondents were asked about their attitudes towards five institutions: the government, parliament, police, courts, and LGBTAQI organizations. The institutions considered in this study attracted varied levels of trust from respondents[32]. Two of them (government and parliament) were mostly distrusted, one

27 A study of attitudes towards homosexual persons was conducted in October 2016 on a sample of N = 1992 heterosexual users of Panel Ariadna.
28 World Values Survey Association (2015). *World Values Survey Wave 6* 2010-2014. OFFICIAL AGGREGATE v.20150418. Produced by: Asep/JDS, Madrid SPAIN. Retrieved from: http://www.worldvaluessurvey.org/WVSDocumentationWV6.jsp
29 Omyla-Rudzka, M. (2016). *Zaufanie spoleczne. Komunikat z badan CBOS.* Warszawa: CBOS. Retrieved from: http://www.cbos.pl/SPISKOM.POL/2016/K_018_16.PDF
30 We did not have access to raw data from the CBOS 2016 study.
31 I.e. of the structure of compared samples based on age and size of place of residence (comparisons to WVS 2012), and age, size of place of residence, level of education, and subjective financial situation (comparisons to Attitudes towards homosexual persons 2016).
32 $F(3{,}11; 21576{,}90) = 9687{,}73$; $p < 0{,}001$.

(LGBTAQI organizations) mostly trusted, while two (police and courts) attracted similar levels of trust and distrust. Figure 13 shows the average level of trust for these institutions.

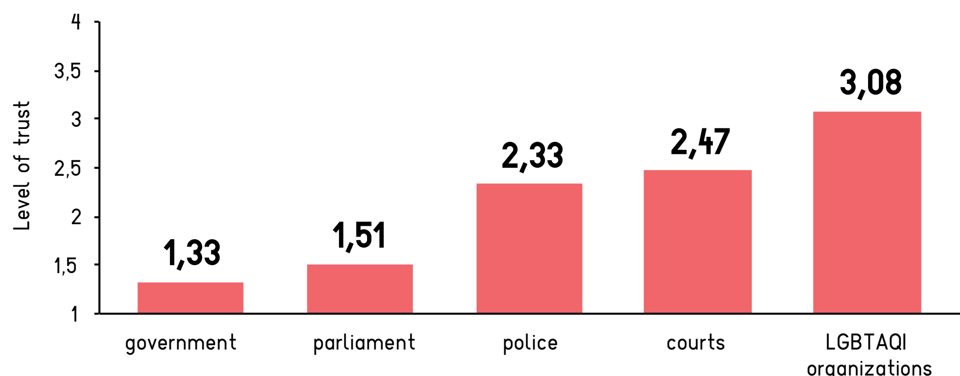


FIG. 13. Average level of trust for institutions* (N = 7133)
* The level of significance of all differences between average estimates for specific institutions was $p < 0{,}001$.

Government

LGBTA respondents declared highest distrust for the government (96,4%). While 71,7% declared no trust at all for the Cabinet, an additional 24,7% claimed that they had a low level of trust (fig.14). Very high and rather high levels of trust for the government were declared by 1,1% and 2,6% respectively. For comparison, in 2012, 26,6% of the general population declared a complete lack of trust for the government, in 2016 – 22,73% (fig.14). When controlled for demographic differences between the samples, respondents had lower levels of trust for the government than Poles surveyed in 2012[33].

33 $B = -0{,}91$; $SE = 0{,}10$; $p < 0{,}001$.

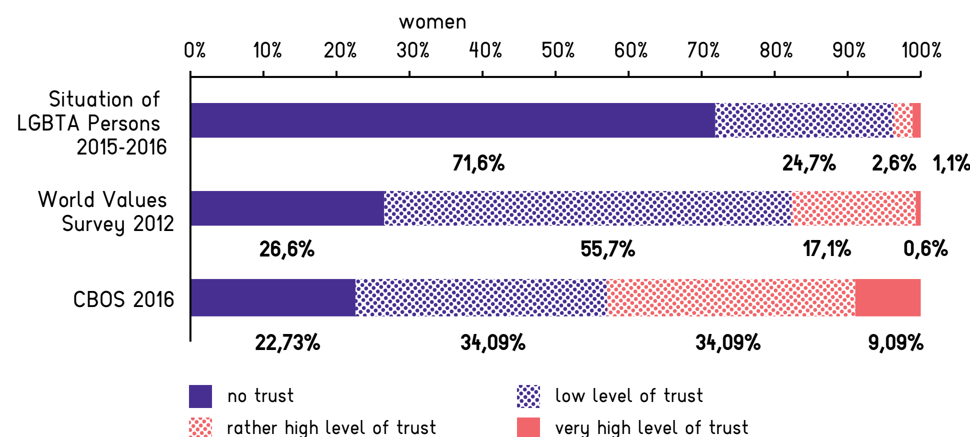


FIG. 14. Distribution of answers to the question about level of trust for the government in the studied sample (N = 7133) and in general Polish population (N = 928 and N = 935)

Level of trust for the government correlated with respondents' sexual orientation and gender identity[34]. Bisexual men were the most trustful towards the government, while lesbians – the least[35]. Level of trust for the government was negatively predicted not only by subgroups of the LGBTA community, but also age, level of education, and size of place of residence and positively by subjective financial situation and religiosity[36]. In other words: people who were younger, worse educated, declared higher religiosity, lived in smaller areas and were in a better financial situation, were more trustful of the government.

Parliament

The parliament enjoys barely higher levels of trust compared to the government. 54,7% of respondents declared no trust at all, and an additional 40,6% - low level of trust (fig.15). Very high and rather high level of trust was declared by 0,8% and 3,9% of respondents, respectively. Importantly, the proportion of respondents who had

34 $F(5, 6931) = 8{,}50$; $p < 0{,}001$; $hp2 = 0{,}01$.
35 Bisexual men: $M = 1{,}44$; $SD = 0{,}68$. Lesbians: $M = 1{,}26$; $SD = 0{,}49$.
36 Effect of age: $B = -0{,}01$; $SE = 0{,}001$; $p < 0{,}001$. Effect of education: $B = -0{,}01$; $SE = 0{,}002$; $p < 0{,}001$. Effect of subjective financial situation: $B = 0{,}01$; $SE = 0{,}004$; $p = 0{,}006$. Effect of religiosity: $B = 0{,}05$; $SE = 0{,}004$; $p < 0{,}001$. Effect of size of place of residence: $B = -0{,}02$; $SE = 0{,}004$; $p < 0{,}001$.

no trust at all for the parliament was higher than in the general population in 2012 (28,5%) and 2016 (25%) (fig.15). The difference with the 2012 study remained when controlled for demographic variables[37].

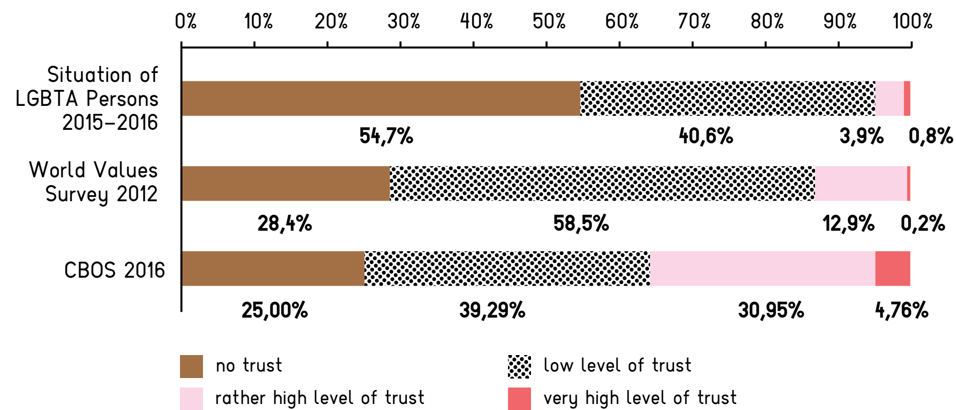


FIG. 15. Distribution of answers to the question about level of trust for the parliament in the studied sample (N = 7133) and in general Polish population (N = 910 and N = 893)

Respondents' answers differed based on sexual orientation and gender identity subgroups[38]. Highest levels of trust for the parliament were found among bisexual men, and lowest – among lesbians[39]. Like in the case of the government, level of trust for the parliament was negatively predicted by age, level of education, and size of place of residence, and positively by subjective financial situation and religiosity[40]. In other words: the younger, worse educated, more religious, the better their financial situation and the smaller the area they lived in, the more the respondents trusted the parliament.

37 B = -0,78; SE = 0,09; p < 0,001.
38 F(5, 6931) = 7,78; p < 0,001; hp2 = 0,01.
39 Bisexual men: M = 1,57; SD = 0,65. Lesbians: M = 1,41; SD = 0,55.
40 Effect of age: B = -0,01; SE = 0,001; p < 0,001. Effect of education: B = -0,01; SE = 0,003; p = 0,001. Effect of subjective financial situation: B = 0,02; SE = 0,004; p < 0,001. Effect of religiosity: B = 0,03; SE = 0,004; p < 0,001. Effect of size of place of residence: B = -0,01; SE = 0,004; p = 0,023.

Police

More than half of respondents (57,5%) declared distrust towards the police. No trust at all was declared by 13,2% of respondents, while 44,3% declared a low level of trust (fig.16). High and very high levels of trust were declared by 39,20% and 3,30% of respondents, respectively. Respondents showed more distrust towards the police than respondents to surveys of general Polish population (2012 – 46,30%, 2016 – 29,35%; fig.16). The difference between this study and the study from 2012 remained in place when controlled for demographic structures of both samples[41].

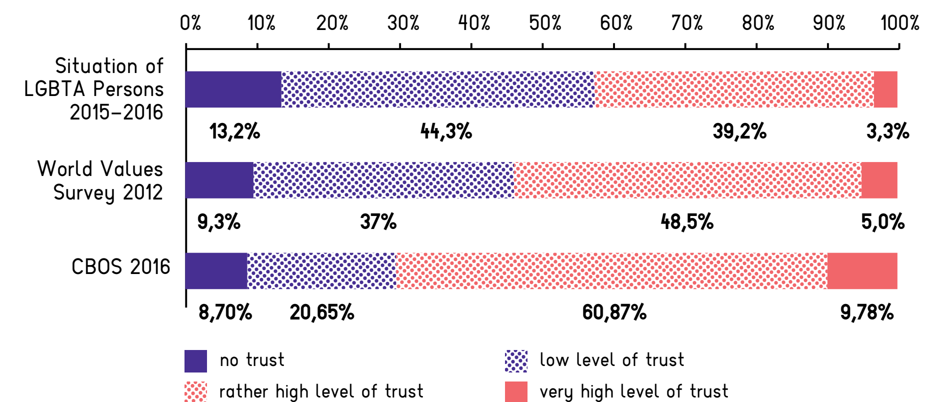


FIG. 16. Distribution of answers to the question about level of trust for the police in the studied sample (N = 7133) and in general Polish population (N = 916 and N = 978)

The level of trust for the police depended on the subgroup to which respondents belonged[42]. Bisexual men were the most trusting, while transgender people – the least[43]. Moreover, level of trust for the police was negatively predicted by age and positively by subjective financial situation[44]. The younger the respondents and the better their financial situation, the higher their level of trust for police.

41 B = -0,34; SE = 0,09; p < 0,001.
42 F(5, 6931) = 10,89; p < 0,001; hp2 = 0,01.
43 Bisexual men: M = 2,40; SD = 0,79. Transgender persons: M = 2,16; SD = 0,78.
44 Effect of age: B = -0,004; SE = 0,001; p = 0,002. Effect of subjective financial situation: B = 0,02; SE = 0,003; p < 0,001:

Courts

Courts were an institution that attracted similar levels of distrust (49%) and trust (51%). Very high and high levels of trust were declared by 6,30% and 44,7% of respondents, respectively (fig.17). No trust at all and low level of trust for the institution was declared by 10,4% and 38,6% of respondents, respectively. These results are similar to the results of the CBOS study from 2016. However, respondents from this study declared higher levels of trust for the courts than Poles surveyed in 2012, the difference was statistically significant also when controlled for demographic variables[45].

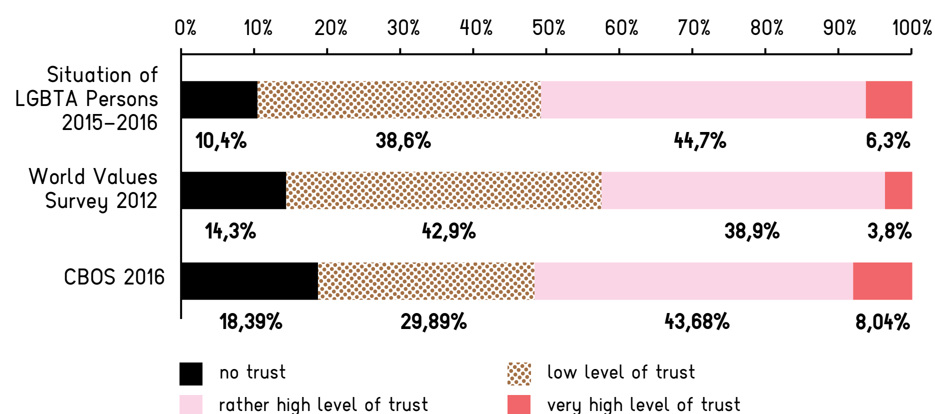


FIG. 17. Distribution of answers to the question about level of trust for the courts in the studied sample (N = 7133) and in general Polish population (N = 886 and N = 925)

Respondents' answers differed by subgroup based on sexual orientation and gender identity[46]. Gay men declared the highest level of trust for the courts, while transgender persons – the lowest[47]. Among the considered demographic variables, age negatively predicted levels of trust for the courts, while education and subjective financial situation – positively[48]. The younger, better educated the respondents were and the better their financial situation was, the more they trusted the courts.

LGBTAQI organizations

LGBTAQI organizations attracted the most trust among respondents (82%) – 29,1% declared very high and 52,90% high levels of trust for these institutions (fig.18). No trust at all or low level of trust was declared by 3,4% and 4,6% of respondents, respectively.

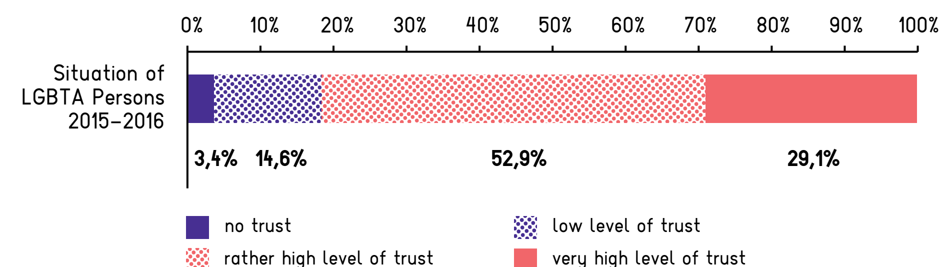


FIG 18. Distribution of answers to the question about level of trust for LGBTAQI organizations in the studied sample (N = 7133)

Subgroups based on sexual orientation and gender identity differed in their trust for LGBTAQI organizations[49]. Lesbians declared highest levels of trust for the organizations, while bisexual men – the lowest[50]. Level of trust for LGBTAQI organizations was negatively predicted by age, education and religiosity and positively by subjective financial situation[51]. The younger, less religious, worse educated the respondents and the better their financial situation, the higher their trust for LGBTAQI organizations.

45 B = 0,46; SE = 0,09; p < 0,001.
46 F(5, 6931) = 28,08; p < 0,001; hp2 = 0,03.
47 Gay men: M = 2,57; SD = 0,77. Transgender persons: M = 2,28; SD = 0,79.
48 Effect of age: B = -0,01; SE = 0,001; p < 0,001. Effect of education: B = -0,01; SE = 0,003; p = 0,001. Effect of subjective financial situation: B = 0,02; SE = 0,004; p < 0,001. Effect of religiosity: B = 0,03; SE = 0,004; p < 0,001. Effect of size of place of residence: B = -0,01; SE = 0,004; p = 0,023.
49 F(5, 6931) = 46,55; p < 0,001; hp2 = 0,02.
50 Lesbians: M = 3,24; SD = 0,68. Bisexual men: M = 2,72; SD = 0,85.
51 Effect of age: B = -0,01; SE = 0,001; p < 0,001. Effect of education: B = -0,01; SE = 0,003; p = 0,002. Effect of subjective financial situation: B = 0,02; SE = 0,01; p < 0,001. Effect of religiosity: B = -0,04; SE = 0,01; p < 0,001.

2015 parliamentary elections

Respondents were also asked about whether they participated in the parliamentary elections in the fall of 2015. Among respondents eligible to vote, most (80,4%) went to the ballot box, while 19,60% did not (fig.19). For comparison, according to data from the National Electoral Commission, voter turnout for the 2015 parliamentary elections was 50,92%.

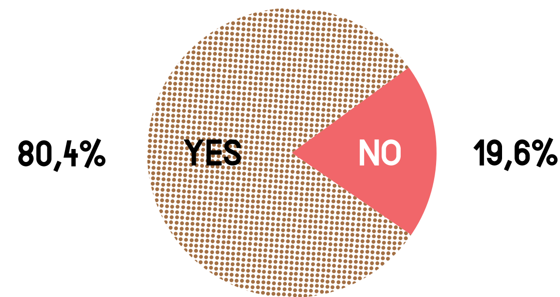


FIG. 19. Voter turnout*
* N = 5291. Only people eligible to vote were considered.

Declared participation in the vote depended on which subgroup respondents belonged to[52]. Gay men were most likely to vote (83,9%), while transgender persons – the least (73,6%). Moreover, voting was positively predicted by age, education, and subjective financial situation[53]. The older, better educated the respondents and the better their financial situation, the more likely they were to have voted in the last parliamentary elections.

Respondents' answers were compared to participants of the study about attitudes towards homosexual persons from 2016. Compared to LGBTA persons, heterosexual persons were less likely to have voted (76,3%) and the difference was statistically significant when controlled for demographic discrepancies between both samples[54].

52 $c^2(5) = 53,62; p < 0,001$.
53 Effect of age: $B = 0,03; SE = 0,01; p < 0,001$ Effect of education: $B = 0,13; SE = 0,01; p < 0,001$. Effect of subjective financial situation: $B = 0,13; SE = 0,02; p < 0,001$.
54 $B = 0,58; SE = 0,08; p < 0,001$.

Summary

1. LGBTA persons are least trustful of the government and parliament and most trustful of LGBTAQI organizations.
2. Level of trust for the government, parliament, and the police is lower among LGBTA persons than in general Polish population.
3. The LGBTA community is internally diversified when it comes to levels of trust for institutions. Bisexual men are most trusting of state institutions (government, parliament, police and courts), while lesbians and transgender persons – least.
4. LGBTA persons declared higher voter turnout in the parliamentary election in 2015 than heterosexual persons. Older persons are less trusting of state institutions and of LGBTAQI organizations.

Coming out and unequal treatment

In this chapter we will look at the social situation of lesbians, gays, bisexual, asexual, and transgender persons regarding disclosure of sexual orientation and gender identity, as well as discrimination resulting from being out.

First, the report will look at which categories of people know about the respondents' sexual orientation and gender identity. Categories in the table below were considered if the respondent declared that at least one person from the category knows about their sexual orientation or gender identity.

TAB. 1. Members of which following groups know about your sexual orientation/gender identity? (N = 3667 – 6535)

	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
Friends	97,4%	95,4%	95,1%	83,4%	85,9%	92,8%
Co-workers / Colleagues from school	82,9%	78,1%	71,8%	52,6%	45,4%	59,6%
Family	75,5%	76,3%	52,2%	40,8%	39,2%	55,9%
Medical personnel	31,1%	33,4%	12,4%	13,4%	17,7%	40,3%
Immediate superior	37,5%	41,4%	15,3%	12,8%	14,3%	23,8%
Neighbours	29,7%	37%	10,9%	15,3%	6,6%	14,2%
Clients at work	23,7%	25,9%	9,1%	8,7%	7,8%	14,8%

As clear from the data above, sexual orientation and gender identity significantly differentiate the level of being out to the selected categories of people[55]. The people who usually know about respondents' sexual orientation or gender identity are friends, co-workers (it seems that this category partially overlaps with the category of friends), followed by family. It should be noted that family members are significantly more aware of the sexual orientation of lesbians and gays, and less aware of bisexual men

55 Significance p<0,01 of all analysed categories of people (questions) established based on single factor analysis of variance using the Welch Test. For sexual orientation: family members F=120,2 , df=4, p<0,001, hp2 =0,08; friends F=36,27, df=4, p<0,001, hp2 =0,02; neighbours F=83,75 , df=4, p<0,001, hp2 =0,07; co-workers/ colleagues from school F=63,9, df=4, p<0,001, hp2 =0,04; immediate superior F=67,98, df=4, p<0,001, hp2 =0,06; clients at work F=34,9, df=4, p<0,001, eta2=0,04; medical personnel F=50,47 , df=4, p<0,001, hp2 =0,04.

and women's, and asexual persons'[56]. Similar pattern can also be traced in other categories of people who found out the respondents' sexual orientation or gender identity. Therefore, one can risk a hypothesis that the sexual orientation of lesbians and gay men is easier to explain to people they interact with than bisexuality or asexuality. However, verification of this hypothesis goes beyond the gathered data and would require further research.

Instead, let's take a closer look at how many people from the categories with highest results were aware of the respondents' sexual orientation or gender identity.

TAB. 2. Members of which of the following groups know about your sexual orientation/gender identity (friends)? (n<4581; 6700>)

	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
No one	2,6%	4,6%	4,9%	16,6%	14,1%	7,2%
A few people	18%	24,2%	35,9%	48,6%	46,5%	38,9%
Most	27%	27,6%	29,4%	17,1%	21,6%	29,5%
Everyone	52,3%	43,6%	29,8%	17,7%	17,8%	24,4%

The only category in which the answer "everyone' clearly dominated, was friends of lesbians and gays. However, it should be noted that compared to other categories, 'friends' is subjectively created by the respondent, unlike groups like coworkers, where membership is de facto forced, and it is not shaped by the respondent. It would seem that this is the reason for the differences between the group of friends and groups of co-workers and school colleagues, even though friends often originate from these groups. In all the other groups (including family) the dominating answers are "no one" and "a few people".

56 Isolating these groups, i.e. gay men, lesbians, bisexual women, bisexual men, and asexual persons confirmed the post hoc analyses based on a series of Ryan-Einot-Gabriel-Welsch F tests.

TAB. 3. Members of which of the following groups know about your sexual orientation/gender identity (co-workers / school colleagues)?(n<4581; 6700>)

	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
No one	17,1%	21,9%	28,2%	47,4%	54,6%	40,4%
A few people	36,8%	38,7%	45,4%	37,1%	31,2%	35,5%
Most	30,6%	24,7%	22%	11,5%	10,7%	16,1%
Everyone	15,6%	14,7%	4,4%	4%	3,4%	8%

TAB. 4. Members of which of the following groups know about your sexual orientation/gender identity (family members)? (n<4581; 6700>)

	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
No one	24,5%	23,7%	47,8%	59,2%	60,8%	44,1%
A few people	41,3%	42,2%	39,2%	28,6%	28,9%	32,2%
Most	21,5%	20,9%	10,2%	8,2%	7,4%	16,6%
Everyone	12,7%	13,2%	2,8%	4,1%	2,9%	7,2%

As indicated before, only some family members are aware of the sexual orientation or gender identity of the respondent. Therefore, let us see which family members are most likely to know about it.

TAB. 5. Do the following family members know about your sexual orientation/gender identity? (n<3667; 6535>)

	Lesbians	Gay men	Bisexual women	Bisexual men	Asexual persons	Transgender persons
Mother	67,8%	68%	39,8%	31,8%	34,8%	56,1%
Father	51,2%	50,1%	22,9%	20,8%	22,5%	38,6%
Sister	64,7%	63,7%	37,9%	26,8%	27,2%	42,1%
Brother	57,8%	56,2%	27,6%	21%	22,5%	38,3%

As shown above, the rule that people are more likely to know about a respondent's sexual orientation if they are a lesbian or a gay man, than if their sexual orientation is different, also applies here. Specific sexual orientations also rank the same as previously.

In the cases of all the studied sexual orientations and of transgender persons, mothers are most likely to know about the sexual orientation or gender identity of their children. They were closely followed by sisters, later by brothers, with fathers being the least likely to know. Therefore, one can say that female family members are more likely to know than male family members.

If the gender of family members plays into the likelihood of them knowing about the sexual orientation or gender identity of respondents, then perhaps their gender also plays a role?

TAB. 6. Do the following family members know about your sexual orientation/gender identity? (N = 3667 – 6535)

	Woman	Man	Different gender identity
Mother	51,8%	64%	48,6%
Father	35,1%	46,8%	34,1%
Sister	48,9%	59,5%	47,4%
Brother	40,8%	52,1%	35%

TAB. 7. Do the following family members know about your sexual orientation/gender identity? (N = 5121 – 8725)

	Lesbians	Gay men	Bisexual women	Bisexual men	Asexual persons	Transgender persons
Mother or sister	55,7%	56,3%	34,4%	25,1%	32,5%	41,4%
At least one of the parents	48,8%	49,9%	26,8%	20%	25,1%	36,5%
Brother or sister	49,5%	51,4%	27,3%	20,3%	23,3%	30,8%
Father or brother	47,8%	48,4%	23,9%	18,2%	22,7%	30,9%
Both parents	33,2%	34,2%	12,5%	11,9%	13,1%	21,8%
Mother and sister	29,4%	33,1%	12%	9,8%	8,3%	15,8%
Father and brother	23,7%	23,8%	6%	6,5%	5,8%	13,7%
Brother and sister	19%	22,5%	6,2%	5,3%	4,1%	9,7%

In the cases of female and male respondents, the vast majority of the sample, mothers and sisters are most likely to know about their sexual orientation or gender identity, followed by fathers and brothers. In the case of men, these frequencies are higher, meaning that men are more often out. However, one should keep in mind that men more often identify as gays than women as lesbians, and family members know about these two sexual orientations most often. In other words: the differences in results based on gender in the table above could be due to sexual orientation, which could be more impactful than gender. This reasoning is also supported by the fact that while sexual orientation and gender identity turned out to be statistically significant, measures of interdependence[57] turned out to be higher for sexual orientation than for gender[58]. Further analyses showed that even when controlled for both

57 In this case Kendall's Tau-b coefficients.

58 Values of Kendall's Tau-b coefficients for gender were between 0,101 (mother) and 0,114 (brothers), and for sexual orientation from 0,238 (father) to 0,265 (brothers).

variables, sexual orientation still has more impact than gender on the results[59].

Keeping in mind the conclusions from data presented earlier, we also analysed configurations of family members who know about the respondent's sexual orientation or gender identity.

As predicted, the most frequent configuration is mother or daughter, so female family members are most likely to know about the respondents' sexual orientation. In half of the cases, at least one parent knew about the sexual orientation of lesbians and gays. Bisexual men reported the lowest numbers. There is a similar distribution regarding at least one of the siblings as well as father or brother. Only in the case of one in three gay men and lesbians, both parents know about their sexual orientation. These numbers are lower for other sexual orientations and for transgender persons and the lowest for bisexual men. At the same time this is the most frequent combined configuration. The least frequent one is brother and sister[60].

Based on descriptions of situations in which respondents' sexual orientation or gender identity was disclosed, it was a very difficult experience for them. In extreme cases, respondents were unable to function normally for about a week after coming out to their parents. Disclosure often happened under the influence of alcohol. These situations were also difficult for parents, who blamed themselves and looked for mistakes in upbringing. In some cases, parents put the blame for their own problems on the sexual orientation or gender identity of their children, for example justifying their alcoholism this way. Another frequent reaction was to send their children to psychologists or psychiatrists. On the other hand, there were also many positive accounts, in which family members remained discreet and appreciated the respondents' courage.

