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A Three Paper Examination of Social Inequity and Health and Illness among Transwomen

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A Three-Paper Examination of Social Inequity and Health and Illness among Transwomen

by

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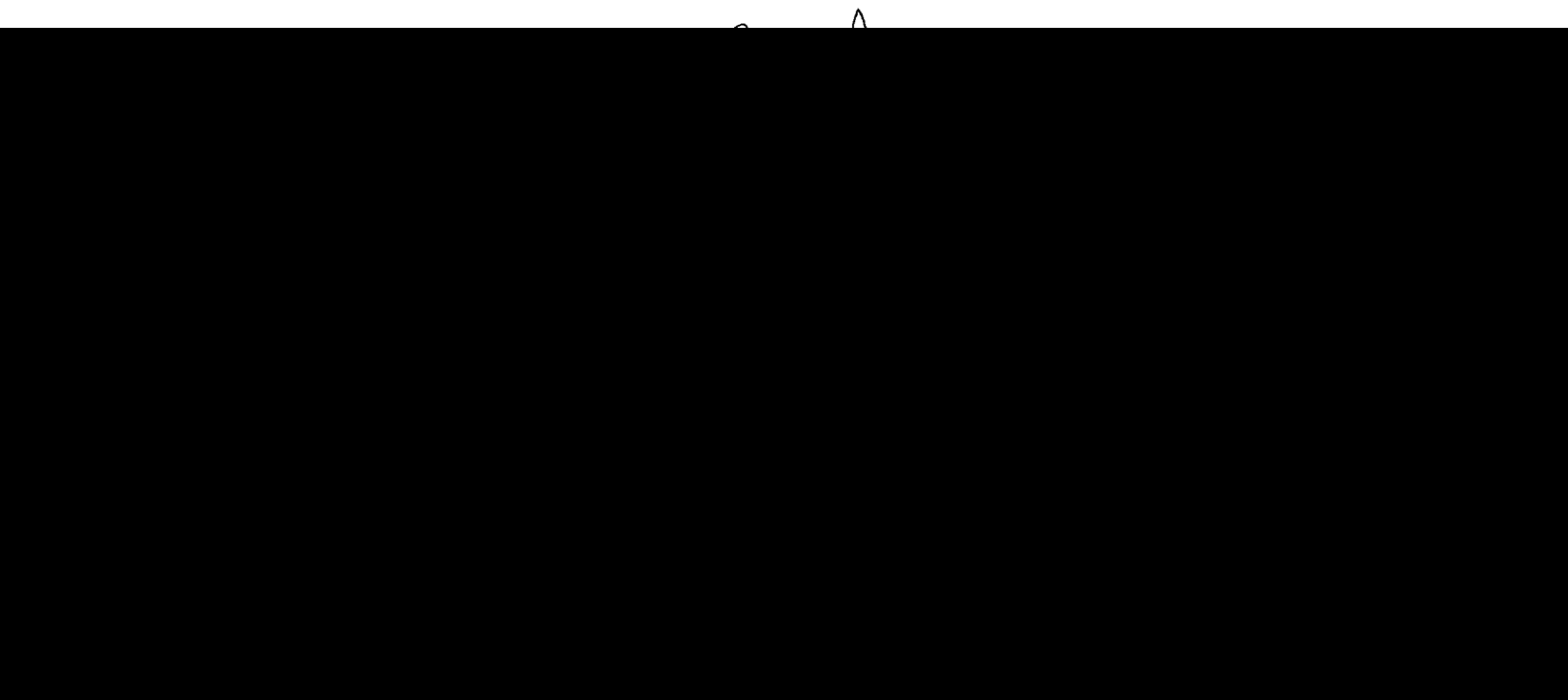

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Abstract

Transwomen are among the most vulnerable populations in the United States and are disproportionately at risk for HIV and other negative health outcomes. Research with transwomen has been largely descriptive, documenting the high prevalence of various co-morbidities, ranging from substance use to negative mental health outcomes. In these studies, singular axes of identity have generally been analyzed. For example, studies have found that race is especially salient in the health of transwomen, finding that transwomen of color experience numerous structural inequalities that drive disparities in health. More intersectional research to examine social inequities in health and illness among transwomen is needed to better understand factors situated in the lived experiences of transwomen. This dissertation draws upon quantitative methods to examine disparities in HIV risk behavior and substance use among transwomen at the intersection of race and gender (Paper 1) and sexuality and gender (Paper 2). Qualitatively, this dissertation examines transmisogyny as a form of intersectional stress among transwomen (Paper 3). This first study is a cross-sectional analysis of data from a sample of 149 HIV-negative adult transwomen in San Francisco collected in 2013 from the TEACH 2 study. The second study is a cross-sectional analysis of data from a sample of 259 young transwomen in the San Francisco Bay Area collected in 2012-2014 from the SHINE study. The third study is a secondary analysis of qualitative, in-depth interview data from the Transgender Research Youth Project (TRYP), collected from 34 young transwomen in Chicago and Los Angeles in 2006. Altogether, these studies argue that future transgender research should increasingly take up intersectionality in order to understand the unique social location of transwomen.

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I. Introduction

Statement of the Research Problem

Transwomen are among the most vulnerable sub-populations in the United States and are disproportionately at risk for HIV and other negative health outcomes. Transwomen face the challenges of weathering experiences related to their gender and transition at many levels - individually, interpersonally and societally. Transwomen face stigma, discrimination and systemic oppression directed toward transgender people, known as transphobia, which leads to unequal access to education, employment, and other economic resources. Economic hardship due to transphobia may be a primary reason why some transwomen turn to sex work, which raises their risk for HIV and other sexually transmitted diseases (Clements-Nolle, Marx, Guzman, and Katz 2001; Nemoto, Operario, Keatley, Han, and Soma 2004; Sugano, Nemoto, and Operario 2006; Wilson, Garofalo, Harris, Herrick, Martinez, Martinez, Belzer, Transgender Advisory, and the Adolescent Medicine Trials Network for 2009). Studies suggest that one in five young transwomen were infected with HIV before 25 years of age (Garofalo, Deleon, Osmer, Doll, and Harper 2006; Wilson et al. 2009). These rates presage the high HIV prevalence found in adult transwomen - more than one-third of samples were HIV positive in San Francisco (Clements-Nolle, Marx, Guzman, and Katz 2001; Rapues, Wilson, Packer, Colfax, and Raymond 2013; Santos, Rapues, Wilson, Macias, Packer, Colfax, and Raymond 2014). These data underscore the need for rigorous HIV prevention research that includes conceptual and theoretical development.

Research studies have found that race is especially salient in the health of transwomen, finding that transwomen of color experience numerous structural inequalities that drive disparities in health. A respondent-driven sampling study in San Francisco found an HIV prevalence of 39.5% among transwomen (Rapues et al. 2013). In that study, racial/ethnic

minorities, injection drug use, and low educational attainment were associated with HIV acquisition (Rapues et al. 2013). Another study demonstrated racial/ethnic disparities among young transwomen in critical resources such as housing, education and residential stability (Wilson, Chen, Arayasirikul, Fisher, Pomart, Le, Raymond, and McFarland 2015).

