Regular Manuscript

Health Care Experiences of Transgender Binary and Nonbinary University Students

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Abstract

An increasing number of young adults identify with nonbinary gender identities. Yet health providers and therapists often lack understanding of such identities. In this mixed-methods study of 506 transgender undergraduate and graduate students, most of whom (75%) had nonbinary gender identities, we aimed to understand participants' mental health and health care experiences, and factors related to misgendering and less affirming treatment by providers. Eighty-five percent of participants reported mental health challenges, and named fear of violence and nonsupport as distal stressors. Experiences with therapists and health providers were mixed. Salient features of negative interactions were invalidation, avoidance, or overemphasis in regard to participants' nonbinary identities. Participants viewed counseling services as more affirming than health services. Nonbinary students reported more misgendering by therapists and health providers, and less trans-affirming care by health service providers, compared to binary students. Undergraduate students reported more misgendering by therapists and health providers than graduate students.

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Transgender (trans) people (i.e., individuals whose gender identity differs from what is typically expected given their sex assigned at birth) may face trans-related stigma at multiple levels, which renders them vulnerable to psychological distress (Bockting, Miner, Romine Swinburne, Hamilton, & Coleman, 2013; White Hughto, Reisner, & Pachankis, 2015). According to gender minority stress theory (Hendricks & Testa, 2012), exposure to such stigma results in negative mental health outcomes, whereby the added stressors related to the stigma associated with gender identity contribute to trans individuals' compromised well-being. For example, structural forms of stigma create stressful environments for trans people, and may contribute to problematic affective, cognitive, and behavioral responses and result in compromised well-being (Hendricks & Testa, 2012). Specifically, many trans people are at an elevated risk for negative mental health outcomes (Perez-Brumer, Day, Russell, & Hatzenbuehler, 2017), and trans-related stigma has been linked to diminished well-being among trans youth and adults (Bockting et al., 2013; Perez-Brumer et al., 2017). Interventions that enhance structural and interpersonal supports (e.g., access to trans-competent providers) can serve as a buffer to minority stress and reduce negative outcomes (White Hughto et al., 2015).

Trans People's Mental Health and Health Care Experiences

Trans people who present for mental health treatment are often seeking help for the same reasons as nontrans people (Meier & Labuski, 2013; Mizock & Lundquist, 2016; Shipherd, Green, & Abramovitz, 2010). However, they may also seek mental health services for reasons specific to their gender, including gender exploration (Rachlin, 2002), coming out (Hunt, 2014), coping with or alleviating isolation (Budge et al., 2013), addressing family nonsupport (Budge, 2015), envisioning a positive future as a trans person (Katz-Wise et al., 2017), or obtaining letters to support their request for medical interventions (Mizock & Lundquist, 2016). In seeking mental health care, trans people are at risk of encountering structural and interpersonal forms of stigma that are pervasive in society. They may face incompetent care or be denied treatment (Institute of Medicine, 2011). Encounters with trans-insensitive care providers may lead them to fear stigma and to avoid seeking help (Shipherd et al., 2010), resulting in the exacerbation of existing mental health problems (Institute of Medicine, 2011).

Some researchers have explored trans youth and adults' mental health care experiences, offering insight into the types of challenges they face when interacting with mental health providers (Gridley et al., 2016; Mizock & Lundquist, 2016). In addition to facing explicit transphobia (e.g., therapists who express disgust toward trans people; Gridley et al., 2016), trans people may encounter therapists who are emphatic about enforcing the gender binary, encourage patients to come out as a particular gender, or have narrow definitions of what it means to be trans (Carroll & Gilroy, 2002; Meier & Labuski, 2013). These encounters can cause clients to feel as if they have to be "trans enough in order to be cleared for gender-affirming treatments" (Gridley et al., 2016, p. 259). Mizock and Lundquist (2016) documented specific therapeutic "missteps," including therapists relying on their clients to educate them about trans issues (education burdening), assuming that gender is central to trans clients' mental health issues (gender inflation), turning away from issues of gender in therapy (gender avoidance), assuming a singular trans experience (gender generalizing), and stigmatizing trans identity as the cause of all problems (gender pathologizing).

Some researchers have also focused on trans-positive psychotherapy experiences. Trans people who view their therapists as more experienced in working with trans issues tend to be more satisfied with therapeutic progress in terms of general personal growth and gender-related issues (Rachlin, 2002). Providers who show respect for clients' gender identities, are empathic, maintain flexibility in their treatment approach, and have effective boundaries appear to facilitate trans clients' self-acceptance and hope for the future (Applegarth & Nuttall, 2016; Rachlin, 2002). When therapists and other providers lack experience with trans populations, being open, supportive, and willing to learn are regarded as positive attributes (Kuvalanka, Weiner, & Mahan, 2014).

Research on trans people's health care experiences has also found that trans people are vulnerable to encountering insensitive care and denial of treatment (James et al., 2016; White Hughto, Rose, Pachankis, & Reisner, 2017). According to the 2015 U.S. Transgender Survey, one third of respondents who saw a health provider in the past year reported at least one negative experience related to being trans, such as being harassed or having to teach the provider about trans people (James et al., 2016). One quarter did not see a doctor when they needed one because of fear of being mistreated as a trans person, and one quarter reported insurance problems related to being trans (e.g., denial of coverage for transition-related care; James et al., 2016). These difficulties reflect, in part, the medical profession's long legacy of pathologizing trans identities (Ansara, 2012) and the lack of training in trans health issues and trans-competent care (Austin, Craig, & McInroy, 2016). Those providers who do have knowledge of trans identities often possess a rigid,

narrow conceptualization of the transition process, which relies heavily on the gender binary and does not account for nonbinary identities (Austin & Goodman, 2018).

Research on trans people's experiences with therapists and health providers has generally focused on adults, who are primarily or exclusively described as binary-identified (e.g., trans man, trans woman; Mizock & Lundquist, 2016; Rachlin, 2002). *Nonbinary* people—individuals who identify as both male and female, neither male nor female, outside of the gender binary, and/or reject all gender identities—may experience unique mental health stressors due to cultural invisibility and ignorance surrounding nonbinary identities (Matsuno & Budge, 2017). In one study, nonbinary people reported more frequent misgendering (not being "read" as one's affirmed gender) than trans men or trans women (McLemore, 2014). Being constantly misgendered across contexts may contribute to elevated gender minority stress for nonbinary people. Specifically, nonbinary individuals must repeatedly decide whether to come out about their gender, which may translate into mental health challenges (Nadal, Skolnik, & Wong, 2012). For example, a recent study found that over half of genderqueer adults reported clinical levels of depression, and over one third reported clinical levels of anxiety (Budge, Rossman, & Howard, 2014). And, using data from the 2015 U.S. Transgender Survey, James et al. (2016) found that nonbinary respondents (49%) were more likely to report current serious distress than trans men and women (35%).

Trans Young Adults in Higher Educational Settings

There is evidence that an increasing number of young adults have nonbinary gender identities (James et al., 2016; Matsuno & Budge, 2017). Trans young adults, and nonbinary young adults specifically, may be especially likely to be navigating their gender identity in college—a time of self-discovery, identity exploration, and personal growth (Beemyn, 2016). In addition to being one of the first contexts for these students to be "out" about their gender identity, college may be their first opportunity to access professional services to support their gender exploration and provide respite from societal (and campus) transphobia (Beemyn, 2016). Among trans adults, persons 18 to 25 years old report the highest levels of severe trans-related distress (James et al., 2016).

Trans students who seek support on campus may face barriers to sensitive care (Beemyn, 2016), and moreover, therapists and health providers in college settings may lack the necessary competence to treat nonbinary students

in particular. Individuals with multiple minority identities are vulnerable to a complex set of intersecting microaggressions in interpersonal settings (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). In turn, trans students' experiences with providers may be shaped by other characteristics beyond whether they identify with binary or nonbinary gender identities, such as their sex assigned at birth, race, and student status (i.e., undergraduate vs. graduate student). Such characteristics might intersect with their gender identity such that, for example, a nonbinary Student of Color would likely experience anxiety due to several factors, which could include negative encounters with providers (see Budge, Thai, Tebbe, & Howard, 2016).

Current Study

This mixed-methods study builds on prior work to explore the mental health and health care experiences of trans students in higher education using survey data from 506 trans students. First, using primarily a qualitative approach, we explored students' understanding of their mental health, including their reports of specific difficulties and diagnoses, with attention to whether and how societal norms surrounding gender create interconnected sources of stress for trans students. We were particularly interested in the experiences of nonbinary students.