Non-heterosexual people who consciously disclose their sexual

59 Betas in regression equations which included variables of sexual orientation and gender, adopted values from 0,128 (father) to 0,156 (brothers) for gender and from 0,310 (father) to 0,321 (sisters) for sexual orientation. R2 for the entire model was low (0,116), however the model was not supposed to explain what the mother's knowledge depends on, just to achieve the goal indicated in the text.

60 The presented data considers that not all families include mothers, fathers, brothers, and sisters. Therefore, the lower frequency of the brother and sister conjunction is not a result of a naturally lower number of people who live in such families.

orientation to their family, as well as those who are outed without their knowledge and consent, certainly hope for acceptance.

TAB. 8. Who among these family members fully accepts your sexual orientation/gender identity? (n<5853; 8903>)

	Lesbians	Gay men	Bisexual women	Bisexual men	Asexual persons	Transgender persons
Mother	37,5%	43,2%	25%	19,5%	23,9%	25,6%
Father	28,1%	27,7%	13,7%	10,3%	14%	15,2%
Sister	23,1%	29%	14,8%	12,4%	10,5%	12,4%
Brother	21,8%	23,2%	11,1%	7,7%	8,5%	11,8%

As clear from the table above, among the family members considered in the analysis, mothers are most likely to accept the sexual orientation of their children. However, contrary to what we might suspect based on the data about being aware of the respondents' sexual orientation or gender identity, fathers, not sisters, place second. Brothers are least likely to be fully accepting. One should, however, take note of the problem of conservative radicalization of young men (in the context of a strong overrepresentation of young people in the sample, one can assume that they are the brother)[61], which appears in literature. This issue can complement the compelling interpretation about socializing girls (and so sisters) to care about family relationships and to be more sensitive.

However, it should be noted that family members generally do not accept the respondents' sexual orientation. Gay men are most accepted – 43,2% of mothers who know about their child's sexual orientation, accept it. However, it should also be noted that the question was about full acceptance – and thus was very restrictive. It is possible that if it was worded differently, all

61 Cf. Instytut Spraw Publicznych, Na prawo, ale nie na PiS – polityczne orientacje młodych Polek i Polaków, http://www.isp.org.pl/aktualnosci,1,1616.html.

sexual orientations and transgender people would score higher frequencies of acceptance.

As in the case of knowing about the respondents' sexual orientation and gender identity, combinations of family members who accept the respondents' sexual orientation and gender identity, were analysed.

TAB. 9. Who among these family members fully accepts your sexual orientation/gender identity (N = 6774 – 8211)

	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
Mother or sister	47,9%	52,9%	33,4%	26,5%	30,7%	32%
At least one of the parents	43,9%	48,7%	29,3%	21,5%	27,2%	30,3%
Brother or sister	39,6%	43,8%	24,3%	18,9%	19%	21,8%
Father or brother	40,2%	40,9%	23,4%	15,7%	20,5%	22,1%
Both parents	24,1%	25,2%	11%	9,6%	13,7%	12,9%
Mother and sister	14,9%	21,7%	9,2%	7,6%	7,1%	8,3%
Father and brother	13,8%	14,2%	4,5%	4,5%	4,6%	7,7%
Brother and sister	8%	11,8%	4,2%	3,4%	2,3%	4,4%

Despite previously observed differences in the distribution of knowledge about sexual orientation / gender identity and in the distribution of its acceptance, the ranking of family member conjunctions, as a rule, remains the same. However, in some cases the combination of "father or brother" outranks "brother or sister".

We also analysed how lack of acceptance from particular family members coexists with general life satisfaction, symptoms of depression, declared state of health, feeling lonely, and frequency of suicidal thoughts. Scales of life satisfaction[62] and symptoms of depression[63] were prepared for this purpose.

TAB. 10. Kendall's Tau-b correlation coefficient of acceptance of sexual orientation/gender identity with selected variables characterizing health and mental wellbeing

	Life satisfaction	Declared state of health	Depression	Felling lonely	Suicidal thoughts
Mother	0,13	0,10	-0,11	-0,12	-0,13
Father	0,16	0,12	-0,10	-0,13	-0,11
Sisters	0,08	0,07	-0,08	-0,08	-0,08
Brothers	0,12	0,09	-0,12	-0,11	-0,13
Both parents	0,15	0,11	-0,10	-0,13	-0,11
At least one of the parents	0,13	0,09	-0,09	-0,09	-0,09
Brother and sister	0,06	0,08	-0,09	-0,05	-0,10
Brother or sister	0,12	0,08	-0,10	-0,11	-0,10

62 Cronbach's alfa = 0,86
63 Cronbach's alfa = 0,89

All correlations turned out to be statistically significant ($p < 0,01$). The correlation between the father's acceptance and life satisfaction turned out to be the strongest. The correlation between life satisfaction and acceptance from both parents was not much weaker. A similar pattern was found in the case of declared state of health – the correlation with acceptance from the father and from both parents was also the most significant, which means that being accepted by the father and both parents is more significant for declared state of health than being accepted by other family members. Other variables had a negative correlation with parents accepting the respondents' sexual orientation or gender identity. Using the example of frequency of suicidal thoughts, this means that the less acceptance from family members (especially the mother) the higher the frequency of suicidal thoughts. In the case of depression, the strongest noted correlation was with acceptance by the brother, while in the case of feeling lonely – with acceptance from both parents. However, it should be noted that we are talking about a correlation, not causation. For example, the correlation between life satisfaction and acceptance could mean both that acceptance affects life satisfaction, or that the families of respondents who are satisfied with their lives are more likely to accept their sexual orientation or gender identity.

Unfortunately, the consequence of disclosing one's sexual orientation can be losing loved ones (tab.11). This problem affected one in five respondents (80,6% did not lose any loved ones).

Even though the differences between particular groups were not big, they turned out to be statistically significant. When analysing data from the answer "none or almost none," one can see that the problem of losing loved ones affects predominantly transgender persons and lesbians. These two groups were the only ones for which the answer "none or almost none" scored below average.

The danger of losing loved ones or worsening of relationships can result in concealing one's sexual orientation or gender identity. Therefore, let us take a look at the scale of this problem.

TAB. 11. Did you lose any loved ones because of your sexual orientation / transgender identity? (N = 6484)

	Total	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
All or almost all	0,7%	0,4%	0,6%	0,4%	0,3%	2,5%	3,5%
Most	2,1%	2,1%	1,8%	2,1%	1,9%	1%	6,3%
About half	2,8%	3,5%	2,7%	1,9%	3,6%	2%	4,5%
A minority	13,7%	15,7%	13,4%	12,2%	10,8%	10%	19,9%
None or almost none	80,6%	78,3%	81,6%	83,4%	83,3%	84,5%	65,7%

TAB. 12. During the period between January 2015 to now, did you ever hide your sexual orientation...in fear of their reaction? (n<4402; 6765)

	Total	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
From neighbours, landlords/ladies, or tenants	50%	51,7%	50,2%	45,5%	54,8%	35,6%	62,1%
In the workplace	71%	69,4%	69,9%	74,8%	73%	70,4%	78,8%
At school / university	73,2%	68,1%	73,2%	73,4%	74,3%	78,3%	78,8%

Results show that respondents are most likely to hide their sexual orientation or gender identity at school and university, followed by the workplace, and least likely to hide from neighbours, landlords/ladies, and tenants. Among all studied groups, this problem affects mostly transgender persons. However, it should be noted that frequencies in almost all table cells are above 50%, and often around 67% or even 75%, meaning that concealing one's sexual orientation or gender identity is common among LGBTA people.

The issue of unequal treatment is strongly correlated with sexual orientation or gender identity. The study looked at three types of situations in which respondents could have experienced unequal treatment: the healthcare system, government offices and public spaces, and in direct contact with a representative(s) of churches and religious organizations.

TAB. 13. Unequal treatment in the healthcare system, government offices and public spaces, and in direct contact with representatives of churches/religious organizations (n1=1606, n2=905, n3=1065)

	Total	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
Healthcare system	13,6%	12,2%	10,9%	17,1%	12,5%	22,9%	27,7%
Government offices or public spaces	40,6%	0%	39,2%	0%	43,3%	21,9%	46,5%
In direct contact with reps of churches/religious org.	63,8%	71,4%	57,9%	76,2%	52,6%	54,8%	59,5%

When looking at the table above, one should note that the only data analysed concerned unequal treatment in situations when sexual orientation or gender identity were disclosed. Meanwhile, in most cases sexual orientation and gender identity are not disclosed. This was the case 75,8% of time for the healthcare system and 78,2% for government offices and public spaces. When it comes to churches and religious organizations, 85,6% of respondents either did not have contact with representatives of these institutions or did not disclose their sexual orientation or gender identity. Therefore, these cases were excluded from the analysis and are not the basis for counting frequency (percentages) of unequal treatment. According to the respondents' declarations, most cases of unequal treatment in all three types of situations, affected transgender persons. In the case of the healthcare systems they were followed by asexual persons and bisexual women, while in government offices and public spaces – by bisexual and gay men.

Among the especially outrageous instances of treatment by healthcare personnel, one has to mention prescribing medication for venereal diseases instead of for ailments that the respondent actually suffered from, refusing to accept blood donations and further processing of data on sexual orientation in Regional Blood Centres despite the fact that it is not supposed to be gathered, and refusing to use a cover during a leg x-ray while stating that it is not needed since the respondent is gay and therefore is unable to and should not have children. Respondents frequently complained about the disrespectful language used by doctors and their reliance on stereotypes, for example "gay people have more sexual partners than straight people," "gay people are unfaithful and promiscuous," "you could infect someone but what do you care". This problem also concerned therapists, who in extreme cases suggested working on changing respondents' sexual orientation.

When it comes to discrimination in government offices, respondents often described situations when they were refused their rights when their sexual orientation was disclosed. In one case, the mayor promised to help a respondent be granted a flat, however right before signing the contract he asked about the respondent's sexual orientation and after receiving confirmation refused to rent the apartment, hiding behind formal issues.

Regarding public spaces, respondents usually described

situations when they were insulted or ridiculed on public transport and in the streets. Aggression was triggered by appearance or behaviours suggesting respondents' sexual orientation (e.g. hugging a partner, recognizing someone from the Equality Parade or perpetrators knowing from other sources). Oftentimes the culprits in these cases were security employees – they insulted non-heteronormative persons, were especially restrictive towards them, or – in extreme cases – joined the perpetrators of battery.

Discrimination by representatives of churches/religious organizations usually meant insults and scoffing by priests, altar boys, or catechists. These occurrences usually happened during religion classes at school or pastoral visits, not as often during sermons. Oftentimes the statements were very radical, e.g. they described non-heteronormative people as sub-human, or called for their burning.

Summary

1. Friends, coworkers, and family members are most likely to know about the respondents' sexual orientation or gender identity. Gay men and lesbians are most likely to be out, bisexual women – less likely, while bisexual men and asexual persons – decidedly less likely.
2. Among family members, mostly mothers and sisters are aware of the respondents' sexual orientation.
3. Respondents' sexual orientation and gender identity is not usually accepted by family members. Mothers are most likely to accept respondents' sexual orientation or gender identity, followed by fathers. The most efficient strategy adopted by respondents in their families was to wait for acceptance from the mother or sister. In these cases, the likelihood of success was about 50% for lesbians and gays, and about one in three for other sexual orientations and for transgender persons.
4. Acceptance of sexual orientation and gender identity correlates positively with life satisfaction and declared state of health, and negatively with symptoms of depression, feeling lonely, and frequency of suicidal thoughts.
5. Respondents usually do not disclose their sexual orientation or gender identity in the healthcare system, government offices, and when in contact with representatives of churches and religious organizations. The problem of unequal treatment is more prevalent in dealing with representatives of religious institutions than in government offices or the healthcare system.

Health and mental wellbeing

This chapter will concern the health and mental wellbeing of LGBTA persons, in particular subjective assessment of quality of life, feeling lonely, suicidal thoughts, and coping strategies in difficult situations. The issue of occurring symptoms of depression among LGBTA persons will also be addressed.

The category of health and mental wellbeing can be defined in various ways. For the purpose of this study a number of indicators were chosen, all of which enable a direct or indirect evaluation of this category. These are: assessment of one's health, assessment of one's life so far, feeling lonely, suicidal thoughts, and coping strategies.

Respondents were asked about how they assess their life so far. Positive answers where overwhelmingly more common than negative ones. 63,4% of respondents assessed their life as quite good, successful, or fantastic, while 18,9% as not great, unhappy, or terrible. A relatively big number of respondents (17,8%) did not give an unambiguous answer, saying it was "neither good, nor bad".

Comparing the results to the previous study on the situation of LGBT persons in Poland, one can see a similar distribution of answers to this question. A slight shift towards a worse assessment of life can be explained by the overrepresentation of people from the youngest age category (under 17) in this edition, who have the lowest scores in this category.

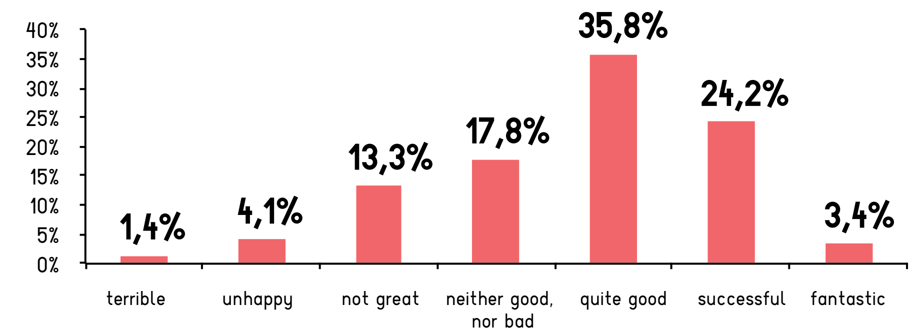


FIG. 20. Overall assessment of respondents' life so far. Answer to the question: How do you assess your life is for, has it been...? (N = 7074)

TAB. 14. Overall assessment of respondents' life so far. Answer to the question: How do you assess your life is for, has it been…? (N = 6952)

	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
Positively	68%	67,4%	55,7%	59,1%	44,4%	37,1%
Neutrally	15,5%	16,4%	21,1%	20,2%	20,4%	20,5%
Negatively	16,4%	16,2%	23,2%	20,7%	35,2%	42,4%
Fantastic	3%	4%	2,9%	2,5%	1,2%	1,2%
Successful	26,3%	26,9%	19,6%	21,4%	13,2%	10,5%
Quite good	38,8%	36,5%	33,2%	35,2%	30%	25,4%
Neither good, nor bad	15,5%	16,4%	21,1%	20,2%	20,4%	20,5%
Not great	11,7%	11,6%	15,9%	14,7%	24%	27,6%
Unhappy	3,5%	3,5%	5,3%	4,4%	5,6%	9,5%
Terrible	1,3%	1%	1,9%	1,6%	5,6%	5,3%

According to the results presented in the table, sexual orientation and gender identity affect the assessment of respondents' life so far. Lesbians and gay men are most likely to assess it positively, followed by bisexual men and bisexual women. Less than half of asexual persons assesses their life so far positively, while in the case of transgender persons it is more often assessed negatively than positively.

Answers to this question also differ by respondents' age – the oldest assess their life the most positively, while the youngest – the most negatively. In the group of respondents under 18, less than half (47%) assessed their life as positive, while 29% as moderately or completely negative (answers: "not great, unhappy, or terrible"). For comparison – in the age group 18-25, 61,8% of respondents had

a positive assessment of their life and 19,9% - a negative one. In the age group above 26, 72,5% of answers were positive and 13,1% - negative.

Place of residence is an additional differentiating variable. Respondents who currently reside in bigger cities assess their life more positively than residents of rural areas and smaller cities. Among those living in areas of less than 100k inhabitants, 51,6% assess their life so far positively, for cities of 100-500k inhabitants it is 64,1%, and for cities of more than 500k inhabitants – 71,5%.

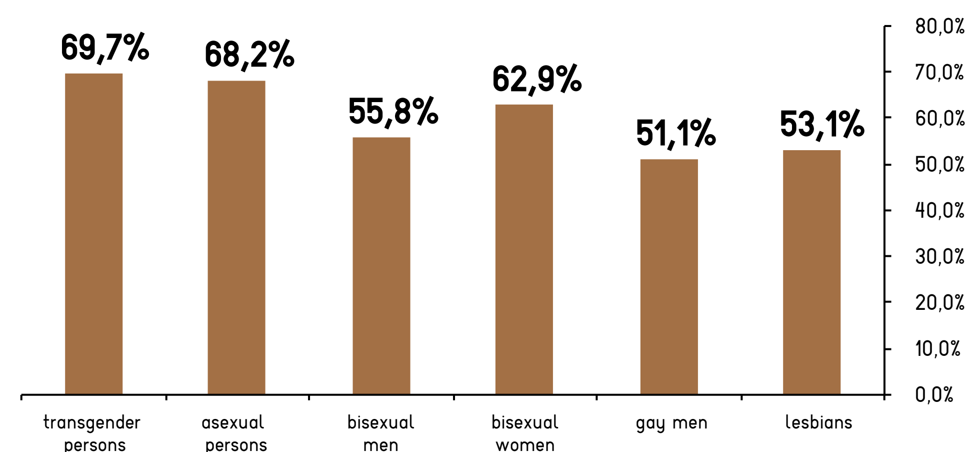


FIG. 21. Feeling lonely overall and differentiated by sexual orientation and gender identity. Answer to the question: Do you feel lonely, despite not wanting to? (N = 5483-5951)

Respondents were also directly asked about whether they feel lonely. Results show, that over half of them feel lonely, even though they do not want to. There is a small difference based on gender – men feel less lonely (51,7%) compared to women (58,7%). This difference is especially noticeable between bisexual men and women. Gay men and lesbians are least lonely, while transgender and asexual persons – the most.

When it comes to feeling lonely – more differences were noted based on age. Respondents under the age of 18 are more lonely (70,3%) than people in the age group 18-25 (59,5%) and older respondents,

over the age of 26 (44,2%). Moreover, respondents living in places of less than 100k inhabitants are more lonely (64,2%) than those living on cities of more than 500k inhabitants (48,8%).

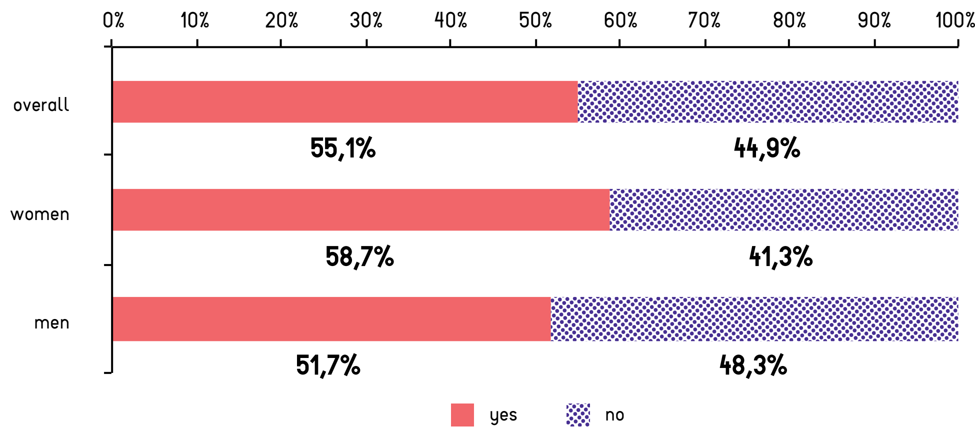


FIG. 22. Feeling lonely overall, and divided by gender. Answer to the question: Do you feel lonely, despite not wanting to? (N = 5590)

Respondents were also asked about whether they ever felt so down that they thought about suicide. In the months preceding the study, almost half of respondents (44,2%) had suicidal thoughts, among whom 5,6% had them very often, 13,4% - quite often, and 25,2% - rarely. When comparing the results to those from 2011, one can note a similar distribution of answers – with one significant difference. In 2011 42% of LGB persons experienced suicidal thoughts – men and women in similar numbers. In 2016 a significant difference appeared between men and women: 52,9% of women had suicidal thoughts compared to 36,5% men. As many as 24,6% of female respondents and 13,5% of male respondents thought about suicide “very often” and “quite often”.

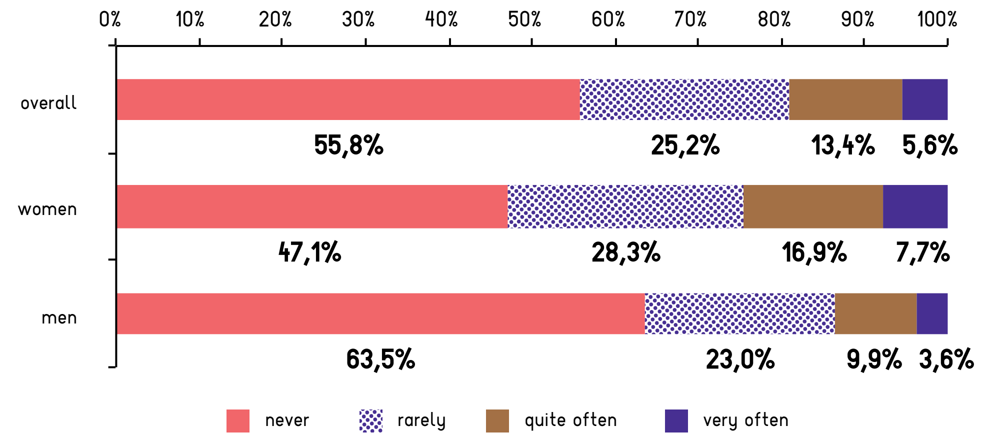


FIG. 23 A. Suicidal thoughts overall and divided by gender. Answer to the question: How often in recent months were you feeling so down, that you thought about suicide? (N = 5590)

TAB. 15. Suicidal thoughts by sexual orientation and gender identity. Answer to the question: How often in recent months were you feeling so down, that you thought about suicide? (N = 5483 – 5951)

	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
Very often	7%	3,4%	8,1%	5,1%	10,3%	18,6%
Quite often	14%	9,4%	19,5%	14%	20,5%	27,2%
Rarely	23,4%	22,9%	31,9%	23,6%	32,3%	27,8%
Never	55,6%	64,3%	40,5%	57,3%	36,9%	26,4%

Differences in frequency of suicidal thoughts based on gender are also visible when analysing data about sexual orientation. Lesbians experience suicidal thoughts more often than gay men, and so do bisexual women in comparison to bisexual men. However, asexual and transgender persons are most likely to have suicidal thoughts.

The youngest respondents (under the age of 18) thought about death much more frequently – more than two thirds of this group (69,4%) considered suicide, while 11,9% of teenagers did so very often. Among respondents aged 18-25 almost half (48,9%) considered ending their life, with 6,1% of them – very often. Among respondents above the age of 26, 28,8% had suicidal thoughts with 2,4% experiencing them very often. Respondents from rural areas and cities with less than 100k inhabitants were more likely to think about death (53,6%) than those living in cities of more than 500k inhabitants (37,8%).

Respondents were also asked about how they cope with difficult situations in their lives. Generally, they tried to address challenges in a constructive way – more than half occupy themselves with things that make them feel better (56,8%), ask others for help (52,1%), or get mobilized and act (51,7%). One in three respondents finds comfort in thinking that other people have it worse (32,3%). One in five is hopeless and usually gives up in difficult situations (20,3%). When encountering difficulties a considerable number turn to drugs – 14,3% use alcohol, and 8,3% use sedatives.

Compared to results from 2011, there are differences in distribution of answers to this question. There is a slight decrease in percentage of respondents who claim that in difficult situations they get mobilized and act, or think comforting thoughts, and an increase of respondents who answer that they are hopeless and give up or distract themselves from their problems. These differences can be caused by an overrepresentation of the youngest in the sample, therefore comparisons should be made carefully.

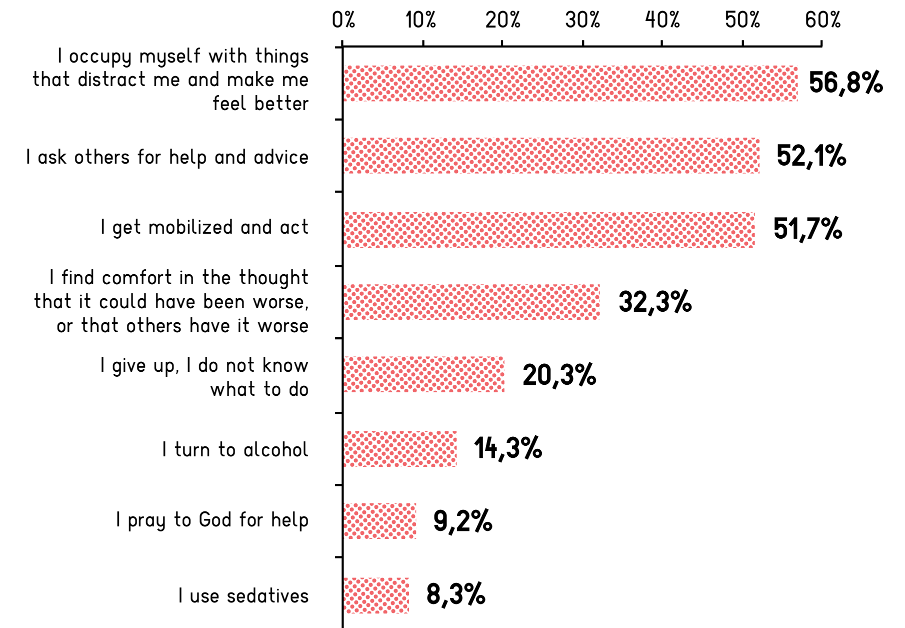


FIG. 23 B. Coping strategies in difficult situations. Answer to the question: Please indicate how you usually react to problems or difficult situations on your life? (N = 5592)

Regarding detailed characteristics of the studied sample (LGB), in some cases there were differences based on gender and age. Men are more likely to get mobilized and act (M – 58,4%, W – 43,1%) and to find comfort in the thought that others have it worse (M – 37,3%; W – 26,2%). Women are more likely to give up (M – 15,5%, W – 25,6%) and to use sedatives (M – 6,7%, W – 9,8%).

Lesbians, as well as bisexual women and transgender persons, tend to occupy themselves with things that distract them or ask others for help and advice. Gay men usually get mobilized and act or ask others for help and advice. Bisexual men also often get mobilized but, like lesbians and bisexual women, they usually occupy themselves with something else. Asexual persons adopt similar coping strategies to bisexual men (mobilizing and distracting themselves.

TAB. 16. Coping strategies in difficult situations. Answer to the question: Please indicate how you usually react to problems or difficult situations on your life? (N = 10704 – 11243)

	Lesbians	Gay men	Bisexsual women	Bisexsual men	Asexsual persons	Transgender persons
I occupy myself with things that distract me and make me feel better	34,8%	33,3%	34,9%	35,2%	41,1%	33,6%
I ask others for help and advice	32,5%	34,2%	28,2%	25,2%	21,7%	20,9%
I get mobilized and act	29,9%	37,3%	21,1%	30,7%	24%	19,7%
I find comfort in the thought that it could have been worse, or that others have it worse	17,2%	23,8%	13,8%	19,3%	11,4%	11,3%
I give up, I do not know what to do	13%	9,9%	16,2%	7,9%	17,9%	16,7%
I turn to alcohol	10,4%	9,2%	7,3%	6,7%	5%	5,6%
I use sedatives	5,4%	4,2%	5,8%	4,3%	7,3%	7,7%
I pray to God for help	4,9%	6%	4,2%	8,3%	6,2%	4,6%

In terms of age, the biggest differences appear between the youngest group (those under 18) and older respondents. When young people find themselves in a difficult situation, they ask for help and advice significantly less often, and are less likely to mobilize to action. It should be noted that they are also less likely

to drink alcohol, which could be related to its limited availability (trouble with buying it). Younger respondents more often feel helpless, resulting in giving up and not knowing what to do.

