

The Presenting Concerns of Transgender and Gender Nonconforming Clients at University Counseling Centers

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Abstract

There is a paucity of research on transgender and gender nonconforming (TGNC) students who present to university counseling centers (UCCs). Using national-level data from the Center for Collegiate Mental Health (2012 to 2015), the current findings indicate that TGNC students seeking services at UCCs are presenting with high acuity and more severe concerns than their cisgender peers. This severity is in nearly every clinical domain including suicidality, history of hospitalization, trauma history, mood disorders, and family distress. Comparing the transgender and gender nonconforming (GNC) collegiate clients, GNC clients have the highest levels of distress and clinical symptoms on nearly every indicator. Overall, these findings for both transgender and GNC clients provide important information for UCCs about treatment and outreach to these high-risk populations. Our findings also mirror the mental health disparities seen in noncollegiate community TGNC samples. We discuss treatment implications, limitations, and suggestions for future research.

Keywords

transgender college students, gender nonconforming college students, university counseling centers, TGNC mental health, collegiate mental health

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Significance of the Scholarship to the Public

Using national-level data, our research investigated the mental health needs of transgender and gender nonconforming (TGNC) collegiate clients who present to university counseling centers. This scholarship is significant because it shows more acute and severe concerns among TGNC collegiate clients as compared to their cisgender peers. Our data can help inform TGNC-affirming practice with this often marginalized population.

Counseling psychologists and other mental health professionals who work with clients at university and college counseling centers (UCCs) provide services to a wide range of student populations. There is a need for more research on transgender and gender nonconforming (TGNC) students who present to UCCs (Singh, Meng, & Hansen, 2013). As a result, less is known about the mental health needs of this often marginalized population despite the increasing visibility of TGNC students on college campuses.

Researchers' and clinicians' understanding of TGNC experiences, especially in collegiate settings, is still relatively new. Historically, much of what was assumed about transgender populations was based on research that aggregated samples of sexual minority (e.g., lesbian, gay, bisexual) individuals together with gender diverse individuals, often under the umbrella acronym of LGBT. However, given the salience and rigidity of gender expectations in everyday life, the psychosocial experiences of transgender individuals are different than their LGB peers (Erickson-Schroth, 2014). The needs of TGNC college students, particularly those who present to UCCs, are still an area in need of more attention. To address this gap, our descriptive analyses used national-level data to present an overview of the mental health needs and demographic information of transgender and gender nonconforming (GNC) student clients seeking services at UCCs nationwide.

Examining the experiences of TGNC collegiate clients is important because there is reason to believe this population may present to UCCs with higher levels of psychological distress and more acuity than their cisgender peers (Effrig, Bieschke, & Locke, 2011). Additionally, TGNC clients face significant challenges with minority stress, social and family support, and risk of victimization, which contributes to mental health disparities (Clements-Nolle, Marx, & Katz, 2006; Hendricks & Testa, 2012). Our study provides an opportunity for UCCs to have data-informed, targeted service delivery to this important population and to more fully understand the needs of TGNC clients.

TGNC Mental Health Needs

Although the mental health needs of collegiate TGNC clients are not well understood, community-level research provides evidence that as a whole, adult and adolescent TGNC individuals have many documented mental health disparities as compared to their cisgender peers (Carmel & Erickson-Schroth, 2016; Grant et al., 2011; Kenagy, 2005; Xavier, Honnold & Bradford, 2007). These disparities are likely attributable, in part, to the cumulative impact of minority stress (Hendricks & Testa, 2012; Meyer, 2003). For most psychological outcomes, the difficulties TGNC individuals experience are striking. For example, mood disorders are quite pervasive in the TGNC community, with some studies putting the lifetime prevalence rate of depression at 50–60% for TGNC individuals (Nuttbrock et al., 2010). Clements-Nolle, Marx, Guzman, and Katz (2001) found 62% of their participants of 515 transgender individuals were above the clinical cutoff on the Center for Epidemiologic Studies Depression Scale (Radloff, 1977). In the same sample, 22% had at least one prior mental health hospitalization (Clements-Nolle et al., 2001). Anxiety disorders are also quite common for TGNC individuals, with some research placing the lifetime prevalence rate as high as 68% (Millet, Longworth, & Arcelus, 2017). Further, studies have found high incidences of panic disorder and social phobia among TGNC samples (Carmel & Erickson-Schroth, 2016; Millet et al., 2017).

High rates of substance use disorders have also been found in transgender samples as well. Xavier, Bobbin, Singer, and Budd (2005) reported a substance abuse rate of 48% among transgender respondents in a community sample. Similarly, Clements-Nolle et al. (2001) reported a substance abuse treatment rate of 28% in their sample of transgender people ($N = 515$). However, Conron, Scott, Stowell, and Landers, (2012) did not find an elevated risk for binge drinking among the transgender respondents in their sample. These mixed findings warrant further examination of substance use within TGNC populations, especially among college student populations where substance abuse is at times socially condoned.

Perhaps the most pressing concern for TGNC clients is the disturbingly high suicide risk consistently found in TGNC samples. Some research has found upwards of 75% of transgender individuals have a history of serious suicidal ideation or attempts (Grant et al., 2011; Kenagy, 2005). In a sample of transgender youth ages 15 to 21 years, Grossman and D'Augelli (2007) found 45% had seriously thought of taking their lives and 26% had a history of life-threatening behaviors, often with multiple suicide attempts. In a study of 350 transgender adults in Virginia, Testa et al. (2012) found very high rates of past suicidal ideation, with 65.3% of transwomen and 83% of transmen in

their sample endorsing that they had thought of killing themselves. In the most recent National Transgender Discrimination Survey of transgender respondents ($N = 6,450$) conducted by the National Center for Transgender Equality, 41% of participants reported at least one suicide attempt in the past. Among those who had experienced family rejection, the rates were even higher at 51% (Grant et al., 2011).

Most of the prior research on TGNC mental health was conducted with nonrepresentative, community samples from a broad range of settings and locations. Very little research has specifically examined the prevalence of psychological concerns in TGNC collegiate samples. Perhaps the most relevant research comes from Effrig et al.'s (2011) work, they found both clinical and nonclinical samples of TGNC college students experienced psychological distress at much higher rates than cisgender men and women in their samples. One alarming finding from this research was that rates of self-injury and suicide attempts were not significantly different in the clinical and non-clinical samples, raising important questions about treatment utilization and campus outreach. However, very few other studies have investigated transgender college student mental health. This paucity of research is a critical gap in the literature given the known mental health disparities seen in community TGNC samples. The community findings, along with the work of Effrig et al. (2011) provide ample evidence to support the likelihood that TGNC clients presenting at UCCs may also have an increase in acuity and risk factors.

Previous research indicates TGNC populations are at increased risk for psychological distress and have more acute mental health needs than their cisgender counterparts. These disparities exist in adult and adolescent samples, as well as some limited college student TGNC samples. However, despite a growing body of research using non-collegiate TGNC samples, there is still an important need to understand the unique psychological concerns of TGNC college students who present to UCCs. As such, our research goals for this study were:

1. To present an overview of the demographic profile of TGNC students seeking services at UCCs in the United States.
2. To present an overview of the psychological profile and severity of mental health needs for TGNC students seeking services at UCCs in the United States as compared to their cisgender peers.