Transwomen are also impacted by disparities in substance use, mental health and violence. Recent studies have found high rates of alcohol, methamphetamine, injection drug and marijuana use among transwomen (Reback and Fletcher 2014; Santos et al. 2014). A three-year prospective study in New York City found that gender abuse, in the form of psychological and physical abuse and major depression were endemic among transwomen (Nuttbrock, Bockting, Rosenblum, Hwahng, Mason, Macri, and Becker 2014). In another study, transwomen, compared to transmen, exhibited lower self-esteem which was associated with greater lifetime internet sexual partners (Benotsch, Zimmerman, Cathers, Heck, McNulty, Pierce, Perrin, and Snipes 2014). The National Transgender Discrimination Study found that 47% of transwomen who have ever been incarcerated reported being victimized while being incarcerated (Reisner, Bailey, and Sevelius 2014). A study in Colorado found that transgender people experienced greater lifetime intimate partner violence compared to their cisgender LGB counterparts (Langenderfer-Magruder, Whitfield, Walls, Kattari, and Ramos 2014).

These disparities are exacerbated by poor access to health care (Sanchez, Sanchez, and Danoff 2009; Socias, Marshall, Aristegui, Romero, Cahn, Kerr, and Sued 2014; Wilson, Arayasirikul, and Johnson 2013b). In San Francisco, Latina and African American adult transwomen had significantly lower utilization of breast augmentation and genital surgery compared to their White counterparts (Wilson, Chen, Arayasirikul, Wenzel, and Raymond 2014). Wilson et al. found that utilization of transition-related medical care was associated with

significantly lower odds of suicidal ideation, binge drinking, and non-injection drug use (Wilson et al. 2014). A qualitative study of HIV-positive, African American transwomen found that gender stigma and institutional distrust were critically raced factors in shaping the health care experiences and ultimately engagement in HIV care among transwomen of color (Wilson, Arayasirikul, and Johnson 2013a). Together, these social inequities play an integral role in the (re)production of health inequities among transwomen.

Despite this emerging work, the majority of what we know about the health of transwomen is based on studies of heterosexual transwomen at highest risk for HIV. Few studies have interrogated gender oppression among transwomen in quantitative studies. Little to no attention has been paid to sexual diversity among transwomen in relation to health in quantitative studies. Additionally, our understanding of the social processes young transwomen experience is limited. I will address these gaps in my dissertation research.

This dissertation is an empirical examination of the health disparities and social inequity among transwomen. Specifically, drawing on an intersectional framework and through both qualitative and quantitative research, my dissertation papers will investigate the following topics and research questions:

1. Paper 1: Racial disparities in transphobic discrimination and associations with alcohol use and HIV among adult transwomen
    a. What is the prevalence of transphobic discrimination among adult transwomen in San Francisco?
    b. How is transphobic discrimination different for transwomen of color compared to their white counterparts?
    c. Is transphobic discrimination associated with risky alcohol use or HIV risk?

2. Paper 2: Sexual minority disparities in alcohol and substance use among young transwomen
    a. What is the prevalence of sexual minority status among young transwomen in the San Francisco Bay Area?
    b. How do the odds of binge drinking and substance use differ among sexual minority transwomen and their heterosexual counterparts?
3. Paper 3: A substantive theory of intersectional oppression and stress among transwomen
    a. How does transmisogyny act as a source of intersectional oppression and stress? What processes reinforce it among young transwomen?
    b. What are the social consequences of transmisogyny?

Theoretical Frameworks

Intersectionality and Health

Intersectionality is a framework that allows for the study of multiple intersecting identities and social structures. Intersectionality has been described as a prism, or a multidimensional lens through which to analyze lived experiences socially located at the intersection of various axes of identity. Intersectionality allows us to understand how multiple forms of stigma, oppression, and power relations converge and work together to shape inequity. Extending the reach of stigma and labeling theory, intersectionality creates space for the intermingling of many stigmas and creation of new, not yet theorized, intersectional stigma.

Crenshaw (1991), a legal scholar and critical theorist, coined the term intersectionality (Crenshaw 1991). Her work problematized identity politics as a failed attempt to look beyond difference, but rather conflated or ignored difference within groups. Her work in particular dealt

with violence against women where she argued that women's experiences of violence are shaped by other dimensions of their identities like race and class. She explains, "when the practices expound identity as woman or person of color as an either/or proposition, they relegate the identity of women of color to a location that resists telling" (Crenshaw 1991: 1242).

Patricia Hill Collins' *Black Feminist Thought* offered important theoretical refinement to the study of intersectionality (Hill Collins 2000). She draws from Weber and Simmel's theories of social action and defines intersectionality as an "analysis claiming that systems of race, social class, gender, sexuality, ethnicity, nation and age form mutually constructing features of social organization, which shape Black women's experiences and, in turn, are shaped by Black women" (Hill Collins 2000: 299). She argues that intersectionality operates within a matrix of domination, and the overall organization of power in a society. A matrix of domination exhibits a specific arrangement of intersecting systems of oppression, organized through four interacting domains of power: structural, disciplinary, hegemonic and interpersonal. Structural power organizes power relations in society, and is enacted by social structures, such as medicine, law, religion, and economy. Disciplinary power manages oppression and is enacted by actors and bureaucratic organizations concerned with social control through surveillance, rationalization, and routinization. Hegemonic power makes oppression legitimate, through culture, ideology and consciousness. The interpersonal domain encompasses all that consists of daily life. All these domains are linked in the matrix of domination and maintain the status quo, making the effects of oppressive ideologies invisible. Hill Collins offers black feminist thought as an intervention to disrupt, dispel and make oppressive ideologies suspect, inciting change at the intrapersonal level and incrementally unraveling the matrix of domination.

Intersectionality creates new possibilities in understanding and problematizing the social organization of power relations. Berger (2004) uses intersectional stigma to theorize and examine the experiences of HIV-positive women (Berger 2004). She explains that intersectional stigma represents "the total synchronistic influence of various forms of oppression, which combine and overlap to form a distinct positionality" (Berger 2004: 4). In her work with HIV-positive women, she argues that HIV stigma combined with their existing social marginality resulted in a "qualitatively distinct form of stigma" and revealing other inequalities in their lives (Berger, 2004: 4). While multiple oppressions "combine to create new and (often) unrecognized forms of discriminatory encounters in everyday life" (Berger, 2004: 19), the stigma from being infected with HIV compounds the axes of inequality of race, class and gender (Berger, 2004: 24). While it is possible to understand each of these axes as independent systems, an intersectional approach strengthens our ability to explain and represent the lived experiences of real people at the intersection of multiple stigmatized identities. "The 'piling up' of stigmas does not result just in a negative effect; it changes and transmutes" (Berger 2004: 30). Traditional frameworks "fragment vulnerabilities" into distinct social categories (Dhamoon and Hankivsky 2011:16) and to fully understand social inequity calls for intersectionality.