In terms of place of residence, it should be noted that people from smaller areas (with less than 100k inhabitants) were significantly less likely to choose constructive coping strategies in difficult situations (mobilizing to act and asking others for help and advice).

One of the indicators of respondents' wellbeing was the subjective assessment of one's health. It turns out that 75,1% of respondents assess their health as very good or good. Men assess it a little better compared to women. Additionally, 3,9% of people in the sample reported having an up-to-date certificate of disability or incapacity for work.

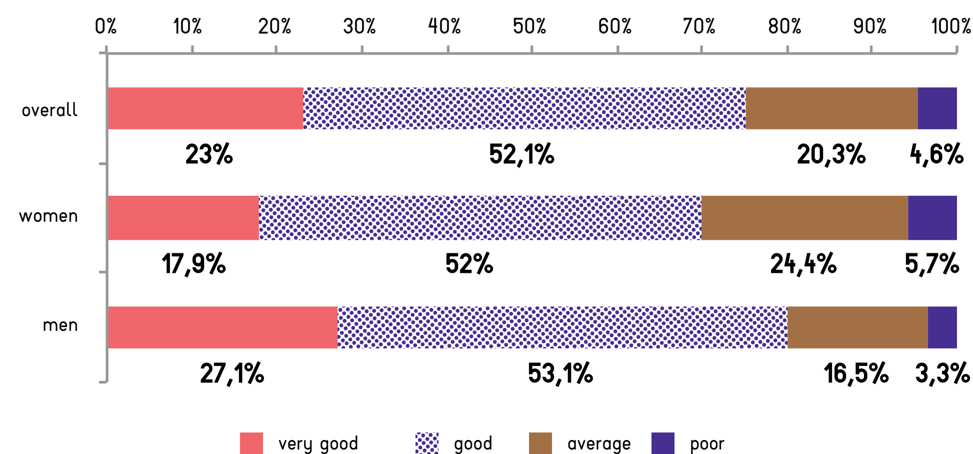


FIG. 24. Current state of health. Answer to the question: Generally speaking, how would you describe your current state of health? (N=5529)

Summary

1. Assessment of life is worse for respondents living in rural areas and smaller cities as well as the youngest ones. It is the worst for transgender and asexual persons.
2. Respondents under 18 and those living in places of less than 100k inhabitants feel more lonely. Gay men and lesbians are least lonely, while transgender and asexual persons – the most.
3. Results concerning suicidal thoughts among school-aged youth are alarming. Almost 70% of young respondents considered suicide.
4. Women are more likely to think about suicide compared to men. Suicidal thoughts are most prevalent among asexual and transgender persons, as well as respondents living in rural areas and cities of less than 100k inhabitants.
5. Results regarding coping strategies in face of difficult situations showed that LGBTA persons are increasingly likely to feel helpless, to give up and distract themselves from problems, and less likely to react with mobilization. Especially young people and those living in less populated areas, ask others for help and advice significantly less often, and are less likely to get mobilized and act.

Symptoms of depression in LGBTA population

One of the goals of the study was diagnosing the mental health of LGBTA persons. Due to the limitations of the questionnaire and the need for comparability of results when possible, the issue of mental health was narrowed down to diagnosing severity of depression symptoms.

Questions about depression were modelled after the European Health Interview Survey (EHIS), conducted in Poland in 2014 by the Central Statistical Office. Questions like these are asked in studies about health which aim at evaluating emotional state, which has a huge impact on the overall health of people, and how they function in their family, workplace, and society. The questions come from the Brief Patient Health Questionnaire, Depression Module (PHQ-9)[64] and are based on criteria of measuring depression from the DSM-IV manual. The questionnaire consisted of eight questions, each of them referring to diagnostic criteria of depression according to DSM-IV[65], such as sadness, depressed mood, loss of interest and pleasure in life. Statements also refer to symptoms such as fatigue or loss of energy, diminished concentration, lower self-esteem, insomnia or sleeping too much, and trouble relaxing. Respondents were asked to choose the answers which best described their mood in the two weeks preceding the study.

In accordance with the tool's guidelines[66], two basic indicators were calculated: occurrence of severe symptoms of depression[67]: which shows the number of people with long term problems and the severity of the occurring symptoms[68], meaning the severity of all symptoms. The second indicator additionally enables designation of four criteria for diagnosing the severity of depression symptoms[69].

Based on the respondents' answers, one can say that in the period of reference 28,4% of the sample exhibited severe symptoms of depression. For comparison, in the study of the Polish population (EHIS) from 2014 a similar indicator (calculated more liberally) revealed the prevalence of people with severe symptoms of depression to be at about 5%.

Basing analysis on the second measure (severity of the

64 Similar to the study conducted by the Central Statistical Office of Poland, a modified version of the questionnaire (which consisted of 8 questions) was used. The question about self-harm was not asked.

65 *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition.*

66 www.phqscreeners.com

67 Respondents, in whom severe symptoms of depression were recognized, reported frequent occurrence of problems ("on more than half of the days", or "almost every day") when answering at least one of the two key questions (questions 1 and 2) and at least five questions on the entire scale.

68 The indicator of severity of occurring symptoms is calculated by summing up all diagnostic answers (1 – on a few days; 2 – on more than half of the days, and 3 – almost every day) for all 8 questions.

69 Diagnostic criteria are set as thresholds: 0-4 – none/minimal; 5-9 – mild; 10-14 – moderate; 15-19 – moderately severe; 20-24 – severe.

occurring symptoms), one can state that symptoms of depression can be observed in more than 73% of the sample. For comparison, according to the EHIS study the percentage of people with any symptoms of depression in the population is 16%. Figure 25 shows detailed results and a comparison between the general population and the LGBTA sample.

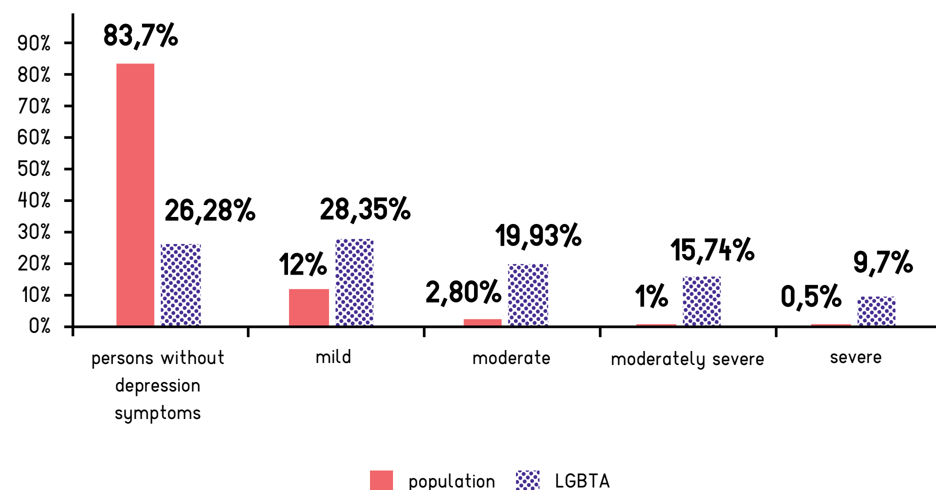


FIG. 25. Percentage of people with symptoms of depression according to four diagnostic criteria PHQ-8. Comparison between Polish population (EHIS) and the LGBTA sample (N = 5947)

Additional analyses show a considerable differentiation in severity of depression symptoms in specific groups of respondents[70]. Detailed analyses show that the average severity of depression symptoms is relatively the lowest among gay and bisexual men, while the highest among transgender persons, asexual persons, and bisexual women, in that order. For these three groups, average severity of depression symptoms is at a moderate level. However, it should be noted that even the low scores for gay and bisexual men are above the criterion (5), which means mild symptoms of depression. Figure 26 shows detailed results.

Respondents who report more symptoms of depression, on

70 $F(5;5773) = 114{,}41$; $p < 0{,}001$; $\eta p2 = 0{,}090$.

average, have a lower level of education[71] and relatively lower income levels[72]. Analyses of demographic variables show that younger LGBTA persons report significantly more symptoms of depression[73]. 49,6% of LGBTA persons under 18 have severe symptoms of depression. This result is quite interesting in light of general population results[74], both for Poland and the world[75]. result is quite interesting in light of general population results , both for Poland and the world . Studies of general population generally show relatively strong correlations between age and symptoms of depression, showing that older people are more likely to suffer from symptoms of depression. When explaining this correlation, it is usually noted that the exacerbated occurrence of depression symptoms with age is mostly linked to symptoms of somatic illnesses and to exclusion. Studies of the LGBT population are consistent with the results of this study. Studies of homosexual men which consider developmental issues, show that the state of mental health, generally speaking, is worse among young gay men[76]. One of the basic factors which can cause worse mental health, including more symptoms of depression among LGBT youth, is internalized homophobia/transphobia[77], which has an especially significant impact on health during adolescence.

71 Analyses were conducted for two diagnostic criteria of depression: presence of severe symptoms of depression $t(5907) = 17{,}08$, $p < 0{,}001$, $d = 0{,}40$, and severity of depression symptoms $r = -0{,}29$, $p < 0{,}001$.
72 Severe symptoms of depression $t(2955{,}525) = 9{,}31$, $p < 0{,}001$, $d = 0{,}27$; severity of depression symptoms $r = -0{,}17$, $p < 0{,}001$.
73 Severe symptoms of depression $t(3674{,}218) = 19{,}56$, $p < 0{,}001$, $d = 0{,}52$; severity of depression symptoms $r = -0{,}33$, $p < 0{,}001$.
74 Piekarzewska, M, Wieczorkowski, R, Zajenkowska-Kozłowska, A. (2016) Stan zdrowia ludności Polski w 2014 roku, GUS – Warszawa.
75 Stordal, E., Mykletun, A., & Dahl, A. A. (2003). *The association between age and depression in the general population: a multivariate examination. Acta Psychiatrica Scandinavica*, 107(2), 132-141.
76 Bybee, J. A., Sullivan, E. L., Zielonka, E., & Moes, E. (2009). *Are gay men in worse mental health than heterosexual men? The role of age, shame and guilt, and coming-out. Journal of Adult Development*, 16(3), 144-154.
77 Igartua, K. J., Gill, K., & Montoro, R. (2009). *Internalized homophobia: A factor in depression, anxiety, and suicide in the gay and lesbian population. Canadian Journal of Community Mental Health*, 22(2), 15-30.

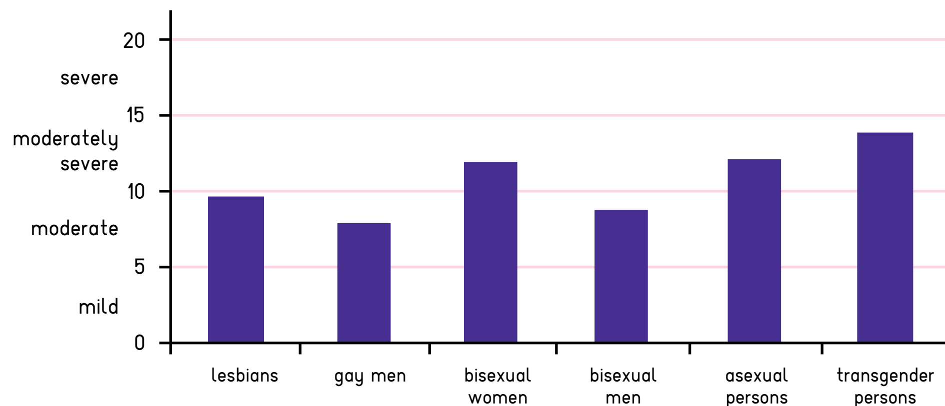


FIG. 26. Severity of symptoms of depression in studied groups. Thick horizontal lines indicate diagnostic criteria (N = 5947)

Severity of depression symptoms is strongly correlated with life satisfaction[78] and relative deprivation[79], meaning a subjective feeling that others have it better (i.e. straight people compared to LGB people, cisgender people compared to transgender people, sexual people compared to asexual people).

Symptoms of depression and their severity occur relatively less often and less severely among people who are more out[80]. The link between level of being out and symptoms of depression can be explained in two ways. Firstly, disclosing one's own identity or sexual orientation is related to experiencing less negative emotions, e.g. anger. Secondly, being out is also related to contextual variables like experienced violence and discrimination[81].

The second major factor limiting symptoms of depression is social support[82] represented by the number of people respondents can rely on, especially stronger support from the family[83].

78 $r = -0,51$, $p < 0,001$.
79 For LGB persons ($N = 5930$) $r = 0,16$, $p < 0,001$; asexual persons ($N = 155$) $r = 0,24$, $p = 0,002$; transgender persons ($N = 360$) $r = 0,26$, $p < 0,001$.
80 Severe symptoms of depression $t(3409,491) = 12,29$, $p < 0,001$, $d = 0,34$; severity of depression symptoms $r = -0,26$, $p < 0,001$.
81 Legate, N., Ryan, R. M., & Weinstein, N. (2012). *Is coming out always a "good thing"? Exploring the relations of autonomy support, outness, and wellness for lesbian, gay, and bisexual individuals. Social Psychological and Personality Science,* 3(2), 145-152.
82 $r = -0,23$, $p < 0,001$ ($N = 5947$).
83 $r = -0,32$, $p < 0,001$ ($N = 6114$).

Summary

1. Results of general analyses show that a significant majority of LGBTA persons exhibit at least mild symptoms of depression, while the percentage of people with severe symptoms of depression is more than five times higher than for the general population.
2. Severity of depression symptoms is correlated with significantly lower quality of life (life satisfaction and relative deprivation).
3. Severity of depression symptoms is especially high among the youth. It can be explained by a number of factors resulting from the model of minority stress (see chapter on minority stress). Main causes for these links come from higher risk of peer violence, feeling lonely and lack of social support, or being dependent on biological family.
4. Among factors protecting from symptoms of depression the most important one is social support (especially from loved ones) and level of being out.

Violence motivated by prejudice

This chapter will look at the scale of violence experienced by LGBTA persons, especially the forms of violence LGBTA persons usually experience, the perpetrators, the places where homophobic and transphobic violence usually happens, the consequences of experienced violence, and the scale of reporting crimes motivated by prejudice.

This report treats the issue of violence motivated by prejudice very broadly. There are three basic reasons for this. First of all, literature on intergroup violence (both individual and collective violence against representatives of a group) highlights the fact that dominating groups use it to maintain social control. Secondly, even the most subtle forms of violence from the majority group have serious consequences for the minority group. Research shows that hate speech or contemptuous epithets can negatively impact the health of members of a minority[84], and even increase the number of suicides within the excluded group[85]. Lastly, frequency or prevalence of even the most subtle forms of violence in society has a strong degrading impact on social norms. Research on desensitization to violence shows that frequent exposition to violence increases aggression – this concerns for example aggression in the media[86] and video games[87]. Latest research shows that similar processes also concern hate speech. Exposure to verbal aggression against minorities desensitizes people to these types of speech and increases prejudice against these groups. The aforementioned arguments speak to the impact of even microaggressions on the wellbeing of a minority, on the relationship between the majority and minority in a society, and on the norms of behaviour in society[88 89].

The definition of violence motivated by prejudices utilized in this report includes all behaviours intended to cause harm (mental or physical) and motivated by someone's (actual or perceived) sexual orientation or gender identity. Besides traditionally recognized forms of violence, this definition also includes passive behaviours like persistent ignoring or refusing services.

84 Burn, S. M., Kadlec, K., & Rexer, R. (2005). *Effects of subtle heterosexism on gays, lesbians, and bisexuals. Journal of homosexuality*, 49(2), 23-38.
85 Mullen, B., Smyth, J. M. (2004). *Immigrant suicide rates as a function of ethnophaulisms: Hate speech predicts death. Psychosomatic Medicine*, 66, 343-348.
86 Anderson, C. A., Berkowitz, L., Donnerstein, E., Huesmann, L. R., Johnson, J., Linz, D., Malamuth, N., & Wartella, E. (2003). *The inXuence of media violence on youth. Psychological Science in the Public Interest*, 4, 81–110.
87 Carnagey, N. L., Anderson, C. A., & Bushman, B. J. (2007). *The effect of video game violence on physiological desensitization to real-life violence. Journal of experimental social psychology*, 43(3), 489-496.
88 Soral, W., Bilewicz, M., & Winiewski, M. (2016). Exposure to hate speech increases prejudice through desensitization. Article awaiting publication.
89 Fasoli, F., Paladino, M. P., Carnaghi, A., Jetten, J., Bastian, B., Bain, P. G. (2015). *Not "just words": Exposure to homophobic epithets leads to dehumanizing and physical distancing from gay men. European Journal of Social Psychology.*

EXPERIENCING VARIOUS FORMS OF VIOLENCE

Have you experienced the following situations because of your actual or perceived sexual orientation / gender identity / gender expression in the last two years (since January 2015), and if yes how many times?

1 Verbal provocation / verbal aggression
2 Insulting, humiliation, ridiculing
3 Spreading negative opinions about you
4 Excessive / constant negative comments
5 Aggressive gestures (pointing at you)
6 Threats
7 Hate mail addressed to you or your loved ones
8 Blackmail
9 Vandalism, destroying property
10 Other non-verbal insults (e.g. a writing or a drawing)
11 Isolation from something or someone
12 Refusal of some kind (e.g. services, sale, service in a restaurant)
13 Pushing, hitting, yanking, kicking
14 Battery
15 Attack with a weapon
16 Sexual advances violating your bodily integrity (e.g. touching you against your will)
17 Sexual assault
18 Other

Overall, the number of respondents who participated in the portion of the questionnaire devoted to violence motivated by prejudice was N = 6348[90]. At first, they were asked a series of 18 questions about experiences (and frequency) of various forms of violence: from verbal (e.g. unpleasant comments) to physical (e.g. attack with a weapon) – the full list can be found in the frame above. The last question on the list was semi-open, which allowed respondents to supplement the list with other incidents, if necessary. Like in 2006 and in 2011 the question was about the last two years (since January 2015). In the next part of the survey we asked respondents about the most recent incidents, a detailed description, and information about the place, perpetrators, and whether it was reported to the police.

90 Despite a significant difference in the number of respondents who answered the questions in this part of the survey compared to the entire sample, the distribution of the majority of demographic variables was generally the same as for the entire sample.

The first part of analyses considered six indicators. The overall indicator of frequency of experiencing violence is a sum of respondents' answers to all 18 questions. The other five indicators are sums of results from detailed questions about five areas of violent behaviours – verbal, physical, and sexual violence, vandalism and discrimination (actions taken against broadly understood belongings), as well as threats and blackmail. Additionally, in order to make comparisons between groups that were not equinumerous, and for the sake of visualizations, the analyses utilized simplified indicators of experiencing violence, which considered whether a respondent reported a particular event. This allowed us to show the percentage distribution of experiencing violence. In the second part, reported latest incidents were analysed in terms of their context (place and perpetrators).

Overall frequency of experiencing violence within the LGBTA population can be estimated by checking what portion of respondents experienced any form of violence motivated by prejudice in the last two years. 68,9% of the studied sample experienced at least one incident like this. Figure 27 shows the distribution of experiences with violence motivated by prejudice by groups of respondents.

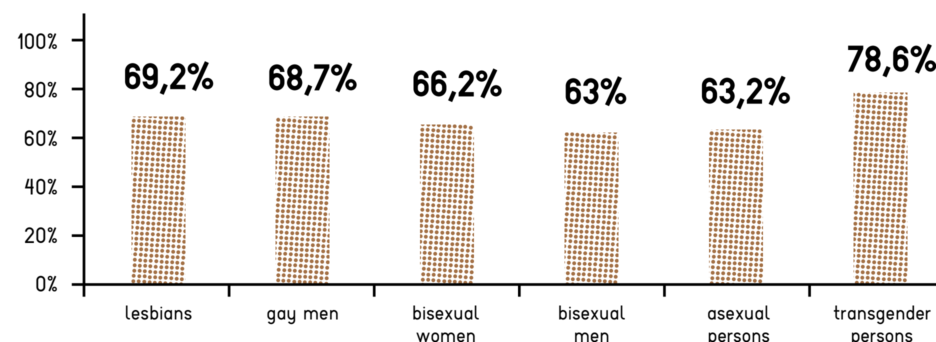


FIG. 27. Percentage of respondents who experienced violence in the last two years (divided by group)

The likelihood of experiencing violence is similar for most of the studied groups, however transgender persons experience these types of situations significantly more often than other groups[91]. Analyses which considered regional differentiation show that there are small but significant differences in frequency of experiencing violence between voivodeships[92].

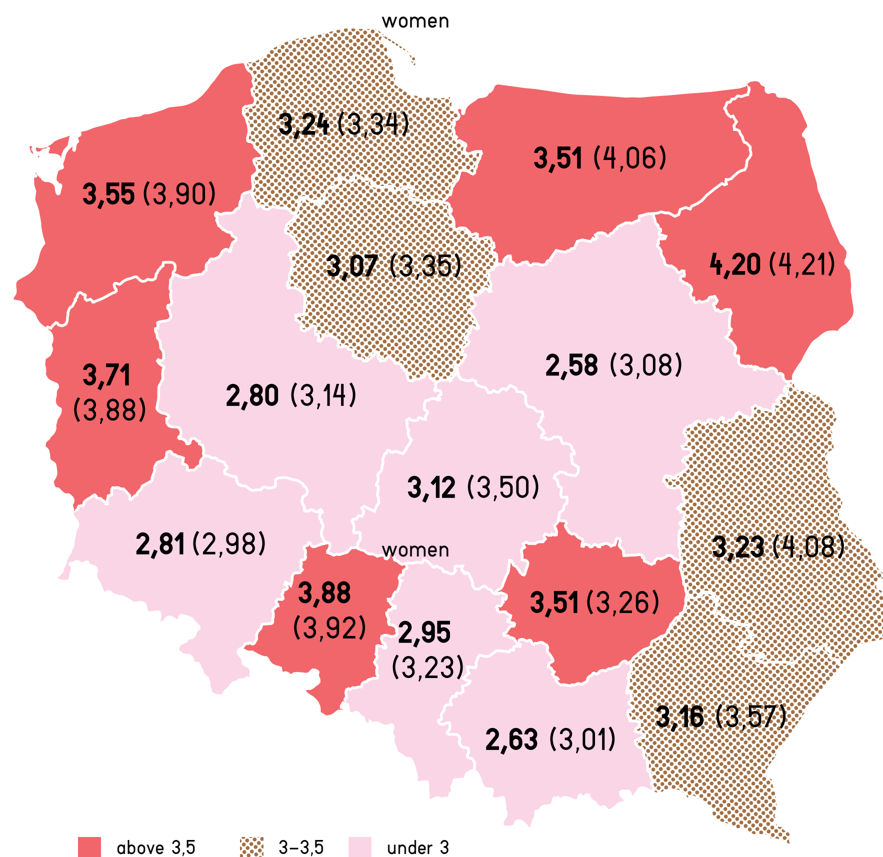


FIG. 28. Average number of violent incidents motivated by prejudice experienced by LGBTAQI respondents between January 2015 and December 2016*

* N = 5826, the numbers in brackets indicate standard deviation

91 $X^2(5) = 48,04$, $p < 0,001$; differences for observation pairs were determined using the Marascuilo procedure.

92 $F(15,5810) = 4,759$, $p < 0,001$, $\eta p^2 = 0,012$.

Detailed analysis shows that Mazovian, Lesser Poland, Greater Poland, Lower Silesian, and Silesian Voivodeships are relatively the safest ones (in this order). The least safe are: Warmian-Masurian, West Pomeranian, Lubusz, Opole, and Podlaskie Voivodeships. It should be noted, that even for voivodeships where respondents experienced violence relatively rarely, this indicator was still higher than an average of two acts of violence in the last two years, which is the case for e.g. the Mazovian or Lesser Poland Voivodeship.

Demographic characteristics of LGBTA persons were subsequently analysed in order to check which variables correlate with more frequent experiences of violence. Analyses show that violence more often affects people who live in rural areas and small cities[93], are poorer[94], worse educated[95], younger[96] and have migration experiences[97]. Results can be understood in two ways. On one hand, people with less economic and cultural capital are more in danger of experiencing violence. On the other, results regarding size of place of residence and migration experiences show that an individual's social relationships can either protect them from or subject to violence. It would seem, that weaker roots in the community (migration experiences) as well as the specific social context (size of place of residence) are related to frequency of experiencing violence.

The gathered data also allow for an analysis of social context and its impact on frequency of experiencing violence motivated by prejudice. The link between a county's characteristics and the frequency of violent incidents motivated by homophobia and/or transphobia occurring there was analysed. Result show that there are not very strong, but significant correlations. Respondents living in less urbanized and less populated counties experience more violence[98]. The county's economic structure also has significance – this type of violence occurs more often in communities where

93 $N = 6348$, $r = -0,13$, $p < 0,001$.

94 $N = 6348$, $r = -0,11$, $p < 0,001$.

95 $N = 6309$, $r = -0,19$, $p < 0,001$.

96 $N = 6345$, $r = -0,19$, $p < 0,001$.

97 $N = 5213$, $r = -0,10$, $p < 0,001$ – information about changing the place of residence (county) between early adolescence and now was used as an indicator.

98 $N = 5577$; number of counties $k = 340$; $B = -0,005(0,002)$ $p=0,026$ for urbanization coefficient; $B = -0,09(0,03)$ $p = 0,007$ – population size coefficient. Data about counties from 2016 – regional database of the Central Statistical Office.

average income is lower and registered unemployment is higher[99].

The most common form of violence experienced by LGBTA persons was subsequently analysed. The 18 types of aggressive or hostile behaviours experienced by respondents were divided into five dimensions of violence (based on their nature).

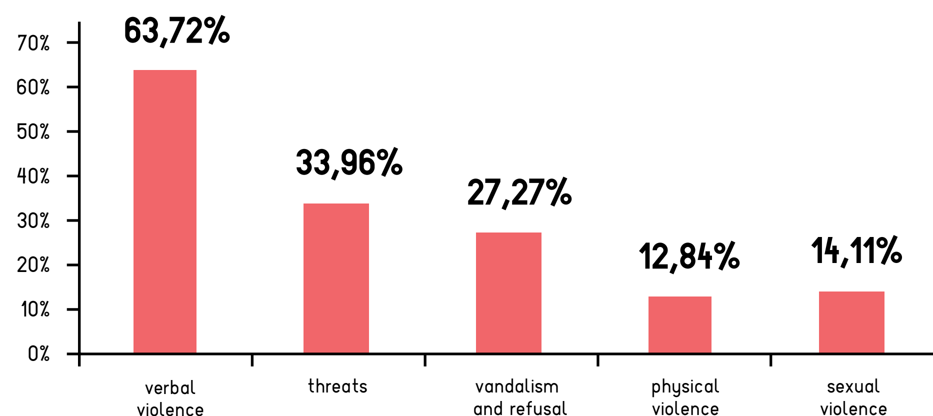


FIG. 29. Percentage of respondents who experienced particular forms of violence in the last two years.

Analyses show that LGBTAQI persons experience verbal violence most often, less frequently – threats, followed by destruction of property (including various forms of vandalism) and discrimination in access to services, significantly less often – physical violence, and least frequently– sexual violence[100]. Detailed percentage distribution of answers can be found in appendix 1.

Subsequent analysis looked at whether particular groups experience particular forms of violence in different rates.

99 N = 5577; number of counties k = 340; B = -0,011(0,004) p=0,012 for average income; B = -0,76(0,019) p < 0,001 – percentage of the unemployed.
100 Analyses were conducted for frequency of experiencing particular situations. F(4,6344) = 874,030, p < 0,001, hp2 = 0,355.