Method

Data and Measures

The data for this descriptive overview and analysis came from the Center for Collegiate Mental Health (CCMH) housed at Penn State University

(Castonguay, Locke, & Hayes, 2011; Locke, Bieschke, Castonguay & Hayes, 2012). CCMH is a nationwide clinical and research consortium of approximately 140 participating college and university counseling centers. Every year, each participating center contributes de-identified data on all clients seeking services. All schools that contribute de-identified data to CCMH received Institutional Review Board approval to conduct research involving human subjects. CCMH is the largest database of collegiate mental health in the United States (CCMH, 2017). The data used in our study was collected between the years 2012 and 2015, and includes aggregated data from 134 UCCs across the United States.

CCMH affiliated UCCs collect client information using the Standardized Data Set form (SDS) and the Counseling Center Assessment of Psychological Symptoms measure (CCAPS).

SDS. The complete SDS (CCMH, 2018) is a roughly 50-core item standardized set of demographic, cultural, and mental health history questions asked of all treatment-seeking students, typically during an initial appointment. All UCCs who participate in the CCMH consortium use the core items on the SDS, thus allowing for standardized, reliable data collection on collegiate mental health across many locations and types of universities (Locke et al., 2012).

Most of the demographic and clinical variables in our analyses come from the items on the SDS. Nine clinical indicators are included in the analyses. These items include a list of mental health history questions in response to the prompt, "Please indicate if you have had the following experiences," with items such as: made a suicide attempt, been hospitalized for mental health concerns, attended counseling for mental health concerns, and received treatment for alcohol or drug use. We included four demographic items in the analyses: age, race and/or ethnicity, academic status, and an item on the SDS which reads, "What is your gender identity?" and provides the prompts (a) *male*, (b) *female*, (c) *transgender*, and (d) *self-identify*. This gender identity item was used to identify the TGNC clients in the current sample. Inclusion of specific demographic and clinical variables into the analyses was based on two factors, their overall relevance to the research questions, and the amount of missing data for each item.

If clients endorsed the "self-identify" response, they were prompted to type-in an open-ended answer. These open-ended responses were coded for the current study to determine the overall nature of the self-described gender identity for these clients. The labels provided by the clients were coded into four categories: (a) GNC responses, (b) transgender, (c) other (including questioning or don't know), and (d) cisgender identification. The definitions of specific terminology provided in the American Psychological Association (2015) "Guidelines for Psychological Practice with Transgender

and Gender Nonconforming People” was used as a foundation for this coding procedure.

The coding indicated that 75% of the open-ended self-identify responses were in the (a) GNC category of this classification. Within the GNC responses, the most common label provided was *genderqueer* (51%). Another portion of the sample (23%) were in the (c) *other* category, by either leaving the open-ended response blank or indicating they were *questioning* or *don't know*. The remainder (2%) either wrote in transgender ($n = 45$) or indicated a cisgender category (*male* or *female*; $n = 6$). Those respondents who endorsed cisgender were moved from the GNC/self-identify group back into either the cisgender female or male categories, or the transgender group from the original options listed in the SDS.

Given that three quarters of the respondents explicitly self-identified a gender identity label that is neither transgender nor cisgender (male, female), but instead chose identifiers known to be under the GNC umbrella (American Psychological Association, 2015), the category of self-identify was operationalized as GNC for the current analyses. Based on the available data, it appears that a client who is GNC or otherwise gender-variant would potentially choose this category if transgender or cisgender is not a good fit with their gender experience.

Although noncisgender identity labels are not always mutually exclusive (e.g. transgender, genderqueer), there are notable differences between those who use the label of transgender and those who self-report GNC labels such as genderqueer, justifying a separate and unique classification. One main distinction is how GNC individuals interact with, and often reject, the traditional expectations of the gender binary system. For many in the GNC population, the experience of gender identity functions outside of the binary system (Singh & dickey, 2017). Instead, gender is a personalized expression incorporating gender-neutral components, and/or gender markers from both the masculine and feminine spectrum (Richards, Bouman, Seal, Barker, Nieder, & T'Sjoen, 2016). There can be fluidity in this expression of gender across the lifespan (Beemyn & Rankin, 2011).

For many, the lived experience of being GNC can be qualitatively different than transgender or cisgender individuals (American Psychological Association, 2015). For example, analyzing open-ended responses from the National Transgender Discrimination Survey, Harrison, Grant, and Herman (2012) found a wide range of responses that were not endorsed as transgender, and those in the self-identify category had significantly more experiences of victimization and violence as compared to their transgender-identified peers. Beemyn and Rankin (2011) demonstrated a similar distinction in their survey and interview data from a large, nationwide TGNC sample. In Beemyn and Rankin's (2011) research, participants who identified as GNC, including

genderqueer, consider themselves to be distinct from transgender individuals. These participants more frequently indicated feelings of isolation, lack of support, and marginalization as compared to the transgender respondents. This research, together with the open-ended self-identify data coded for the current study, meant that transgender respondents were operationalized as being a separate group from the self-identify clients, with the latter being conceptualized as GNC.

CCAPS. The CCAPS (Locke et al., 2011) is either a 34- or 62-item multi-dimensional symptom assessment instrument designed to be clinically useful for UCCs. The present study analyzed data from the 62-item version of CCAPS (CCAPS-62). Within the CCAPS-62 are eight subscales including: depression, generalized anxiety, social anxiety, academic distress, eating concerns, family distress, hostility, and substance use. The CCAPS-62 also incorporates a general distress index. Respondents are asked to rate themselves over the previous two weeks, with each item rated on a 5-point Likert-type scale ranging from 0 (*not at all like me*) to 4 (*extremely like me*). After reverse scoring several items, the subscale scores are calculated by summing item scores, such that higher scores indicate more distress. The CCAPS-62 takes between 7–10 min for a client to complete and is most often used as part of the intake or initial assessment at UCCs (Locke et al., 2011).

The CCAPS-62 has demonstrated strong psychometric properties. Locke et al. (2011) report good 2-week test–retest reliability, ranging from $r = .75$ to $.91$ across the subscales. Internal consistency also ranged from acceptable to very good, with a range from $\alpha = .78$ to $.91$ in large test samples. The eight subscales of the CCAPS-62 also showed evidence of convergent validity with other known measures of the constructs, with correlation coefficients ranging from $r = .56$ to $.81$. The CCAPS-62 also provides peer-based norms drawn from large samples ($N = 233,000$ in 2015), indicating clinical cut off points and high distress.

Analyses and Results

The data analyses we present are intended to provide a descriptive overview of TGNC collegiate client demographic information and clinical outcomes, using a large, nationally obtained sample.