Second, we used qualitative methods to examine students' experiences with mental health care, with attention to the types of interactions, dynamics, and assumptions described by nonbinary identified students, who are rarely included in research. A secondary goal was to gain insight into students' experiences with health providers—which have implications for clients' well-being.

Third, we used quantitative methods to determine which trans students' personal characteristics are related to their (a) perceptions of more affirming treatment by campus counseling and campus health (i.e., medical) providers and (b) reports of more frequent misgendering by campus therapists and health providers. Counseling services and health services are interconnected systems, particularly in the lives of trans college students (Singh, Meng, & Hansen, 2013). Difficulties in accessing trans-affirming health care have implications for trans clients' emotional, physical, and academic well-being (Mizock & Lundquist, 2016); in turn, knowledge of such challenges can inform therapists' case conceptualization, and may alert them of the need to engage in advocacy efforts (e.g., offering trans-affirming training to local providers; Austin & Goodman, 2018; Ruben et al., 2017). We examined in one multivariate model for each outcome:

1. Whether binary versus nonbinary status is related to perceived misgendering and reports of treatment as gender affirming. We hypothesized that nonbinary students would perceive greater misgendering and less affirming treatment by providers on campus compared to binary-identified students, given the pervasiveness of the gender binary in society and the lack of societal discourse surrounding nonbinary identities (Beemyn, 2016; Goldberg & Kuvalanka, 2018).
2. Whether sex assigned at birth (assigned female [AFAB] vs. male [AMAB]) is related to perceived misgendering and gender affirming treatment, given evidence that gender nonconformity among persons AMAB is regarded less positively than gender nonconformity among persons AFAB (Toomey, Card, & Casper, 2014) and that trans women report more harassment and discrimination than trans men (Bockting et al., 2013).
3. Whether race (being a Person of Color vs. White) is related to perceived misgendering and affirming treatment, as LGBTQ People of Color face a unique constellation of microaggressions stemming from racial, sexual orientation, and gender-related stigmas (Balsam et al., 2011).
4. Whether student status (graduate vs. undergraduate student) is related to perceived misgendering and affirming treatment. Graduate students are typically older than undergraduates, given that they are pursuing advanced academic study (Sweitzer, 2009), and may be regarded by providers as further along in, and more reliable reporters of, their gender identity formation. Thus, they may perceive less misgendering and more affirming treatment by providers. Alternatively, as more experienced consumers of mental health and health services, they may be more critical of their providers and report worse treatment. For instance, trans graduate students in McKinney's (2005) qualitative research were especially likely to emphasize the lack of trans-specific health care on campus as a problem for them.

Method

Data Collection

The data (collected May–November 2016) were drawn from an online survey of trans students' experiences in higher education, developed by the first author. Focus groups with trans students—led by trained trans-identified members of the research team—helped to inform the development of the survey. It was pilot tested for ease of use and functionality by members of the

target population prior to survey launch. Feedback by this group and by scholars who study trans populations led to minor changes in the survey. The survey, which was approved by the Human Subjects Board at Clark University and constructed using the Qualtrics software application, was disseminated widely. Study information was distributed to LGBTQ groups, clubs, and resource centers on college campuses across the United States. Some colleges did not have LGBTQ groups or resource centers, but rather a designated staff member within a larger center, such as multicultural affairs, who provided support or resources to LGBTQ students. In such cases, we provided study information to them directly with a request to disseminate the survey to relevant individuals. We also advertised the study through listservs and social media pages aimed at trans people and/or college students.

The survey included questions on a range of topics, including demographics, gender identity, experiences with faculty, and sense of belonging on campus. Participants were instructed:

> You may complete this survey if you (a) identify as trans, gender nonconforming, gender questioning, genderqueer, gender nonbinary, agender, or anywhere on the gender-nonconforming spectrum, and (b) are currently enrolled at least part-time in a college/university (or recently graduated). Graduate students may also participate. *Students with nonbinary gender identities are particularly encouraged to participate*.

We instructed participants not to include any identifying data on the survey, and that upon completion, they would be directed to a link to enter their name and email—which would not be linked to their data—to enter a drawing for one of 10 $50 gift cards for a large online retailer.

A total of 649 respondents initiated the survey; 509 (78%) completed all of the closed-ended items used in the study, which were presented first, before the open-ended questions. Of the 509 complete responses, 430 (85%) completed the open-ended (qualitative) questions analyzed in the current study.

The median and modal time to completion was 39 min. Respondents were prevented from completing the survey more than once. To enhance validity, respondents' answers to similar questions were inspected for evidence of inattentive or fraudulent responding; we also assessed response times and missing data patterns (Dillman, Smyth, & Christian, 2009). Respondents who (a) did not answer any open-ended questions or (b) completed the survey in under 15 min, were subjected to careful review of their data to ensure logical responding patterns (Meade & Craig, 2012), which led to the deletion of three surveys. Thus, the final sample for the study was 506 participants.

Participants

The 506 participants (M_{age} = 22.39 years; *SD* = 5.57) resided across the United States (95.1%) and abroad (4.9%; see Table 1 for demographic data.). Most participants attended 4-year public universities (*n* = 283) and 4-year nonreligious private universities (*n* = 149), with smaller numbers attending 2-year public universities (*n* = 44), 4-year private religious universities (*n* = 21), and 2-year private universities (*n* = 9). Only 350 participants chose to provide an estimate of the total student population at their institution; among these, estimates ranged from 100 to 95,000, with a median of 6,500 (*M* = 13,620, *SD* = 15,610).

Most participants (74.9%; *n* = 379) were undergraduates and recent graduates; the remainder were graduate students. Most (72.3%; *n* = 366) identified their race and/or ethnicity as White only; 27.7% *(n* = 140) chose other racial and/or ethnic categories and were classified as Students of Color. Students could select multiple racial or ethnic categories; thus, percentages presented in Table 1 add up to over 100. Regarding sex assignment, 78.3% (*n* = 396) were assigned female, 20.7% (*n* = 105) were assigned male, and 1% (*n* = 5) were intersex and assigned female; these five individuals were included as "female" in the analyses. Students selected from a variety of gender identity options and could choose as many as desired. Most identified as at least one of the nonbinary identity options (e.g., nonbinary, genderqueer, gender fluid) and can thus be classified as nonbinary (75.1%; *n* = 380); the remaining participants identified as binary (24.9%; *n* = 126). (Details on the decision-making that informed this reduction of categories can be found in the section "Closed-Ended Questions.") Most were nonbinary and AFAB (61.5%; *n* = 311). The remainder were binary trans AFAB (17.8%; *n* = 90), nonbinary AMAB (13.6%; *n* = 69), and binary trans AMAB (7.1%; *n* = 36). The greater participation of AFAB persons is consistent with the demographics of younger, particularly nonbinary, trans participants in other studies (Grant et al., 2011; James et al., 2016).

Closed-Ended Questions

Participants were presented with closed-ended questions that assessed their perceptions of, and experiences with, providers. In addition, questions were included to assess for various demographic characteristics.

Misgendering by providers. Students indicated, on a 0–3 scale, how often they were misgendered by campus therapists, where 0 = *never* and 3 = *often*. They also indicated frequency of misgendering by campus health providers. They could also indicate *not applicable* for both.

Table 1. Sample Demographics

Student Characteristic	*n*	%
Region		
United States		
Midwest	138	27.3
South	119	23.5
East Coast	113	22.3
West Coast	111	22.0
Non-United States	25	4.9
Student status		
First-year undergraduates	68	13.4
Second-year undergraduates	98	19.4
Third-year undergraduates	74	14.6
Fourth-year undergraduates	70	13.8
Fifth-year undergraduates and above	31	6.1
Recent graduates (in the past year)	38	7.5
Current graduate students	127	25.1
Race and/or ethnicity		
White	414	81.8
Latino/a/x/Latin American	49	9.7
Asian	38	7.5
Black/African American	23	4.5
Native American	18	3.5
Middle Eastern	9	1.8
Sex assigned at birth		
Female	396	78.3
Male	105	20.7
Intersex, assigned female	5	1.0
Gender identity		
Transgender/trans	210	41.5
Nonbinary	199	39.3
Genderqueer	136	26.8
Trans man	106	20.9
Gender nonconforming	91	17.9
Gender fluid	89	17.6
Agender	85	16.8
Masculine of center	64	12.6
Androgynous	58	11.5
Questioning	50	9.9
Trans woman	36	7.1

Table 1. (continued)

Student Characteristic	n	%
Demigender	24	4.7
Feminine of center	24	4.7
Bigender	7	1.4
Other identities not listed (man, woman, MtF, FtM, demigirl, transsexual, neutrois, two spirit, third gender)	20	4.0
Sexual orientation		
Queer	152	30.0
Pansexual	81	16.0
Bisexual	58	11.5
Asexual	53	10.5
Gay	33	6.5
Lesbian	24	4.7
Questioning	17	3.4
Heterosexual	17	3.4
Demisexual	12	2.4
Something else (e.g., I identify as multiple orientations; e.g., gay and asexual)	59	11.6

Note. N = 506.