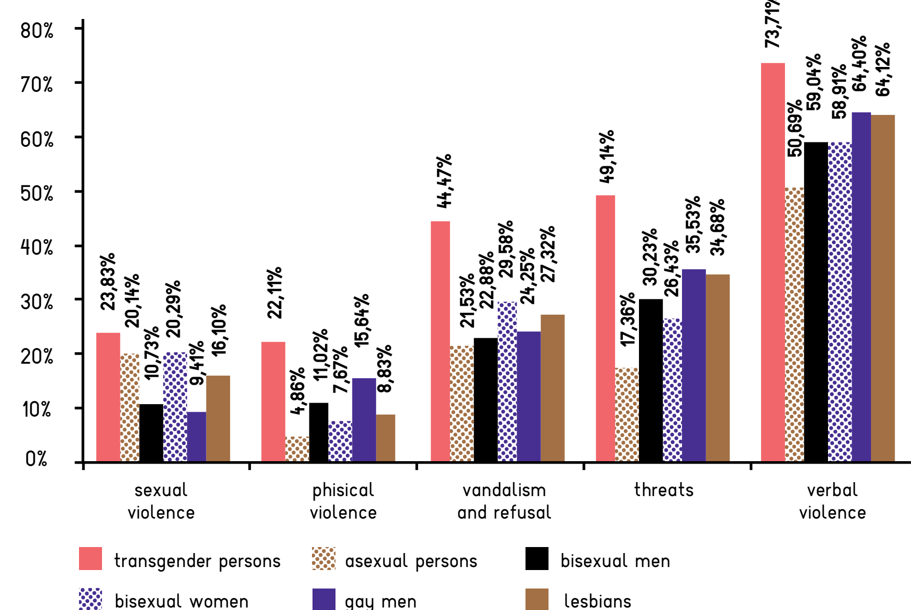


FIG. 30. Percentage of respondents in particular groups who experienced various types of violence between January 2015 and December 2016.

When considering which type of violence members of particular groups are most endangered by, one realizes that in the case of verbal violence only transgender persons are significantly more likely than other groups to experience it[101]. In the case of threats, asexual persons and bisexual women are least likely to be affected, while transgender persons – the most (compared to other groups)[102]. When it comes to vandalism, transgender persons are victims significantly more often than others[103]. Physical violence usually affects transgender persons, followed by gay men, and bisexual men, relatively less often – asexual persons, bisexual women, and lesbians[104]. Gay and bisexual men are less endangered by sexual

101 $\chi^2(5) = 43{,}23$, $p < 0{,}001$; differences for observation pairs were determined using the Marascuilo procedure.
102 $\chi^2(5) = 95{,}07$, $p < 0{,}001$; differences for observation pairs were determined using the Marascuilo procedure.
103 $\chi^2(5) = 83{,}82$, $p < 0{,}001$; differences for observation pairs were determined using the Marascuilo procedure.
104 X2(5) = 105,14, p < 0,001; differences for observation pairs were determined using the Marascuilo procedure.

violence than other groups[105]. Results quite clearly show that transgender persons are most likely to be subject to all forms of violence. In other groups, gender seems to be most determinative. Men, regardless of sexual orientation, are more endangered by physical violence, while women – by sexual violence. The results are consistent with those from 2011[106].

Context – perpetrators, location, and reporting violence motivated by prejudice

In order to find out the context of reported incidents, respondents were asked in the questionnaire to recall the last incident (physical/sexual attack, threat of violence, or other form of harassment experienced because of their actual or perceived sexual orientation/gender identity) and describe it using similar categories to those in the previous question about all incidents. Respondents were also asked to answer a few questions about the incident. 3122 respondents answered this question, all of whom described one incident. Comparison between the question about a specific incident and the distribution of answers to the series of questions about all incidents from the last two years show a similar distribution, with one difference – when describing individual incidents, respondents recalled more verbal violence.

After analysing all incidents, regardless of their nature, one can say that most of them happened in places associated with LGBT people (e.g. clubs, bars) or during an event (e.g. Equality Parade), followed by public outdoor spaces (streets, carparks, parks etc.) and schools/universities. A detailed distribution is presented on figure 31.

105 $\chi 2(5) = 135{,}84$, $p < 0{,}001$; differences for observation pairs were determined using the Marascuilo procedure.
106 Makuchowska, M., Pawlęga, M. (ed.) (2012), *Situation Of LGBT Persons In Poland. Report for 2010 and 2011*, Campaign Against Homophobia, Warsaw.

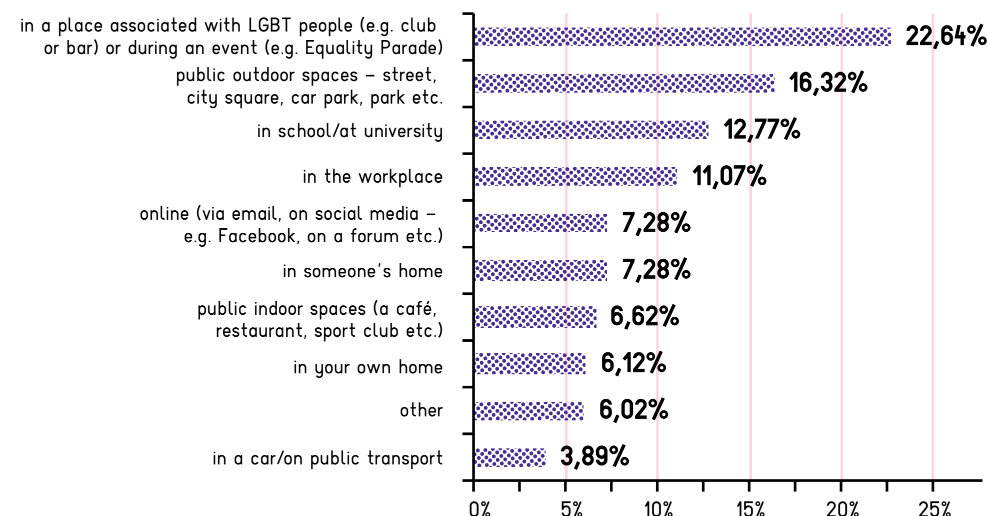


FIG. 31. Percentage distribution of where described incidents of violence happen

The results allow us to determine where do particular attacks take place. Verbal violence usually happens in places associated with LGBT people (24,6%), in public spaces – in the streets, in parks (15,3%), at universities and in schools (12,9%), and in the workplace (12,5%). Threats usually take place in public spaces (22,9%), in places associated with LGBT persons and online (in both cases around 13,9%). Vandalism and refusal mostly happen in schools (21,9%) and respondents' own homes (17,1%), less frequently in public spaces (13%). Physical violence usually happens in places and during events associated with LGBT people (44,3%) and in public spaces (21,4%). Sexual violence takes place mostly in schools/universities and public buildings, like restaurants and sport clubs (18,1%), in public (17,5%), and at other people's homes (13,8%).

Respondents were also asked to describe the perpetrators. Detailed analyses show that in most cases the number of perpetrators (one or more) is not related to the type of attack, or where it took place. The most frequent category of perpetrators are colleagues. Loved ones are also a big group – 18,11% of all perpetrators are relatives and unrelated loved ones. A relatively small portion of perpetrators are people from respondents' work environment – only about 7% were clients, coworkers, and supervisors.

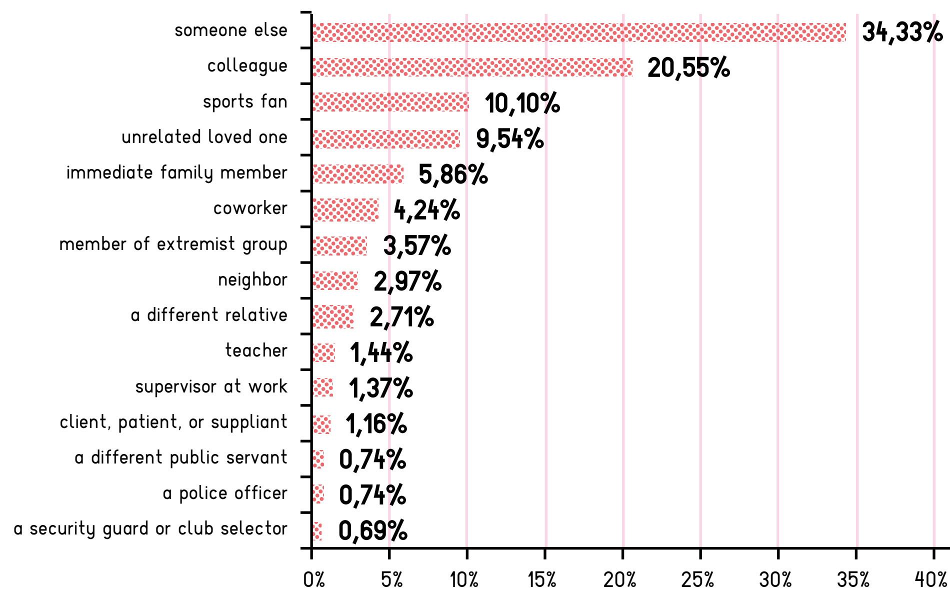


FIG. 32. Percentage distribution of categories of perpetrators.

Detailed analysis of links between where the incident took place and the perpetrator brought mostly predictable results. A sizeable portion of attacks in private spaces (e.g. respondents' or someone else's home) are perpetrated by family and loved ones. In work environments and at universities the perpetrators are colleagues and coworkers. In public spaces these are mostly strangers (sports fans, members of extremist groups). However, it is worth noting that the biggest group of perpetrators (an undefined category of "someone else") commits acts of violence in public (70,7%) and places associated with LGBTQ people (77,2%). Therefore, it is highly likely that these are random people (e.g. passers-by) who reacted to signals indicating that the victim was LGBT with aggression.

The last series of questions was about reporting the described incident to the police (or other services) and, if the incident was not reported, about the reasons behind the decision. It turns out that of the 3122 incidents, only 104 were reported, which is less than 4%. Interestingly, respondents usually did not answer the question about why they did not report it[107]. Detailed analyses show that for most types of violence rates of reporting are very low (1,5% for verbal violence, 6,9% for threats, 6,5% for vandalism, and 3,1% for sexual violence). The only type of attack which is reported relatively often is physical violence (27,3%). While rates of reporting are low, they are consistent with results of recent studies on crimes motivated by prejudice[108]. Moreover, results concerning reporting of physical violence are consistent with criminological research, which shows that reporting is related to the severity of the crime.

107 Very low numbers do not allow for more detailed analyses.

Consequences of violence

Studies of ethnic minorities show that experiences of verbal or physical violence increase the risk of physical (e.g. respiratory diseases) and mental (e.g. depression, or psychotic disorders) health problems[109]. Recent studies conducted in Poland show that mental and social consequences of crimes motivated by prejudice against the LGBT minority are especially severe (compared to representatives of the majority who fell victim to similar crimes)[110].

The gathered data allowed us to check whether experiences of violence in the LGBTA sample correlates to indicators of mental and physical health, as well mood and life satisfaction. Analyses of the overall violence indicator show that an increase in these types of experiences over the last two years correlated with worse (subjectively) physical health, taking sedatives, significantly lower life satisfaction, exacerbated symptoms of depression, and suicidal thoughts[111].

108 Winiewski, M, Górska, P. (2016), *Przestępstwa motywowane nienawiścią*, unpublished report commissioned by the Polish Commissioner of Human Rights.
109 Karlsen, S., & Nazroo, J. Y. (2002). *Relation between racial discrimination, social class, and health among ethnic minority groups. American journal of public health*, 92(4), 624-631.
110 Winiewski, M, Górska, P. (2016), *Przestępstwa motywowane nienawiścią*, unpublished report commissioned by the Polish Commissioner of Human Rights. Górska, P., Budziszewska, M., Knut, P., Łada, P. (2016) *Raport o Polsce: Homofobiczne i transfobiczne przestępstwa z nienawiści a wymiar sprawiedliwości*, Kampania Przeciw Homofobii, Warszawa.
111 The model controlled for demographic variables (age, education, income, and migration experiences) β = -0,04, p = 0,032 for health; β = 0,06, p < 0,001 taking tranquilizers; β = 0,15, p < 0,001 symptoms of depression; β = -0,05, p < 0,001 life satisfaction; β = 0,10, p < 0,001 msuicidal thoughts; R2 = 0,15; N = 4845.

Summary

1. Results paint a worrying picture of violence and discrimination affecting the entire LGBTAQI community. More than two thirds of respondents experienced at least one incident of violence motivated by prejudice in the last two years. LGBTAQI people most often experience verbal violence, however the number of respondents who experienced physical and sexual violence in the last two years is very high.
2. Frequency of violence experienced by LGBTAQI people is to some degree related to their place of residence. Respondents living in big cities experience such incidents less often. However, it would seem that it is not only the result of more anonymity (in more populated areas), but also of the financial situation of the region. Experiences of violence correlate with overall higher unemployment rates and relatively lower earnings. These results can be interpreted in the context of the Frustration-Aggression Theory[112] which says that violence and aggression result from frustration and deprivation. In other words, in regions where the entire population is in a worse financial situation, the overall level of aggression is higher, and what follows, the level of violence is also higher. However, this study is unable to tell whether the overall level of violence is higher in those regions, or it just concerns the level of violence against LGBTAQI people and other minorities[113].
3. The results of the study quite clearly show that violence motivated by prejudice against LGBTQIA people is omnipresent. Acts of violence happen both in private and public spaces. Notably, violent incidents against non-heteronormative people happen in spaces traditionally associated with members of this community, i.e. in clubs for LGBT people or during the Equality Parade.
4. Violence and discrimination against LGBTAQI people results in negative consequences for the physical and mental health of this group.

112 Dollard, J., Miller, N. E., Doob, L. W., Mowrer, O. H., & Sears, R. R. (1939). *Frustration and aggression*.
113 Glick, P. (2002). *Sacrificial Lambs Dressed in Wolves' Clothing. Understanding genocide: The social psychology of the Holocaust*, 113.

Family life

Respondents were asked whether they are currently in a relationship, about stability of the relationship, and their plans regarding family life. This chapter discusses LGBTA persons' attitudes towards civil partnerships, marriage, and child adoption, as well as their future plans regarding children.

Answers were compared to data from previous editions of the study. At the time of the study, about half of the respondents were in a relationship.

TAB. 17. Are you currently in a same-sex relationship? (re. LGB)

	2016 (n = 6488)	2011 (n = 11137)	2006 (n = 996)
YES	47,5%	43,8%	59,2%
NO	52,5%	56,2%	40,8%

The sample was broken down by sexual orientation and gender identity. Lesbians were most likely to be in relationships, followed by gay men and transgender persons. Asexual persons were least likely to be in a relationship.

TAB. 18. Being in a relationship (same-sex – re. LGB) by declared sexual orientation and gender identity.

	2016 (N=6950)	Homosexual		Bisexual		Asexual	Transgender
		K	M	K	M		
YES	47,1%	63,8%	53,4%	28,9%	27,4%	22,7%	40,3%
NO	52,9%	36,2%	46,6%	71,1%	72,6%	77,3%	52,5%

Respondents who were in relationships were asked about the length of their relationship. Data from this edition of the study show a rising trend regarding stability of non-heteronormative relationships. As shown by table 19, the number of people in a relationship shorter than a year fell significantly – it is less than 20% of respondents compared to one third in 2011. Almost 30% of respondents have been in relationships for more than five years, which is ten percent higher compared to 2011.

TAB. 19. How long has your current relationship lasted (same-sex – re. LGB)?

	2016 (n=3228)	2011 (n=4872)	2006 (n=583)
less than 6 months	7,9%	21,9%	22,4%
6-12 months	12,3%	15,1%	16,8%
1-2 years	21,3%	22,2%	22,5%
2-5 years	31%	23,2%	24,4%
5-10 years	17,7%	11,7%	7,5%
more than 10 years	9,9%	5,9%	3,3%

As shown by the conducted analyses, being in a relationship significantly ($p<0,01$) correlates with declared health[114] and variables characterizing mental wellbeing. Variables chosen for analysis are: overall life satisfaction[115], scale of depression symptoms[116], feeling lonely, and frequency of suicidal thoughts. The strongest correlation was between being single and feeling lonely[117], as well as being in a relationship and life satisfaction[118]. Being single was also related to symptoms of depression[119] and frequency of suicidal thoughts[120].

TAB. 20. If it was possible in Poland, being in a same-sex relationship, would you decide to…? (N=6273)

	Yes	No	I don't know
enter a civil partnership	87,2%	3,7%	9,1%
get married	61,8%	14,9%	23,2%
adopt children	32,1%	30,7%	37,2%

114 Spearman's rho = 0,11.
115 Cronbach's Alfa = 0,86.
116 Cronbach's Alfa = 0,89.
117 Spearman's rho = 0,30.
118 Spearman's rho = 0,23.
119 Spearman's rho = 0,22.
120 Spearman's rho = 0,20.

Respondents were also asked about their attitudes towards legal regulations for same-sex couples. Respondents were most interested in entering a civil partnership, only less than 4% would decide against it. More than 60% of respondents would also be interested in getting married, compared to less than 15%, who would decide against it. Compared to the previous edition, there is a significantly higher interest in getting married – in 2011 half of respondents (49,7%) wanted to get married. Interest in civil partnerships and adoption is at a relatively stable level.

TAB. 21. If it was possible in Poland, being in a same-sex relationship, would you decide to…? (n<3667; 6535>)

	Lesbians	Gay men	Bisexual women	Bisexual men
enter a civil partnership	92,2%	87,3%	87,6%	70,6%
get married	72,2%	60,4%	63,4%	38,6%
adopt children	44,5%	25%	41,9%	21,5%

We also looked at the responses from lesbians, gay men, and bisexual persons. More than 90% of lesbians and almost 88% of gay men in the sample were interested in a civil partnership. Marriage was most appealing to lesbians, while bisexual men were least interested in a formal relationship. Non-heterosexual women were most interested in adoption. At the same time, when asked about future plans regarding children, the vast majority (64,9%) declares that they do not plan to have children in the next five years.

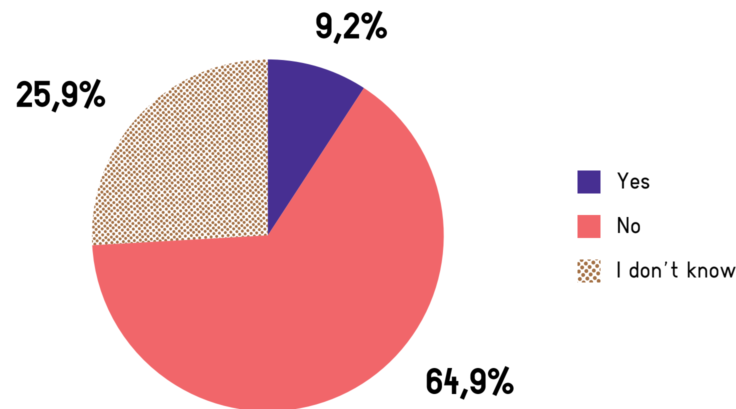
Support for introducing civil partnerships was negatively predicted by age[121] and religiosity[122] – the older and more religious the respondents, the more convinced they were that same-sex couples should not have the right to civil partnerships.

121 $B = -0,03; SE = 0,01; p = 0,001$.
122 $B = -0,40; SE = 0,06; p < 0,001$.

Support for marriage equality was negatively predicted by age[123] and religiosity[124] , and positively by number of county inhabitants[125]– the older and more religious the respondents, and the smaller the county they lived in, the less likely they were to support same-sex couples right to marriage.

Age[126] and religiosity[127] also negatively predicted support for adoption by same-sex couples. Moreover, belief that same-sex couples should have the right to adopt correlated positively with level of education[128]. The older, more religious, and less educated the respondents, the less likely they were to support adoption by same-sex couples.

FIG. 33. Distribution of answers to the question: Do you plan to have a child in the next five years? (N = 6449)



When it comes to the issue of children, 2,4% of respondents are a biological parent, less than one percent (0,7%) is an adoptive parent, and only 1,1% is a social parent. It could be a result of an unequal age distribution, since young respondents are a majority

123 $B = -0{,}03; SE = 0{,}01; p < 0{,}001$.
124 $B = -0{,}23; SE = 0{,}03; p < 0{,}001$.
125 $B = 0{,}03; SE = 0{,}01; p = 0{,}033$.
126 $B = -0{,}03; SE = 0{,}004; p < 0{,}001$.
127 $B = -0{,}21; SE = 0{,}02; p < 0{,}001$.
128 $B = 0{,}09; SE = 0{,}01; p < 0{,}001$.

of the sample. Having children is a function of age, and the sample is dominated by young people, therefore parents are a small portion of the sample.

LGB parents who raise kids in same-sex couples are about 4% of respondents. If the sample was representative, it would mean that there is 76 000 LGB parents raising children in same-sex couples, in Poland. Despite a lack of legal regulations for so called 'rainbow families' these types of families do exist in Poland.

Summary

1. Results presented in this chapter show that relationships formed by non-heteronormative people are increasingly stable. Lesbians form relationships most often, followed by gay men and transgender persons, while asexual persons – least often.
2. Results show the need for legal recognition of same-sex relationships in Poland. Almost 90% of respondents are interested in a civil partnership and more than 60% - in marriage. In comparison to five years ago, there is a 12 percentage points increase in respondents interested in marriage. Lesbians would benefit most often from legal regulations regarding civil partnerships, marriage, and adoption.
3. Respondents who were single, were also less satisfied with their lives, felt more lonely, exhibited more symptoms of depression, and thought about suicide more often. This could largely concern underage non-heteronormative youth, which constituted one fifth of the sample.
4. Legal regulations concerning same-sex relationships are least likely to be supported by older and more religious people.

Minority stress

One of the experiences unique to members of socially stigmatized groups is minority stress. It is an additional burden which affects members of minorities, besides general stressors like bad health or bad financial situation[129]. In the case of LGBTA persons, minority stress is a result of discordance between their own desires and perception of reality, and institutions and structures that exist outside of the individual, such as tradition, ideological climate, religion, or legal system. Constant mental tension resulting from this discrepancy can lead to worse functioning, especially in the area of mental health.

129 Iniewicz, G., Grabski, B. i Mijas, M. (2012). *Zdrowie psychiczne osób homoseksualnych i biseksualnych – rola stresu mniejszościowego,* Psychiatria Polska, 4, 649-663.

The concept of minority stress experienced by LGB persons was most fully developed by Ilan Meyer[130]. In his model (fig.34) he differentiates between two sources of minority stress: external processes aimed at the individual (distal) and internal processes (proximal). External processes include physical and psychological violence motivated by hate, while internal processes include internalized stigma, expectation of rejection, and concealment of identity. Internalized stigma (e.g. internalized homophobia) relates to negative feelings (e.g. shame, anger) aimed at oneself due to one's own minority sexual orientation or gender identity. Expectation of rejection means the degree to which an individual expects negative reactions (e.g. discrimination) in response to their sexual orientation or gender identity. Finally, life in hiding means controlling information about one's own sexual orientation or gender identity. Even though strict limiting of information about oneself requires a lot of cognitive resources and energy and may result in worse mental functioning, it is sometimes an effective strategy for avoiding violence motivated by prejudice. To sum up, external processes related to minority stress could be described as more objective, and internal processes as more subjective (meaning depending on a person's convictions). However, it should be noted that negative consequences for mental health are real in both cases.

Importantly, the model specifies not only elements related to minority stress, but also factors which raise resilience to stress. The second group includes: received social support, adopted strategies for coping with stress, and identification with one's own minority group. Meyer claims that individuals who have support from the outside, cope with tension in a constructive way, and strongly identify with their group are less prone to negative effects of minority stress.

130 Meyer, I. H. (1995). *Minority stress and mental health in gay men. Journal of Health and Social Behaviour*, 38-56.
Meyer, I. H. (2003). *Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin*, 129, 674–697.

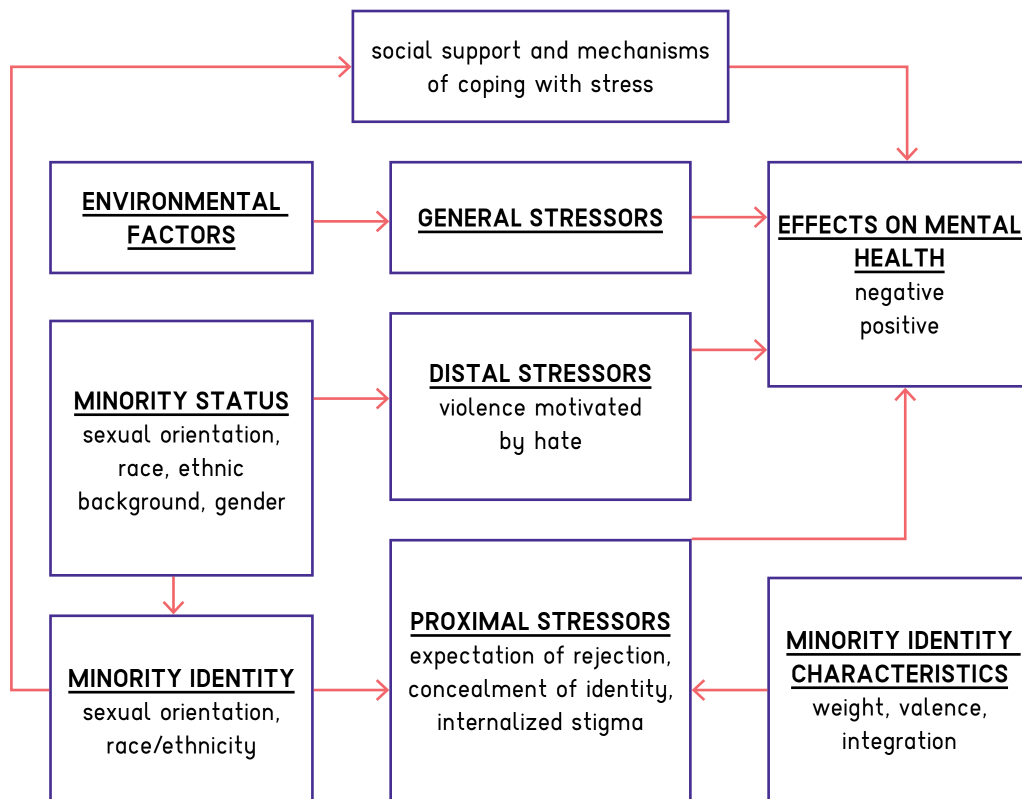


FIG. 34. Model of minority stress

The concept of minority stress was utilized in the process of planning this study. By measuring factors included in Meyer's model we wanted to understand what exactly worsens and what protects mental functioning of LGB, T, and A persons in Poland. For all of these groups, we measured general stressors, processes related to minority stress, social support, coping strategies, identification with one's own group, and four aspects of mental health: severity of depression symptoms, suicidal thoughts, life satisfaction, and self-esteem.

This chapter discusses the results of internal processes related to minority stress for all three groups (results for external processes can be found in the chapter on violence motivated by prejudice) and looks at how general and minority stressors affect the mental health of respondents. We also point to factors which increase resilience to minority stress. Importantly, the analyses

presented below consider the role of objective characteristics of social context (counties) such as population size, religiosity, and financial situation. As shown by previous studies[131], they also have an impact on the mental health of LGBTA persons.

Analytical strategy

Analyses in which the predicted variables were internal processes and factors protecting from the consequences of minority stress, were conducted following the same pattern. First, subgroups of the LGBTA population were checked for differences in the levels of a particular characteristic. This was followed by an evaluation of the variables' effect on an individual level (i.e. age, level of education defined as completed years of education, subjective financial situation, and religiosity) and on a county level (i.e. population size[132], unemployment rate, average wages, and proportion of religious people in the population), while controlling for the LGBTA subgroup. In order to make interpretation easier, besides unstandardized regression coefficients for variables on the individual level, their correlations with result variables were also included. It should be noted that the reported effects of county characteristics (e.g. unemployment rate) were independent from the effects of variables on an individual level. For example, if it was stated that the unemployment rate reduces coping with stress through mobilization, it meant that when comparing two people with the same individual characteristics (i.a. age or education) the one living in a county with more unemployment would be less likely to get mobilized when faced with problems.