The application of intersectionality to health not only sheds light on social inequities but also explains how complexity and social unevenness is perpetuated at the intersection of multiple axes of identity (McGibbon 2011). For example, Agenor et al (2014) uses intersectionality to examine women's health, specifically the utilization of a Pap test, at the intersection of sexual orientation and race/ethnicity (Agenor, Krieger, Austin, Haneuse, and Gottlieb 2014). Women with only female sexual partners were less likely to have reported a Pap test in the last year compared to women with only male sexual partners. Nested within this finding, the authors

found that this disparity is greater for Black women compared to White women. This study finds that sexual minority disparities are exacerbated for those at the intersection of minority sexual orientation and ethnic-racial identity. Not only can intersectionality show how society is structured unevenly, it can also challenge explanatory frameworks. Viruell-Fuentes and co-authors (2012) argue for an intersectional approach rather than individual culture-based frameworks in explaining health disparities among immigrants. They explain that while individual culture-based frameworks organize around the problem of acculturation, that is, poor health as a result of having to replace their own culture with the cultural characteristics of the country they have immigrated to, intersectional approaches are critical to problematizing immigrant health (Viruell-Fuentes, Miranda, and Abdulrahim 2012). Rather than over relying on cultural explanations, research on immigrant health must employ intersectionality, undergo a conceptual shift and consider the meanings of structural racism, racialization and structural heirarchies, residential segregation, immigration policies and other determinants altogether (Viruell-Fuentes, Miranda, and Abdulrahim 2012). Other studies have found that structural and social factors over contextual factors alone are intricately linked to inequities in health (Krieger, Waterman, Gryparis, and Coull 2015; Seng, Lopez, Sperlich, Hamama, and Reed Meldrum 2012; Veenstra 2011).

While theoretically robust, the operationalization and measurement of intersectionality in quantitative research is challenging (Veenstra 2011). As Veenstra (2011) explains, "from the perspective of intersectionality theory, by focusing on a subset of the inequality identities or by treating multiple axes of inequality as distinct rather than intersected processes, a social researcher is in danger of misunderstanding the nature of social experiences and identities manifested in specific contexts and thus in danger of producing results and interpretations that

are as misleading as they are incomplete" (Veenstra 2011: 8). Aside from this significant methodological assumption, disseminating and reporting findings at multiple intersections is difficult. First, additive models are easiest to understand. Models that consider multiplicative interaction effects most frequently report two-way interaction effects between two axes of identity rather than three-way interactions, for example. Without applying more complex, higher-level statistical theory to comprehend the intersection at multiple axes of identity (Sen, Iyer, and Mukherjee 2009), the majority of studies rely on reductively reporting on the intersection of two axes at a time. Even if these higher-level statistical methods are applied, it can be difficult to explain to non-statisticians the significance or meaning of such a derived result. For an intersectional analysis to consider greater numbers of axes, very large sample sizes are needed so that there are sufficient numbers of individuals who exhibit every possible combination. Additionally, there are intersections that may be invisible to researchers that were not previously conceived and therefore not measured in any one study which makes multiple subordinate-group identities invisible (Purdie-Vaughns and Eibach 2008). These limitations in quantitative intersectional research condition who is epidemiologically fathomable and limit the kinds of questions and hypothesis that can be tested (Dworkin 2005; Sen, Iyer, and Mukherjee 2009).

Despite these challenges and limitations, quantitative intersectional research can expand our understanding in important ways. For example, Reidpath and Chan (2005) apply intersectionality to quantitative data on stigma. They not only found unique sources of stigma associated with a stigmatized identity (e.g. bisexuality and using intravenous drugs), they were also able to measure a shared source of stigma and synergistic stigma (Reidpath and Chan 2005). Quantitative intersectional research has the potential to encourage the dialogue between theory and practice, confirming intersectional theories and being able to test new hypotheses that

investigate novel intersections in large secondary datasets that have been collected (Stirratt, Meyer, Ouellette, and Gara 2008).

Research with transgender populations that has taken up intersectional approaches is scant. Lacombe-Duncan (2016) explains that the majority of quantitative studies on transgender health do not explicitly apply theory and few qualitative studies that have applied intersectionality to understand the experiences of transgender women living with HIV (Lacombe-Duncan 2016). One qualitative study of stigma among 104 women in Ontario, Canada of which 22% were transwomen, argued that these women experienced independent and mutually constitutive relationships between their marginalized identities and social inequities (Logie, James, Tharao, and Loutfy 2011; Logie, James, Tharao, and Loutfy 2012). One psychological study used an intersectional approach integrating theories from sexual minority stigma, body objectification and HIV stigma to develop a framework for gender affirmation (Sevelius 2013). A limitation of these studies is that they are so focused on analyzing HIV risk at the individual micro-level and less so at the socio-structural meso- and macro-levels.

Sex, Gender and Transgender

The sociology of gender deconstructs social differences attributed to sex, a biological construct. Lorber (1993) traces the history of these differences as western ideology organized behind biology to take up biological dichotomies, framing two sexes – male and female. Socially constructed differences in behavior and social status have been naturalized through gender where men and women have become two distinct social classes. Lorber argues that social practices transform bodies to fit the categories of "female" and "male" and "women" and "men" (Lorber 1993). She contests how research operationalizes sex and gender, a process that begins with two

social categories and the assumption they are different biologically, and attributing similarities and differences to sex. Instead, Lorber suggests an approach that examines patterns in behavior and then analyzing identity markers. Additionally, not only must sociological research consider how these social categories intermingle, it is important to consider how individuals and groups vary within these social categories (Lorber 1996). Consider sex, for example. While male and female genitalia derive from the same fetal tissue, phenotypic variation or ambiguity in genitalia can occur. In this circumstance, physicians arbitrarily assign a sex for these infants to fit into society organized around a system of binary sex categories. All individuals within a social category (e.g. sex, gender, etc.) are not homogenous, and the differences between social categories blurred. While males and females have biological similarities, there is variation, a continuum of physiological sex. Deconstructing these dichotomies in sex and gender are critical to understanding the complexity in the social construction and meanings of sex and gender.

Sex and gender are distinct and not interchangeable (West and Zimmerman 1987); gender relations and sex-linked biology each may have sole, independent and together synergistic impact on health outcomes (Krieger 2003). Understanding how these categories unevenly distribute power in society may create opportunities to disrupt and reorganize these power relationships. Sex and gender are embedded in and constitutive of social structure (Springer, Hankivsky, and Bates 2012). West and Zimmerman explain that "the 'doing' of gender is undertaken by women and men whose competence as members of society is hostage to its production" (West and Zimmerman 1987: 126). While seen as "natural," gender is constituted through interaction. West and Zimmerman (1987) build on Goffman's work, framing gender as a performance, a display, a dramatization of "cultures's idealization of feminine and masculine natures" or in ways that align with their sex (West and Zimmerman 1987: 130).

Contemporary sociological work near the turn of the century brought transgender identity into focus as a space to contest the dominant framing of sex and gender as natural constructs (Vidal-Ortiz 2008). This work critiques medicine and psychology, which has framed transgender as an identity category that disrupted the "authenticity" of relating sex and gender, spurring "born in the wrong body" narratives (Ekins and King 1999; Fausto-Sterling 1993). Sociology has attempted to shift the conceptualization of transgender as a question of authenticity to one of performativity (Hird 2002), embodiment (Ekins and King 1999; Featherstone and Turner 1995) and critiques of heteronormativity (Schilt and Westbrook 2009).