Perceptions of providers. Students indicated, on a 1–5 scale, their perceptions of how trans-affirming campus counseling services were (1 = *very affirming* and 5 = *not at all affirming* or very transphobic). Students also indicated their perceptions of how trans-affirming campus health services were, using the same response options. Students could also indicate *not applicable* for both types of services.

Nonbinary versus binary students. We were interested in comparing students with binary and nonbinary gender identities, which necessitated combining categories. Although we recognized the problems inherent in reducing these identities to a dichotomous variable, we felt that differences between binary and nonbinary identities were important to consider. We created a binary/nonbinary category, such that all students who identified as transgender, trans, trans woman, trans man, FTM, MTF, woman, man, and who did not indicate any nonbinary options, were reclassified as gender binary (coded as *1*). Those who identified as any of the nonbinary options (nonbinary, genderqueer, gender nonconforming, gender fluid, androgynous, agender, demigender, third gender, transmasculine, masculine/feminine of center, questioning) were coded as gender nonbinary (*0*). We recognize that masculine of center and feminine of center can be conceptualized

as gender expressions and not gender identities, and identifying as questioning is vague and does not clearly denote a binary or nonbinary identification. Thus, we carefully examined these participants' endorsement of other identities to best categorize them.

Female versus male sex assigned at birth. We included sex (1 = *male*, 0 = *female*) given that (a) most participants were AFAB, and it was appropriate to account for this in analyses, and (b) AMAB people who identify as gender nonconforming often encounter greater stigma (Bockting et al., 2013).

White students versus Students of Color. Participants who indicated a racial category other than White were classified as Students of Color (coded as *1*), and students who solely indicated White were coded as White (*0*).

Graduate students versus undergraduate students. Current undergraduate students (and students who graduated from undergraduate institutions in the last 2 years, who were not currently graduate students) were coded as *1*, and current graduate students were coded as *0*.

Age. Participant age, in years, was included in follow-up analyses.

Current gender identity. Length of time identifying as current gender identity, in months, was included in follow-up analyses.

Open-Ended Questions

Participants were presented with several open-ended questions regarding their mental health, mental health and health care experiences, and experiences on campus more broadly:

1. Have you been diagnosed (e.g., by a therapist) with depression, anxiety, or some other emotional problem? (Yes, I have been diagnosed with the following….; It is not diagnosed, but I struggle with the following…; No). Explain.
2. If you are currently struggling with difficult emotions/feelings, are these in any way related to social norms around gender or your own gender identity? (Yes/No). Explain.
3. Feel free to elaborate here, as well as provide any details about your experiences seeking psychotherapy or psychotropic medication (e.g., antidepressants), on or off campus (please specify), including whether and how providers were sensitive/affirming of your gender.

4. Describe your "wish list" for what you wish your university/college would do differently or better in regard to trans/gender nonconforming issues/students. Consider recommendations related to language, policies, coursework, health services, counseling services, trainings, etc.

Data Analysis

Qualitative analysis. We conducted a qualitative analysis using responses to the open-ended survey portions, which ranged from several sentences to several pages of text, with most students providing responses of three to five sentences. More specifically, we utilized thematic analysis, which is a standard means for considering responses to open-ended questions and represents a process of identifying, coding, and categorizing the primary patterns or themes in the data (Bogdan & Biklen, 2007). Thematic analysis emphasizes examining and recording patterns (or "themes" within data) with the goal of creating a coding system to organize the data (Bogdan & Biklen, 2007). Because of the large amount of qualitative material, we used the qualitative software NVivo to facilitate data management and coding. The first author initiated the coding process with open coding, which involves examining responses and highlighting relevant passages. Initial coding was informed by the relevant literatures and gender minority stress theory (Hendricks & Testa, 2012). The fifth author independently read through the data, and then both authors discussed salient points they noted in the responses. This process led to the refinement of emerging codes. Next, focused coding was used to sort the data. For example, types of negative experiences with providers were examined for their relationship to each other and to broader constructs. In turn, a distinction was drawn between explicit invalidation and avoidance—behaviors that therapists engaged in relation to gender identity but differed in content and impact. This process of organizing is more conceptual than initial coding; the categories that emerge are those that best synthesize the data (Bogdan & Biklen, 2007). At this stage, the authors examined quotes in relation to participant characteristics (race, gender identity) to determine whether they nuanced or helped to make sense of key patterns in the data. The authors applied the coding scheme to the data, which allowed for the identification of more descriptive coding categories and the generation of themes with the most substantiation.

Intercoder agreement was calculated at two points in the analysis to verify the usefulness and soundness of the coding scheme. This process of code checking can help to clarify categories and definitions and confirm reliability (Miles, Huberman, & Saldana, 2013). Intercoder agreement was initially 85% (reliability = number of agreements/ [number of agreements + disagreements]); after discussion of emerging codes, agreement increased to 98%, providing evidence of the coding scheme's utility for describing the data.

Quantitative analysis. Reports of misgendering by campus therapists and health providers, as well as levels of trans-affirming care of campus counseling and health services, were examined for group differences according to gender identity (nonbinary vs. binary), sex assigned at birth, race, and student status (undergraduate vs. graduate student) in the 298 students who had attended both counseling and health services and provided data on all measures. Due to the ordinal nature of the variables, we used Mann-Whitney *U*-tests to examine group differences. We then used logistic regression models to assess which personal characteristics predicted perceptions of misgendering and trans-affirming services. The outcomes were reduced to only two categories (i.e., low vs. high levels of misgendering; low vs. high trans-affirming services); we used logistic regression in order to avoid the 0 cell counts produced when the outcome was treated as ordinal. In additional models, we examined two exploratory interactions: Race (White/People of Color) x Gender Identity Status (binary/nonbinary), and Sex Assigned at Birth (AFAB/AMAB) x Gender Identity Status. We also conducted several follow-up tests to aid in the interpretation of the findings. Independent-samples *t*-tests were used to examine differences in participant age and length of time (in months) identifying as current gender according to student status (undergraduate vs. graduate student).

Results

Our results are organized into four sections: (a) participants' attributions surrounding endorsed mental health difficulties, (b) participants' experiences with therapists, (c) participants' experiences with health providers, and (d) participant characteristics associated with perceptions of misgendering and trans-insensitive treatment by therapists and health providers.

Mental Health Diagnoses and Difficulties

A total of 57.7% of students (*n* = 292) reported at least one mental health diagnosis from a health provider, and another 26.8% (*n* = 136) said they struggled with mental health concerns that had not been diagnosed. Thus, only 14.8% (*n* = 75) said that they were not dealing with any mental health issues (*n* = 3 missing data). Across diagnosed and undiagnosed difficulties, 68% reported mood disorders (including major depressive disorder and bipolar disorder), 67% reported anxiety (including social anxiety and generalized anxiety disorders), 4% endorsed ADHD, 4% reported eating disorders, and 4% indicated having a personality disorder. Smaller percentages reported other issues, such as autism spectrum disorder and schizoaffective disorder. Because James et al. (2016) documented higher rates of distress

among nonbinary trans adults than binary trans adults, we calculated chi-square statistics to determine whether diagnosed or undiagnosed difficulties in general, or specific difficulties, varied by gender status. This revealed two differences: Nonbinary students were more likely to report a personality disorder than binary students ($n = 20$ vs. $n = 0$), $\chi^2(1) = 6.94$, $p = .008$, as well as an eating disorder ($n = 19$ vs. $n = 1$), $\chi^2(1) = 4.43$, $p = .035$. Of the 20 students who reported personality disorders, 16 said they had received a diagnosis. Among the 20 students who reported an eating disorder, 17 said they had received a diagnosis.

Although less than one third (29%) of those with mental health diagnoses or difficulties asserted that they did not feel that these issues were related to their gender, some students (one sixth), especially those who reported depression, anxiety, and eating disorder symptoms, noted that key sources of their current distress involved (a) gender identity confusion and uncertainty, and (b) body dysphoria. Students reporting gender identity confusion largely identified as nonbinary and questioning. Some students were in the early or active stages of "figuring out [their] gender identity," such that they were "trying to figure out where on the gender spectrum [they] lie." One White graduate student who identified as genderfluid and described how they had

> been recently blindsided by nonbinary gender expression. I felt secure about my gender in the past but have started to feel much more fluid in terms of gender over the past few months. . . [in retrospect] I think that it has contributed a lot to [my] depression and anxiety.