Analyses in which four manifestations of mental health (symptoms of depression, suicidal thoughts, life satisfaction, and self-esteem) were predicted, took a different shape. They checked for effects of factors on an individual level (general stressors and internal and external processes related to minority stress) and on county level, from the beginning. General stressors included disability (0 = no, 1 = yes), bad financial situation (1 = highest income bracket in the country; 10 = lowest income bracket in the country) and being single (0 = having a partner, 1 = no partner).

131 Hatzenbuehler, M. L. (2014). *Structural stigma and the health of lesbian, gay, and bisexual populations. Current Directions in Psychological Science*, 23, 127-132.
132 1 unit = 100k inhabitants.

The analyses presented below utilized a number of statistical techniques like variance analysis and X2 test for two variables (to check if the LGBTA subgroup differentiated between respondents' answers), moderator analysis (searching for factors contributing to psychological resilience), and multilevel models (determining the role of characteristics on an individual and county level in predicting respondents' answers).

While the data on an individual level came from the study we conducted, data about counties came from publicly available data archives. Information about population size, average wages, and unemployment rates came from the Local Data Bank (bdl.stat.gov.pl). Data about the proportion of religious people in county populations came from the National Census from 2011.

Internalized stigma

Depending on the reference group, internalized stigma can take the form of internalized homophobia (LGB persons), transphobia (transgender persons), and aphobia (asexual persons). This study measured all of these variables.

Internalized homophobia

In order to measure internalized homophobia, a shorter version of the scale prepared by Herek et al.[133], was utilized (already used in Poland before[134]). Figure 35 shows the distribution of answers to each of the five questions asked.

133 Herek, G. M., Gillis, J. and Cogan, J. (2009). *Internalized stigma among sexual minority adults: Insights from a social psychological perspective. Journal of Counseling Psychology*, 56, 32–43.
134 See: Górska, P., Bilewicz, M., and Winiewski, M. (2017). *Invisible to the state. Institutional sexual stigma and collective action of LGB individuals in five East European countries. Group Processes and Intergroup Relations*, 20, 367-381.

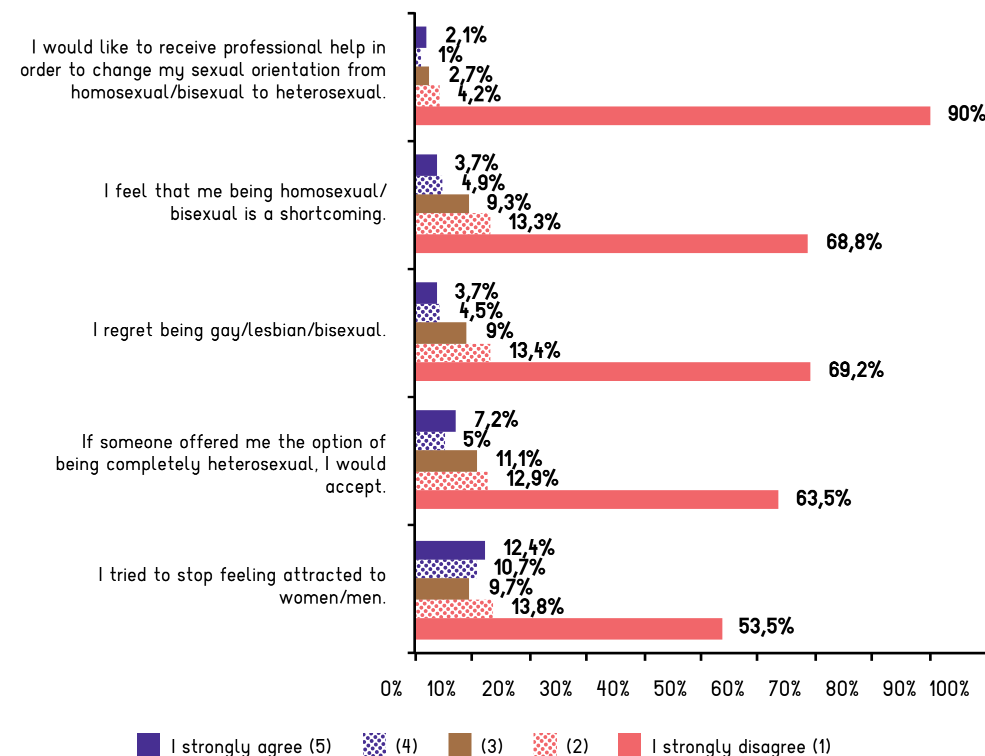


FIG. 35. Distribution of answers to questions measuring internalized homophobia (N = 5189)

Only a small percentage of respondents agreed in any way (answers 4-5) with statements measuring internalized homophobia. A relatively highest number of respondents (13,1%) declared that they try to stop feeling attracted to persons of the same gender. The smallest number of respondents (2,1%) agreed with the statement that they would like to receive professional help in order to change their sexual orientation to heterosexual.

By averaging the answers to the five presented questions[135] an indicator of internalized homophobia was constructed; higher value indicated stronger internalized stigma. The level of internalized homophobia depended on the LGB subgroup[136]. Bisexual men exhibited highest levels of internalized homophobia, followed by

135 M = 1,67; SD = 0,85; α = 0,79.
136 F(3, 5185) = 28,90; p < 0,001.

gay men, bisexual women and lesbians[137]. Moreover, internalized homophobia was negatively predicted by age and positively by religiosity[138] . This means that highest levels of internalized stigma were exhibited by young and deeply religious respondents.

Internalized transphobia

The statement "I do not feel uncomfortable when publicly talking about being transgender" was used as an indicator of internalized transphobia. Figure 36 shows the distribution of answers to this questions.

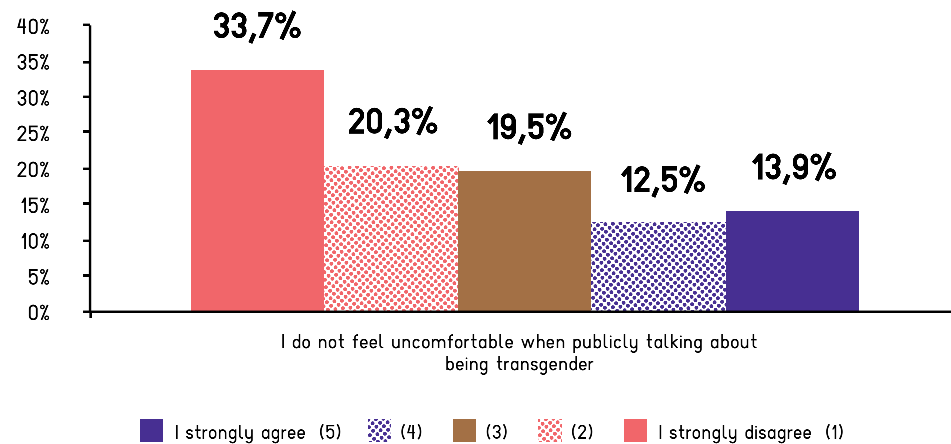


FIG. 36. Distribution of answers to the question measuring internalized transphobia (N = 359)[139]

Most respondents (54%) did not agree with this statement, exhibiting some degree of internalized stigma[140]. A little more than a quarter (26,4%) of respondents declared that they do not feel uncomfortable discussing their trans identity. Internalized transphobia was negatively predicted by age and positively by

137 M = 2,00; SD = 1,02; M = 1,71; SD = 0,86; M = 1,59; SD = 0,81; M = 1,56; SD = 0,74, respectively.
138 Effect of age: B = -0,01; SE = 0,002; $p < 0,001$; r = 0,04; p = 0,004 . Effect of religiosity: B = 0,08; SE = 0,01; $p < 0,001$; r = 0,18; $p < 0,001$.
139 Before further analysis the answers to the questions were re-coded so that higher values indicated stronger internalized transphobia.
140 M = 2,52. SD = 1,42. Higher values mean higher levels of internalized transphobia.

unemployment rate in the county[141]. Young respondents and those living in regions with high unemployment exhibited the highest levels of internalized stigma.

Internalized aphobia

The last group for whom processes related to minority stress were measured, were asexual persons. Since psychological literature does not provide a tool for measuring internalized aphobia, we measured this characteristic by using an adapted version of the scale of internalized homophobia. Figure 37 shows the distribution of answers to specific questions.

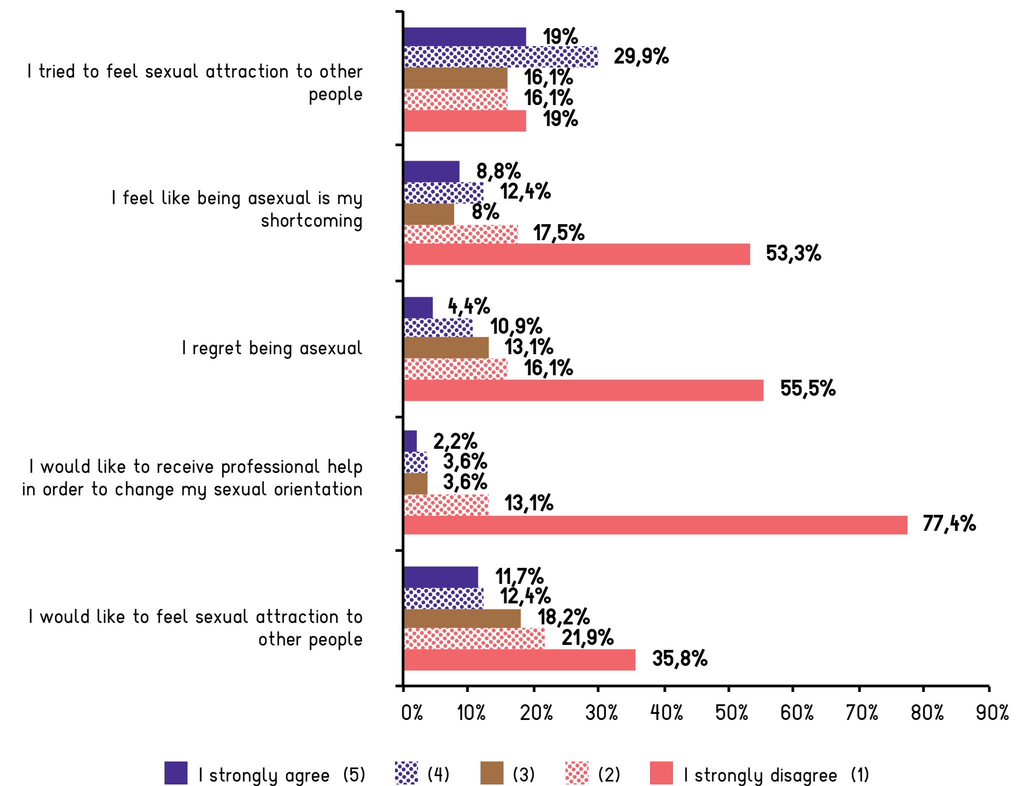


FIG. 37. Distribution of answers to the question measuring internalized aphobia (N = 137)

141 Effect of age: B = -0,03; SE = 0,01; p = 0,009; r = -0,15, p = 0,006. Effect of unemployment rate: B = 0,07; SE = 0,03; p = 0,009.

Almost half of the respondents (48,9%) declared attempts to feel sexual attraction to other people. The least respondents agreed with the statement that they would like to receive professional help in order to change their sexual orientation (9,6%). The average from answers to five questions was used as a general indicator of internalized aphobia[142]. None of the considered socio-demographic variables predicted internalized aphobia.

Concealment of identity – LGB persons

LGB respondents were asked two questions measuring concealment of identity (fig.38). Most of them declared that they consider their sexual orientation to be a private matter (61,9%) and that they closely control who knows about their relationships with people of the same gender (64%). The average from answers to these two questions was used as an indicator of concealment of identity[143]

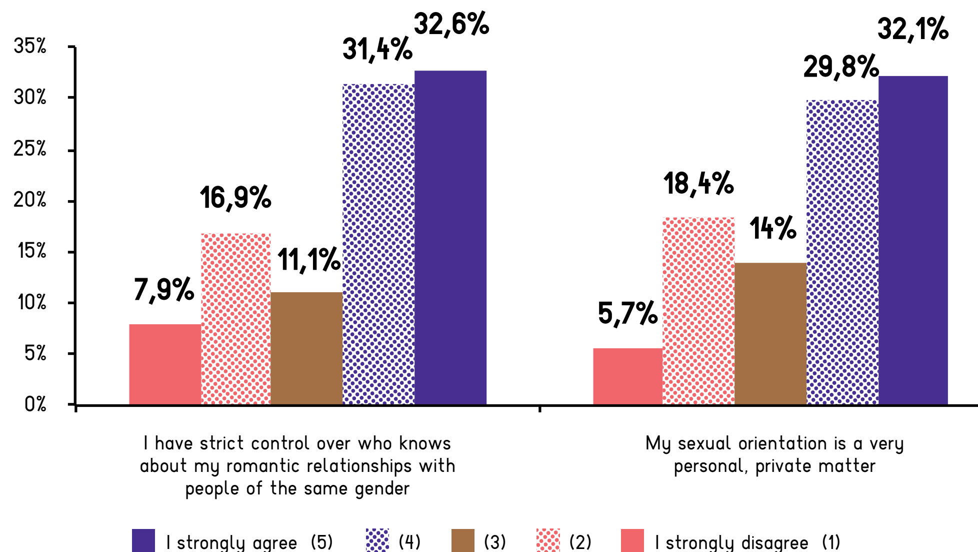


FIG. 38. Answers to the questions measuring concealment of identity (N = 5129)

142 M = 2,19, SD = 0,96; α = 0,81.
143 M = 4,98; SD = 1,67; r = 0,51; p < 0,001.

Control over information about their sexual orientation is mostly exercised by bisexual men, followed by gay men, bisexual women, and lesbians[144]. Concealment of identity was positively predicted by age and religiosity and negatively by subjective financial situation[145]. . In other words: the older, more religious the respondents and the worse their financial situation, the more control they exercised over information about their sexual orientation and considered it a private matter.

Concealment of identity – transgender persons

Transgender people were asked whether they agree with the statement "My transgender identity is very personal, private matter". Distribution of answers was presented on fig.39.

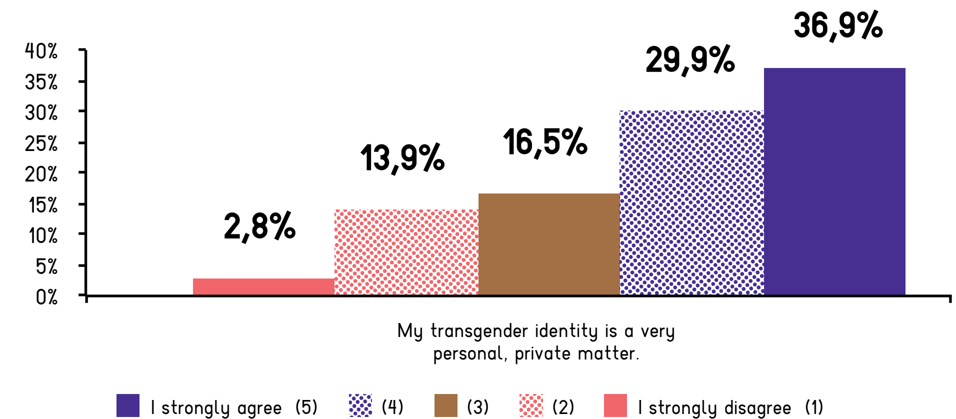


FIG. 39. Distribution of answers to the question measuring concealment of identity (N=358)

More than half of respondents (57,8%) agreed with the presented statement, which shows that most of the transgender persons who took part in the study, conceal their identity to some degree[146]. Considering one's trans identity to be a personal matter

144 M = 5,57; SD = 1,63; M = 5,03; SD = 1,63; M = 4,99; SD = 1,67; M = 4,66; SD = 1,70. F (3, 5125) = 26,76; p < 0,001, respectively.
145 Effect of age: B = 0,01; SE = 0,003; p < 0,001; r = 0,04; p = 0,004. Effect of religiosity: B = 0,08; SE = 0,02; p < 0,001; r = 0,10; p < 0,001. Effect of subjective financial situation: B = -0,03; SE = 0,01; p = 0,014; r = -0,06; p < 0,001.
146 M = 5,28; SD = 1,74.

positively correlated with education and number of inhabitants in the county[147]. This means that the more educated the respondents and the more populated their place of residence, the more they considered their identity to be private.

Concealment of identity – asexual persons

Similarly to transgender persons, concealment of identity by asexual persons was measured by one question. Distribution of answers is presented on fig.40.

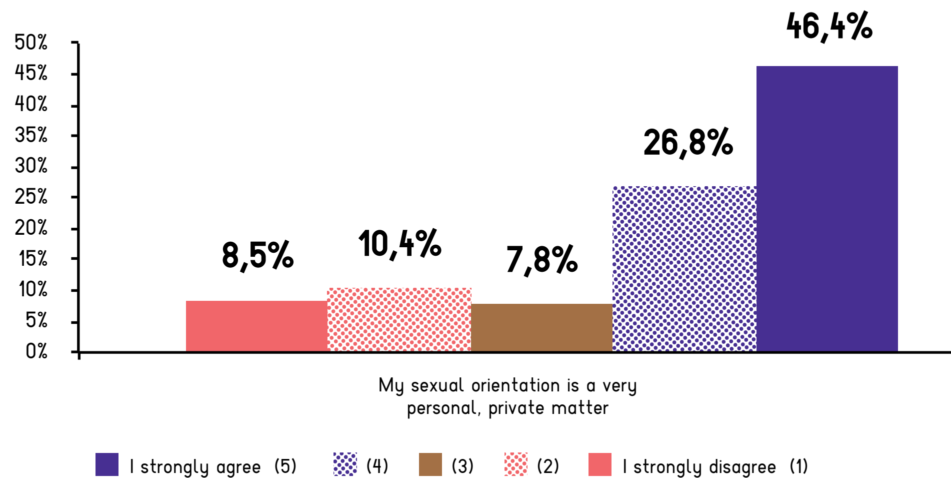


FIG. 40. Distribution of answers to the question measuring concealment of identity (N = 153)

Almost three quarters or respondents declared that they consider their sexual orientation to be a personal, private matter[148]. Concealment of identity was not predicted by any socio-demographic factors.

Expectation of rejection – LGB persons

Two statements measured expectation of rejection or discrimination based on sexual orientation (fig.41). Most respondents reported that they avoid places where they could experience discrimination (58,6%) and occasionally leave their sexual orientation unmentioned in fear of discrimination (69,3%). The average from answers to these questions was used as an indicator of expectation of rejection[149].

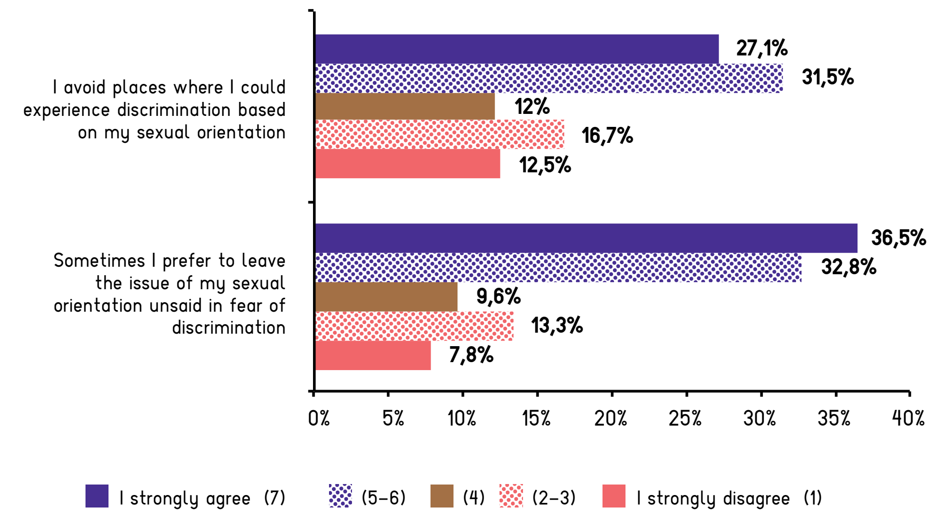


FIG. 41. Distribution of answers to questions measuring expectation of rejection (N = 5129)

Gay men most often expected discrimination based on sexual orientation, followed by bisexual men, lesbians, and bisexual women[150]. Outside of the LGB subgroup, expectation of rejection was positively predicted by education and percentage of religious people in the place of residence and negatively by subjective financial situation[151] – better educated respondents, those who considered their financial situation to be worse, and those living in more religious communities expected negative reactions to information about their sexual orientation to a larger degree.

147 Effect of education: B = 0,08; SE = 0,03; p = 0,008; r = 0,08; p = 0,131. Effect of a county's number of inhabitants: B = 0,06; SE = 0,03; p = 0,021.
148 M = 5,39; SD = 2,00.

149 M = 4,91; SD = 1,75; r = 0,47; p < 0,001.
150 M = 5,11; SD = 1,69; M = 4,99; SD = 1,81; M = 4,64; SD = 1,80; M = 4,65; SD = 1,79. F (3, 5125) = 28.61; p < 0,001, respectively.
151 Effect of education: B = 0,04; SE = 0,01; p < 0,001; r = 0,03; p = 0,018. Effect of subjective financial situation: B = -0,05; SE = 0,01; p < 0,001; r = -0,06; p < 0,001. Effect of percentage of religious people in place of residence: B = 0,02; SE = 0,01; p = 0,041.

Expectation of rejection – transgender persons

Two questions in the survey concerned expectation of rejection by transgender people. Respondents were asked whether they avoid certain places in fear of discrimination or prefer to leave their trans identity unmentioned sometimes (fig.42).

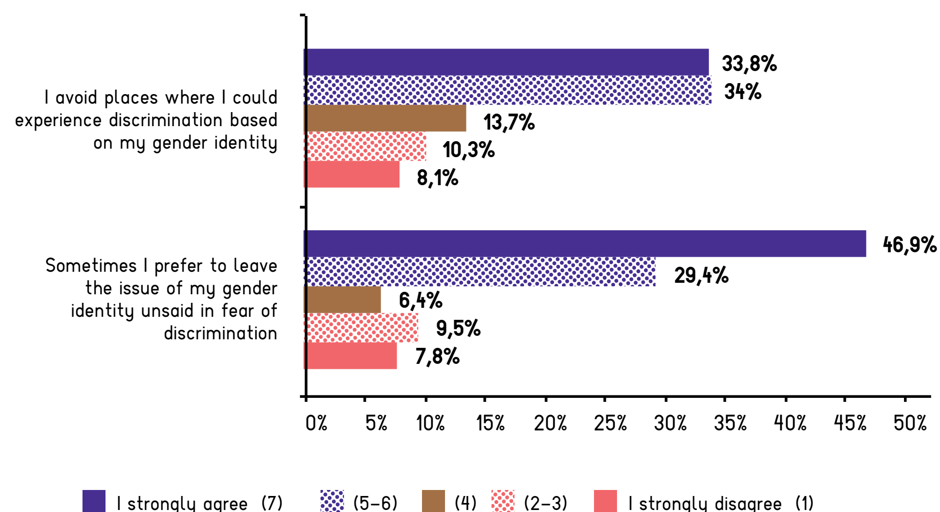


FIG. 42. Distribution of answers to questions measuring expectations of rejection (N = 358)

More than 2/3 of respondents declared that they avoid certain places because they expect discrimination there (67,8%) or they leave their trans identity unsaid (76,3%). Contrary behaviours were reported by 18,4% and 17,3% of respondents, respectively. The general indicator of rejection, which is the average from answers to both questions[152], as not predicted by any socio-demographic variables.

Expectation of rejection – asexual persons

Two questions in the survey measured the expectation of rejection by asexual persons. Figure 43 presents distribution of answers. More than 2/3 of respondents (68,6%) reported that they prefer to leave their sexual orientation unsaid sometimes, in fear of discrimination. For the same reason, almost half of

152 $M = 5,33$; $SD = 1,68$; $r = 0,51$; $p < 0,001$.

respondents (46,4%) reported avoiding certain places[153]. Similarly to transgender persons, expectation of rejection by asexual persons did not correlate with any demographic variables.

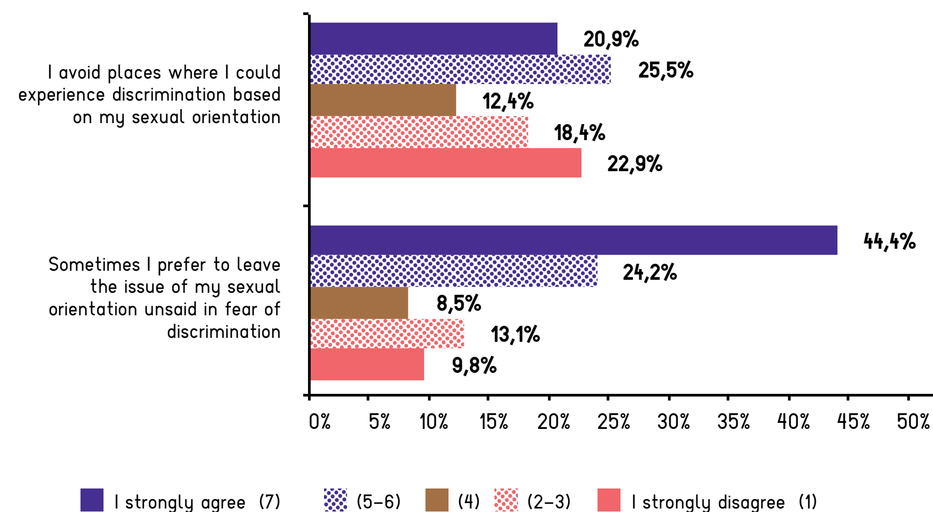


FIG. 43. Distribution of answers to questions measuring expectations of rejection (N = 153)

Minority stress and mental health

Subsequently, we checked, independently of general stressors, socio-demographic characteristics, and contextual circumstances, whether external and internal processes related to minority stress impact the mental health of LGB, T, and A persons. The four indicators of mental health we considered were: severity of depression symptoms, intensity of suicidal thoughts, life satisfaction, and self-esteem. General stressors included disability, bad financial situation, and lack of partner. Socio-demographic characteristics included in the analyses were age, education, and religiosity. Population size, average wages, unemployment rate, and percentage of religious persons in the population were the controlled county characteristics. Among LGB persons, gay men were the point of reference. Results of the analyses were synthesized in table 22. The symbol "+" means a positive correlation between variables, while "-" a negative one.

153 $M = 4,62$; $SD = 1,93$; $r = 0,56$; $p < 0,001$.

Both internal and external processes related to minority stress impacted the mental health of LGB, T, and A persons. LGB persons with higher levels of internalized homophobia exhibited higher severity of depression symptoms, thought about suicide more often, declared lower life satisfaction and had lower self-esteem. In the case of trans persons, internalized transphobia correlated with higher exacerbation severity of depression symptoms and lower life satisfaction. Internalized aphobia was related to lower self-esteem.

Concealment of identity by LGB persons was related to lower life satisfaction and lower self-esteem. Interestingly, LGB persons who concealed their identity exhibited lower severity of depression symptoms. A similar result was found among transgender respondents, among whom concealment of identity translated to lower frequency of suicidal thoughts.

LGB persons who expected rejection due to their sexual orientation exhibited more severe symptoms of depression, more frequent suicidal thoughts, lower life satisfaction, and lower self-esteem. Among trans persons, expectation of rejection was related to more severe symptoms of depression and more frequent suicidal thoughts. Last, but not least, asexual persons who expected rejection reported more frequent suicidal thoughts and lower life satisfaction.

Experiencing violence motivated by hate had negative consequences for mental health. LGB persons who experienced physical violence because of their sexual orientation reported more exacerbated symptoms of depression, more frequent suicidal thoughts, lower life satisfaction, and lower self-esteem. Psychological violence was found to have similar consequences (except for the link to self-esteem). Violence motivated by hate did not impact the mental health of asexual persons.