Hind's (2002) work traces the history of and pathologization of transgender identity. Influenced by Mead and Goffman's symbolic interactionism, Hind argues that conceptions of sex and gender are the products of social interactions, as opposed to nature. Medicine and psychology take up authenticity arguments, framing transgender as an ill fit of one's "real" sex and their "real" gender, assuming a relationship between "sex, gender and reality" as defined by external sex structures (Hind 2002:581). Authenticity explanations fix sex and gender as static concepts. Performativity explanations conceptualize sex and gender as a result of a discursive social process. Drawing from Butler's work in *Gender Trouble* and Foucault's work in *The History of Sexuality*, Hind explains performativity as an analytic lens allowing the "truth" of gender to be free from bodies and instead view it as a process of enactment or performance, rendering the social mechanisms "through which sex and gender are naturalized and essentialized" visible (Hind 2002:581).

Featherstone and Turner (1995) outline major theoretical developments in the sociology of the body and the sociology of health and illness. Not only do they locate gender relations and the observable differences between men and women as socially constructed and the product of

how power is structured in a patriarchal society, they also identify emerging developments at the intersection of technology and the body (Featherstone and Turner 1995). At the time of their work, the focus on technology and the body centered around genetic engineering and "machine-body fusions" or cyborgs (Featherstone and Turner 1995:4). These issues of embodiment are incredibly salient for transwomen, especially as gender affirmative healthcare becomes a gold standard practice. Gender affirmative healthcare is comprised of practices that do not pathologize and/or stigmatize transwomen for the discordance of their gender identity and their assigned sex at birth. It refers to the entirety of the healthcare encounter from patient-provider communication to a variety of biomedical practices, including hormone replacement therapy and surgical intervention on one's body to aid in the transition from one gender to another, such as a breast augmentation or "bottom surgery," more commonly referred to as gender confirmation surgery or sexual reassignment surgery.

Sociological work not only provides an understanding of the lived experiences of trans people but also allows us to shine light on societal forces that operate at the macro level. An example of this is Schilt and Westbrook's (2009) work with trans and cisgender narratives, in particular focused on interactions with "gender normals" (Schilt and Westbrook 2009:441). Schilt interviewed over fifty trans men out at the workplace and Westbrook analyzed the discourse that framed media reports of trans murders. Drawing from two case studies, their comparative analysis reveals the process by which the doing of gender by trans people is intricately linked to heteronormativity. They show that trans people do gender in public and in private relationships to pass as the gender with which they identify, foregrounding the preservation of heteronormativity through these social interactions in both public and private relationships.

A great deal of scholarship involving transgender people is concerned with gender conformity or alignment of one's gender expression and gender identity. From Garfinkel's study of Agnes to the coming out of Christine Jorgensen, passing as cisgender has been held as a gold standard, rationalizing one's transition from one gender to another (Vidal-Ortiz 2008). Passing has been studied as a way to manage stigma (Kando 1972), mitigating the stigmatization and transphobic discrimination from society, and as an act of resistance (Kanuha 1999). Doing gender outside of society's gender ideals may lead to being ostracized from society, reinforcing the necessity for gender conformity (Pfeffer 2010).

Gender conformity stigma has been linked to inequities in health. A study examining gender non-conformity among a large national sample of trans people was conducted using the National Transgender Discrimination Survey (Miller and Grollman 2015). Miller and Grollman (2015) draw from the sociology of gender, symbolic interactionism, Goffmanian stigma and the minority stress theory, a social psychological framework for understanding the impact of discrimination on mental health among sexual minorities of color. The authors hypothesized that gender non-conformity, a visible marker of trans identity, was associated with greater discrimination. They found that compared to gender conforming trans people, gender non-conforming trans people face more discrimination and are more likely to engage in negative health behaviors, specifically attempted suicide, drug and alcohol abuse and smoking. Transwomen are particularly vulnerable, navigating the intersection of sexism and transphobia. Serano (2007) describes the intersection between transphobia and sexism as transmisogyny. Transmisogyny is understudied and has been used to describe interlocking forms of gender oppression (Serano 2007) and associated with barriers to health care access, self-esteem and safety (Vidal-Ortiz 2008).

Stigmatization, Deviance, and Labeling Theory

In order to understand transwomen's health, it is critical to examine the social processes of stigmatization and societal responses to deviance. This is a central area of sociological inquiry with a rich history. Its presence in public health literature is both an established and a burgeoning area. Public health research has attempted to address complex social concepts such as stigma and deviance in the study of discrimination and its impact on health outcomes. In this section, I review labeling theory in terms of how it frames stigmatization and discuss how public health literature has examined the study of discrimination and health.

Deviance as a social construction is a relatively recent sociological endeavor (1960s). The study of deviance has historically been embedded in the disciplines of psychology and biology that has tended to view deviance as a pathology located within the individual. The investigation of deviance relied solely on structures of personality and biology, completely removed from social interaction (Becker 1964). However, sociological work on deviance has positioned deviance in, around and between the interactions of the individual labeled as deviant and the rest of society (Becker 1964). Central to the social psychological study of deviance is not the deviant act per se, but the process of labeling that occurs at the intersection of society and the labeled deviant. Becker (1964) explains that socially sanctioned rules define what is deviant and deviance as a label acts as a "consequence" to those who have committed such an act (Becker 1964). Labeling theory, or the societal reaction to deviance, is a sociologically robust area of study, intimately linked to the study of social problems.

Symbolic interactionism lays the foundation for labeling theory or the study of society's reaction to deviance. Deviance is socially constructed through processes grounded in the ways

that human beings interpret it – and involves a process of what is labeled as deviant as well as what is deemed to be normal. This scholarship has not only looked at the processes of labeling attributes as problems and the individuals who embodied these behaviors or attributes as deviant, but also its social and social psychological consequences. The most prominent of these consequences is the production of stigma in Goffman's work. Not only grounded in symbolic interactionism, Goffman's work is also central to processes of medical labeling and is implicated in the early theorizing of medicalization as the dominance of medical knowledge and institutions expanded in the 1960s and 1970s.

A major contributor to the theoretical development of symbolic interaction, Erving Goffman's 1963 work, *Stigma*, added to our understanding of identity by examining the social and social psychological responses to a "spoiled identity," or stigma. Goffman explained that in social settings individuals present with a particular social identity – the presentation of self that the individual believes is appropriate for the social setting. Others adopt similar expectations and anticipations about normative behavior in that particular social setting (Goffman 1963). There is a type of concordance – or agreement – influencing individuals and their demands of one another in a social setting. This virtual social identity ought to match the actual social identity. If this is not the case and an individual cannot fulfill a particular demand that is expected of him/her, then his/her identity is seen as spoiled and discrediting (Goffman 1963). The discrediting attribute is referred to as a stigma.