Uncertainty related to seeking social, legal, and medical changes was a source of distress for some, including one undergraduate Student of Color who identified as nonbinary and questioning:

> I am considering different measures that trans people do (legal name change, breast removal, hormones), but I can't come to a decision for or against it at the moment. I feel stuck. . . I am not sure if taking on a male name or changing my body would make me feel better. So a lot of my emotional problems come from not feeling able to choose or decide.

Body dysphoria was also described as creating anxiety and distress, and as triggering eating disorder symptomatology specifically (e.g., restrictive eating). Participants did not look the way they wanted to, and sometimes worried about how others would see them; this prompted a range of negative emotions. For instance, one undergraduate Student of Color who identified as nonbinary and masculine of center stated, "I think about starving myself because of being

seen as something I'm not." A White genderqueer undergraduate shared that they "struggled with extremely negative feelings about [their] weight, body hair, facial hair, and bone structure," and that "efforts to appear more feminine have led to not eating . . . and hiding body parts when they started to regrow hair after shaving." Thus, for some, distress was in part tied to uncertainty about their gender identity or expression, and discomfort with the disconnect between their bodies and their gender identity.

Gender-Specific Minority Stress and Mental Health Challenges

Two thirds of participants—especially those who reported depression, anxiety, and eating issues—commented on ways that their difficulties stemmed from or were exacerbated by distal stressors, including structural and interpersonal sources of stigma. They highlighted how inhabiting a highly gendered society in which trans people were stigmatized or rendered invisible (especially in the case of nonbinary individuals) had contributed to their stress. They pointed to how encountering rejection or invalidation of their gender identity (e.g., via misgendering) had led to proximal or internalized stress processes, such as anticipation of stigma and gender identity concealment.

Discrimination and violence. Some participants (one fourth) explicitly attributed their mental health challenges to society's response to trans people and the associated experiences or fears of violence. Some students described being physically or sexually assaulted based on their gender, and experiencing acts directed at "erasing [their] gender" (White genderqueer undergraduate). In other cases, their fears were grounded in awareness of the pervasiveness of transphobia, and thus the potential for harm. As one White agender undergraduate shared, "I feel like some of my anxiety and depression has to do with others not accepting or even hating nonbinary gender identities." For some, awareness of the "realities of being trans—being unable to access housing, healthcare, and work, being incarcerated, and being assaulted" occupied their consciousness, creating ongoing worry and stress (White genderqueer graduate student).

Some trans students had experienced, or feared, discrimination or violence associated with multiple marginalized identities (e.g., identifying as a Person of Color, having a disability). A genderfluid undergraduate Student of Color said, "Societal transphobia, sexism, homophobia, classism, and racism are so connected [and influence] how people interact with me [creating] lots of anxiety." A genderqueer undergraduate Student of Color said: "Some of my mental health problems originate from being constantly under stress of not fitting in

with all of my intersectional identities. I am constantly worried about being misgendered [or] discriminated against." An undergraduate Trans Man of Color said, "Some of my anxiety is due to my anticipation . . . that at any moment on or off campus, someone could commit a hate crime . . . against me, and I wouldn't know what to do."

Fear of discrimination and violence influenced participants' comfort and willingness to authentically express their gender, and in some cases led to concealment of their gender identity. A White undergraduate trans woman shared a worry of

> being attacked or hurt by other people. I know that transgender people can be at risk for harassment and harm at a higher rate. I have a fear of putting myself 'out there' in the world and tend to withdraw.

An undergraduate Student of Color who identified as trans and masculine of center reflected:

> I'm a lot more anxious now because I have seen real hate, real carelessness and cruelty, in people. I've been called names on the street and hurt by people without provocation. That creates fear of being hurt and insulted over and over. When a complete stranger spits at you . . . it affects your self-esteem and will to live. I miss being normal and moving in the world more freely. The awareness that some people see me as a freak and wouldn't mind if I died . . . is hard to live with. It takes a lot of support to process this new reality and cope with it.

These students were critically aware of how their status and visibility as trans people rendered them vulnerable to threats of or actual violence, which influenced their sense of emotional and physical safety, and shaped how they presented in, interacted with, and moved about in the world.

Invisibility and invalidation. Feelings of invalidation and erasure of one's gender identity, particularly one's nonbinary identity, were described by more than half of students as contributing to their distress. These students were cognizant of the fact that trans experiences, particularly nonbinary experiences, were often treated as illegitimate by the larger society. They noted that society did not recognize identities outside the gender binary, resulting in a lack of intelligibility and awareness of nonbinary identities in particular. In turn, students were aware they would face an "uphill battle" in terms of gaining recognition and acceptance of their gender, whereby they feared "others will say my gender is not real and that I've made it up" (White nonbinary undergraduate). One nonbinary undergraduate Student of Color

said, "After being closeted in a really intensely gendered society for so long . . . I have general anxiety [about] people not taking me seriously because I'm transgender."

For many students, invalidation concerns manifested in the form of anxiety about being misgendered, or not "read" as their affirmed gender. One White undergraduate trans woman said, "The thought of being misgendered or mistreated keeps me anxiously in bed for far too long, on many days." A White agender and questioning undergraduate student shared:

> I have anxiety and find it emotionally distressing confronting people about my pronouns and identity when I'll probably have to follow up with some long-winded explanation about nonbinary identities, try to defend myself and my identity, or face discrimination. I typically only talk about my identity with people who I . . . expect to stick around in my life.

In the context of misgendering, students recognized that they had an opportunity to come out as nonbinary—but anticipated that doing so would be met with more confusion or resistance than if they came out as a trans man or woman, and that they would face an "exhausting process" of trying to explain their gender identity. In turn, coming out as nonbinary was especially anxiety-provoking: "Since nonbinary genders are not generally recognized, I feel some stress and fear about coming out" (White nonbinary undergraduate). Some nonbinary students felt that to be viewed as having a valid gender identity, and thus minimize the likelihood of being misgendered, they had to "pick" one side of the gender coin. A nonbinary undergraduate Student of Color said, "I feel pressured to be overly masculine all the time in fear of being perceived as anything less than male." These students noted the difficult balance between presenting in a way that met the least amount of "pushback" and being authentic in expressing their gender, sometimes leading to "guilt about not dressing and expressing myself as fully as I want to, and guilt about concealing my identity . . . to feel accepted" (White genderfluid and agender undergraduate student).

Some outlined the interconnections among distal, proximal, and mental health stressors for nonbinary people specifically. The societal invisibility of nonbinary identities led to misrecognition of their gender identity and misgendering on a daily basis, contributing to feelings of helplessness and powerlessness as well as self-doubt, self-loathing, and isolation. A nonbinary graduate Student of Color articulated feeling "deeply invisible sometimes when I'm being misgendered or incorrectly seen as the gender I was assigned at birth." A White genderqueer undergraduate student stated:

I just feel really isolated. . . . I'm trying to unlearn the ways the world has taught me to fear and reject my own femininity, I'm trying to reclaim it and own it, and own masculinity in a way that isn't about erasing femininity—that's why I don't want to take T [testosterone]. But I don't know other trans people struggling with this stuff too, and so I just increasingly feel alone, and feel crazy, and feel like I'm making shit up and making this all more complicated for myself. And as cis and straight and queer and trans people . . . continue to misgender me, it makes it harder for me to believe in myself, believe that my feelings are real and believe that I'm trans—something I've known since I was 5. . . . At some points in time, being trans has felt like a possibility. But recently, being trans has felt like grief.

Similarly, several nonbinary persons described how fears of harassment and rejection led them to endure invisibility and invalidation through concealment of their gender identity, which in turn reinforced their distress. A White, nonbinary, questioning undergraduate student said: "I have seen the judgment present towards members of my community and I would rather suffer the discomfort of being misgendered almost constantly than be viewed as less than a person."

Family invalidation and nonsupport. One third of participants emphasized the role of family nonsupport in their mental health challenges, which sometimes undermined their efforts to accept themselves. Several shared that their parents had tried to send them to conversion therapy and/or therapists known for "curing" trans people of their "gender disorder." More often, family nonsupport manifested in a refusal to accept the participant's gender identity and, by extension, an unwillingness to support any medical or social changes that might facilitate the participant's gender transition. Fear of alienating family members was sometimes a barrier to initiating medical or social transition-related changes (e.g., hormones, name change). An agender undergraduate Student of Color shared:

I sometimes feel hopeless about my transition, that I can never fully transition without the support of my family. I'm scared of their reaction, and with the history of abuse by my father, I have developed anxiety and the fear that everyone hates me.