Resilience to minority stress

Resilience, meaning factors limiting the negative effects of stressful circumstances in mental health, is an important issue in research on stress. This subchapter will discuss protective factors singled out in the minority stress model (fig.34), i.e. social support, strategies for coping with stress, and identification with one's own group. We will also check whether they suppressed the effects of

minority stress in the studied sample.

Social support

Social support is considered one of the basic sources of resilience to stress – mental functioning of people who can rely on others is less dependent on stressful circumstances[154]. The role of social support as a buffer limiting negative effects of minority stress is also pointed out in relation to LGBTIA persons[155].

Our study measured social support in a number of ways. First of all, respondents were asked on how many people they can rely when they have serious personal problems. Almost all respondents (95%) declared that they could count on at least one person. Almost half of them (45%) indicated that they have three to five such persons, 1/3 (33%) had one or two persons like this, and 17% chose the answer "six or more".

Subgroups of sexual orientation and gender identity differed by declared support[156]. Gay men could count on the most people, while transgender persons – on the least[157]. Individual level factors that positively predicted the number of potential sources of support also included age, education, subjective financial situation, and religiosity[158]. The older, better educated, more religious the respondents and the better their financial situation, the larger the number of persons they could count on. The influence of county characteristics was also significant. The larger the population of a county and the lower percentage of religious persons in it, the more persons respondents could count on[159].

Respondents were also asked about the degree to which others (e.g. family, friends, acquaintances) show positive interest in them. 37% of respondents reported a lot of positive interest, while

154 See: Frese, M. (1999). *Social support as a moderator of the relationship between work stressors and psychological dysfunctioning: A longitudinal study with objective measures. Journal of Occupational Health Psychology*, 4, 179-192.
155 Meyer, I. H. (2015). *Resilience in the study of minority stress and health of sexual and gender minorities. Psychology of Sexual Orientation and Gender Diversity*, 2, 209-213.
156 $F(5, 5756) = 25{,}87$, $p < 0{,}001$
157 Gay men: M = 2,85: SD = 0,79. Lesbians: M = 2,76; SD = 0,79. Bisexual women: M = 2,65; SD = 0,78. Bisexual men: M = 2,54; SD = 0,81. Asexual persons: M = 2,47; SD = 0,80. Transgender persons: M = 2,45; SD = 0,79.
158 Effect of age: B = 0,003; SE = 0,001; p = 0,021. Effect of education: B = 0,02; SE = 0,01; p < 0,001. Effect of financial situation: B = 0,05; SE = 0,01; p < 0,001. Effect of religiosity: B = 0,02; SE = 0,01; p < 0,001.
159 Effect of population size: B = 0,01; SE = 0,003; p = 0,049. Effect of percentage of religious persons: B = -0,01; SE = 0,004; p = 0,039.

TAB. 22. Minority stress and mental health of LGB, T, and A persons*

Indicator of mental health:	Depression			Suicidal thoughts			Life satisfaction			Self-esteem		
LGBTA subgroup:	LGB	T	A	LGB	T	A	LGB	T	A	LGB	T	A
LGB subgroup												
Lesbians	+			+						–		
Bisexual men												
Bisexual women	+			+						–		
Internal processes related to minority stress												
Internalized stigma	+	+		+			–	–		–		–
Concealment of identity	–				–		–			–		
Expectation of rejection	+	+		+	+	+	–		–	–		
External processes related to minority stress												
Physical violence	+	+		+	+		–	–		–		
Psychological violence	+	+		+	+		–					
General stressors												
Disability	+			+			–					
Subjective financial situation	–			–			+	+	+	+		
Lack of partner	+			+			–	–	–	–		–
Socio-demographic characteristics												
Age	–	–	–	–	–	–			+	+		+
Education	–	–		–			+			+		
Religiosity	–		–	–			+	+	+	+		+
Contextual variables (county)												
Population	+											
Average salary												
Unemployment rate												
Percentage of religious persons		+			+							

* only statistically significant effects were indicated (p<0,05).

35% - some interest. Answers indicating little positive interest or lack thereof were chosen by 12% of respondents. Some respondents (16%) were unable to judge whether they receive a lot of or little positive interest.

Respondents' answers differed by LGBTA subgroup[160]. Gay men received the largest amount of positive interest from others, while transgender persons – the least[161]. Moreover, interest was positively predicted by education, perceived financial situation, and religiosity and negatively by the unemployment rate and percentage of religious persons in the county[162]. In other words, the better educated, more religious the respondents, the better their financial situation and the less unemployed and religious people in their county, the more positive interest they received from others.

In the study we also measured integration with the LGBA community – respondents were asked to indicate what percentage of their friends are heterosexual, homosexual, bisexual, and asexual. Heterosexual persons were the largest percentage of respondents' friends (71,4%), followed by homosexual (20,85%), bisexual (6,77%) and asexual (0,98%) persons. The percentage of heterosexual persons differed by LGBA subgroup[163]. Bisexual men had the most heterosexual persons in their friend network, while gay men – the least[164]. It should be noted that the percentage of homosexual, bisexual, and asexual persons was higher among respondents' close friends (34,9%) than their friends (28,6%). This result shows homophily in action, a tendency for people to form relationships with people who have similar characteristics[165]. In the case of respondents to this study, the characteristic was a minority identity.

160 F(5, 5772) = 25,51, p < 0,001.
161 Gay men: M = 4,06; SD = 1.05. Lesbians: M = 3,97; SD = 1,08. Bisexual women: M = 3,86; SD = 1,10. Bisexual men: M = 3,77; SD = 1,13. Asexual persons: M = 3,73; SD = 1,18. Transgender persons: M = 3,44; SD = 1,25.
162 Effect of education: B = 0,03; SD = 0,01; p < 0,001. Effect of financial situation: B = 0,07; SD = 0,01; p < 0,001. Effect of religiosity: B = 0,03; SD = 0,01; p < 0,001. Effect of unemployment rate: B = -0,02; SD = 0,01; p = 0,023, Effect of percentage of religious persons B = -0,01; SD = 0,01; p = 0,039.
163 F(4, 5570) = 17,16, p < 0,001.
164 Bisexual men: M = 79,14; SD = 20,18. Asexual persons: M = 76,98; SD = 22,02. Bisexual women: M = 73,87; SD = 20,70. Lesbians: M = 70,52; SD = 23,86. Gay men: M = 70,31; SD = 23,17.
165 McPherson, M., Smith-Lovin, L. and Cook, J. M. (2001). *Birds of a feather: Homophily in social networks. Annual Review of Sociology,* 27, 415-444.

Strategies for coping with stress

Strategies for coping with difficult situations were described in detail in the chapter on mental wellbeing. However, it is worth adding that strategies for coping with stress are a potential buffer against the impact of minority stress on mental health. Especially constructive solutions, like seeking help from others and mobilizing to action, can curb the negative consequences of minority stress. Therefore, we decided to take a closer look at them.

Seeking help from others was negatively predicted by age and positively by education and religiosity[166] – respondents who were younger, better educated, and more religious – were more likely to seek out external support.

Mobilization in the face of problems was positively predicted by age, education, and perceived financial situation[167]. The older, better educated the respondents and the better their financial situation, the more likely they were to react to problems with action.

Identifying with LGBTIA people

The last factor with the potential to curb negative effects of minority stress is identification with a minority group. As many studies show[168], strong identification with a minority provides emotional, social, and cognitive resources to respond to experienced discrimination in a constructive way. In our study we asked LGBTA persons to respond to three statements measuring identification with one's own group (fig.44). A collective identification indicator was constructed by averaging answers to these questions[169].

166 Effect of age: B = -0,02; SE = 0,01; p < 0,001. Effect of education: B = 0,07; SE = 0,01; p < 0,001. Effect of religiosity: B = 0,05; SE = 0,01; p < 0,001.
167 Effect of age: B = 0,02; SE = 0,003; p < 0,001. Effect of education: B = 0,07; SE = 0,01; p < 0,001. Effect of financial situation: B = 0,112; SE = 0,02; p < 0,001.
168 Barreto, M., & Ellemers, N. (2015). Chapter three-Detecting and experiencing prejudice: New answers to old questions. Advances in Experimental Social Psychology, 52, 139-219.
169 M = 5,10; SD = 1,50; a = 0,79.

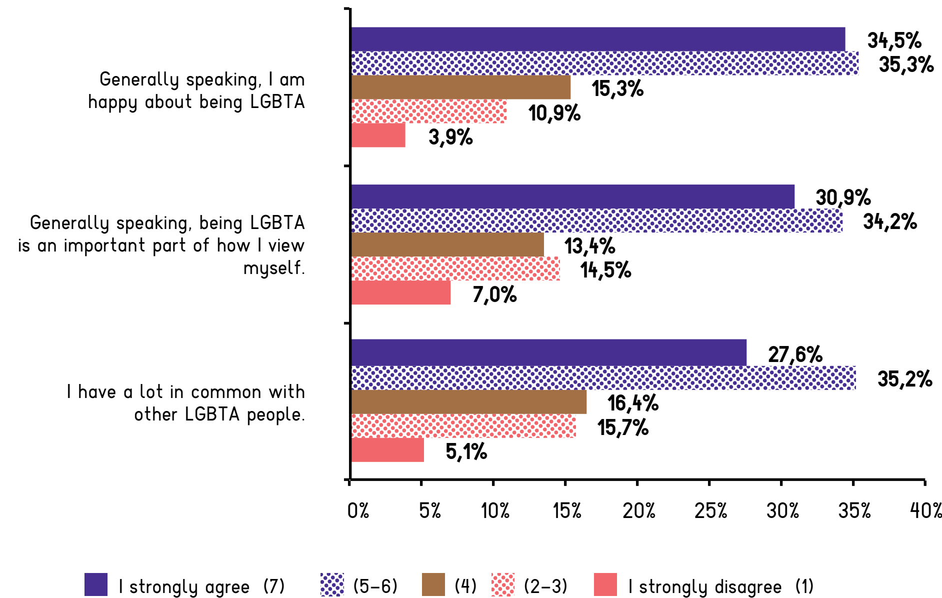


FIG. 44. Distribution of answers to questions measuring identification with one's own group (N = 5562)

Most respondents declared that they are happy about being an LGBTA person (69,8%), that they have a lot in common with other LGBTA persons (62,8%), and that being LGBTA is an important part of their identity (65,1%). LGBTA subgroups differed by identification[170]. Lesbians identified most with their group, while bisexual men – the least[171].

Identifying with one's own group was negatively predicted by age and religiosity – the better educated and more religious the respondents, the less they identified with LGBTA persons[172].

170 F(5, 5556) = 45,54; p < 0,001.
171 Lesbians: M = 5,50; SD = 1,34. Bisexual women: M = 5,15; SD = 1,41. Transgender persons: M = 5,13; SD = 1,65. Gay men: M = 5,07; SD = 1,50. Asexual persons: M = 4,75; SD = 1,33. Bisexual men: M = 4,11; SD = 1,64.
172 Effect of education: B = -0,03; SE = 0,01; p < 0,001. Effect of religiosity: B = -0,08; SE = 0,01; p < 0,001.

Factors reducing the impact of minority stress on mental health

We subsequently checked whether the three groups of factors – social support, strategies for coping with stress and identifying with one's own group weakened the negative effects of minority stress on the four measured indicators of mental health – symptoms of depression, suicidal thoughts, life satisfaction, and self-esteem. Additionally, we also checked whether reactions to minority stress depended on respondents' socio-demographic characteristics like age, education, size of place of residence, income, subjective financial situation, and viewing the local community's attitudes towards LGB persons as positive. The results of our analyses are presented in table 23 in an abbreviated version.

The more people respondents could count on, the weaker the negative consequences of psychological violence, concealment of identity, and expectation of rejection. For example, while concealment of identity lead to a lower self-esteem for respondents who had little support, for respondents who had a lot of support this correlation did not exist.

Positive interest from loved ones curbed negative consequences of internalized sigma. For LGB persons who reported low positive interest from loved ones, internalized homophobia translated to higher frequency of suicidal thoughts. While this regularity also existed for respondents who received a lot of positive interest, it was weaker.

Seeking out help from others effectively protected respondents from negative consequences of minority stress – employing this coping strategy weakened the effects of physical and psychological violence, internalized stigma, and expectation of rejection. For example, expectation of rejection caused less exacerbation of suicidal thoughts in respondents who were used to receiving help and advice from others.

TAB. 23. Factors which weaken the negative impact of minority stress on respondents' mental health

Protective factors	*External processes related to minority stress*	
	Physical violence	Psychological violence
	Age Education Income Size of place of residence Seeking out help from others Mobilization	Age Education Income Size of place of residence Number of people respondent can rely on Seeking out help from others Mobilization

Protective factors	*Internal processes related to minority stress*		
	Internalized stigma	Concealment of identity	Expectation of rejection
	Positive interest Seeking out help from others	Number of people respondent can rely on	Subjective financial situation Number of people respondent can rely on Seeking out help from others

Mobilization in face of problems protected from negative consequences of physical violence, e.g. exacerbation of suicidal thoughts. Experience of physical violence had more of an impact on suicidal thoughts for respondents who did not mobilize to action when faced with problems, than on those who utilized this coping strategy.

Age of respondents determined the consequences of physical and psychological violence motivated by hate. The older the respondents, the weaker the negative consequences of experiencing violence. For example, young respondents were most prone to an increase in suicidal thoughts related to experienced violence (fig.45).

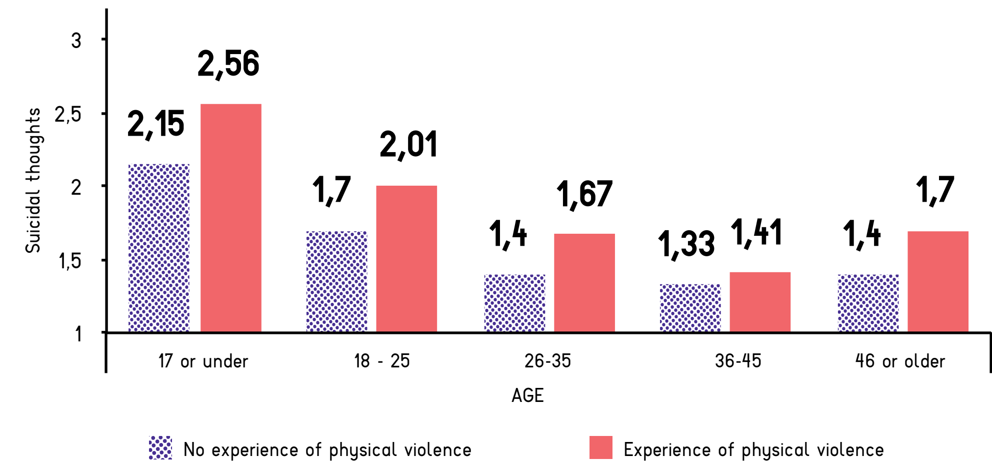


FIG. 45. Effects of physical violence on suicidal thoughts in subgroups by age (N = 5782)

Education also protected from a decrease in wellbeing as a result of physical and psychological violence. For example, psychological violence motivated by hate lowered self-esteem of persons with primary and vocational education, but not of those with secondary or higher education.

Income also played a role of buffer curbing negative consequences of physical and psychological violence. For example, respondents with little money reacted to experiences of physical violence with a bigger decrease in life satisfaction than those in a better financial situation.

Subjective financial situation alleviated the negative effects of physical and psychological violence, and expectation of rejection. For example, for people who perceived their financial situation as bad, expectation of rejection exacerbated suicidal thoughts more than for people who perceived their financial situation as good.

Size of place of residence alleviated negative consequences of experiencing physical or psychological violence. Experiencing physical violence led to a larger increase in suicidal thoughts for respondents living in smaller areas than for those living in more populated ones.

Consequences of psychological violence motivated by hate

were reduced by viewing the local community's attitudes towards LGB persons as positive. Psychological violence led to a decrease in self-esteem when social norms in place of residence were considered less positive.

Identifying with one's group and a large percentage of minorities among friends and close friends did not curb the effects of minority stress.

Summary

1. Minority stress impacted the wellbeing of LGB, T, and A respondents and its influence was independent of general stressors, which can also affect members of the majority (e.g. disabilities, bad financial situation, lack of partner).
2. Experience of physical violence motivated by hate led to a worse state of mental health, which was linked to exacerbated symptoms of depression, more frequent suicidal thoughts, lower self-esteem, and lower life satisfaction among LGBT persons
3. Experience of psychological violence, expectation of rejection, and internalized stigma had a negative effect on mental health.
4. Surprisingly, concealment of identity turned out to have adaptive potential, as it lowered the severity of depression symptoms among LGB persons and the frequency of suicidal thoughts among transgender persons.
5. Effects of minority stress were limited by utilizing constructive coping strategies (i.e. seeking help from others and mobilization in face of problems), high levels of social support (i.e. the number of people one can rely on and positive interest from loved ones), and demographic characteristics, such as advanced age, better education, living in a more populated area, high income, and a subjectively good financial situation. Negative effects of minority stress were not alleviated by identification with one's own group and saturation of friend networks with members of sexual minorities.
6. The situation of LGBTA subgroups differs. Gay men and lesbians are in a relatively good situation. Even though gay men are the most afraid of rejection among LGB people, they also have the most resources to cope with minority stress. Homosexual men are more integrated with their community, have more people they can count on, receive most positive interest from loved ones and most often utilize constructive strategies of coping with stress. Lesbians exhibited lower levels of internalized homophobia than other LGB persons and concealed their identity less often.
7. Bisexual men are in a difficult situation. Functioning on the

border between two worlds – the heterosexual majority and LGBTA minority – has a lot of consequences for this group. Bisexual men exhibited the highest levels of internalized homophobia and concealed their identity to the largest degree among LGB persons. They are also not as integrated with the LGBTA community, as indicated by their low identification with this group and a relatively low percentage of LGBTA persons among their friends and close friends. This was largely not true for bisexual women, who, among LGB persons, were least likely to expect rejection due to their sexual orientation.

8. The situation of transgender persons is difficult – they receive the least social support and are least likely to get mobilized in face of problems.
9. Asexual persons sought out help from others least often from all studied subgroups.
10. The extent of experienced consequences of minority stress turned out to be a class issue. Similar to the Hate No More 2015[173] study, the decrease in wellbeing of LGBTA persons due to minority stress was lower for those respondents who had higher incomes or perceived their financial situation as good. Financial resources play two roles – they not only directly impact wellbeing (increasing e.g. life satisfaction), but also curb negative consequences of incidents (e.g. experiences of violence) and negative attitudes (e.g. expectation of rejection).
11. Education protected from consequences of minority stress – the wellbeing of respondents who spent more years studying did not worsen as a result of minority stress as much as it did for worse educated respondents.
12. Inhabitants of larger cities experienced less consequences of minority stress than inhabitants of rural areas and smaller cities.
13. Age was an important resilience factor – the older the respondents, the lesser the negative consequences of minority stress.
14. The protective nature of demographic characteristics: income, perceived financial situation, education, size of place of residence, and age corresponds with the results from our previous studies, according to which persons with less resources (young, worse educated, in a worse financial situation, living in smaller areas) bear the brunt of consequences of violence motivated by homophobia and transphobia.
15. Among individual characteristics, religiosity turned out to have an unclear impact. On one hand, religious respondents exhibited more internalized homophobia and concealed their identity to a larger degree, but on the other, had more social support and sought out help from others more often.
16. Living in counties with more inhabitants contributed to a better mental state; regardless of considered individual characteristics (age, education, financial situation, and religiosity) and other county characteristics, it translated to more sources of support. In counties with more unemployment, transgender persons reported more internalized transphobia, and all respondents received less support.
17. In order to combat the negative consequences of minority stress, LGBTA can adopt a few individual strategies. One of them is an attempt to increase the number of people one can get supports from and asking loved ones for help when in crisis. The second one is to pursue increasing hard resources like education or income, which grant independence from aggravating communities (e.g. local community or family) and support spatial mobility. However, potentially the most effective way to alleviate the effects of minority stress, is to engage in systemic actions (e.g. educational projects) which could limit the number of stressors (e.g. violence) experienced by LGBTA persons.

173 Górska P., Budziszewska M., Knut P. i Łada P., *Raport o Polsce – homofobiczne i transfobiczne przestępstwa z nienawiści a wymiar sprawiedliwości*, Kampania Przeciw Homofobii, 2016.

Hate speech against lesbians and gays

The aim of this chapter is to describe the scale of hate speech among those directly affected by it – gay men and lesbians, and to compare it to the general Polish population. It will also point to potential consequences of coming in contact with hate speech for the mental wellbeing of these minority groups.

Hate speech – offensive statements aimed at minority groups – only recently became an area of interest for Polish social sciences' researchers. A study conducted in 2016 (Winiewski et al, 2017) showed the scale of hate speech in Poland and its negative consequences for attitudes and behaviours of the majority of Polish society. The research pointed to, i.a. correlations between hate speech and more prejudice towards minority groups, more disposition to accept violence, stronger support for anti-immigrant government policies, and political radicalization.

This study focused on gay men and lesbians, because it is difficult to isolate hate speech aimed strictly at bisexual, queer, and asexual persons – perpetrators often do not recognize the diversity of sexual orientations. Concerning transgender persons, their version of the questionnaire was longer than the one for cisgender persons, so in order to avoid overburdening this group of respondents, we did not present them with this portion of the survey.

Frequency of encountering hate speech by gays and lesbians

As part of the conducted survey, respondents who identified themselves as gays or lesbians were presented with three examples of hate speech against their identity and were subsequently asked to indicate how often they encounter similar statements. The results for the two groups were almost identical. 25% of gays and lesbians reported encountering statements like these often or very often[174]. About 50% of gays and lesbians reported a moderate frequency of encounters with hate speech, while 25% said it happened rarely or very rarely. For comparison, most Polish people encounter hate speech against gays much less frequently – 18% of them encounter it often or very often, 32% - moderately often, while 47% - rarely or very rarely. Similarly, in the case of hate speech against lesbians, 5% of adult Poles encounters it often or very often, 22% - moderately often, while 68% - rarely or very rarely (figure 46). These comparisons quite clearly show that the problem of hate speech against gays and lesbians seems unnoticeable for the majority of the Polish population.

174 Answers to most questions about hate speech were coded on a 7-point scale. For clarity of results the particular values were divided into three categories: 1) 1-2; 2)3-4-5; 3)6-7 where categories 1 and 3 refer to a decisive answer, while category 2 to a moderate or neutral answer.

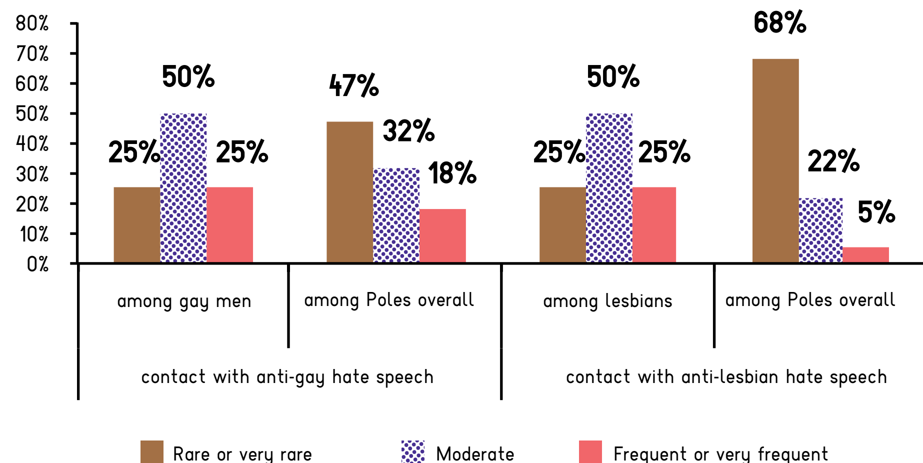


FIG. 46. Comparison of how often gays and lesbians, and Poles overall encounter anti-gay and anti-lesbian hate speech.

Places where gays and lesbians encounter hate speech

Respondents – gays and lesbians – were also asked to indicate where they encounter hate speech. Both groups pointed to the internet- 90% of lesbians and 89% of gay men indicated that they encounter offensive statements online. In the case of gays other frequently indicated places were: television (56%), streets, bus stops, and public transport (48%), demonstrations, protests, and rallies (47%) as well as conversations with acquaintances (36%). In the case of lesbians, other frequently indicated places were: streets, bus stops, and public transport (49%), demonstrations, protests, and rallies (45%), and conversations with acquaintances (36%). It should be noted that the same places (i.e. television, internet, streets, conversations with acquaintances) were indicated in the overall Polish sample as places where one can encounter hate speech.

Attitudes towards hate speech among gays and lesbians

Respondents were asked to indicate how offensive they consider the three examples of hate speech they were presented with. Among gays, between 73% and 92% (depending on the statement)

considered the presented statements to be (definitely) offensive and only between 4% and 6% - (definitely) inoffensive. It should be noted that sensitivity to the same statements in the general Polish population is significantly lower – in the general Polish sample between 54% and 71% of adults considered them to be offensive. In the case of three statements judged by lesbians, between 89% and 96% of respondents decided the examples of hate speech were offensive, and only between 2% and 3% - that they were inoffensive. The same statements were considered offensive by 74% to 89% of the general Polish samples. These analyses quite clearly show that part of Polish society does not seem to notice how harmful some statements, which appear in public, can be for minority groups.

Respondents were asked to indicate whether they think the presented statements should be banned or allowed. 62% of gay men indicated a willingness to ban them, while 7% thought they should be allowed, and 31% chose neutral answers. In the case of lesbians, 80% favored banning them, while only 2% declared they should be allowed, and 19% remained neutral. For comparison, in the general Polish population sample, 49% favored banning hate speech against gays and 58% - against lesbians.

Consequences of encountering hate speech among gays and lesbians

Declared frequencies of encountering hate speech by gays and lesbians were compared to various indicators of mental wellbeing: life satisfaction, loneliness, bad health, results on the scale of internalized homophobia, depression, and tendency to use sedatives. In case of all indicators, small but significant correlations were observed, suggesting that frequent contact with hate speech among gays and lesbians can have a negative impact on their overall mental wellbeing (figure 47). The observed correlations turned out to be relatively strong regarding indicators of depression – frequent contact fosters occurrence of depression symptoms. Moreover, especially among lesbians, frequent contact with hate speech fosters tendencies to use sedatives, and higher levels of internalized homophobia.

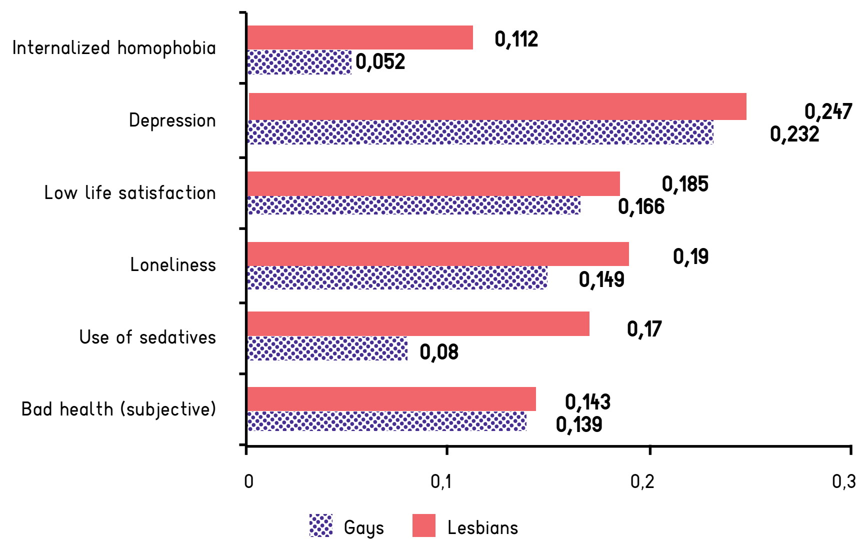


FIG. 47. Contact with hate speech and selected indicators of mental wellbeing. The chart presents correlation coefficients between declared frequency of contact with hate speech and exacerbation of all indicators of mental wellbeing. Analyses are presented separately for gays and lesbians, concerning anti-gay and ant-lesbian hate speech, respectively

Summary

1. Compared to general Polish population, gays and lesbians encounter offensive statements against them much more often.
2. Gays and lesbians are more likely to consider hate speech harmful and express more support for banning it than the general Polish population.
3. Exposure to hate speech has negative consequences for health and mental wellbeing.