Goffman describes three types of stigma – "abominations of the body," "blemishes of individual character," and "tribal stigma of race, nation, and religion" (that which "can be transmitted through lineages") (Goffman 1963). When the stigmatized are confronted by the unstigmatized, or "normals," a stigma-theory is constructed in an effort to help normals

understand the stigmatized individual. In this process, cascading imputation occurs causing other types of handicaps to be lumped together with the original discrediting attribute. As a result, treatment of the stigmatized individual is often dictated by these processes and not based on their actual social identity. These interactions are extremely powerful in shaping the behavior and conduct of social action in social settings. These unspoken "rules" become institutionalized, socially reinforced and enacted.

In large part, Goffman's work is based on the "visibly stigmatized," individuals with visibly discrediting attributes in "mixed contact" with "normals" (Goffman 1963). Rather than limit his analysis to stigma that is "known" by both the individual actor and those presumably mixed contacts with normals s/he may interact with, HIV/AIDS may pose new ways of theorizing stigma. With the exception of lipodystrophy as a side effect of early antiretroviral therapies, HIV/AIDS and the risk associated with HIV/AIDS carries with it an invisible stigma that at times is conditioned by the social setting.

Goffman suggests a critical analysis of "deviance," emphasizing deviation and difference. Deviance is not singular, static, or unchanging. Goffman explains that deviance is dependent on a "system of reference" (Goffman 1963). Traditionally, that system of reference is society at large. However, Goffman explains that deviance can be studied along a continuum of shifting systems of reference, including investigating deviants in small groups. For example, deviants are not always on the outside of society, in-group deviants play a specific role in a group and may be considered a member of the same group (albeit different in some way), especially in contrast to the group's response to a social deviant who lies outside the boundary of that group (Goffman 1963).

Labeling theory has also contributed to our current understanding of homosexuality as a social construct and a social role. Mary McIntosh's (1968) article in *Social Problems* was one of the first pieces of work to contest the framing of deviant sexuality as pathological and criminal. McIntosh calls for the study of homosexuality as a social object, able to be studied in order to explain how labels are produced and used as a form of social control, and argues against homosexuality as a condition. McIntosh argues that by treating homosexuality as a social role, it allows for homosexuality to stand outside of and in contrast to heterosexuality (McIntosh 1968). McIntosh analyzes the role of homosexuality in different cultural contexts, finding a specific social role formation in England and America with the Kinsey studies, to understand the social processes that frame expectations of homosexuality as a social role. McIntosh explains that reading homosexuality as a social category frees it from the constraints of medicine and psychiatry, and enables the sociologist to interrogate it as a social group (McIntosh 1968).

Stigma and Discrimination

Stigma plays a significant role in social stratification, engendering logics of difference that are reproduced across all levels of society. The resulting matrix of oppression is legitimized, reified and perpetuated in society through discrimination. Discrimination is the differential treatment of non-dominant groups by social institutions and people often based on a stigmatized status, characteristics, roles and/or traits (Williams and Mohammed 2013). Discrimination is a multi-dimensional construct, addressing that which is internalized, interpersonal, institutional, and social (Williams and Mohammed 2013). The case of discrimination on the basis of racist ideology in the United States is a cornerstone of not only American Sociology (Morris 2015), but also lays the foundation for studying the impact of discrimination on health. Racism is "an

organized system premised on the categorization and ranking of social groups into races and devalues, disempowers, and differentially allocates desirable societal opportunities and resources to racial groups regarded as inferior" (Williams and Mohammed 2013). Racism is productive of prejudice, or negative attitudes toward non-dominant groups, stereotypes, or beliefs about non-dominant groups, and discrimination (Williams and Mohammed 2013).

Williams and Mohammed (2013) present a framework for the study of racism and health. In this framework, the authors tie together "basic causes" such as biology or geographic difference, social institutions, and institutional and cultural racism to markers of social status (e.g. socioeconomic status, race, gender, etc.). They explain that there are pathways that perpetuate the impact of racism and discrimination on health. Some of these pathways include: stigma, prejudice and stereotypes (cultural transmission of racism); racial discrimination and trauma (stress); incarceration, lack of access to educational or employment (socioeconomic status opportunities); medical care, housing, community (societal resources); and knowledge (Williams and Mohammed 2013). These social pathways for racism elicit particular behavioral, psychological, physiological, individual and collective responses that frame health (Williams and Mohammed 2013).

Public health research on discrimination has primarily operationalized racial discrimination as a psychosocial stressor with an impact on a plethora of health outcomes and behaviors, such as cardiovascular disease (Chae, Lincoln, Adler, and Syme 2010; Lewis, Barnes, Bienias, Lackland, Evans, and Mendes de Leon 2009; Lewis, Everson-Rose, Powell, Matthews, Brown, Karavolos, Sutton-Tyrrell, Jacobs, and Wesley 2006; Profant and Dimsdale 1999), obesity (Lewis, Kravitz, Janssen, and Powell 2011), increased mortality (Barnes, de Leon, Lewis, Bienias, Wilson, and Evans 2008), and risk taking (Jamieson, Koslov, Nock, and Mendes

2013). These same approaches have been applied to examining the impact of discrimination on the health of LGBT people. This research, though scant, has also found comparable deleterious effects on health. Chae et al. analyzed data from 178 working-class sexual minorities, examining how LGB identified participants differed from non-LGB identified sexual minority participants in the United for Health Study (Chae, Krieger, Bennett, Lindsey, Stoddard, and Barbeau 2010). They found that LGB identified participants reported higher levels of psychological distress and that racial and ethnic discrimination in addition to sexuality discrimination were associated with higher levels of psychological distress (Chae et al. 2010). In another study of secondary school students in Massachusetts, Almeida et al. found that emotional distress among LGBT students was mediated by perceptions discrimination due to their LGBT identity (Almeida, Johnson, Corliss, Molnar, and Azrael 2009). The authors also found that LGBT youth were more depressed than non-LGBT youth and that LGBT males exhibited an increased risk of self-harm and suicidal (Almeida et al. 2009). Though important, these findings have limited generalizability for trans participants with only 17 trans-identified participants in a total sample of 1,032. Another study collected and analyzed data from a national sample of transgender adults and their nontransgender, or cisgender, siblings. The authors of this study found that though transgender siblings appeared to be more educated than their cisgender counterparts, transgender siblings earned lower incomes and were more likely to experience discrimination (Factor and Rothblum 2007).

Sexual Minority Stress Model for Lesbian, Gay and Bisexual Populations

Minority stress frameworks have provided a theoretical platform for investigating the impact of stigmatization and chronic stress that minorities, in particular sexual minorities,

experience within the context of living in a heterosexist society (Meyer 1995; Meyer 2003). Research on minority stress has furthered our understanding of the consequences of discrimination, or enacted stigma, on mental health in particular (Meyer 2010). The minority stress framework posits that sexual minorities are exposed to excess stress related to a variety of stigma-related experiences (Meyer 2003). These stigma experiences may include prejudice-related events such as being physically attacked or denied housing, everyday discrimination, self-devaluation and the anticipation of discrimination related to the internalization of heteronormativity and heterosexism (Meyer 2003). Minority stress researchers have gone on to argue that multiple minority statuses, for example minority sexuality and racial identity, exacerbate discrimination and stress and its deleterious effect on health (Meyer 2010).