Initial Data Preparation

CCMH collects data from a wide range of UCCs across the nation, and creating a consortium from such heterogeneous institutions creates a number of challenges (McAleavey, Lockard, Castonguay, Hayes, & Locke, 2015). As such,

the CCMH database has segments of missing data across variables. This missing data stems from clients declining to answer certain questions, as well as UCCs opting out of certain items, and other procedural issues. The variable-specific rate of missing data in the variables utilized in the current study range from 2% to 17%, with a rate of 20% missing data serving as a cutoff for inclusion in the analyses. Across all measures, listwise deletion would reduce the sample by 42%. To account for the missing data, we conducted a multivariate imputation using chained equations ($m = 10$; White, Royston, & Wood, 2011). Imputation is a preferred technique to listwise or pairwise deletion when the number of missing cases is substantial and when it is difficult to determine if systematic patterns exist within the missing data (Parent, 2013; White et al., 2011). For our data, it was likely systematic patterns existed in the missing data for two reasons. As noted previously, some UCCs opted-out of certain questions and this was especially true for private institutions where certain items could be perceived as controversial or going against the stated religious mission of the university. Asking students explicitly about their gender identity, and including transgender as an option, is one example of such an item. Also, data could be missing because a client declined to answer. Given the sensitive nature of many of the clinical items, a client's decision to skip a question was likely not random, but instead reflected clinically relevant information. These patterns in the missing data, combined with the volume of omitted data, made imputation a preferred approach as compared to listwise deletion (White et al., 2011). After the imputation analyses were complete, the final analytical sample size was $N = 236,601$.

Final Data Analytic Plan

Using the final analytical sample, the data analysis plan was two-fold. The first step was to generate descriptive analyses for the demographic information for all four gender identity categories in the sample. In this step, the tests were based on ordinary least squares regression models for the age outcome and multinomial regression models for the race and academic status outcomes, at the alpha level of .01. This allows for a presentation of the demographic profile of TGNC clients presenting to UCCs nationwide, as well as comparisons to their cisgender peers.

In the second step of data analysis, using the SDS and CCAPS-62 data, we examined multinomial logistic regression models or logistic regression models depending on the type of variables included. These analyses, evaluated at the alpha level of .01, provide an overview of the psychological profile and severity of mental health needs for transgender and GNC students seeking services at UCCs as compared to their cisgender peers. Given that cisgender

clients are socially viewed as representing the traditional college student, as well as representing the numerical majority, they were chosen as the reference group to compare TGNC clients against. As discussed next, demographically, the two groups (cisgender and TGNC) were similar, with gender experiences being the main difference between the two. This difference allowed for a clear path for comparison. Regression modeling was chosen for the ease of changing the reference categories as necessary when seeking to compare TGNC to cisgender women and cisgender men individually in the sample. Also, regression modeling is robust and can be conducted on uneven groups, such as those present in our dataset (Slinker & Glantz, 1988).

Client Demographic Information

The first research goal of the present study was to present a demographic profile of TGNC clients presenting to UCCs nationwide. Table 1 displays the demographic information for the four gender identity groups in the data (cis-female, cis-male, transgender, and GNC/self-identify). In most categories, transgender and GNC clients are demographically similar to the cisgender (female and male) collegiate clients. The main differences are in the race and ethnicity breakdowns across the groups. Comparisons were generated using either ordinary least squares regression models or multinomial regression models, depending on the type of variables included.

Transgender client demographic information. Among the total sample, the percentage of UCC clients who identified as transgender equates to approximately 662 respondents. The average age for the transgender clients in the sample was just over 22 years. This average is nearly identical to the other groups in the sample. Regarding race and ethnicity, almost two-thirds of transgender clients self-identified as White, which is significantly higher than the cisgender female and GNC clients. However, they were less likely to endorse the racial category of Asian/Asian-American. Compared to cisgender female clients, transgender clients were less likely to endorse African-American/Black, but when compared to cisgender male clients, there was no statistical difference. For statistical simplicity due to relatively low numbers, the racial categories of American Indian, Alaskan Native, Native Hawaiian, Pacific Islander, multi-racial, and self-identify are collapsed into one category labeled as *Other* in Table 1. Transgender clients were significantly more likely to endorse a race and/or ethnicity within this combined category as compared to cisgender female and cisgender male clients. This finding indicates transgender clients more often possess certain multiple oppressed identities including race and/or ethnicity. Regarding academic status, the most prominent finding

Table 1. Demographic Information for Total CCMH Sample

Demographic variables	Cis-female [99% CI]	Cis-male [99% CI]	Transgender [99% CI]	GNC (self-identify) [99% CI]
Approximate <i>n</i>	147,639	79,374	662	1,301
Estimated proportion of imputed sample size	62.4% [62.1, 62.7]	36.7% [36.4, 37.0]	0.28% [0.24, 0.30]	0.55% [0.51, 0.59]
Race and/or Ethnicity				
White	68.2% ^b [67.8, 68.5]	71.3% ^a [70.9, 71.7]	73.7% ^a [68.8, 78.4]	68.5% [65.0, 72.0]
African American/Black	10.3% ^b [10.2, 10.5]	7.7% ^a [7.4, 7.9]	6.4% ^a [3.8, 9.0]	3.4% ^{ab} [2.0, 4.8]
Hispanic/Latino/a	8.0% ^b [7.8, 8.2]	7.1% ^a [6.8, 7.3]	5.6% [3.1, 8.1]	5.6% ^a [3.8, 7.3]
Asian/Asian American	6.5% ^b [6.4, 6.7]	6.9% ^a [6.7, 7.2]	3.0% ^{ab} [1.2, 5.1]	3.9% ^{ab} [2.3, 5.6]
Other	6.7% [6.5, 6.9]	6.8% [6.5, 7.0]	11.1% ^{ab} [7.6, 14.4]	18.4% ^{ab} [15.5, 21.3]
Mean Age	22.16 ^b [22.13, 22.19]	22.57 ^a [22.53, 22.61]	22.57 [22.05, 23.09]	22.20 [21.89, 22.54]
Academic Status				
First-year	21.8% ^b [21.5, 22.1]	20.9% ^a [20.5, 21.3]	27.6% ^{ab} [22.4, 32.0]	21.8% [18.6, 24.7]
Sophomore	20.2% ^b [19.9, 20.5]	19.7% ^a [19.3, 20.1]	15.8% ^a [11.8, 19.7]	20.2% [17.2, 23.5]
Junior	21.6% ^b [21.3, 21.8]	22.4% ^a [22.0, 22.8]	22.8% [18.6, 27.2]	20.5% [17.7, 23.5]
Senior	20.1% ^b [19.8, 20.4]	21.1% ^a [20.8, 21.5]	19.0% [15.3, 23.6]	19.6% [16.4, 22.3]
Graduate student	14.5% ^b [14.2, 14.7]	13.6% ^a [13.3, 13.9]	11.6% [8.3, 14.9]	14.3% [11.9, 17.2]
Other	1.6% ^b [1.5, 1.7]	2.0% ^a [1.8, 2.1]	2.9% [1.1, 4.6]	3.2% ^a [1.9, 4.5]

Note. *N* = 236,601 (missing data imputed using multivariate chained equations; *m* = 10). CCMH = Center for Collegiate Mental Health; GNC = gender nonconforming.

^aSignificantly different from female at $p < .01$ (tests based on ordinary least squares regression models for age outcome, multinomial regression models for race and academic status outcomes). ^bSignificantly different from male at $p < .01$ (tests based on ordinary least squares regression models for age outcome, multinomial regression models for race and academic status outcomes).

is that transgender students seek services at UCCs in their first year of school more often than other groups. This percentage is significantly different and higher than first-year cisgender women and cisgender male students.