Fears of familial rejection (e.g., due to family members' political affiliation, religiosity, or prior negative reaction to their coming out as a sexual minority) and withdrawal of emotional and financial support led some participants to conceal their gender identity—a theme particularly marked among nonbinary Students of Color. A nonbinary undergraduate Student of Color

said: "I am not open about my gender identity at all with my immediate family. I have tried gently introducing ideas and it has not been received well. My family is homophobic and transphobic." A genderfluid undergraduate Student of Color shared that they were out on campus but would "never" come out to family as this would "risk my sanity and financial and emotional security."

Lack of community and isolation. One sixth of students explicitly noted that they lacked a community of other trans and, specifically, nonbinary people, which seemed to exacerbate their feelings of loneliness and not belonging. A White genderqueer graduate student said:

> When I decided to come to terms with being genderqueer, I was depressed and suicidal. I felt like I did not know who I was. . . . I have yet to be able to find someone to talk to who is genderqueer and gets what I am going through.

A few students' isolation was magnified upon entering graduate school. A White genderqueer student related their current depression to the absence of a trans community in graduate school: "I'm struggling with the transition from a college experience . . . with a trans community to a small school [with] no trans community. . . . I feel very isolated."

Experiences With Mental Health Providers

Experiences with mental health care providers have the potential to reflect and exacerbate the stigma trans people encounter in society, or to offset and buffer such stigma. Students provided descriptions of both negative and affirming encounters they had with counseling services, on and off campus; location was often unspecified. Slightly over one third of students described only negative experiences of therapy, and less than one third of students shared only positive experiences. In addition, approximately one third of students highlighted both negative and positive experiences with mental health providers.

Trans-negative experiences. Students' descriptions of negative experiences with mental health care providers often involved explicit invalidation of their gender identity, whereby therapists had denied their particular trans experience or identity, especially nonbinary identities. A White pangender, questioning graduate student stated: "[I was] misgendered and belittled by my previous therapist for my gender identity. . . . He also told me that to him I was a girl and there was nothing that could change that." A White genderfluid undergraduate student shared:

> I go to a trans-affirming therapist for my PTSD, which was caused by a very violent assault where my gender identity was the main trigger. [Before that] I had non-affirming therapists who suggested I go off hormones and try to live as a female.

A White agender graduate student described negative therapeutic experiences on and off campus:

> The therapist, who knew I identified as agender, kept referring to my "inner little girl." She could have easily said "inner child" but she didn't. I stopped seeing her. Several other therapists I've seen off-campus have not been able to handle using "they" pronouns and continued to call me "she." How am I supposed to feel uplifted and supported by so-called professionals who can't put in the effort to use the right pronoun?

Indeed, some therapists failed to use students' affirmed name and pronouns, and misgendered them even after many sessions and reminders. A White genderqueer undergraduate student shared, "After seeing my counselor for a year, he still refers to me as my assigned sex, but not how I identify." A White undergraduate trans man noted that his "first attempt seeking therapy was at a university facility [where] the staff member . . . was very awkward and had no idea what to do with me. He had to be told by his supervisor to ask about my preferred pronouns and use them. I stopped going after two visits since the stress of going outweighed the benefits." (Although this student uses the phrase "preferred pronouns," this language is increasingly seen as inappropriate, because "preference" indicates a choice or inclination; trans people's "preferred" pronouns [or names] are their actual pronouns and names, and others should not think they have a choice in what pronoun or name to use for a trans person.) Some therapists seemed to rely heavily on a rigid metanarrative about trans experience that presumed bodily alterations and did not allow room for nonbinary identities. A demigender graduate Student of Color recalled: "One therapist said she thought most trans people aren't really trans, and that to be trans you have to feel like you were 'born in the wrong body' and want surgery. . . . She said my wanting to identify as a demigirl and queer was wrong because I was really just bisexual and didn't like being oppressed as a woman." Several students noted especially invalidating experiences with psychiatrists (e.g., "He literally asked me if I was trans because I'd been sexually assaulted"; "He believed all trans people are transsexuals").

Some described how their therapists overemphasized their gender identity, centering it as the root cause of all their mental health issues, which participants felt was misplaced. "Campus therapists are constantly . . . insinuating that all my problems are caused by my gender," said a White genderfluid undergraduate. As one White nonbinary graduate student

shared, "My therapists always assume my depression stems from my gender identity, but it doesn't. So they are sensitive to my gender, but also make it my defining aspect." Several students noted that this overemphasis on their gender as the root cause of their distress seemed to reflect assumptions about the inevitability of "sadness and suicide in a trans person's life" whereby they were "expected to suffer from depression or suicidality." As one White agender undergraduate student said:

> When it became obvious to me that the depression wasn't just linked with transphobia, I had problems with therapists expecting me to be talking about my struggles with gender or family. Like it almost seemed odd for the depression of someone trans to have nothing to do with their being trans.

In contrast, some students encountered avoidance of their trans identity, wherein therapists seemed unwilling or uninterested in addressing their gender, "skirting around [it]." As one White agender, questioning graduate student shared, "I feel like my gender concerns have been ignored or downplayed as not a problem or something we should discuss." A White nonbinary and questioning undergraduate recounted, "I went to a campus counselor, brought up my gender issues, and she ignored them. Instead, she focused on my depression, which was nice, but I really wish I was able to talk about my gender." Psychiatrists were cast as especially avoidant of, and uncomfortable with, students' gender identity, "never asking" about it, even when prescribing medication.

Some students stated that their therapists were never explicitly transphobic, but they lacked competence in trans issues, were generally unhelpful, and sometimes expected clients to educate them about trans issues. Typical responses were: "The psychology clinic staffed only trainees who had no familiarity with or sensitivity to my needs at all" (White, genderqueer, feminine of center graduate student) and "She kept asking questions about the definition of genderqueer" (White nonbinary undergraduate). In turn, some students felt they had to "educate [their therapists] about trans people." Spending their time in therapy in this way was "the opposite of affirming because I have spent so many sessions explaining gender and sexuality terms to them and trying to get them to understand who I am" (White nonbinary, agender undergraduate). Such incompetence resulted in students not getting help at a time of great need for support. As one White nonbinary undergraduate student shared,

> I sought counseling last semester, mainly about my nonbinary identity, and wanting to talk about my options and how to best go about my name change and telling people. The counselor had little knowledge about nonbinary and trans individuals and could not help me.

Several nonbinary Students of Color feared stigma and insensitivity related to both gender and race, such as a nonbinary undergraduate student who said, "It is hard to find queer Counselors of Color," fearing "microaggressions" based on their multiple "intersecting, layered" identities.

Trans-positive encounters. Positive encounters, with explanations of what therapists did to be affirming and validating, were narrated by one sixth of the respondents. Therapists who used participants' affirmed name/pronouns were praised and appreciated, as were those who showed knowledge of trans identities and issues. As a White undergraduate trans man shared: "I [had] one therapist at my university's counseling center who was incredibly nice and accepting and who not only used my correct pronouns all the time, but seemed very well-educated and knowledgeable about diverse genders and sexualities." A White genderqueer undergraduate outlined multiple ways that their therapist had been affirming and helpful: "She's very supportive of my gender identity and has been trying to help me some with coming to terms with it, helping me overcome my fears, and talking with me about what to do about my prejudiced family."

Several binary trans students emphasized how counseling had been particularly important to them during their gender transition. They were grateful they had had access to a trans-competent therapist during such an important period of their life. A White trans graduate student shared:

> Before my transition and during (even though I am still transitioning), I went to counseling weekly and/or biweekly and this was *very* helpful as literally everything down to the nuclei in my cells were changing. Especially when I first came out and when I started taking testosterone, things were very shaky in my life, as far as emotions and feeling stable. I depended on the support from my counselor and [trans support] group.

A few nonbinary students noted that they especially appreciated therapists who recognized that their gender identity was not necessarily fixed and might change. One White nonbinary undergraduate noted that their therapist was "very good about checking in once [in] a while [to ask] if my gender identity has shifted at all or if my pronouns or preferred name have changed."