LGBT school-aged youth

This chapter discusses the situation of the youngest members of the LGBTA community (aged 13-19) who are still in school, especially since they were almost 1/3 of all respondents (N = 2666, including 254 transgender persons). We decided to take a closer look at this group, because results of this study point to their especially difficult social situation.

In the case of the youngest respondents we paid attention to data about how many people from their environment (immediate or not) know about their sexual orientation/gender identity and how accepting they are. When it comes to immediate family, mainly mothers have complete knowledge about respondents' sexual orientation or identity, while fathers largely have no idea. The chart below presents detailed information about the phenomenon.

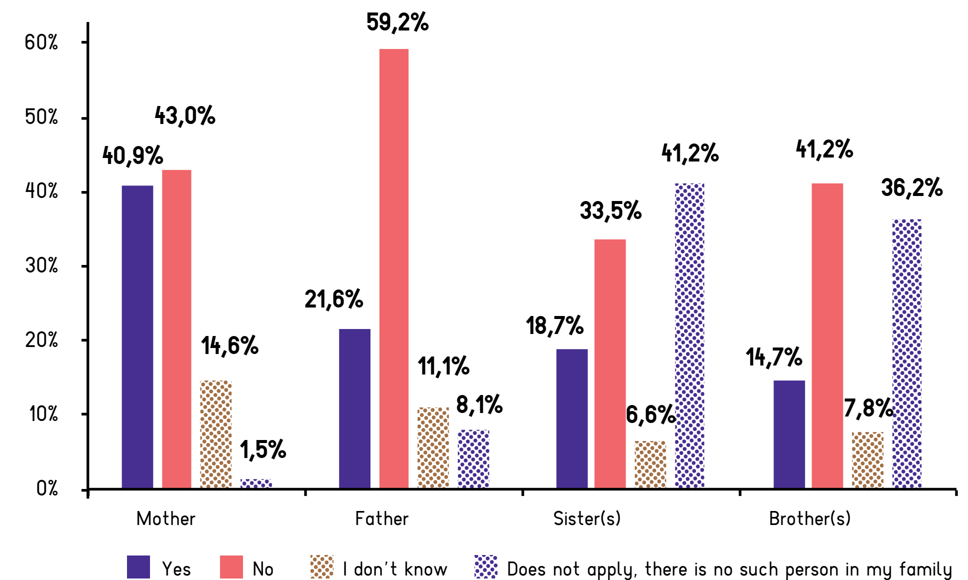


FIG. 48. Distribution of answers by the youngest respondents to the question about who from their immediate family knows about their sexual orientation/gender identity.

Interestingly, in the case of 73% of respondents at least a few of their friends know about their sexual orientation or gender identity. Therefore, it would seem that young people share information about their lives primarily with peers, looking for understanding among them. In this context, one should also look at the data regarding acceptance from family members. According to reports from the youngest respondents, among those whose parents know about their sexual orientation/gender identity, less than 1/4 of respondents feel completely accepted by their mothers, and a little

over 12% - by their fathers. For comparison – the same indicators for the rest of respondents are 40,4% and 47%, respectively. Figure 49 presents detailed information about acceptance from immediate family members, differentiating between school-aged youth and the rest of the sample.

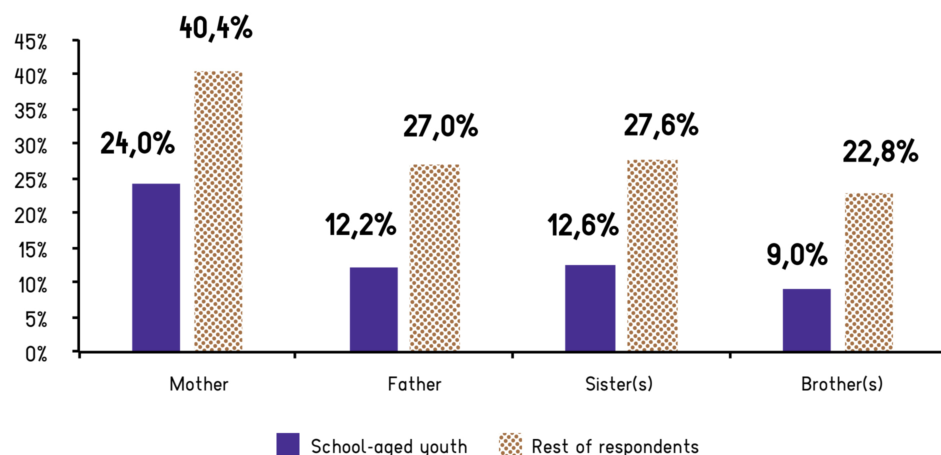


FIG. 49. Distributions of answers from the youngest respondents to the question about who from their immediate family, knowing about their sexual orientation/gender identity, accepts it fully

Moreover, it should be noted that 72% of LGBTA youth felt like they had to conceal their identity/sexual orientation at school, at least in some situations.

Another issue worth pointing to is the experience of violence based on sexual orientation and/or gender identity, especially if it happened at school. 26% of respondents, when asked to recall the last violent attack (including physical, verbal, sexual, or other form of harassment) from the last two years, admitted that it happened at school. School was most often indicated as the place where respondents from this age group encountered violence the last time it happened. For comparison, only 6,4% of respondents admitted that the last incident of this sort happened at home. According to respondents' declarations, the violence they most frequently encountered at school was verbal aggression and taunts, less often – spreading negative opinions about them, insults, humiliation, and constant negative comments.

Importantly, among indicated perpetrators of the last incident of violence, colleagues from school ranked first (19,1%), regardless of where the incident took place.

This data shows that homophobic and transphobic peer violence is a prevalent problem in Polish schools. At the same time, young LGBTA persons who encounter it, are more likely than their heterosexual and cisgender peers, to experience anxiety, stress, lack of self-confidence, low self-esteem, loneliness, self-harm, depression, and suicide attempts[175].

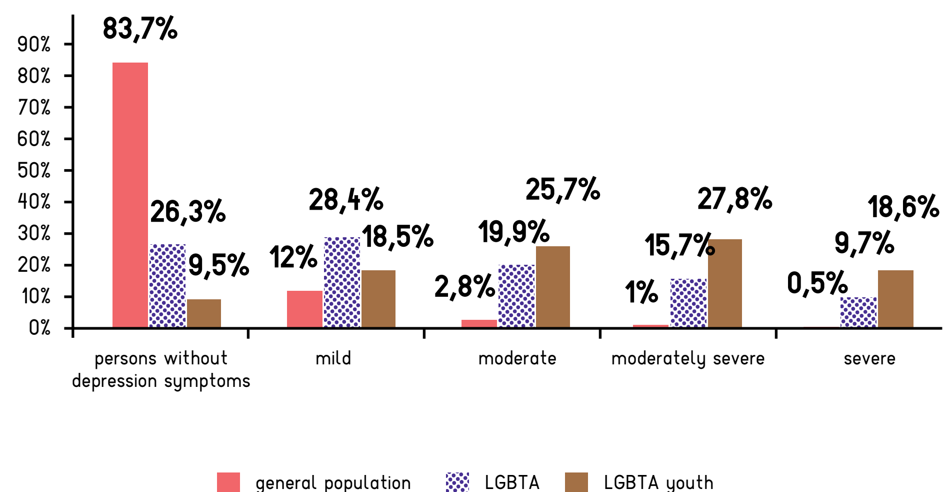
Moreover, incidents of peer violence motivated by homophobia and/or transphobia can result in worse school performance, less frequent presence at school, and early dropping out, which seriously affects the chances of gaining professional qualifications, and therefore, getting a well-paid job in the future. At the same time, perpetrators of peer violence are more likely than their peers to exhibit anti-social behaviour, and experience legal problems in adult life[176]. A school where homophobic peer violence happens, is an unsafe school, where children's access to quality education and optimal development is impaired.

At the same time, according to research by Campaign Against Homophobia, educators in Poland have neither the knowledge about how to combat homophobic peer violence nor the skills to do it effectively; they admit that the curriculum does not include sufficient information about sexual orientations and gender identities[177].

175 *Out in the Open: Education sector responses to violence based on sexual orientation or gender identity/expression. Summary report*, UNESCO, 2016.
176 *Booklet 8: Good Policy and Practice in HIV and Health Education – Education Sector Responses to Homophobic Bullying*, UNESCO, 2012.
177 Świerszcz, J., *Postawy i potrzeby kadry szkolnej i młodzieży wobec homofobii w szkole*, Kampania Przeciw Homofobii, 2012.

When discussing school-aged youth, one should take a look at data regarding their frame of mind. As discussed in the chapter on mental wellbeing, almost 1/3 of respondents under 18 negatively assess their lives. More than 70% feel lonely and close to this number (69,4%) thinks about suicide (11,9% of them do it very often). As indicated in the subchapter about depression, respondents who are school-aged significantly more often exhibit symptoms of depression, than adult respondents do[178]. Figure 50 presents severity of depression symptoms in general Polish population and in the LGBTA community, also isolating LGBTA youth. An important element influencing young LGBTA persons' frame of mind is simultaneous acceptance and positive interest from their family.

FIG. 50. Severity of depression symptoms in Polish population and LGBTA community



The situation of school students is insomuch severe that it depends on many factors, which are difficult to control, i.e. lack of social support, internalized homophobia, and dependency on family. As mentioned before, LGBTA youth receives less acceptance from their families than LGBTA adults. Lack of acceptance

178 t= -25,019; p = 0,00.

negatively affects mental wellbeing. At the same time, compared to adults, young people have less social skills to deal with violence or discrimination. This social group also has less chances to become self-reliant because they are usually dependent on their families, the majority of which are unaccepting and unsupportive. As research shows, the risk group of persons experiencing peer violence includes mostly students who have little support from family, friends, and teachers[179]. A young LGBTA person who experiences violence has no support from school educators (who feel incompetent to fight homo- and transphobia) or from the family (which is unaccepting), which increases peer violence.

179 Komendant-Brodowska, A., Giza-Poleszczuk, A., Baczko-Dombi, A. (2011). *Przemoc w szkole: Raport z badań, lipiec 2011. Szkoła bez Przemocy*. Downloaded from: www.szkolabezprzemocy.pl/479,badania

Summary

1. A little over 20% of fathers know about the sexual orientation/gender identity of their child, and almost twice as many mothers.
2. Among those who are out to their parents, less than 1/4 feels fully accepted by the mother and only about 12% - by fathers.
3. In the case of 73% of respondents, at least a few of their friends know about their sexual orientation or gender identity.
4. 26% of violent incidents experienced by LGBTA youth happened at school, while perpetrators were school colleagues 19,1% of the time.
5. School students feel lonely (70,3%) more often than adults, are more likely to have suicidal thoughts (69,4%) and to exhibit symptoms of depression.

Non-heterosexual women

This chapter will discuss the differences between women and men regarding their social situation in Poland. It will address the issue of intersectional discrimination based on gender and sexual orientation.

The conducted study reveals a number of significant differences in the situation of non-heterosexual cisgender men and non-heterosexual cisgender women who participated in the study. The first clear difference is the distribution of respondents by gender and sexual orientation. Among women, the numbers of respondents who identified as homosexual and bisexual were much more proportional; 52% of female respondents identified as bisexual and 43% as lesbians, while in the case of male respondents, the vast majority (88%) identified as gay, and only 12% as bisexual. This distribution is relatively similar to the LGB sample from the 2011 study. The previous edition included a group of women among whom 61% identified as lesbians while 39% as bisexual, and a group of men among whom 85% were gay and 15% - bisexual[180].The significantly higher, and possibly increasing percentage of bisexual women in the population of non-heterosexual women is clearly visible compared to the relatively low and stable percentage of bisexual men and corresponds with international research[181], including studies from the US[182] and the UK[183]. There are a few hypothesis regarding this phenomenon; feminist researchers situate intimate relationships between women in the space of resistance to the unequal gender regime, for which heterosexual relationships are not only the basis, but are also one of its most oppressive symptoms, as is "compulsory heterosexuality"[184] [185]. On the other hand, the existing unequal gender order within which men have much better chances of achieving higher social status than women do, means that women have either very little, or incomparably less to lose by engaging in non-normative practices, than men do. Modern cultural changes in gender relations have much more of an emancipatory impact on norms regulating behaviours and attitudes of women, than those

180 Calculations based on: Makuchowska, M., Pawlęga, M., *Situation of LGBT Persons in Poland. Report for 2010 and 2011*. Warsaw: Campaign Against Homophobia, 2012.
181 Patterson, Ch. J., D'Augelli, A. R. (2015). *Handbook of Psychology and Sexual Orientation*. Oxford: Oxford University Press.
182 England, P., Mishel, E., Caudillo, M. L. (2016). *Increases in Sex with Same-Sex Partners and Bisexual Identity Across Cohorts of Women (but Not Men)*. Sociological Science, 3, 951-970.
183 Office for National Statistics. (2015). *Sexual identity, UK: 2015. Experimental Official Statistics on sexual identity in the UK in 2015 by region, sex, age, marital status, ethnicity and NS-SEC*. Downloaded from: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2015. on July 19, 2017.
184 Gajewska, A. (2014). Lesbianizm. In: M. Rudaś - Grodzka, K. Nadana - Sokołowska, A. Mrozik, K. Szczuka, K. Czeczot, B. Smoleń, A. Nasiłowska, E. Serafin, A. Wróbel (ed.), *Encyklopedia gender. Płeć w kulturze* (ss. 256-269). Warszawa: Wydawnictwo Czarna Owca.
185 Rich, A. (1980). *Compulsory Heterosexuality and Lesbian Existence. Signs*, 5(4), 631-660.

of men. Hence, women's sexual behaviour is more fluid, their intimate relationships formed over the course of their lives (with men and/or women) - more flexible, and their identification with a particular sexual orientation – subject to change, as it is more of a continuum (or one characteristic with varying intensity) than rigid, clearly distinct categories[186].

Data from the study concerning income shows the existence of an unequal gender regime, which has a significant impact on the situation of non-heterosexual women. Assuming (based on data gathered by the Central Statistical Office of Poland) that the average net salary in the first quarter of 2017 in Poland was less than 3100PLN[187], we can see that in the studied sample of non-heterosexual persons, men were in a decidedly better financial situation. While only 18,2% of women earned more than a net salary of 3000PLN, the percentage of men with such an income was more than 10 percentage points higher (29,9%). At the same time, only 7,8% of non-heterosexual men were among the group earning the least (net salary of less than 500PLN per month) while the percentage of women with such an income was almost twice as high (15,5%). The differences in income could be a result of so called pay disparity[188] and they suggest that non-heterosexual women experience discrimination based on gender in the area of compensation. It is possible that their situation in this particular area is similar to that of women in general.

The study shows that the percentage of non-heterosexual women who experienced unequal treatment in the healthcare system is higher; experience of this kind (after disclosing one's sexual orientation to medical personnel) was reported by 14% of non-heterosexual women and 11% of non-heterosexual men. Among

186 Diamond, L. M. (2008). *Female Bisexuality From Adolescence to Adulthood: Results From a 10-Year Longitudinal Study.* Developmental Psychology, 44(1), 5–14.

187 Central Statistical Office of Poland. (2017). *Komunikat Prezesa Głównego Urzędu Statystycznego z dnia 11 maja 2017 r. w sprawie przeciętnego wynagrodzenia w pierwszym kwartale 2017 r.*, retrieved from: http://stat.gov.pl/sygnalne/komunikaty-i-obwieszczenia/lista-komunikatow-i-obwieszczen/komunikat-w-sprawie-przecietnego-wynagrodzenia-w-i-kwartale-2017-roku,271,16.html, Dnia (2017,07,19).

188 Instytut Badań Strukturalnych. (2015). *Nierówności płacowe kobiet i mężczyzn. Pomiar, trendy, wyjaśnienia*, Warszawa: IBS. Retrieved from: http://ibs.org.pl/app/uploads/2016/05/IBS_Nierownosc_Placowa_raport.pdf.

stories recalled by women, discriminatory incidents during visits to the gynecologist related to their gender, come to the forefront. The study revealed i.a. the following examples of discrimination:

After the gynecologist found out that I'm in a relationship with a woman, but also am bisexual, he suggested I should enter a relationship with a man and start having children.

A gynecologist asked if I was sexually active. I answered that yes, but only with women. He asked how do we do it.

A visit to the gynecologist. When I told her about my sexual orientation she immediately changed her attitude. During the first 10 minutes she was very nice, later (…) she became curt. She was still discussing my health etc. but her disapproval was obvious. She also did not want to talk about the illness in the context of my relationship. I told her I asked my female partner to get tested to make sure we were not giving each other a certain bacteria, she answered: "why are you telling me this, this lady is not my patient"

The last report by the Campaign Against Homophobia dedicated to LGT health recalls very similar, discriminatory incidents. The publication clearly identifies such instances as against patients' rights to dignity and intimacy[189]. It should be noted that the latest study about the situation of LGBT persons in the European Union shows that non-heterosexual women experience discrimination and molestation more often, compared to non-heterosexual men – 55% of lesbians and 45% of gay men, as well as 47% of bisexual women and 36% of bisexual men experienced unequal treatment in the twelve months preceding the study[190].

Gender also differentiates the type and scale of violence experienced by non-heterosexual women. The study shows a much higher percentage of women who experienced sexual violence, in the form of sexual teasing (including touching a woman against her will), attempted rape, and rape. 4,4% of non-heterosexual women,

189 Kowalczyk, R., Rodzinka, M. i Krzystanek, M. (2016). *Zdrowie LGBT. Przewodnik dla kadry medycznej. Warszawa: Kampania Przeciw Homofobii*.

190 European Union Agency for Fundamental Rights [FRA]. (2014). *European Union lesbian, gay, bisexual and transgender survey. Main results,* Luxembourg: Publication Office for the European Union.

when recalling their last experience of violence, mentioned sexual molestation (compared to 1,2% of men), while 1% experienced rape (compared to 0,5% of men). Men are more likely to experience physical violence – pushing, jerking (1,5% of men and 0,6% of women) and battery (1,3% of men and 0,3% of women). Higher risk of sexual violence in the case of women confirms data from the previous study about LGBT persons in Poland. The report for 2010 and 2011 showed that 11,5% of female respondents and 6% of male respondents experienced sexual violence[191]. The study of LGBT persons in various countries of the EU show an identical dependence. Data averaged for the entire EU shows that among all respondents who experienced violence motivated by prejudice during the last 12 months 22% of lesbians (compared to 105 of gay men) and 53% of bisexual women (compared to 12% of bisexual men) indicated a sexual attack[192]. In other words, lesbians and bisexual women experience intersectional discrimination as non-heterosexual persons and women at the same time – they are at risk of unequal treatment and violence motivated by homophobia and/or hatred towards women. The risk of experiencing sexual violence is an integral part of women's lives, regardless of sexual orientation or any demographic characteristics[193]. . Non-heterosexual women were less likely than non-heterosexual men to report violent incidents to the police. 2% of female respondents and 4,8% of male respondents did so. Aforementioned study about the situation of LGBT persons in EU countries show a similar dependence and highlights that compared to other forms of violence experienced by non-heterosexual persons, sexual attacks are least likely to be reported to the police[194].

The study shows that non-heterosexual women experience suicidal thoughts more often than non-heterosexual men. 7,7% of non-heterosexual women (compared to 3,6% of non-heterosexual men) reported thinking about suicide "very often" in the months

191 Makuchowska, M., Pawlęga, M. (2012). *Situation of LGBT Persons in Poland. Report for 2010 and 2011*. Warsaw: Campaign Against Homophobia.
192 FRA, 2014, 62.
193 Grabowska, M., Rawłuszko M. (2016). *Powszechność i trwałość przemocy seksualnej wobec kobiet: wyzwania metodologiczne i wyniki badań ankietowych*. W: M. Grabowska, A. Grzybek (ed.), *Przełamać tabu. Raport o przemocy seksualnej*. Warszawa: Fundacja na rzez Równości i Emancypacji STER.
194 FRA, 2014, s 66-67

preceding the study. 16,9% of women thought about it "often" (compared to 9,9% of men). The earlier study for 2010-2011 did not show differences in answers to the same question based on gender. However, these differences do appear in other foreign studies, for example the latest study on LGBT persons living in Ireland confirms the higher percentage of suicide attempts and self-harm among non-heterosexual women[195].

To sum up, it should be highlighted that this is the first report on the social situation of LGBT persons in Poland which devotes a separate section to non-heterosexual women. Striving to better understand and depict the experiences of women within the LGBTAQI community, this is important from a cognitive, as well as a political standpoint. Emancipation of the most marginalized groups requires more visibility, highlighting diverse perspectives. It is vital to stress the existing limitations of quantitative analyses on which the study of non-heterosexual women is entirely based on, and which only in general describe the experiences of women subjected to sexism and homophobia. In striving to better understand the social standing of non-heterosexual women, it seems that future research must also utilize feminist methodologies based on the paradigms of qualitative studies, which allow for marginalized, dispersed, and "outside" voices[196], to be heard; these voices recognize other dimensions of women's identities – not only their gender and sexual orientation, but also age, class, and place of residence.

195 Gay+Lesbian Equality Network. (2016). *The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland.* Dublin: GLEN, BeLonG To.
196 Struzik, J. (2012). *Spoza centrum widać więcej – przeciwdziałanie dyskryminacji krzyżowej ze względu na płeć, orientację seksualną i miejsce zamieszkania.* Raport z badań. Szczawnica: Fundacja Przestrzeń Kobiet.

Summary

1. In the studied sample, women were in a worse financial situation than men.
2. Women experienced discrimination in the healthcare system more often.
3. Women experience sexual violence more often than men, but report it to the police in lower numbers.
4. Women think about suicide more often than men.

Transgender persons

In this study we decided to take a closer look at the social situation of transgender persons in Poland. Their situation in aspects such as being out, violence, mental welling, and minority stress was already discussed in previous chapters. This one will focus on the lives of transgender persons and persons with a transgender past in areas such as: self-identification, attitudes towards reassignment, medical and legal gender reassignment, and the so called "real-life test".

Sample characteristics

Transgender persons and persons with a transgender past were 6,6% of all respondents (N = 607). Among them, most respondents were assigned female at birth (71%), compared to those assigned as male (30%). Therefore, most respondents strive for being considered male and potential changes in the direction of being a man.

Transgender persons relate their sexual orientation to their gender identity, not the one they were assigned at birth. For example, a person who was assigned male may consider themselves heterosexual if they are attracted to men, because they identify as a woman. For this reason, it is possible that sometimes the declared sexual orientation was a mistake, however these were most likely sporadic instances. Distribution of sexual orientation was as follows: almost half of respondents (47,6%) declared that they were bisexual, more than 1/4 (28,2%) considers themselves homosexual, 13,3% - heterosexual, and 10,9% - asexual.

Answers to the question about gender identity show that transgender persons often identify outside of the binary gender system (woman or man). 47,1% identified their gender as male, and 17,6% as female which means that 2/3 of respondents (64,7%) identify as either men or women (meaning they are declared transsexual persons). The remaining 1/3 of respondents identify as: non-binary (11,2%), agender (6,8%), androgynous (6,4%), genderqueer (5,6%) and other (5,3%). When this data is related to gender assigned at birth, it turns out that even though transgender respondents and respondents with a transgender past were assigned female at birth they are most likely to identity as male. Therefore, the study reflects the Polish context; in our society there is approximately four times as many FtM than MtF transsexual persons[197].

197 There is various data regarding how often transsexual persons are born: male cases of transsexualism (MtF) are three times as frequent as cases of female transsexualism (FtM). Clinical research in different countries show contradictory results. It is estimated than one transsexual MtF person is born for every 20k of men and one FtM transsexual person is born for every 50k of women. One in 100k female assigned persons and one in 30k male assigned persons strive for sex reassignment surgery. These proportions depend on specific countries. Curiously, in the countries of Eastern Bloc, the number of FtM cases is larger than that of MtF.

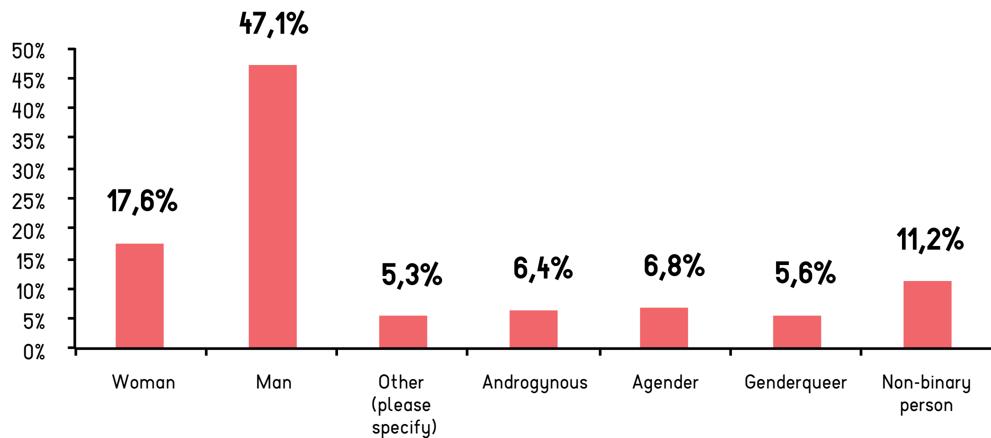


FIG. 51. Distribution of answers to the question about gender identity among transgender respondents (N = 607)

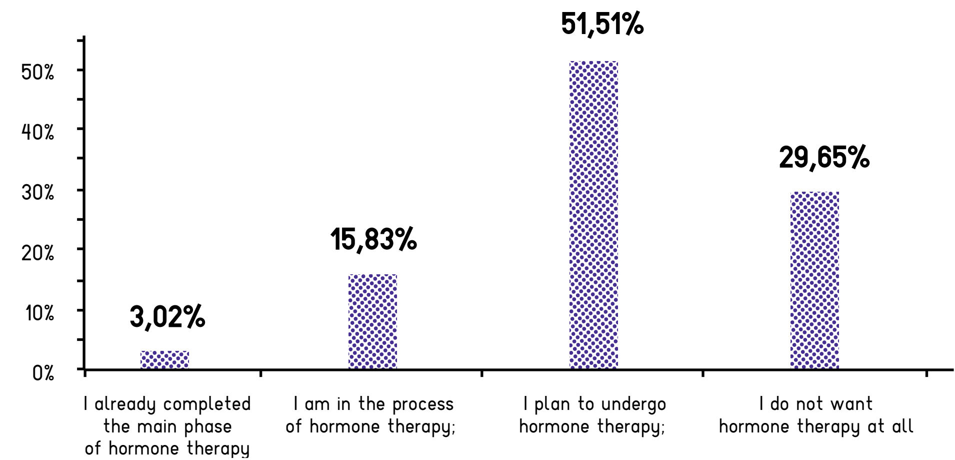
Attitudes towards gender reassignment and hormone therapy

The feeling of discordance between sex and gender identity raises the issue of whether one should strive to change this situation or not. Therefore, respondents were asked about their attitude towards legal gender reassignment, genital surgery, and changing one's body in other ways. Table 24 shows the percentage distribution of answers to the questions about various procedures linked to gender reassignment, while figure 52 the distribution of answers to the question about attitudes towards hormone therapy.