GNC (self-identify) clients demographic information. As shown in Table 1, less than 1% of the sample identified as “self-identify,” which is operationalized

as GNC. The percentage of GNC clients equates to approximately 1,301 respondents. The average age for the GNC clients in the sample was slightly over 22 years. This average age is nearly identical to the other groups in the sample. For race and ethnicity, the percentage of GNC clients who identified as White was statistically no different than cisgender female and cisgender male clients who identified as White. However, GNC clients were less likely to endorse the racial categories of African-American/Black or Asian/Asian-American as compared to cisgender female and male clients. GNC clients were significantly more likely to endorse a race and/or ethnicity within the combined race and/or ethnicity category as compare to cisgender female and male clients and transgender clients. In regard to academic status, the most prominent finding was the similar percentages across the first four years of when a GNC client seeks services. Although GNC clients are less likely to be seen during their first year as compared to transgender clients, GNC clients tend to seek services throughout their matriculation.

SDS Clinical Items

The second research goal of our study was to present an overview of the psychological profile and severity of mental health needs for TGNC students seeking services at UCCs as compared to their cisgender peers. In most categories, TGNC clients are presenting to UCCs with more acuity and higher levels of distress as compared to the cisgender collegiate clients, especially concerning suicidality (see Table 2). Comparisons between groups were computed using multinomial logistic regression models or logistic regression models depending on the type of variables included.

Transgender clients. The descriptive data in Table 2 provides an overview of frequency data and indicate significant differences across groups. It is noteworthy that across the nine SDS clinical outcome items analyzed, transgender clients have a higher frequency of mental health concerns as compared to their cisgender peers in every category. In some cases, the frequency of transgender client endorsement of an item is two or three times as high as their cisgender counterparts. For example, nearly two-thirds of transgender clients indicated they had considered suicide in the past, as compared to one-third of cisgender women clients and over a quarter of cisgender male clients. The rate of prior suicide attempts among transgender clients was exceptionally high and more than double that of their cisgender peers.

Also shown in Table 2, transgender collegiate clients also endorsed higher rates of traumatic events and experiencing abuse, as compared to both categories of cisgender clients in the sample. Compared to cisgender men, transgender clients

Table 2. Comparisons on SDS Clinical Indicators Across CCMH Data Groups

SDS variables	Cis-female [99% CI]	Cis-male [99% CI]	Transgender [99% CI]	GNC (self-identify) [99% CI]
Counseling Experience				
Never	53.0% ^b [52.7, 53.2]	59.8% ^a [59.4, 60.1]	30.8% ^{ab} [27.2, 34.4]	30.8% ^{ab} [28.0, 33.5]
Prior to college	21.1% ^b [20.9, 21.3]	17.6% ^a [17.3, 17.9]	26.5% ^{ab} [23.0, 30.1]	27.9% ^{ab} [25.2, 30.7]
After starting	13.7% [13.5, 13.9]	13.3% [13.0, 13.5]	15.9% [12.9, 19.0]	16.9% ^{ab} [14.8, 19.1]
Both	12.1% ^b [11.9, 12.2]	9.1% ^a [8.9, 9.3]	26.5% ^{ab} [22.8, 30.2]	24.2% ^{ab} [21.7, 26.6]
Medication Experience				
Never	68.4% ^b [68.0, 68.7]	70.9% ^a [70.5, 71.3]	53.4% ^{ab} [48.5, 59.0]	52.3% ^{ab} [48.2, 56.3]
Prior to college	8.9% [8.7, 9.1]	8.8% [8.5, 9.1]	12.2% [8.7, 15.7]	14.0% ^{ab} [11.3, 16.7]
After starting	11.6% ^b [11.4, 11.8]	11.0% ^a [10.7, 11.3]	10.9% [7.3, 14.4]	14.8% ^{ab} [12.0, 17.6]
Both	10.9% ^b [10.7, 11.2]	9.1% ^a [8.8, 9.3]	23.3% ^{ab} [18.5, 27.6]	18.8% ^{ab} [15.7, 21.8]
Substance abuse treatment	2.7% ^b [2.6, 2.8]	6.4% ^a [6.2, 6.6]	4.7% ^a [2.5, 7.0]	4.1% ^{ab} [2.6, 5.6]
Prior hospitalization	9.6% ^b [9.4, 9.8]	10.0% ^a [9.8, 10.3]	17.6% ^{ab} [13.2, 21.9]	18.3% ^{ab} [15.2, 21.3]
Considered suicide previously	31.0% ^b [30.7, 31.3]	28.5% ^a [28.1, 28.9]	62.6% ^{ab} [57.5, 67.6]	65.5% ^{ab} [61.7, 69.1]
Attempted suicide previously	9.5% ^b [9.3, 9.7]	7.1% ^a [6.8, 7.3]	26.5% ^{ab} [21.9, 31.0]	24.3% ^{ab} [21.1, 27.6]
Experienced abuse previously	37.3% ^b [36.9, 37.6]	24.0% ^a [23.6, 24.4]	54.0% ^{ab} [48.6, 59.3]	62.9% ^{ab} [59.3, 66.5]
Experiences of unwanted sex	25.8% ^b [25.4, 26.1]	6.3% ^a [6.1, 6.5]	26.9% ^b [22.2, 31.5]	41.0% ^{ab} [37.2, 44.7]
Prior trauma	40.4% ^b [40.1, 40.8]	32.0% ^a [31.6, 32.5]	45.5% ^b [40.3, 50.7]	54.0% ^{ab} [50.3, 57.7]

Note. $N = 236,601$ (missing data imputed using multivariate chained equations; $m = 10$). SDS = standardized data set; CCMH = Center for Collegiate Mental Health; GNC = gender nonconforming.

^aSignificantly different from female at $p < .01$ (tests based on multinomial logistic regression models for counseling and medication outcomes, logistic regression models for remaining outcomes). ^bSignificantly different from male at $p < .01$ (tests based on multinomial logistic regression models for counseling and medication outcomes, logistic regression models for remaining outcomes).

report having unwanted sexual experiences at a statistically higher rate, which is comparable to the cisgender women in the sample. Additionally, compared to cisgender clients, the transgender clients have higher rates of past counseling experiences, both prior to and after starting college. The transgender clients also have significantly more history of taking psychiatric medication, with nearly a quarter of them indicating having taken medication both prior to and after starting college. Further, transgender clients have significantly more history of psychiatric hospitalization as compared to cisgender women and men clients. This data points to a consistent trend that transgender collegiate clients are presenting to UCCs with more mental health needs and higher risk for suicidality than their cisgender peers.

GNC (self-identify) clients. The GNC clients are very similar to transgender clients in most categories (see Table 2). Like transgender clients, across the nine SDS clinical outcome items analyzed, GNC clients have a higher frequency of mental health concerns as compared to their cisgender peers in every category. Identical to the transgender clients, in some cases the rate of GNC client endorsement of an item is two or three times as high as the cisgender clients. For example, nearly two-thirds of GNC clients indicated they had considered suicide in the past, as compared to approximately one-third for cisgender women clients and over a quarter for cisgender male clients. The rate of prior suicide attempts among GNC clients was more than double that of cisgender women and male clients.