Experiences With Health Care Providers

Participants were not specifically queried about experiences with health providers, but one third highlighted relevant challenges and concerns. Some encountered similar dynamics as with therapists, whereby they were expected

to educate health providers about gender—which was especially taxing when their presenting issue was unrelated to gender. A White undergraduate trans man said:

> I went into university health services because I was having stomachaches, and I ended up having to talk all about my transition to the doctor. It was a total waste of time. I was basically answering her questions that she was asking out of curiosity instead of talking about the ailment that brought me in! I wish I didn't feel so much like a curiosity when I go to the doctor on campus.

Some noted that health providers did not ask for, or track, participants' affirmed names, genders, and pronouns, and instead made assumptions about their gender (and sometimes their reproductive organs), which was invalidating. Contrasting their experiences with campus therapy and health services, a White nonbinary undergraduate said, "The therapists at my university have been helpful to me and sensitive to my gender. However, the health network staff has repeatedly misgendered me."

Some students voiced frustration with the absence of campus providers who were able and willing to provide transition-related medical care such as hormones, electrolysis, and gender-affirming medical procedures. One graduate student, a White trans man, said, "Health services had no knowledge of hormone therapy and refused to administer my shot when I brought in all necessary supplies and paperwork, saying they didn't 'deal with that stuff.'" In the absence of any trans-competent providers, health services sometimes "did not provide any support whatsoever, even just referrals," said one undergraduate trans Man of Color. Being told that they could not be seen on campus was difficult enough; but then to be told that "there is nothing we can do to help" further undermined participants' sense of being valued or cared for by the institution they attended.

About a quarter of students highlighted concerns related to health insurance, desiring trans-inclusive coverage. A White undergraduate trans man asserted, "School health insurance should provide trans and gender nonconforming students access to hormones and other services . . . doctor's visits, blood work, hormones, and surgery are . . . outrageously expensive." Several students noted the inflexibility of coverage to meet individualized needs. As one White genderfluid undergraduate said: "We need an insurance policy that covers hormones, surgery, surgery without hormones, and hormones without surgery. Many policies cover either of these require the other and that is not acceptable."

It is notable that only a few students spontaneously described positive experiences with health care providers. With one exception, these providers

Table 2. Experiences With On-Campus Counseling and Health Services

Campus Experiences	Counseling Services, *n* (%)		Health Services, *n* (%)	
	Full Sample	Regressions	Full Sample	Regressions
Have never been seen there	108 (18.6%)		159 (27%)	
Have been seen by on-campus services	472 (81.4%)		422 (73%)	
Misgendering "not applicable"	67 (14.2%)		49 (11.6%)	
Misgendering[a]	*n* = 405	*n* = 298	*n* = 373	*n* = 298
Never misgendered	165 (40.7%)	113 (37.9%)	91 (24.4%)	68 (22.8%)
Misgendered rarely	94 (23.2%)	73 (24.5%)	76 (20.4%)	67 (22.5%)
Misgendered sometimes	69 (17.0%)	49 (16.4%)	81 (21.7%)	62 (20.8%)
Misgendered often	77 (19.0%)	63 (21.1%)	125 (33.5%)	101 (33.9%)
Trans-affirming services	*n* = 472	*n* = 298	*n* = 422	*n* = 298
Not at all affirming	9 (1.9%)	9 (3.0%)	10 (2.4%)	8 (2.7%)
Not very affirming	24 (5.1%)	18 (6.0%)	67 (15.9%)	50 (16.8%)
Neutral/mixed	73 (15.5%)	42 (14.1%)	121 (28.7%)	79 (26.5%)
Somewhat affirming	147 (31.1%)	87 (29.2%)	126 (29.9%)	85 (28.5%)
Very affirming	219 (46.4%)	142 (47.7%)	98 (23.2%)	76 (25.5%)

[a]Regarding frequency of misgendering by therapists, 67 of the 472 (14.2%) participants who reported they had been to counseling services indicated that this question was not applicable to them, and 49 of the 422 (11.6%) participants who reported they had been to health services indicated that this question was not applicable to them. It is unknown whether they indicated this because their gender was never a focus of attention, or for other reasons. Thus, the percents are computed based on the 405 and 373 who answered the questions on misgendering in counseling and health care settings, respectively.

were identified as being located off campus (e.g., "I go to an LGBTQ-specific healthcare provider in [city] for most of my healthcare needs. They are very affirming and I have not had any trouble getting medication, including anti-depressants, from them" [White nonbinary undergraduate student]).

Quantitative Analyses: Misgendering and Trans-Affirming Care by Providers

Students responded to closed-ended questions about the degree to which counseling and health providers on campus (a) had misgendered them and (b) were trans-affirming (see Table 2). As Table 2 shows, over one third of students who received campus counseling services reported being misgendered

sometimes or often, and over half of students who went to campus health services reported being misgendered sometimes or often. Almost one quarter of students who went to campus counseling described their experiences as mixed or not affirming, whereas almost half of students who went to health services described their experiences as mixed or not affirming. Students who did not attend both counseling and health services, and those who reported "not applicable" for misgendering by either provider type, were excluded, and those with missing data for predictors ($n = 12$) were also dropped from the analyses. Thus, we conducted analyses on the 298 students who provided ratings on all measures, to ensure that the same group was considered in all analyses.

Group differences. Reports of (a) misgendering by campus counseling staff, (b) misgendering by campus health services staff, (c) trans-affirming care by campus counseling staff, and (d) trans-affirming care by campus health services staff, were examined for differences according to whether students were categorized as binary, assigned male at birth, of Color, or an undergraduate. We conducted a series of Mann-Whitney U-tests to account for the ordinal nature of the outcome, and calculated the effect size r (i.e., the Z-statistic from the U-test divided by the square root of N).

Binary students (*Mdn* = 1.00) reported less misgendering by counseling services than nonbinary students (*Mdn* = 2.00), $U = 5,310.00$, $p < .001$, $r = .30$. Binary students (*Mdn* = 2.00) also reported less misgendering by health services than nonbinary students (*Mdn* = 3.00), $U = 5,358.00$, $p < .001$, $r = .29$. Although binary students did not rate counseling services significantly differently than nonbinary students, binary students (*Mdn* = 5.00) rated health services as more trans-affirming than nonbinary students (*Mdn* = 4.00), $U = 9,988.00$, $p = .019$, $r = .14$. AMAB students (*Mdn* = 1.00) reported less misgendering by counseling services than AFAB students (*Mdn* = 2.00), $U = 4,994.00$, $p = .002$, $r = .18$. AMAB students (*Mdn* = 2.00) also reported less misgendering by health services than AFAB students (*Mdn* = 3.00), $U = 5,269.00$, $p = .011$, $r = .15$. However, ratings of the trans-affirming nature of counseling and health services did not differ by sex assigned at birth.

Undergraduates (*Mdn* = 2.00) reported more misgendering by counseling services than graduate students (*Mdn* = 1.50), $U = 9,608.00$, $p = .007$, $r = .16$. Undergraduate students (*Mdn* = 3.00) also reported more misgendering by health services staff than graduate students (*Mdn* = 2.00), $U = 9,368.00$, $p = .022$, $r = .13$. Ratings of the trans-affirming nature of counseling and health services did not differ by student status. No differences on any of the outcomes were found on the basis of race and ethnicity (of Color vs. White).

Chi-square tests showed no significant differences between binary and non-binary students according to sex assigned at birth, race, or student status.

Regression analyses. Next, a series of four logistic regression models were fit: (a) misgendering by counseling services staff, (b) misgendering by health services staff, (c) trans-affirming care by counseling services staff, and (d) trans-affirming care by health services staff. The outcomes were reduced to only two categories in order to avoid zero-cell counts in the analyses. In additional models, we examined two exploratory interactions: Race (White vs. of Color) x Gender Identity Status (binary vs. nonbinary), and Sex Assigned at Birth (AFAB vs. AMAB) x Gender Identity Status.

In the first regression, misgendering by counseling services was the outcome (sometimes or often vs. rarely or never), and binary versus nonbinary, female versus male sex assigned at birth, of Color versus White, and undergraduate versus graduate student were entered as predictors (see Table 3). Gender identity emerged as significant, with binary students being 71% less likely (i.e., $1 - e^B$) than nonbinary students to report being misgendered sometimes or often. Sex assignment was significant, with AMAB students being 51% less likely than AFAB students to report misgendering sometimes or often. Also, compared to graduate students, undergraduates had 2.25 higher odds of reporting being misgendered sometimes or often. However, neither of the two exploratory interactions was significant.

When the same predictors were regressed on misgendering by health services staff, the same pattern emerged. Binary students were 76% less likely than nonbinary students to report being misgendered sometimes or often. AMAB students were 52% less likely than AFAB students to report misgendering sometimes or often. The odds of reporting being misgendered sometimes or often were 2.08 times higher for undergraduates than for graduate students. Neither of the interactions was significant.