Meyer's work (2003) explains how the social environment shapes minority status and minority identity. While all people experience general stressors, sexual minorities experience greater stress due to living in a heterosexist society. Sexual minorities experience internalized homophobia, expectations of rejection and the need to conceal one's identity as a proximal stress process, linked to discrimination and violence distally. Meyer explains that potential points of intervention might lie in changing how sexual minorities cope with sexual minority stress through the provision of social support on both a community level and individual level and changing the characteristics of being a sexual minority in a homophobic society. An example of the latter is attributing a positive valence on sexual minority identity; instead of associating sexual minority identity with negative stereotypes, reclaiming sexual minority identity. Another example is reducing the prominence of sexual minority identity through foregrounding other identities (e.g. "I am not only a lesbian woman, I am also a strong Black woman" or "Being LGB is a small part of my life.").

Minority stress frameworks have been widely adopted by sexual minority researchers; however, this work does not adequately describe the type of social stress process or intersectional stress that transwomen face, in particular. Few researchers have attempted to simply substitute gender minority stress for sexual minority stress (Gamarel, Reisner, Laurenceau, Nemoto, and Operario 2014; Reisner, Gamarel, Nemoto, and Operario 2014).These applications assume little differences between gender and sexual minorities, falling short in attending to the specific social location of transwomen. While there are some generalities, the differences are numerous and stark. This dissertation explores these differences.

Methodological Approaches

This dissertation examines the health disparities among transwomen at the intersection of race, transgender identity, sexuality and sex. The first two papers quantitatively examine racial and sexual minority disparities within large samples of transwomen in San Francisco. The third paper is a qualitative study of intersectional stress among young transwomen. The disparities I examine in Papers 1 and 2 may point to more a nuanced understanding of the social inequity transwomen face. Paper 3 investigates the boundaries of transmisogyny as form of intersectional stress and its social consequences for young transwomen.

The first paper in this dissertation examines racial disparities in transphobic discrimination and relationships with risky alcohol use and HIV infection. Specifically, I investigate three related research questions: how is transphobic discrimination different for transwomen of color compared to their white counterparts, and is transphobic discrimination associated with risky alcohol use or HIV infection? This is a cross-sectional analysis of data from a sample of 233 adult transwomen in San Francisco. The data for this analysis was

collected in 2013 from the TEACH 2 study, a respondent-driven sampling study of HIV risk behavior and HIV prevalence.

The second paper in this dissertation examines sexual minority disparities in alcohol use and substance use among young transwomen. Specifically, I investigate the following two related research questions: What is the prevalence of sexual minority status among young transwomen in the San Francisco Bay Area and how do the odds of binge drinking and substance use differ among sexual minority transwomen and their heterosexual counterparts? This is a cross-sectional analysis of data from a sample of 259 young transwomen. The data for this analysis was collected in 2012-2014 from the SHINE study, a longitudinal study of HIV risk and resilience among young transwomen ages 16-24 in the San Francisco Bay Area. I served as the Study Director for this project that included training research assistants, as well as intensive outreach, recruitment, interviewing and retention of participants.

The third paper in this dissertation is a secondary analysis of qualitative, in-depth interview data from the Transgender Research Youth Project (TRYP). These data were collected from 34 young transwomen in Chicago and Los Angeles and transcribed in 2006 and I use grounded theory (Charmaz 2006; Strauss 1967) to investigate the following research question, what is transmisogyny, how does it work at the intersection of sex and gender, and what are its social consequences?

II. Paper 1 – Examining the effects of transphobic discrimination and race on HIV risk among transwomen in San Francisco

1. Introduction

In an unprecedented time of transgender visibility, transwomen are among the most vulnerable populations at risk for HIV and other negative health outcomes in the United States (Clements-Nolle, Marx, Guzman, and Katz 2001; Nemoto, Operario, Keatley, and Villegas 2004; Sugano, Nemoto, and Operario 2006; Wilson et al. 2009). Studies suggest that one in five young transwomen were infected with HIV before 25 years of age (Garofalo et al. 2006; Wilson et al. 2009). These rates presage the high HIV prevalence found in adult transwomen – more than one-third in San Francisco are HIV+ (Clements-Nolle, Marx, Guzman, and Katz 2001; Rapues et al. 2013; Santos et al. 2014). While HIV is an important trans health issue (Clements-Nolle, Marx, Guzman, and Katz 2001; Garofalo et al. 2006; Rapues et al. 2013; Santos et al. 2014; Wilson et al. 2009), research has found HIV to disproportionately impact transwomen of color (TWOC) (Rapues et al. 2013). TWOC face poorer access to structural determinants of health such as housing, education and residential stability due to their multiple minority status as a gender and racial minority (Wilson et al. 2015).

Minority stress frameworks have provided a theoretical platform for investigating the impact of stigmatization and chronic stress that minorities, in particular sexual minorities, experience within the context of living in a heterosexist society (Meyer 1995; Meyer 2003). Research on minority stress has furthered our understanding of the consequences of discrimination, or enacted stigma, on mental health in particular (Meyer 2010). The minority stress framework posits that sexual minorities are exposed to excess stress related to a variety of stigma-related experiences (Meyer 2003). These stigma experiences may include prejudice-

related events such as being physically attacked or denied housing, everyday discrimination, self-devaluation and the anticipation of discrimination related to the internalization of heteronormativity and heterosexism (Meyer 2003). Minority stress researchers have gone on to argue that multiple minority statuses, for example minority sexuality and racial identity, exacerbate discrimination and stress and its deleterious effect on health (Meyer 2010).

Transwomen face stigma and systemic oppression directed toward transgender people, known as transphobia. Research finds that transphobic discrimination produces gender minority stress and has led to unequal access to education, employment, and subsequently to health disparities. For example, a study based of a national sample of trans adults and their non-trans, or cisgender (or cis), siblings found that though trans siblings were more educated than their cis siblings, trans siblings earned lower incomes and were more likely to experience discrimination (Factor and Rothblum 2007). A three-year prospective study in New York City found that transphobic discrimination, in the form of psychological and physical abuse and major depression were endemic among transwomen (Nuttbrock et al. 2014).

Transwomen are also victimized as a result of transphobia. The National Transgender Discrimination Study (NTDS) found that 47% of transwomen who have ever been incarcerated reported being victimized while being incarcerated (Reisner, Bailey, and Sevelius 2014). A study in Colorado found that trans people experienced greater lifetime intimate partner violence compared to their cis sexual minority counterparts (Langenderfer-Magruder et al. 2014). Moreover, studies are beginning to discover social unevenness and health disparities among trans people. One analysis of the NTDS found that gender non-conformity was associated with a greater likelihood of experiencing transphobic discrimination (Miller and Grollman 2015). Gender non-conformity among trans people was theorized as a form of stigma visibility, the

ability for others to perceive someone's trans status or one's sex, gender identity and gender expression do not align. Miller and Grollman (2015) found that compared to gender conforming trans people, gender non-conforming trans people faced more discrimination and are more likely to engage in negative health behaviors, specifically attempted suicide, drug and alcohol abuse and smoking (Miller and Grollman 2015).