The rates of victimization among GNC clients were significantly higher than cisgender clients and higher than the transgender clients in the sample. GNC collegiate clients endorse very high rates of traumatic events, experiencing abuse, and having unwanted sexual experiences (Table 2).

Like the transgender clients, compared to cisgender clients, the GNC clients have higher rates of past counseling experiences, both prior to and after starting college. The GNC clients also have significantly more history of taking psychiatric medication, with nearly one out of five indicating having taken medication both prior to and after starting college. Additionally, GNC clients have significantly more history of psychiatric hospitalization as compared to cisgender women and cisgender male clients. This data points to a clear trend that, like transgender collegiate clients, GNC clients in the sample are presenting to UCCs with increased mental health needs and higher risk for suicidality than their cisgender peers.

CCAPS-62 Clinical Information

Transgender clients. The descriptive data in Table 3 provides an overview of frequency data and indicates significant differences across groups in the

Table 3. Comparisons of Means on CCAPS-62 Scales Across CCMH Data Groups

CCAPS subscales	No. of items	Cis-female [99% CI]	Cis-male [99% CI]	Transgender [99% CI]	GNC (self-identify) [99% CI]
Academic distress	5	1.85 ^b [1.84, 1.86]	1.89 ^a [1.88, 1.90]	1.80 [1.68, 1.91]	2.03 ^{ab} [1.95, 2.10]
Family distress	6	1.37 ^b [1.36, 1.38]	1.18 ^a [1.17, 1.19]	1.83 ^{ab} [1.74, 1.93]	1.90 ^{ab} [1.82, 1.98]
Generalized anxiety	9	1.82 ^b [1.81, 1.82]	1.49 ^a [1.48, 1.50]	1.89 ^b [1.77, 1.99]	2.13 ^{ab} [2.05, 2.19]
Social anxiety	7	1.93 ^b [1.93, 1.94]	1.81 ^a [1.80, 1.82]	2.35 ^{ab} [2.23, 2.47]	2.36 ^{ab} [2.28, 2.43]
Hostility	7	1.02 ^b [1.02, 1.03]	1.04 ^a [1.03, 1.05]	1.17 ^{ab} [1.05, 1.27]	1.28 ^{ab} [1.21, 1.35]
Substance use	6	.67 ^b [.66, .67]	.86 ^a [.85, .86]	.58 ^b [.46, .70]	.64 ^b [.57, .71]
Eating concerns	9	1.15 ^b [1.14, 1.15]	.75 ^a [.75, .76]	1.07 ^b [.99, 1.14]	1.12 ^b [1.06, 1.18]
Depression	13	1.72 ^b [1.71, 1.72]	1.56 ^a [1.55, 1.57]	1.83 ^b [1.71, 1.95]	2.07 ^{ab} [2.00, 2.13]
Distress index	Total	1.75 ^b [1.75, 1.76]	1.63 ^a [1.62, 1.64]	1.90 ^{ab} [1.79, 2.00]	2.12 ^{ab} [2.06, 2.18]

Note. $N = 236,601$ (missing data imputed using multivariate chained equations; $m = 10$).

CCAPS-62 = The Counseling Center Assessment of Psychological Symptoms-62 item;

CCMH = Center for Collegiate Mental Health; GNC = gender nonconforming.

^aSignificantly different from female at $p < .01$ (tests based on ordinary least squares regression models). ^bSignificantly different from male at $p < .01$ (tests based on ordinary least squares regression models).

CCAPS-62 scores of the collegiate clients in the sample. Similar to the SDS items, many of the CCAPS-62 items also show a pattern of distress for transgender clients. Among the eight CCAPS-62 clinical subscales, the response scores of transgender clients were significantly higher in four categories as compared to cisgender clients (both male and female separately). These categories include family distress, social anxiety, hostility, and depression. The response scores of transgender clients were also higher on the overall distress index as compared to the cisgender clients. Transgender clients were also significantly higher than cisgender men on eating concerns but were lower in this domain than the cisgender women clients. Transgender clients scored similar to cisgender women on generalized anxiety, but significantly higher than cisgender men. Transgender clients did not significantly differ from cisgender clients on the subscale of academic distress and were significantly

lower than cisgender men on the subscale of substance use. These findings are further evidence of an overall trend toward transgender collegiate clients presenting to UCCs with high distress and a broad range of symptoms. However, there are areas, such as academic distress and substance use concerns, where transgender clients are functioning similarly or better than their cisgender peers as well.

GNC (*self-identify*) clients. GNC clients show similar patterns of distress to the transgender clients in CCAPS-62 scores when compared to cisgender clients (see Table 3). Similar to the SDS items, many of the CCAPS-62 items also show a pattern of distress for GNC clients. Compared to cisgender clients, among the eight CCAPS-62 clinical subscales, GNC client scores were significantly higher in six categories. These categories include academic distress, family distress, generalized anxiety, social anxiety, hostility, and depression. GNC clients also scored higher on the overall distress index as compared to the cisgender clients. GNC clients also scored significantly higher than cisgender men on eating concerns but were not significantly different in this domain to cisgender women clients. GNC clients scored significantly lower in the subscale of substance use as compared to cisgender men.

The data trends of GNC client's CCAPS-62 scores show more clinical symptomology when compared to transgender collegiate client's data. For example, as compared to transgender clients, GNC clients scored significantly higher on academic distress, hostility, substance use, depression, generalized anxiety, and the overall distress index. In other words, among the four groups (cisgender female, cisgender male, transgender, and GNC) whose CCAPS-62 data was compared, GNC clients appear to experience the most mental health distress. Similar to the findings on transgender clients, this information is further evidence of an overall trend toward GNC collegiate clients presenting to UCCs with high distress and wide-ranging symptoms. It also points to the possibility that the GNC experience of minority stress, family distress, and other daily life stressors is particularly difficult.

Discussion

Our findings indicate that TGNC students seeking services at UCCs were presenting with high acuity and more severe concerns than their cisgender peers. This disparity is in nearly every clinical domain including suicidality, history of hospitalization, trauma history, mood disorders, and family distress. These findings are striking and provide important information for UCCs for treatment and outreach to this high-risk population. They also correspond to the mental health disparities seen in noncollegiate community TGNC samples.

Although many clinical outcomes included in the analyses indicate more severity for TGNC students, the high suicidality is particularly concerning. Nearly two-thirds of all TGNC clients presenting to UCC's have considered suicide, and around 25% have previously attempted suicide. This rate of prior suicide attempts is nearly three times as high as their cisgender counterparts indicating that TGNC collegiate clients are at high risk for suicidality and should be assessed and treated accordingly. Although suicidal intention and behavior are multifaceted, this data also highlights that TGNC clients are likely facing differential, often extreme life stressors that are severe enough to contribute to very high rates of suicidality. The constellation of minority stress, noninclusive campuses, widespread transphobia, and lack of family support all likely play a role in the suicidality seen in the current findings. Unfortunately, this high suicidality in collegiate TGNC clients is similar to rates seen in noncollegiate TGNC samples as well (Grant et al., 2011; Grossman & D'Augelli, 2007). Although college campuses are viewed as safer, more accepting environments as compared to the broader community, this data indicates TGNC collegiate clients are still considering ending their lives at strikingly high rates.