The same set of predictors was regressed on the nature of trans-affirming counseling services (very or somewhat trans-affirming vs. less than somewhat trans-affirming). None of the predictors were significant, nor were either of the exploratory interactions.

When the nature of trans-affirming health services was the outcome, the only significant predictor was gender identity: The odds that binary students would report that health services were very or somewhat trans-affirming were 1.83 times higher than for nonbinary students. Neither of the interactions was significant.

To aid our interpretation of the finding that undergraduates were more likely to report higher levels of misgendering, we conducted several follow-up analyses. Undergraduates were younger (M_{age}= 20.81, SD = 2.91) than graduate

Table 3. Logistic Regression Analysis Predicting Misgendering and Trans-Affirmingness of Counseling and Health Services

Predictor	Misgendering by Counseling Services Staff		Misgendering by Health Services Staff		Trans-affirming Counseling Services		Trans-affirming Health Services	
	B (SE)	e^B	B (SE)	e^B	B (SE)	e^B	B (SE)	e^B
Binary (vs. nonbinary)	−1.23 (0.33)***	.29	−1.44 (0.29)***	.24	0.17 (0.33)	1.18	0.61 (0.28)*	1.83
Assigned male at birth (vs. assigned female at birth)	−0.71 (−0.36)*	.49	−0.73 (0.32)*	.48	−0.21 (0.35)	.81	0.07 (0.31)	1.07
Of Color (vs. White)	0.28 (0.27)	1.32	−0.28 (0.27)	.76	−0.05 (0.30)	.95	0.05 (0.26)	1.05
Undergraduate (vs. graduate) student	0.81 (0.33)*	2.25	0.73 (0.30)*	2.08	−0.60 (0.36)	.55	0.03 (0.28)	1.03
Constant	−0.85 (0.31)**		0.22 (0.28)		1.69 (0.36)		−0.04 (0.27)	.96
χ^2	42.04***		30.86***		5.14		3.63	
df	4		4		4		4	
% Endorsing	37.6%		54.7%		76.8%		54.0%	

Note. $n = 298$. e^B = exponentiated B (i.e., odds ratio). Predictors coded as 0 = *no* and 1 = *yes*. Misgendering is coded such that 0 = *rarely/never* and 1 = *often/sometimes*. Trans-affirming service is coded so that 0 = *less than somewhat trans-affirming* (i.e., not at all affirming, not very affirming, neutral) and 1 = *somewhat or very trans-affirming*.
*p < .05. **p < .01. ***p < .001.

students (M_{age} = 26.57, SD = 5.47) according to independent-samples t-tests (t = 8.45, df = 81.36, p < .001). Undergraduates also reported identifying as their current gender identity for a shorter period of time (in months; M = 33.02, Mdn = 36.00, SD = 38.30, range: 4–350) than graduate students (M = 56.61, Mdn = 60.00, SD = 54.78, range: 4–350; t = 3.36, df = 90.65, p = .001). When we added age and length of time identifying as current gender to the models, however, we found the same pattern of findings for the primary predictors, with neither age nor length of identification emerging as significant.

Discussion

Our study provides much-needed insight into trans students' mental health, counseling experiences, and health service experiences. Our focus on predominantly nonbinary-identified young adults is a particular strength, given their absence in research (Matsuno & Budge, 2017). Findings point to the need to explore the variation that exists among trans students' mental health care challenges and needs, including the unique forms of gender minority stress that nonbinary trans students may face (Webb et al., 2017).

   Our finding that more than three quarters of students reported mental health challenges (with almost 60% reporting a diagnosis) is notable in that there was no reference to mental health issues in the call for participants. These high rates of mental health challenges echo prior work on trans youth (Perez-Brumer et al., 2017), and are higher than nationally representative survey data on nontrans college students (Hunt & Eisenberg, 2010). In one study, researchers found that almost half of college students met diagnostic criteria for at least one mental disorder in the prior year, including 12% for an anxiety disorder and 11% for a mood disorder (Bianco et al., 2008). Adding to the literature on greater rates of distress among nonbinary adults than binary adults (James et al., 2016), we documented differences in personality disorders and eating disorders, with nonbinary people reporting higher rates of both. In interpreting this, it is important to note that people with nonbinary gender identities are vulnerable to misdiagnosis by providers who, unfamiliar with the spectrum of trans identities, may view gender dysphoria in the absence of strong cross-gender identification as indicative of pathology (à Campo, Nijman, Merckelbach, & Evers, 2003).

   The fact that most participants were experiencing mental health challenges while simultaneously earning undergraduate or advanced degrees suggests remarkable resiliency. Yet alongside this resiliency, trans students in this sample—consistent with gender minority stress theory (Hendricks & Testa, 2012)—described trans-related stigma at multiple levels as heightening their current distress. Even the intrapersonal processes they described as

contributing to distress (e.g., uncertainty about where they lie on the gender spectrum; gender dysphoria) are inevitably shaped by distal minority stressors, such as the striking lack of visible trans and, in particular, nonbinary role models in society. Media images of trans people present a narrow depiction of trans experience that is alienating for trans and especially nonbinary people (Meier & Labuski, 2013).

Participants reported experiences and fears related to discrimination and violence as key sources of minority stress. Unique intersections emerged whereby nonbinary Participants of Color often referred to the complex interplay of structural stigmas that influenced them daily. Participants described experiencing invisibility and invalidation in relation to their gender identities, with nonbinary individuals especially describing resistance to their affirmed gender, reflecting the profound societal ignorance and lack of visibility surrounding nonbinary identities (Goldberg & Kuvalanka, 2018). Experiencing these microaggressions (interpersonally mediated "othering" messages related to a person's perceived marginalized status) can have negative mental health consequences (Nadal et al., 2012). Rather than being misgendered, some participants, especially nonbinary participants, avoided discussing or revealing their gender identity, or presented in ways that would invite the least amount of questioning. Nonbinary Students of Color were especially likely to underscore fears of coming out to family, illustrating the complexity of lived experience, whereby diverse identities intersect to shape vulnerability and resilience (Balsam et al., 2011). This finding points to the utility of our mixed-methods design, wherein our qualitative data revealed how and in what ways misgendering took place, adding deeper dimensions to our quantitative findings regarding group differences.

Participants identified rejection and nonsupport—in general, from family and within the trans community—as salient distal stressors. These qualitative data add nuance to prior studies' findings that loss of family support is related to poorer psychological and physical health among sexual and gender minority youth (McConnell, Birkett, & Mustanski, 2015). Furthermore, these findings extend our understanding of family dynamics beyond trans youth and highlight the unique concerns of nonbinary young adults. For instance, our finding that nonbinary participants emphasized feelings of alienation in the larger trans community suggests that targeted exploration of the support needs of nonbinary trans people is necessary. Additionally, campus support groups primarily comprised of binary trans young adults may not be viewed by nonbinary young adults as a primary source of connection and community, given the lack of representation of nonbinary identities and experiences (Goldberg & Kuvalanka, 2018). Such support groups may also be avoided, if individuals are fearful of having their gender identity questioned. Given that

a sense of belonging to the trans community has been linked to mental health (Barr, Budge, & Adelson, 2016), it is important to understand the barriers that nonbinary trans young adults face in forming trans community connections.

Participants reported positive, affirming therapeutic experiences while also providing many examples of invalidating, incompetent care. Consistent with Mizock and Lundquist (2016) and Hunt (2014), we documented descriptions of gender inflation and avoidance on the part of therapists, as well as the persistence of a trans metanarrative whereby therapists seemed to assume a singular trans experience. Our study builds on prior work to reveal the implications of these restrictive assumptions for nonbinary students specifically: When providers presume a single "correct" trans history or identity (e.g., feeling "trapped" in the wrong body since childhood; feeling 100% the "other" gender), the experiences and identities of nonbinary individuals are negated (Meier & Labuski, 2013). Our quantitative analysis did not indicate that perceived trans-affirming treatment on the part of therapists varied by students' gender identity. Our qualitative findings, however, suggest that therapists' failure to recognize the range and sometimes changing nature of trans identities—and the preponderance of nonbinary identities specifically—as valid, contributes to feelings of alienation in a setting that is meant to offer support. Such practices likely reflect lack of training in trans issues, and possible gaps in therapeutic competence more generally, such as in conveying empathy, respect, and openness, which are foundational to building trust and facilitating positive therapeutic outcomes for trans people (Applegarth & Nuttall, 2016; Rachlin, 2002). Participants with positive counseling experiences pointed specifically to the importance of therapists being affirming of their gender identity (including its fluidity where appropriate) and being educated about trans identities and issues, which highlights the importance of therapist training regarding the spectrum and fluidity of gender identities (Austin & Goodman, 2018).