While many scientific knowledge gaps in trans health remain, MacCarthy et al. (2015) advocate for the application and development of theoretical frameworks that address social determinants of health, social stress and intersecting minority statuses (MacCarthy, Reisner, Nunn, Perez-Brumer, and Operario 2015). Intersectionality is a framework that allows for the study of multiple intersecting identities. Intersectionality has been described as a prism, a multidimensional lens through which to analyze lived experiences socially located at the intersection of various axes of identity (Crenshaw 1991) . It allows researchers to better understand how multiple forms of stigma, oppression, and power relations converge and work together to shape inequity. Intersectionality acknowledges that the overall organization of power in a society exists within a matrix of domination consisted of intersecting systems of oppression, organized through interacting of power domains: structural, disciplinary, hegemonic and interpersonal (Hill Collins 2000). Traditional frameworks "fragment vulnerabilities" into distinct social categories (Dhamoon and Hankivsky 2011:16) and to fully understand social inequity calls for intersectionality.

The application of intersectionality to health does not only shed light on social inequities but also explains how complexity and social unevenness is perpetuated at the intersection of multiple axes of identity (McGibbon 2011). For example, Agenor et al (2014) uses intersectionality to examine women's health, specifically the utilization of a Pap test, at the

intersection of sexual orientation and race/ethnicity (Agenor et al. 2014). Women with only female sexual partners were less likely to have reported a Pap test in the last year compared to women with only male sexual partners. Nested within this finding, the authors found that this disparity is greater for Black women compared to White women. This study finds that sexual minority disparities are exacerbated for those at the intersection of minority sexual orientation and ethnic-racial identity. Other studies have found that structural and social factors over contextual factors alone are intricately linked to inequities in health (Krieger, Waterman, Gryparis, and Coull 2015; Seng et al. 2012; Veenstra 2011).

Transwomen are not often examined with an intersectional lens and it is critical to understanding their health. Lacombe-Duncan (2016) explains that the majority of quantitative studies on transgender health do not explicitly apply theory and few qualitative studies that have applied intersectionality to understand the experiences of transgender women living with HIV (Lacombe-Duncan 2016). One qualitative study of stigma among 104 women in Ontario, Canada of which 22% were transwomen, argued that these women experienced independent and mutually constitutive relationships between their marginalized identities and social inequities (Logie, James, Tharao, and Loutfy 2011; Logie, James, Tharao, and Loutfy 2012). One psychological study used an intersectional approach integrating theories from sexual minority stigma, body objectification and HIV stigma to develop a framework for gender affirmation (Sevelius 2013). Informed by gender minority stress framework, this analysis takes an "intersectionality-informed stance" and examines differences in transphobic discrimination on HIV risk factors, specifically binge drinking and unprotected receptive anal intercourse (Bowleg 2012: 1270).

2. Materials and methods

2.1 Study sample and data collection

Sampling for the TEACH2 (Transwomen Empowered to Advance Community Health) Study, a cross sectional HIV risk behavior survey among transwomen in San Francisco was conducted from August to December 2013. Participants were recruited using Respondent-Driven Sampling (RDS), a peer referral sampling method used to recruit members of hard to reach populations (Heckathorn 1997a; Heckathorn 1997b). In order to begin recruitment, 12 seeds were selected, who broadly represented the racial and socio-economic status of the transwomen population in San Francisco. Participants who completed the survey and were eligible to recruit others were given 3-5 referral coupons, where were used to recruit others from their social networks.

250 transwomen were screened for eligibility, and 233 were eligible and completed the survey. The final sample of 149 excludes HIV+ participants in order to assess HIV risk. Verbal consent was obtained before beginning the survey. The TEACH2 survey was designed in QDS 2.6 (Nova Research) and administered by interviewers using hand held tablet computers. INSTI HIV-1 Antibody Tests were conducted following interviews. Participants who completed the survey and consented to HIV testing were given $50, and $10 was given for each coupon that recruited an eligible participant. All activities were approved by the University of California, San Francisco Committee on Human Research.

2.1 Independent Variables

Demographics. Age, race/ethnicity, education, and nativity, monthly income and health insurance status were reported. We constructed TWOC status by categorizing non-white race as TWOC.

Transphobic Discrimination and Gender Minority Stress Events. Transphobic discrimination was measured by seven gender minority stress events. Distal gender minority stressors included the following dichotomous measures: (1) Have you ever been fired from a job because of your gender identity or presentation?; (2) Have you ever experienced trouble getting a job because of your gender identity or presentation?; (3) Have you ever been denied housing or been evicted because of your gender identity or presentation?; and (4) Have you ever experienced problems getting health or medical services because of your gender identity or presentation? Proximal gender minority stressors included the following dichotomous measures: (1) Have you ever been "clocked" (or had your gender identity questioned)?; (2) Have you ever been verbally abused or harassed because of your gender identity or presentation?; and (3) Have you ever been physically abused or harassed because of your gender identity or presentation? These seven gender minority stress events were summed and cut points were made at tertiles to create categories – low, moderate and high levels – of transphobic discrimination.

2.2 Dependent Variables

HIV Risk. HIV risk was measured dichotomously and assessed the occurrence of any unprotected receptive anal intercourse (URAI) in the last six months.

Alcohol Use. Alcohol use was measured by assessing for binge drinking. Binge drinking was measured as a dichotomous outcome indicating if participants reported any or no occasion of consuming 5 or more drinks in one episode during the past six months (Wechsler and Nelson 2006).

2.3 Statistical analysis

I used univariate and bivariate statistics to determine differences in demographic characteristics, gender minority stressors, binge drinking and URAI between white transwomen and TWOC. We used logistic regression models to examine the relationship between levels of gender minority stress and binge drinking and URAI, controlling for potential confounders such as age, race/ethnicity and socioeconomic status. Regression models were constructed for each outcome for which there was a statistically significant difference in demographic characteristics at the bivariate level between sexual minority and heterosexual young transwomen. Stepwise models were built to consider the effects of demographic variables and TWOC status on levels of gender minority stress in the model.

3. Results

3.1 Sample characteristics

Table 1 describes differences in demographics, gender minority events, binge alcohol use and URAI stratified by transwomen of color status. Of the sample of 149 transwomen, 38 were white and 111 were TWOC. Compared to TWOC, white transwomen were more likely to be 50 years or older (χ^2=8.003, P-value=0.046), have more than a high school education (χ^2=6.821, P-value=0.009), be born in the United States (χ^2=10.225, P-value=0.001), and be insured (χ^2=4.439, P-value=0.035). A greater proportion of TWOC reported any URAI in the past six months (41.4% vs. 18.4%, χ^2=6.546, P-value=0.011), compared to their white counterparts.

Gender minority stress events are described in Table 1. Compared to TWOC, greater proportions of white transwomen reported ever been denied housing (47.4% vs. 26.1%,

χ^2=5.5.916, P-value=0.015), and had problems with medical care due to their gender identity (44.7% vs. 26.1%, χ^2=4.594, P-value=0.032). Greater proportions of white transwomen reported ever been "clocked" (or had their gender identity questioned) (94.74% vs. 83.2%, χ^2=4.786, P-value=0.029), and been physically abused due to their gender identity (81.6% vs. 63.1%, χ^2=4.444, P-value=0.035).