The current data also highlights the severity of mental health concerns TGNC clients are experiencing. They are significantly more likely to have received counseling and taken medication prior to, and after, starting college and have much higher rates of prior hospitalization as compared to cisgender clients. Looking at the CCAPS-62 data, TGNC clients are also significantly more likely to have depression, social anxiety, and overall distress as compared to their cisgender peers. These elevated mental health markers couple with significantly higher family distress and more experiences of traumatic events, including unwanted sexual experiences. The level of psychological distress in this collegiate sample is similar to the intensity of mental health distress measured in community TGNC samples, where lifetime prevalence estimates are as high as 60% for mood disorders. This high acuity warrants specialized attention from UCC providers, especially given the high risk for suicidality.

Notably, one area where there were no significant differences between the sample groups was in substance use concerns. This finding differs from community samples where substance use disorders are found to be higher in TGNC populations than the other groups (Xavier et al., 2005), although not exclusively (Conron et al., 2012). More research is needed to understand TGNC collegiate use and abuse of substances and why the findings in these data differ from community samples. Given the severity of concerns seen in nearly every other domain, it was unexpected that TGNC collegiate clients are not also experiencing high levels of substance use concerns. Despite these

findings, thorough assessment of substance use disorders is prudent in a UCC setting, especially given the availability of drugs and alcohol on college campuses and the other risk factors seen in TGNC clients.

Differences in Transgender and GNC clients

The differences between transgender and GNC clients in the current sample are also noteworthy. Transgender and other gender diverse identities are often collapsed and conceptualized as one group. However, in recent years, there is a growing understanding that in many cases those who identify as transgender may have qualitatively different experiences of gender identity, and the social world, as compared to those who identify as GNC (i.e., gender-neutral, genderqueer, gender fluid, etc.). Although more research is needed to parse out such differences, the current analyses indicated that in many domains, GNC collegiate clients are reporting higher levels of symptomatology as compared to cisgender and transgender clients. For example, transgender and GNC clients differ in several important areas such as trauma history, history of unwanted sexual experiences, experiences of abuse, depression, and overall distress, with GNC clients endorsing these problems most frequently. The GNC clients also have the highest scores on the CCAPS-62 measures across all domains, both compared to cisgender clients, as well as transgender clients. Although the descriptive data in the current analyses limit extended interpretation, these findings do point to the possibility that the lived experience of being a GNC college student is especially difficult. This theory is supported by past research that indicates social backlash is frequent and harsh when one violates expected gender roles within the binary gender system (Nuttbrock et al., 2010; Toomey, Card, & Casper, 2014). Future research should continue to explore the differences between transgender and GNC collegiate clients, especially in their experiences of minority stress in the social environment.

Limitations

Although the descriptive analyses we present provide important information on TGNC collegiate clients, there are several limitations to consider. First, these analyses are descriptive and informational based on self-report data collected across numerous heterogeneous clinical settings. Although the sample is large and obtained nationally, it was not gathered using representative sampling procedures. Additionally, although imputation techniques are commonly used to handle missing data (White et al., 2011), the ideal circumstance would be a complete dataset at the outset.

Second, the data collected for the current analyses represent TGNC students who are seeking psychological services, and therefore should be considered a clinical sample. Caution should be used in generalizing the findings to nonclinical TGNC student populations, who may have better overall health and wellbeing than those students seeking services. More research is warranted to understand the health and emotional needs of both clinical and nonclinical TGNC college students (Effrig et al., 2011).

Finally, the conceptualization of the self-identify category under gender identity as GNC is a limitation as well. It is acknowledged that some participants who endorsed this category may have done so for several reasons that may or may not indicate they are GNC. However, given the available data in the open-ended responses, the majority of participants endorse this category because the other three options are not representative of their gender identity, presumably placing them in the category of GNC, such as the most common response of genderqueer. The severity of clinical distress seen in the self-identify category further supports this assumption, as this group is most similar to the transgender respondents on acuity of needs. The addition of a specific option of GNC could be an important addition to future research using CCMH data.

Implications for Practice, Advocacy, Education/Training, and Research

UCCs are often at the forefront of innovative approaches to practice, advocacy and training in counseling psychology, especially in their commitments to serving marginalized populations such as TGNC clients. The findings from the current study can inform this forward-thinking momentum toward expansive, inclusive, and TGNC affirmative care.

Practice considerations. In the realm of practice, Singh and dickey (2017) define TGNC affirmative care as,

counseling that is culturally relevant and responsive to TGNC clients and their multiple social identities, addresses the influence of social inequities on the lives of TGNC clients, enhances TGNC client resilience and coping, advocates to reduce systemic barriers to TGNC mental and physical health, and leverages TGNC client strengths. (p. 4)

Given that TGNC clients are presenting to UCCs with many needs, it is important for centers to provide TGNC affirmative care.

To that end, it is imperative for UCC providers to implement assessment, intake screening, and treatment plans that account for the high-level needs of

this client population and include TGNC-affirmative integrative care (Coleman et al., 2012). There are steps UCCs can take to maximize multicultural competence with the TGNC students they serve. A first step is having providers on staff who are trained and competent in working with TGNC clients (Dickey, Singh, Chang, & Rehrig, 2017). Part of these necessary competencies includes understanding the complexity of gender transition where appropriate, understanding the nuances of the gender diverse experience, conflicted family relationships, the importance of peer relationships, and navigating transphobia in the larger community (Lev, 2004). Additionally, it is important to set up a center-wide culture that is TGNC affirmative such as gender-neutral bathrooms, appropriate pronoun use, well trained front desk staff, and TGNC inclusive paperwork (Donatone & Rachlin, 2013).

The second step is conducting thorough screening for suicidal ideation in TGNC clients (Maguen & Shipherd, 2010). Although suicidal ideation may not always be present, the current findings suggest the majority of TGNC clients have a history of suicidality and clinical acumen may be required to comprehensively assess for such concern. Relatedly, the treatment plan, intake screening, and assessment should carefully attend to depression, anxiety, and other mood disorders (Perez-Brumer, Hatzzenbuehler, Oldenburg, & Bockting, 2015). Given the high incidence of trauma in TGNC clients, treatment plans should also include trauma-informed therapy and intervention when warranted. This approach is especially relevant for GNC clients who are presenting to UCCs with very high rates of prior victimization. UCCs should also carefully consider their referral network when the need arises to refer a TGNC client out of a center. Many community-based services are not adequately equipped to be culturally competent with a TGNC client, which can cause further problems for short and long-term treatment (Safer et al., 2016; Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012). Although in times of crisis such as a hospitalization, UCC staff may not have a choice as to where more acute care is obtained, they can at least prepare the TGNC client on what to expect and provide validation about their needs. UCC staff may need to advocate for TGNC in these circumstances.