TAB. 24. Attitudes of transgender respondents towards procedures linked to gender reassignment (N= 398)

Please indicate your attitude towards reassignment (or a procedure):	I already underwent reassignment	I am in the process of reassignment	I plan to undergo reassignment	I do not want reassignment
Legal gender	5,28%	6,53%	57,79%	30,4%
Top surgery	4,02%	2,26%	60,8%	32,92%
Genital surgery	3,02%	1,26%	42,96%	52,76%
Other body altering procedures	2,76%	2,76%	45,23%	49,25%

FIG. 52. Transgender respondents' attitudes towards hormone therapy (N=398)



It turned out that most transgender persons are considering top surgery (60,8%), which is probably a result of the large proportion of FtM respondents, as well as legal gender reassignment, meaning changing their gender in government issued documents. More than one in ten respondents (11,81%) already underwent legal gender reassignment or is in the process of doing so, while 57,79% plan on doing it.

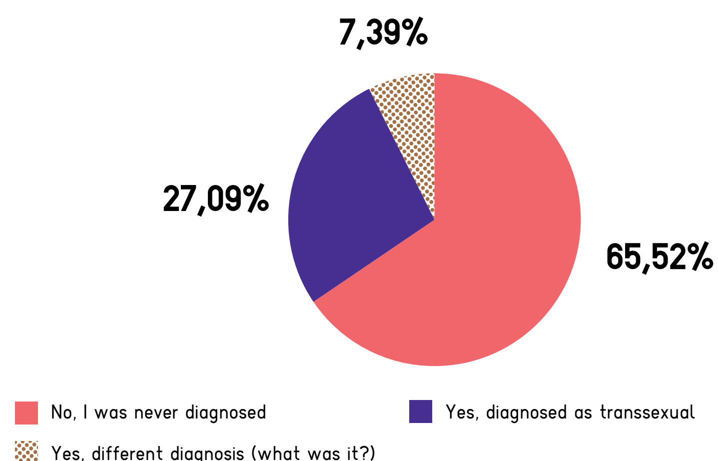
Respondents less frequently consider genital surgery (52,76% of them does not want to do it) and other body altering procedures (49,25% of them do not want to do it). This is understandable, because genital surgery is the most radical (in terms of body alteration) and results in a complete change of sex. Among respondents, 12 (3,02%) had genital surgery, five (1,26%) are in the process of changes, and 42,96% are thinking about it. 5,53% of respondents underwent other body altering procedures or are in the process of doing so, while 45,23% plan to undergo them.

Besides aforementioned types of reassignment in order to achieve a full physical change, hormone therapy seems indispensable. While 29,65% of respondents do not want it at all, more than two thirds (70,35%) either want to undergo hormone therapy (51,51%), are in the process of doing so (15,83%), or already completed the main phase (3,02%).

The process of reassignment

The study was supposed to show i.e. which phase of reassignment the respondents are in. The first phase is the diagnostic procedure conducted by a psychological and a medical sexologist. As it turns out, 2/3 of respondents were never diagnosed (65,52%). Those who were, declared that they were diagnosed with transsexualism (27,09%) or something else (7,39%).

FIG. 53. Distribution of transgender respondents' answers to the question about diagnosis (N= 406)

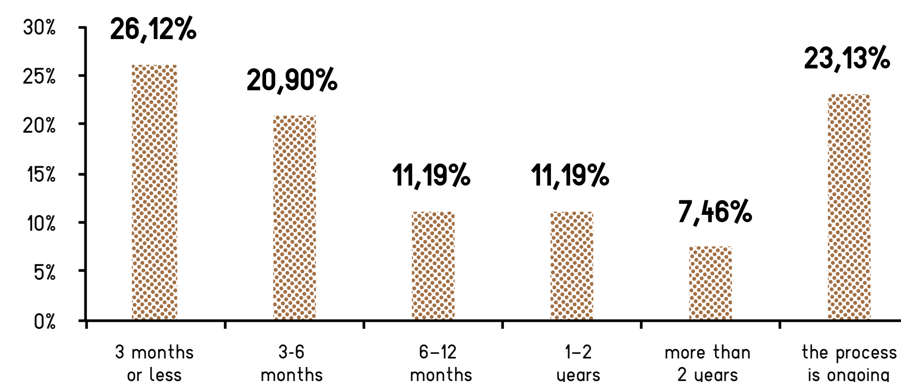


It should be mentioned that respondents who underwent diagnosis visited various professionals, although a relatively low number disclosed which ones. Almost all persons diagnosed with something else than transsexualism disclosed their diagnosis (27 respondents out of 30). Qualitative analysis of answers showed that:

1. respondents said that the person diagnosing them was incompetent (*The therapist said I was not transgender, because I did not show any signs in childhood*) or that the diagnosis was unprofessional (*As a 'weird' person with high scales of all negative indicators (depression etc.) in MMPI-2 tests, Asperger's Syndrome*);
2. they were diagnosed with mental illnesses (schizophrenia, borderline personality disorder);
3. the diagnosis was very general (gender dysphoria, androgynous person, agender person, transgender person, emotional disorders, gender identity disorders).

For one in four diagnosed respondents (26,12%) the diagnostic process was short – less than 3 months, one in five respondents (20,9%) described it as "between 3 and 6 months." One in ten respondents (11,19%) was diagnosed over the period of 6-12 months. In the case of 18,65% of respondents the diagnose lasted between a year and two years. For more than one in five respondents (23,13%) the diagnostic process was still going on.

FIG. 54. Distribution of transgender respondents' answers to the questions about how long the diagnosis process lasted (N= 134)



Sex reassignment therapy

A diagnosis affirming transsexuality opens the door to legally adjust one's body to the gender a transgender person identifies with. Some people begin the process even before the diagnosis, taking advantage of both legal body alterations (e.g. laser hair removal – facial and otherwise, plastic surgery), and black-market options (hormones or alleged substitutes in the form of herbal medicine, containing phytoestrogens, which are considered safer[198]).

Legal gender reassignment does not mean that a person

198 http://www.crossdressing.pl/main.php?lv3_id=246&lv1_id=3&lv2_id=77&lang=pl

underwent all possible procedures, treatments, and surgeries. Hormone therapy is necessary even after surgical sex reassignment, in order to prevent changes from being undone. The main goals of other procedures are prettifying and authenticating in a new gender role. In this regard there is certain freedom in which procedures one undergoes, depending on a person's self-esteem, financial resources, and desire to look as best as possible in the eyes of others.

Results of the study show that respondents decide on their own which procedures, treatments, or surgeries to undergo. Pressure to undergo procedures was the same as in the study from 2011 (5,5%).

TAB. 25. Pressure to undergo treatments/procedures

Did you ever feel pressure from doctors to undergo treatments/procedures?	frequency	percentage	overall
Yes	23	5,94	387=10%
No	364	94,06	387=100%

From the statements by respondents who admitted to being forced by doctors to undergo treatments/procedures, one can conclude that:

1. some doctors believe that persons diagnosed as transsexual have to undergo all procedures and therapies, even if they do not wish to do so;
   A ton of pointless blood and urine tests, EEG, ECG, x-ray, karyotype, diagnoses, psychological/psychiatric tests.
   Doctors tried to persuade me to undergo testosterone treatment, despite my protests. It was a result of their unfamiliarity with my case of IS.
   At first, I was informed that panhysterectomy is compulsory. I didn't like it because I was afraid of the consequences for my body and the lack of choice. Now I know that it is not a compulsory procedure, just a recommended one, for health reasons. Lack of choice about my own body terrified me.
2. doctors are influenced by stereotypical thinking that "if someone does not necessarily want all the surgeries then they

are not transsexual, and so it is much more difficult, if at all possible to get a positive diagnosis (TS) and access to hormone treatment." One of the respondents wrote:
   I feel pressure from the sexologist and the psychologist, to undergo panhysterectomy, even though I know it is not a requirement in Poland.
3. some doctors order tests which are not directly linked to the patients' ailment/problem. This is illustrated by the following statements:
   Gynecological examinations when I explained that I don't feel sexual attraction or have a sex drive.
   A gynecological examination, no option of having the test through the abdominal wall.
   It was quite brutally suggested that I see a psychologist or psychiatrist

Thanks to online forums,[199] transsexual persons know very well which doctors in Poland specialize in diagnosing and treating people like them. There are not many doctors like this, meaning that sometimes it is necessary to go to a different city, (or even a far-away part of the country) which generates additional costs and requires a lot of money. Very often transgender persons have only one doctor over the entire course of their treatment. Changes can be a result of characterological differences, a less than friendly attitude from the doctor, or the process stretching out for too long. Sometimes the change of specialist is dictated by money. Some doctors extend treatment for as long as possible, for their own gain. However, most of respondents (77,89%) did not change their doctor during treatment.

199 www.transseksualizm.pl

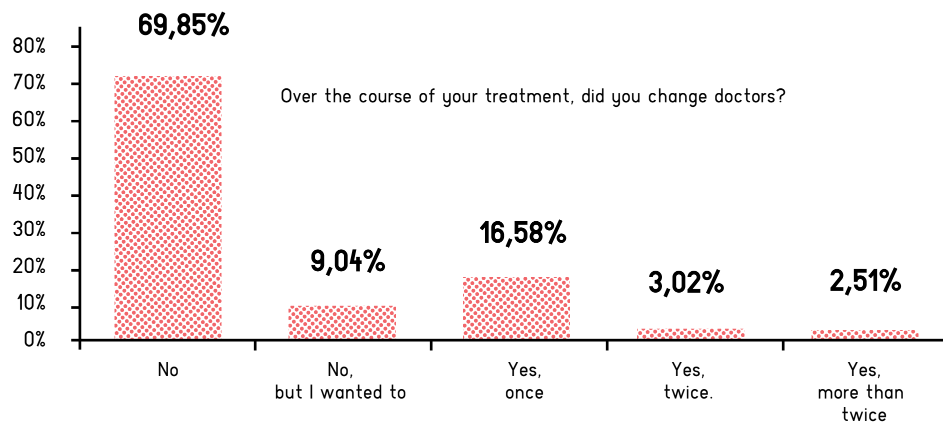


FIG. 55. Distribution of transgender respondents' answers to the question about changing their doctor during treatment (N = 199)

When asked about why they changed doctors during treatments, half of respondents (49,15%) said that they did not like their doctor as a person. Another important reason was money (16,95%). It should be mentioned that an appointment with the primary doctor usually costs 100PLN or 150PLN. The third reason was distance between the doctor's office and respondent's place of residence (13,56%).

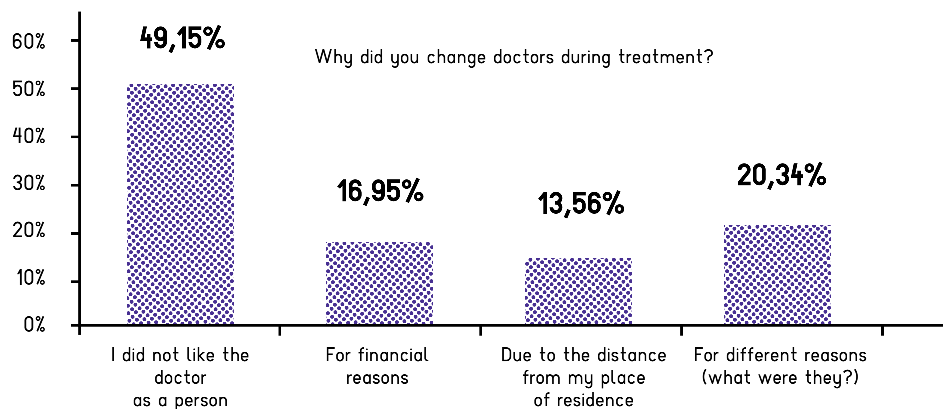


FIG. 56. Distribution of answers to the question about reasons for changing doctors during treatment (N = 59)

Different reasons mentioned by respondents were:

1. due to unforeseeable events, e.g. moving to a different city
2. realizing during appointments that the doctor was not qualified to give a diagnosis
3. lack of trust for the doctor's/specialist's medical and legal competences

The first psychologist pressured me to accept a diagnosis of gender dysphoria, without explaining the legal consequences of various diagnoses.

It turned out that gender dysphoria is not enough from a legal standpoint.

(…) too high doses of hormones, no possibility of negotiating doses and types of medicine.

Attitudes of health care personnel

The results of the study show that respondents' transgender identity is rarely a cause of worse treatment within the healthcare system or the basis of refusal of services. According to 91,8% of respondents, incidents like this did not happen.

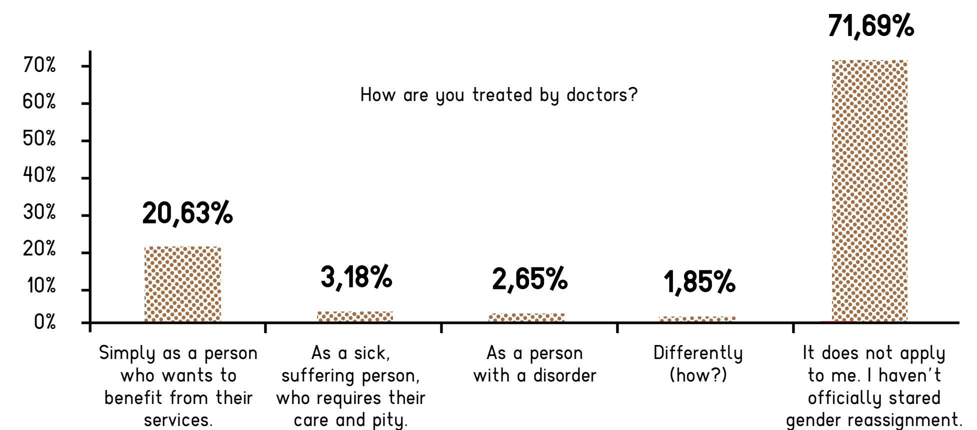


FIG. 57. Distribution of transgender respondents' answers to the question about treatment by doctors (N = 378)

Transsexual respondents were also asked about how they are treated by doctors who assist them in their physical and legal gender reassignment. Most respondents were simply treated as persons who wanted to use health services (20,63%). Rarely were respondents treated as persons with disorders (2,65%). Not much more often did doctors treat respondents as sick, suffering and evoking pity (3,18%).

From the descriptions of treatment by doctors, the following conclusions can be drawn:

1 doctors, even though they know who they are talking to, very often use pronouns which do not match the respondent's declared gender, when addressing them;
In theory, my psychiatrist accepts it, but because of our discussion about social gender she must have decided that I'm above it and she uses female word endings;

2 if the appearance, timbre of voice, or behaviour are not convincing enough for the doctor, they may adopt a suspicious, aggressive, or reluctant attitude;
Doctors treat me worse. I'm always treated worse when I act feminine and have to pretend to be manly, which I am not. I am myself when I act feminine, but when doctors here my not-so-feminine voice they become suspicious, aggressive, etc.
My transgender identity is always known. There were issues with the psychologist and psychiatrist because I don't fit the typical image of a trans dude in some respects, so they pressured me to accept a diagnosis of gender dysphoria, which would make it impossible to progress in my treatment.

3 sometimes situations arise in which someone (a receptionist, psychologist, doctor) has to be informed who one is and why their personal information do not match appearance, pronouns used, etc.
Yes, at the reception desk they doubted my information, after I explained my history the receptionist addressed my history in a weird way in the context of the whole situation. Apparently, she heard "about a friend's son, who wanted to be a woman" but "she never heard of a case like mine".

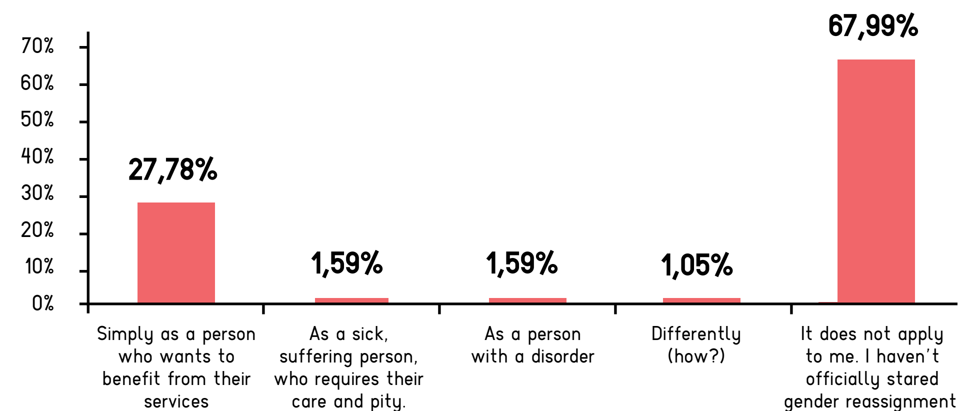


FIG. 58. Distribution of transgender respondents' answers to the question about how the perceive themselves in interactions with doctors (N = 378)

Transgender respondents were asked about how they perceive themselves in interactions with doctors. Most of them did not yet start the process of gender reassignment (67,99%, N=378). Others (N=121) usually think of themselves as someone who simply wants to benefit from health services. Rarely did respondents think of themselves as having a disorder, or as someone sick, suffering, and evoking pity. The chart above includes all the answers given to this question.

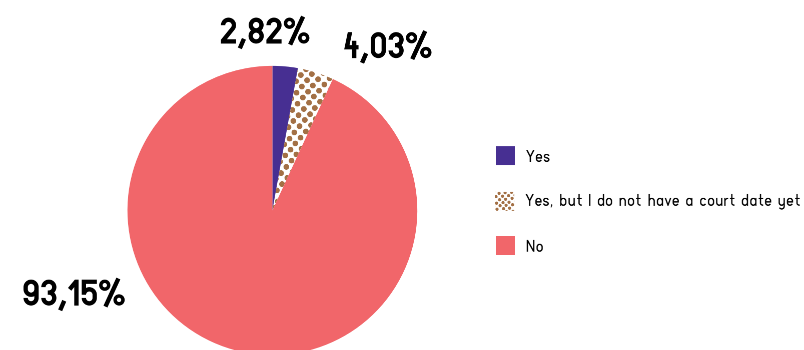


FIG. 59. Distribution of transgender respondents' answers to the question about whether they filed the suit to reassign their gender (N = 248)

Legal gender reassignment

As mentioned before, more than one in ten respondents (11,8%) already completed legal gender reassignment or is in the process of doing so, while 57,79% plan on doing it in the future. The survey asked a question: Did you file the suit to reassign your gender? 6,85% of respondents answered affirmatively (4,03% of them do not have a court date yet). The vast majority of respondents did not file the suit yet, but according to the survey some of them plan to do so. The waiting period between filing suit for gender reassignment and the first court date is usually not long.

Transsexual respondents were also asked about what they think about the divorce requirement before filing for legal gender reassignment. This requirement is a result of the fact that same-sex marriage is illegal in Poland. Therefore, a marriage between a man and a woman has to end if one of them wants to formally reassign their legal gender. While most respondents who answered this question are either not married (65,96%) or have no intention of reassigning their legal gender (10,42%), among the rest, most would like to remain married (61,76%) despite filing suit for legal gender reassignment.

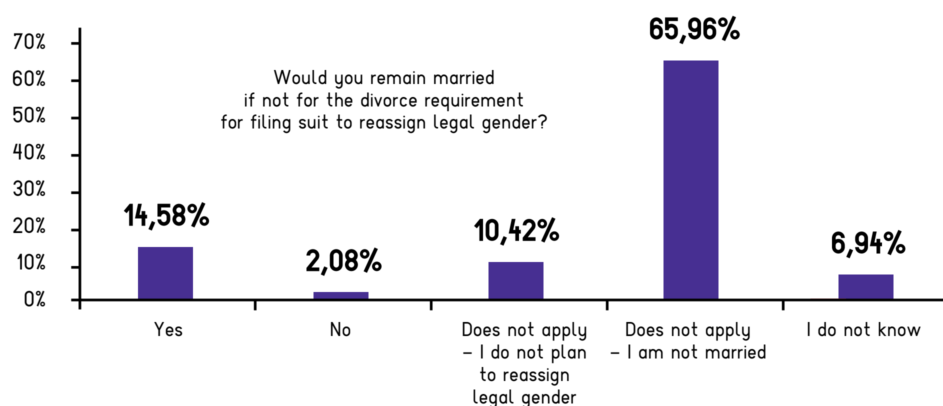


FIG. 60. Distribution of transgender respondents' answers to the question about remaining married (N= 144)

Real-life test

In Poland, a transsexual person must pass a so-called real-life test[200]. It is the period between staring to live in the preferred gender and surgical reassignment. This time allows the patient and the doctor to monitor experiences with the new gender role and gain new forms of expression and interaction with people. A patient can confront their image of the gender they identify with and how clearly they are received in their social environment, meaning whether they are convincing and credible in the role of a man or a woman. Through interactions with other people in public spaces, a person can find out how they will feel in the new gender. There are no formal requirements about how long such a test should last. The requirement to live like this for two years is often mentioned, but it is not formal. Transgender respondents were asked about their experiences regarding the real-life test. Figure 61 presents the distribution of answers to the question about the length of this test.

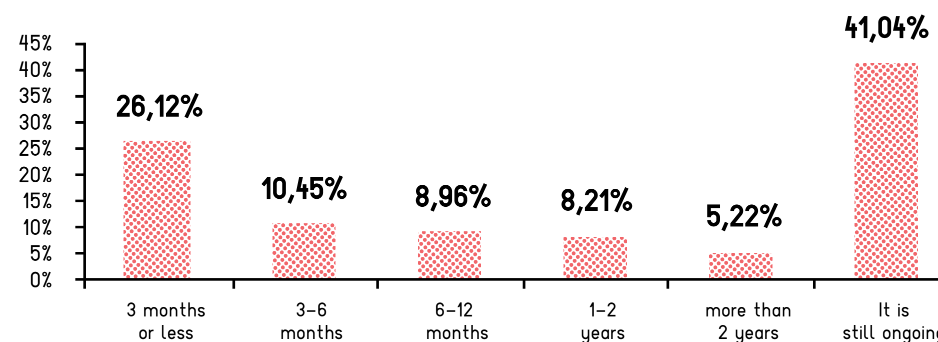


FIG. 61. Distribution of transgender respondents' answers to the question about the length of the real-life test (N = 134)

For 41,04% of respondents who answered this question, the test is still in progress. More than 1/4 of respondents (26,12%) declared that this period of their life lasted up to 3 months. It seems that it is not long enough to see how a person feels like in a new gender role and how they are perceived by others. The rest of respondents

200 http://wsparcie.transoptymista.pl/tranzycja/diagnostyka-transseksualnosci/czym-jest-test-realnego-zycia/

reported their real-life test as lasting 6-12 months or 1-2 years in similar rates (8,96% and 8,21% respectively). One respondent in 20 (5,22%) experienced a really long test, that is lasting more than 2 years. Compared to previous studies, the real-life test is becoming shorter (previously, it lasted less than 3 months for 7,5% of respondents, and for 26,12% this time around).

Sex reassignment surgery (SRS) is irreversible and its consequences for one's personal life are far reaching. Not many people who underwent SRS took part in the study, so there is no point in looking for correlations between SRS and e.g. life satisfaction. Of course, one can either be happy with the changes, or not[201], however the results of our study show that if it was possible to once again make a decision about sex reassignment, almost all respondents (93,94%, N=66) who already underwent it, would do it again.

201 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4261554/. The article presents result of a study conducted by the Clinic for Urology at Essen University in 2014, among 119 persons (MtF) who underwent SRS 1-7 years prior. 90,2% of respondents were glad.

Summary

1. Few of the respondents underwent reassignment or were in the process of doing so. A significant majority was so at the planning stage. Top surgery and legal gender reassignment are the most popular, while genital surgery – the least. Almost 16% of respondents were undergoing hormone therapy at the time of the study.
2. Diagnosing transsexuality takes between three months and over two years. Sometimes the diagnosis is unprofessional, or transsexuality is diagnosed as a mental disorder, e.g. a personality disorder or schizophrenia
3. In the vast majority of cases transsexual respondents did not feel pressure to undergo procedures/treatments (94,06%), although sometimes doctors do order tests which are not directly related to the patient's ailment.
4. Less than 10% or respondents experienced worse treatment in the healthcare system or were refused medical service due to their transsexuality. More than 2/3 of transsexual respondents did not change their doctor.
5. Among married transsexual persons the majority (61,76%) would like to remain married despite filing a suit for legal gender reassignment.
6. The "real-life test" is getting shorter, one in four respondents reported it lasted less than 3 months.

Conclusions and recommendations

The study concerned many areas important to the LGBTAQI community. On many occasions the results disproved stereotypes about non-heteronormative people, like the stereotypes about instability of same-sex relationships. This chapter presents the most important conclusions and recommendations.

1. The study we conducted on many occasions pointed to the significantly worse situation of non-heteronormative persons living in rural areas and small cities. LGBTA persons living in smaller areas suffer from minority stress, depression, feel lonely, and have suicidal thoughts more often. At the same time, when faced with problems they are less likely to ask others for help and advice or to mobilize to action. Because of all this, the only way to gain more social support and to live openly is to leave their hometown. Therefore, it seems that pro-equality activities should be aimed at rural areas and small cities.

2. Level of education and wealth are factors differentiating the social situation of LGBTA persons. In order to effectively work on creating more equal opportunities, one has to consider intersectional discrimination based on sexual orientation and poverty.

3. Sexual orientation and gender identity usually are not accepted by family members. More than half of gay men and lesbians are not accepted by any of their parents. This problem affects one in three asexual persons, bisexual women, and transgender persons, as well as four in five bisexual men. Lack of acceptance for one's sexual orientation or transgender identity by family members is related to symptoms of depression, feeling lonely, and higher frequency of suicidal thoughts. Non-heteronormative persons whose sexual orientation or gender identity is not accepted by family members are less satisfied with their lives and report a worse state of health than LGBTA persons who are accepted. Keeping this in mind, one should engage in activities focused on raising social acceptance of LGBTA persons, especially among their family members.

4 Taking into consideration:

a. low social capital of Polish school students;
b. their problems with loneliness and mental health;
c. widespread homophobic and transphobic peer violence
d. educators' lack of knowledge and skills for coping with this type of violence;
e. lack of topics concerning sexual orientation and gender identity in the curriculum;
f. lack of acceptance of a child's sexual orientation or gender identity with their simultaneous dependence on family;

activities focused on supporting LGBTAQI school students should be aimed at educating society about LGBTAQI persons, raising social acceptance of diverse sexual orientations and gender identities, engaging in anti-violence activities in schools, increasing resources for psychological support for school students, and educating teachers.

5 LGBTA persons are generally distrustful of the government and parliament. It could be a sign of insufficient support and disregard for the problems of the LGBTA community by these institutions.

6 LGBTA persons experience minority stress and suffer from depression five times as often as heterosexual persons. Therefore, prevention programs for mental health should include the problems of depression and minority stress experienced by LGBTA persons. Systemic actions (e.g. introducing comprehensive sex education to schools, providing training about LGBTAQI issues for help centres all over Poland) which could limit the number of stressors (e.g. violence) experienced by LGBTA are potentially the most effective way to curb consequences of minority stress.

7 The results of the study show that LGBTA persons differ in the area of experienced violence. Therefore, anti-violence programs should consider the needs of diverse groups of different sexual orientations and gender identities. Transgender persons are at most risk of violence of any kind; men regardless of sexual orientation are more at risk of physical violence, while women of sexual violence.

8 Law enforcement should consider the low reportability crimes motivated by homophobia and/or transphobia (reportability under 4%). The obstacle in reporting these crimes could be low levels of trust for the police – more than half of respondents distrusts the police.

9 The issue of same-sex relationships' legal status in Poland should be regulated. It would meet the needs of lesbians, gay men, and bisexual persons, as well as allow transgender persons to remain married despite filling a suit to reassign legal gender.

10 One in four lesbians or gay men reports frequent or very frequent contact with homophobic hate speech. 50% of gay men and lesbians report regular contact with such content. Frequency of contact with hate speech significantly correlates with gay's and lesbian's mental wellbeing, especially with symptoms of depression, low life satisfaction, and feeling lonely. In the case of lesbians, hate speech strongly correlates with a tendency to take sedatives. Therefore, one should take actions limiting homophobic hate speech in public spaces, e.g. by adopting law regulating it.

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