Although participants were asked to qualitatively describe their experiences with therapists and health providers across various settings, our quantitative analyses specifically focused on providers based in a university or college campus. Compared to binary students, nonbinary students reported more misgendering by therapists and health providers, and more negative experiences with health (but not counseling) services staff. Persons AFAB reported more misgendering in both settings than persons AMAB. Also, undergraduates reported more misgendering by therapists and health providers than graduate students. Although race was salient in the qualitative responses and intersected with participants' experiences in mental health care settings, Students of Color and White students did not differ in their experiences with campus providers. These findings must be interpreted in light of

our binary treatment of race (as White vs. of Color); thus, closer examination of the experiences of individuals with specific racial and/or ethnic identities is warranted.

Given that nonbinary participants reported more negative experiences than binary participants in campus health care settings, it is possible that many health providers—perhaps even more so than therapists—possess an idea of "trans" that does not allow for identities outside of the gender binary and may conceptualize gender transition in ways that conflate biomedical, personal, and social changes (Austin & Goodman, 2018). Grant et al. (2011) found that 78% of trans participants reported wanting to take hormones, but only 49% of them had pursued hormone therapy. Although there are many reasons for why trans people might not pursue hormone treatment if they want it, barriers to pursuing medical treatment may be especially prohibitive for nonbinary people, who may meet resistance when they fail to conform to the expected (and reductionistic) metanarrative of trans people (i.e., the notion that they want to fully transition from one gender to "the other," undergoing surgery and taking hormones). Some participants alluded to such challenges with health providers, noting that providers and insurance carriers often presume that any trans person who wants surgery also wants hormones and vice versa. It is essential that therapists are aware of these types of health care related challenges, as they have implications for trans clients' physical and mental health (Mizock & Lundquist, 2016) and may require therapists to advocate on behalf of their clients (Austin & Goodman, 2018).

In light of prior work indicating that trans women may experience greater discrimination than trans men (e.g., Bockting et al., 2013), we were somewhat surprised that AMAB individuals reported less misgendering than AFAB individuals in campus counseling and health settings—although AMAB individuals did not report more negative experiences in these settings than AFAB individuals. Notably, we examined misgendering rather than harassment, and these represent different constructs. Perhaps people AMAB have to do "less" (in terms of modifying their appearance, for example) to be recognized as not conforming to the gender binary, whereas when individuals AFAB present in "masculine" ways, this may be seen as well within the bounds of "female" gender role expectations. In turn, providers may be more cautious about (mis)gendering AMAB students than AFAB students. Future researchers can explore this possibility.

Our finding that graduate students reported less misgendering than undergraduates, even after accounting for their age and length of time identifying as their current gender, might reflect their status as professionals-in-training, whereby they are (a) more confident in advocating for themselves (e.g., asserting their name/pronouns), and/or (b) more likely to have their stated

names and pronouns respected, possibly because they are regarded as more mature and further along in their gender identity development. They also may be more able and likely to take advantage of LGBTQ-affirming treatment in the community.

Limitations

There are several noteworthy limitations of the study. First, we did not specify a time frame (e.g., past year) in inquiring about mental health diagnoses; thus, rates of diagnosed mental health disorders are not directly comparable to the work of Bianco et al. (2008) and other researchers that ask about past-year diagnoses. Also, although we believe that it is important to document reports of "undiagnosed" difficulties—because conversations about possible or likely diagnoses occur at rates greater than recorded diagnoses—we do not have details about the reasons for a lack of an official diagnosis (e.g., provider concern about diagnoses becoming part of the permanent health record). In addition, in students' descriptions of mental health care experiences, they did not always specify the location of care (on or off campus, or both); in turn, these data cannot be perfectly triangulated with, and compared to, our quantitative questions regarding on-campus counseling and health service settings. Also unknown is whether off-campus providers were less affirming than campus providers. Future work can compare trans students' encounters with, and reasons for seeking treatment from, on-campus and off-campus therapists, psychiatrists, and medical providers. Another limitation was our use of single-item measures to assess misgendering and the level of trans-affirming of care; analyses would be enhanced with the use of multi-item scales assessing different aspects of these constructs.

Our study focused on trans undergraduate and graduate students. Although we purposefully sought to examine this subpopulation of trans young adults, their experiences are likely different from those of trans young adults who are not attending an institution of higher education. Trans young adults who do not attend college may have different mental health care experiences and needs, including access to fewer mental health resources, which may actually prevent them from attending college. Second, most participants were AFAB. Thus, our qualitative findings may primarily reflect the experiences of those who have lived a majority of their lives with a female sex assignment. We also specifically recruited nonbinary young adults. Thus, young adults who identify as trans men, trans women, men, and women, may be underrepresented in our sample. Finally, some of our recruitment mechanisms (e.g., campus LGBTQ resource centers, trans-focused listservs) undoubtedly led to the recruitment of students who were connected to these specific types of

support. Trans students who were not engaged with such resources may be underrepresented.

Implications for Practice

Our findings hold many important implications for clinical practice. As our participants' narratives make clear, it is not fair for providers to expect trans clients to provide "Trans 101" training to them (Webb et al., 2017); rather, providers should educate themselves about trans individuals and experiences. We urge providers to seek information about nonbinary populations in the professional literature, personal accounts, and blogs, as this will help ease the burden on nonbinary clients, who face invisibility, invalidation, and significant pressure to educate others in their daily lives.

On a practical level, providers should recognize gender as a nonbinary and fluid construct, understand there is no one way to transition, and avoid making assumptions about gender based on appearance (Webb et al., 2017). Specifically, intake forms should ask for clients' affirmed names, gender, and pronouns, and providers should practice using "they" and/or "them" as a singular pronoun. Efforts to honor and respect clients' affirmed names, gender, and pronouns can build rapport (Gridley et al., 2016), as can using other trans-affirming language (Hendricks & Testa, 2012). It is also important that providers recognize the influence of prejudice on trans clients; indeed, both actual and anticipated discrimination pose a barrier to trans youth envisioning a positive future for themselves (Katz-Wise et al., 2017), which may have implications for therapeutic interventions.

Counseling psychologists have noted the importance of social justice work being front and center to the mission of the field (Vera & Speight, 2003). To promote social justice, we encourage therapists and health providers to understand the need to engage in advocacy for trans clients (American Psychological Association, 2015), which may involve efforts to transform the cultural context that surrounds trans people (Webb et al., 2017). For example, campus providers can urge administrators to put in place basic changes that will vastly improve the counseling and health care experiences of trans students, such as reviewing health insurance coverage, paperwork, and community resources, to facilitate more gender-affirming practices. Amidst the recognition that trans Students of Color are vulnerable to multiple forms of minority stress, campus providers should also be aware of the fact that existing campus resources (e.g., counseling centers) are often primarily White spaces, limiting their utility and meaning to trans Students of Color (Nicolazzo, 2016). In turn, providers should seek to transform these spaces to be more welcoming and inclusive of trans Students of Color.

Our findings call attention to the reality that trans people may have different experiences with regard to therapy versus health care, possibly finding it easier to identify an affirming therapist (Austin & Goodman, 2018). Trans students will benefit from (a) the presence of campus counselors who are cognizant of the barriers that students face in accessing trans-affirming medical care, and (b) greater coordination between therapeutic and medical services on campus. Indeed, trans students would benefit from an interdisciplinary team approach, such that therapists and health providers share information about clients (e.g., via a shared records system and case consultation; Davenport, 2017). Campus providers should also seek (a) refinement of all policies and documentation to be inclusive of trans students, and (b) continuing education opportunities to enhance provider competence in transgender care (Davenport, 2017; Ruben et al., 2017). An interdisciplinary team approach can more effectively meet the multilayered needs and concerns of trans students than a fragmented and siloed approach to treatment (Davenport, 2017).

Conclusion

The experiences of invalidation and invisibility that nonbinary trans people frequently face in society may be amplified or resisted in mental health and health care settings. Therapists and other providers have the capacity to reinforce and exacerbate the gender minority stress experienced by nonbinary people (e.g., by denying nonbinary identities or experiences)—or, alternatively, can provide a unique and powerful context to support resilience, growth, and empowerment. Amidst a sometimes frightening societal climate of rejection and hostility, as well as the threat of ongoing and escalating vulnerability to policy changes that harm trans people, trans young adults need supportive, committed, and competent providers more than ever.

Declaration of Conflicting Interests

Funding

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