Advocacy. In the realm of campus advocacy, UCCs are uniquely positioned to provide specialized outreach programming and promote campus collaboration, with the goals of reaching more TGNC students and providing a comprehensive campus approach to TGNC wellness (Rankin, 2003). Prior research (Beemyn, 2005; Garvey & Rankin, 2015; McKinney, 2005; Pryor, 2015) and the results from the current study support a need for outreach and advocacy. Advocacy collaborations could include outreach with campus LGBTQ+ centers, other student affairs departments, working with residential life, and perhaps spiritual

leaders on campus. Although many UCCs are striving for TGNC inclusive environments within their centers, many are situated in a broader institutional context that is slower to act on these concerns (Beemyn, 2005; Beemyn, Curtis, Davis, & Tubbs, 2005; Seelman, 2016). Some prior research provides evidence that TGNC students are more engaged and have better educational outcomes when at a college or university that is more TGNC inclusive (Dugan, Kusel, & Simounet, 2012; Garvey & Rankin, 2015; Seelman, 2016). Given that TGNC clients are presenting to UCCs with a multitude of high-level needs, this type of advocacy outreach could potentially reach TGNC clients earlier as well as promote a more inclusive campus environment (Beemyn, 2003).

Training and education. Singh and dickey (2017) found less than 30% of practicing psychologists report familiarity with TGNC client considerations, yet the current data clearly indicates TGNC collegiate clients have high acuity in their mental health needs. There is a critical need to improve training of future psychologists on how to conduct a TGNC affirmative practice (Singh & dickey, 2016). Since UCCs often serve as training programs at the practicum, predoctoral internship, and postdoctoral levels for future counseling psychologists, improvements in training toward TGNC affirmative practice must continue to be of importance given the acute severity seen in the current sample of TGNC collegiate clients. Such training should include information on how to integrate the minority stress model, trauma-informed approaches, strengths-based applications, and multicultural and social justice advocacy work for best practice with TGNC clients (Singh & dickey, 2017).

Additionally, training must also include building clinical skills to avoid some common pitfalls in work with TGNC clients. For example, Mizock and Lundquist (2016) identified how psychotherapists often make errors in over-emphasizing, underemphasizing, or stigmatizing TGNC identities in psychotherapy sessions. The goal in UCC training programs should be to model and provide education on TGNC affirmative counseling and practice to meet the needs of this marginalized population.

Research. Regarding research and scholarship, the present study adds to the extant literature in several important ways. Tebbe, Moradi, and Budge (2016) describe how there is still a need for focused attention on TGNC people and their needs, especially among certain segments of this population, despite some growth in the area of gender minority scholarship. To that end, there has been very little research explicitly looking at TGNC college students and their mental health. Although similar mental health disparities exist in broad, community samples, it is noteworthy that even on college campuses, where there is a perception that TGNC might be more sheltered from adverse experiences,

they are still presenting with high need for treatment. Given the unique institutional and cultural contexts for UCCs serving collegiate clients, the current findings are a significant contribution. Second, the current TGNC collegiate sample size is relatively large, given the statistical frequency of TGNC individuals in the general population. Although the sample should be considered a convenience sample, it is relatively representative as compared to smaller, one-site samples often used in TGNC research (Moradi et al., 2016). Third, this research provides important information to UCCs who are striving to provide appropriate care to their TGNC collegiate clients, by identifying specific areas of need and comparing transgender and GNC clients on mental health outcomes. Perhaps the current study can serve as a starting point for continued scholarly work in understanding and improving the lives of TGNC individuals, especially among collegiate clients.

In conclusion, the present study extends the scholarship on the needs of TGNC collegiate clients. TGNC clients' mental health needs are likely best addressed in TGNC affirmative care that integrates practice considerations, advocacy, training, and research for UCCs and beyond.

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References

- American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, 70, 832–864. doi:10.1037/a0039906
- Beemyn, B. G. (2003). Serving the needs of transgender college students. *Journal of Gay & Lesbian Issues in Education*, 1, 33–50. doi:10.1300/J367v01n01_03
- Beemyn, B. G. (2005). Making campuses more inclusive of transgender students. *Journal of Gay & Lesbian Issues In Education*, 3, 77–87. doi:10.1300/J367v03n01_08
- Beemyn, B., Curtis, B., Davis, M., & Tubbs, N. J. (2005). Transgender issues on college campuses. In R. Sanlo (Ed.), *Gender identity and sexual orientation: Research, policy, and personal* (New Directions for Student Services, No. 111, pp. 49–60). San Francisco, CA: Jossey-Bass.

- Beemyn, G., & Rankin, S. (2011). *The lives of transgender people*. New York, NY: Columbia University Press.
- Carmel, T. C., & Erickson-Schroth, L. (2016). Mental health and the transgender population. *Psychiatric Annals*, 46, 346–349. doi:10.3928/00485713-20160419-02
- Castonguay, L. G., Locke, B. D., & Hayes, J. A. (2011). The Center for Collegiate Mental Health: An example of a practice-research network in university counseling centers. *Journal of College Student Psychotherapy*, 25, 105–119.
- Center for Collegiate Mental Health. (2017). *CCMH 2017 annual report*. Retrieved from https://ccmh.psu.edu/files/2018/02/2017_CCMH_Report-1r4m88x.pdf
- Center for Collegiate Mental Health. (2018). *CCMH Standardized Data Set*. Retrieved from https://ccmh.psu.edu/files/2018/02/2017_CCMH_Report-1r4m88x.pdf
- Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health*, 91, 915–921. doi:10.2105/ajph.91.6.915
- Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality*, 51, 53–69. doi:10.1300/J082v51n03_04
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Monstrey, S. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, 13, 165–232. doi:10.1080/15532739.2011.700873
- Conron, K. J., Scott, G., Stowell, G. S., & Landers, S. J. (2012). Transgender health in Massachusetts: Results from a household probability sample of adults. *American Journal of Public Health*, 102, 118–122. doi:10.2105/AJPH.2011.300315
- dickey, I. M., Singh, A., Chang, S. C., & Rehrig, M. (2017). Advocacy and social justice: The next generation of counseling and psychological practice with transgender and gender nonconforming clients. In A. Singh, & I. dickey (Eds.), *Affirmative counseling and psychological practice with transgender and gender nonconforming clients*. Washington, DC: American Psychological Association.
- Donatone, B., & Rachlin, K. (2013). An intake template for transgender, transsexual, genderqueer, gender nonconforming, and gender variant college students seeking mental health services. *Journal of College Student Psychotherapy*, 27, 200–211. doi:10.1080/87568225.2013.798221
- Dugan, J. P., Kusel, M. L., & Simounet, D. M. (2012). Transgender college students: An exploratory study of perceptions, engagement, and educational outcomes. *Journal of College Student Development*, 53, 719–736. doi:10.1353/csd.2012.0067
- Effrig, J. C., Bieschke, K. J., & Locke, B. D. (2011). Examining victimization and psychological distress in transgender college students. *Journal of College Counseling*, 14, 143–157. doi:10.1002/j.2161-1882.2011.tb00269.x
- Erickson-Schroth, L. (2014). *Trans bodies, trans selves: A resource for the transgender community*. Oxford University Press.
- Garvey, J. C., & Rankin, S. R. (2015). The influence of campus experiences on the level of outness among trans-spectrum and queer-spectrum students. *Journal of Homosexuality*, 62, 374–393. doi:10.1080/00918369.2014.977113

- Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality.
- Grossman, A. H., & D'augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior*, 37, 527–537. doi:10.1521/suli.2007.37.5.527
- Harrison, J., Grant, J., & Herman, J. L. (2012). A gender not listed here: Genderqueers, gender rebels, and otherwise in the National Transgender Discrimination Survey. *LGBTQ Public Policy Journal at the Harvard Kennedy School*, 2, 13–24.
- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research and Practice*, 43, 460. doi:10.1037/a0029597
- Kenagy, G. P. (2005). Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work*, 30, 19–26. doi:10.1093/hsw/30.1.19
- Lev, A. I. (2004). *Transgender emergence*. New York, NY: Haworth Clinical Practice Press.
- Locke, B. D., Bieschke, K. J., Castonguay, L. G., & Hayes, J. A. (2012). The Center for Collegiate Mental Health (CCMH): Studying college student mental health through an innovative research infrastructure that brings science and practice together. *Harvard Review of Psychiatry*, 20, 233–245.
- Locke, B. D., Soet Buzolitz, J., Lei, P. W., Boswell, J. F., McAleavey, A. A., Sevig, T. D., . . . Hayes, J. A. (2011). Development of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62). *Journal of Counseling Psychology*, 58, 97–109. doi:10.1037/a0021282
- Maguen, S., & Shipherd, J. C. (2010). Suicide risk among transgender individuals. *Psychology & Sexuality*, 1, 34–43. doi:10.1080/19419891003634430
- McAleavey, A. A., Lockard, A. J., Castonguay, L. G., Hayes, J. A., & Locke, B. D. (2015). Building a practice research network: Obstacles faced and lessons learned at the Center for Collegiate Mental Health. *Psychotherapy Research*, 25, 134–151. doi:10.1080/10503307.2014.883652
- McKinney, J. S. (2005). On the margins: A study of the experiences of transgender college students. *Journal of Gay & Lesbian Issues in Education*, 3, 63–76. doi:10.1300/J367v03n01_07
- 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. doi:10.1037/0033-2909.129.5.674
- Millet, N., Longworth, J., & Arcelus, J. (2017). Prevalence of anxiety symptoms and disorders in the transgender population: A systematic review of the literature. *International Journal of Transgenderism*, 18, 27–38. doi:10.1080/15532739.2016.1258353
- Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity*, 3, 148–155. doi:10.1037/sgd0000177

- Moradi, B., Tebbe, E. A., Brewster, M. E., Budge, S. L., Lenzen, A., Ege, E., . . . Flores, M. J. (2016). A content analysis of literature on trans people and issues: 2002–2012. *The Counseling Psychologist*, 44, 960–995. doi:10.1177/0011000015609044
- Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research*, 47, 12–23. doi:10.1080/00224490903062258
- Parent, M. C. (2013). Handling item-level missing data: Simpler is just as good. *The Counseling Psychologist*, 41, 568–600. doi:10.1177/0011000012445176
- Perez-Brumer, A., Hatzenbuehler, M. L., Oldenburg, C. E., & Bockting, W. (2015). Individual-and structural-level risk factors for suicide attempts among transgender adults. *Behavioral Medicine*, 41, 164–171. doi:10.1080/08964289.2015.1028322
- Pryor, J. T. (2015). Out in the classroom: Transgender student experiences at a large public university. *Journal of College Student Development*, 56, 440–455. doi:10.1353/csd.2015.0044
- Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385–401. doi:10.1177/014662167700100306
- Rankin, S. R. (2003). *Campus climate for gay, lesbian, bisexual and transgender people: A national perspective*. Washington DC: National Gay and Lesbian Task Force Policy Institute.
- Richards, C., Bouman, W. P., Seal, L., Barker, M. J., Nieder, T. O., & T'Sjoen, G. (2016). Non-binary or genderqueer genders. *International Review of Psychiatry*, 28, 95–102. doi:10.3109/09540261.2015.1106446
- Safer, J. D., Colman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016). Barriers to health care for transgender individuals. *Current Opinions in Endocrinology, Diabetes, and Obesity*, 23, 168–171. doi:10.1097/MED.0000000000000227
- Seelman, K. L. (2016). Transgender adults' access to college bathrooms and housing and the relationship to suicidality. *Journal of Homosexuality*, 63, 1378–1399. doi:10.1080/00918369.2016.1157998
- Singh, A. A., & dickey, l. m. (2016). Implementing the APA guidelines on psychological practice with transgender and gender nonconforming people: A call to action to the field of psychology. *Psychology of Sexual Orientation and Gender Diversity*, 3, 195–200. doi:10.1037/sgd0000179
- Singh, A., & dickey, l. m. (Eds.). (2017). *Perspectives on sexual orientation and diversity. Affirmative counseling and psychological practice with transgender and gender nonconforming clients*. Washington, DC: American Psychological Association. doi:10.1037/14957-000
- Singh, A. A., Meng, S., & Hansen, A. (2013). "It's already hard enough being a student": Developing affirming college environments for trans youth. *Journal of LGBT Youth*, 10, 208–223. doi:10.1080/19361653.2013.800770

- Slinker, B.K., & Glantz, S.A. (1988). Multiple linear regression is a useful alternative to traditional analysis of variance. *American Journal of Physiology*, 255, 353–367. doi:10.1152/ajpregu.1988.255.3.R353
- Snelgrove, J. W., Jasudavicius, A. M., Rowe, B. W., Head, E. M., & Bauer, G. R. (2012). “Completely out-at-sea” with “two-gender medicine”: A qualitative analysis of physician-side barriers to providing healthcare for transgender patients. *BMC Health Service Research*, 12, 1–13. doi:10.1186/1472-6963-12-110
- Tebbe, E. A., Moradi, B., & Budge, S. L. (2016). Enhancing scholarship focused on trans people and issues. *The Counseling Psychologist*, 44, 950–959. doi:10.1177/0011000015608950
- Testa, R. J., Sciacca, L. M., Wang, F., Hendricks, M. L., Goldblum, P., Bradford, J., & Bongar, B. (2012). Effects of violence on transgender people. *Professional Psychology: Research and Practice*, 43, 452–459.
- Toomey, R. B., Card, N. A., & Casper, D. M. (2014). Peers’ perceptions of gender nonconformity: Associations with overt and relational peer victimization and aggression in early adolescence. *The Journal of Early Adolescence*, 34, 463–485. doi:10.1177/0272431613495446
- White, I. R., Royston, P., & Wood, A. M. (2011). Multiple imputation using chained equations: Issues and guidance for practice. *Statistics in Medicine*, 30, 377–399. doi:10.1002/sim.4067
- Xavier, J. M., Bobbin, M., Singer, B., & Budd, E. (2005). A needs assessment of transgendered people of color living in Washington, DC. *International Journal of Transgenderism*, 8, 31–47. doi:10.1300/J485v08n02_04
- Xavier, J., Honnold, J. A., & Bradford, J. (2007). *The health, health-related needs, and lifecourse experiences of transgender Virginians*. Virginia: Virginia HIV Community Planning Committee and Virginia Department of Health.

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