3.2 Multivariable analysis

The results of the multivariable analyses are summarized in Table 2. Transwomen who reported high levels of transphobic discrimination had more than three and a half fold greater odds of engaging in binge drinking in the past six months compared to those who reported a low level of transphobic discrimination [AOR, 3.590 (95% CI, 1.284-10.034; p-value = 0.015)], independent of TWOC status, age, education, nativity, and insurance status. Whereas, TWOC had a 2.9 fold greater odds of URAI in the last six months compared to white transwomen, controlling for levels of discrimination, age, education, nativity, and insurance status [AOR, 3.617 (95% CI, 1.438-9.098; p-value = 0.006)].

4. Discussion

This study found that a high level of transphobic discrimination was predictive of recent binge drinking. Minority stress frameworks may explain why those with high levels of transphobic discrimination binge drink compared to those with low levels. A minority stress framework argues that multiple minority statuses – and in this case, identifying as a gender and a racial minority – may exacerbate the effects of discrimination on health. Other studies have theorized this relationship and have found similar associations between transphobic discrimination and substance use (Keuroghlian, Reisner, White, and Weiss 2015), smoking

(Gamarel, Mereish, Manning, Iwamoto, Operario, and Nemoto 2016; Shires and Jaffee 2015b), as well as unsuccessful cessation attempts and never attempting cessation (Gamarel et al. 2016). In a study among young transwomen, those who experienced transphobic discrimination had increased odds of drug use, drug use concurrent with sex and use of multiple drugs (Rowe, Santos, McFarland, and Wilson 2015). While minority stress may explain the relationship between transphobic discrimination and binge drinking, this was not the case for models regressing on URAI where instead this study found race to be a significant correlate. This suggests that while transphobic discrimination and race may indeed have independent deleterious effects on trans health, their impact is not even across all types of HIV risk behaviors. In this case, there are risk differentials in binge drinking and URAI associated with high levels of transphobic discrimination and separately racial minority status.

In addition to this study's main findings, at the bivariate level, greater proportions of white transwomen compared to transwomen of color across four of the seven discrimination events were statistically significant. In keeping with minority stress frameworks, we initially hypothesized that a greater proportion of transwomen of color would report more transphobic discrimination. However, instead White transwomen reported greater transphobic discrimination. This finding is worth further exploration; for example, one remaining question is: how are transphobic discrimination and gender minority stress racialized? Going beyond the descriptive disparity that this study finds, what conceptions of risk for transphobic discrimination and gender minority stress are involved that may be shaped by race? One body of literature that might offer an explanation to why transwomen of color did not report greater gender minority stress events involves the practice of body modification and medical transition. Some transwomen may engage in medical transition such as initiating hormone replacement therapy to stimulate body

fat redistribution and breast tissue development. Body modification practices outside of medical transition include the injection of silicone or other fillers in certain parts of the body. Both of these gender transition practices are aimed toward achieving a binary gender presentation and body in order to pass as cisgender women. Passing may be one reason some transwomen do (or do not) experience transphobic discrimination or gender minority stress events. Passing has been studied as a way to manage stigma (Kando 1972), mitigating the stigmatization and transphobic discrimination from society, and as an act of resistance (Kanuha 1999). These passing practices may be taken up by transwomen differentially depending not only on race, but the cultural context of what a desirable body type might be. For example, the desired body type and/or expressions of femininity for an African American transwoman may be different than that of a White transwoman. Studies have shown racial disparities in conceptions of body size between White and Black women. One study found that lower socioeconomic status Black women had a wider range of what they considered to be "normal" and attractive body size, that was shaped by their lived experiences at the intersection of race, class, and gender (Allan, Mayo, and Michel 1993). Another study found that while most women preferred a curvaceous body type, more White women preferred an ideal that was slender and more Black women preferred a curvier ideal (Overstreet, Quinn, and Agocha 2010). No such studies have been conducted among transwomen. However, a study in San Francisco found that filler prevalence among transwomen was 16.7% (Wilson, Rapues, Jin, and Raymond 2014). Of transwomen who used injection fillers, 74.1% were transwomen of color with 33.2% being Latina, 40.9% African American and 1.6% Asian. These data may point to different conceptions of ideal body types which may in turn influence how some transwomen are able to navigate social spaces without being identified as

transgender – or pass – which may be a key precursor to experiencing discrimination based on transgender status.

This study is not without limitations. First, as with all cross-sectional studies, we cannot determine what behaviors are most likely contributing to HIV infection in this population. Also, a greater proportion of White transwomen were older compared to transwomen of color and two-thirds of the sample were transwomen of color who were not born in the US. As a result, while these findings may comparable to other diverse urban trans communities , it may not be generalizable to the nation where others have found to be less racially diverse (Shires and Jaffee 2015a). Second, how we operationalized transphobic discrimination was a crude approach to measuring lifetime exposure of a specific discrimination event and a distal proxy for gender minority stress. Instead of using a lifetime measure (e.g. have you ever experienced …?), it was our intention to measure gender minority stress events in the same temporal interval as potential HIV risk behaviors. At present there are no valid or reliable instruments to assess for gender minority stress. Future work in measurement of acute, chronic and everyday gender minority stress is needed. Additionally, this study did not measure racial discrimination. While transwomen of color did not report higher levels of transphobic discrimination, it is likely that they experienced higher levels of racial discrimination. We are unable to assess the impact of racial discrimination in conjunction with transphobic discrimination on HIV risk behaviors. How to best sample and the representativeness of RDS studies among transwomen is unclear. Bauer and Scheim published their concern over selection bias in studies of transwomen reported in Baral et al.'s systematic review and meta-analysis which found a pooled HIV prevalence of 19.1 % worldwide (Baral, Poteat, Stromdahl, Wirtz, Guadamuz, and Beyrer 2013; Bauer and Scheim 2013). In response to Bauer and Scheim, Baral et al. explained, ''sampling strategies that are

most pragmatic in most settings tend to oversample high risk transgender women,'' subsequently calling for improved sampling strategies (Baral, Poteat, Guadamuz, and Beyrer 2013). Due to this study's methods, these finding may only pertain to a subset of transwomen, in particular transwomen of lower socioeconomic status and higher risk.

Measurement of intersectionality in quantitative research is challenging (Veenstra 2011). For example, without applying more complex, higher-level statistical theory to comprehend the intersection at multiple axes of identity (Sen, Iyer, and Mukherjee 2009), the majority of studies rely on reductively reporting on the intersection of two axes at a time. For an intersectional analysis to consider greater numbers of axes, very large sample sizes are needed so that there are sufficient numbers of individuals who exhibit every possible combination. Additionally, there are intersections that may be invisible to researchers that were not previously conceived and therefore not measured in any one study which makes multiple subordinate-group identities invisible (Purdie-Vaughns and Eibach 2008). These limitations in quantitative intersectional research condition who is epidemiologically fathomable and limit the kinds of questions and hypothesis that can be tested (Dworkin 2005; Sen, Iyer, and Mukherjee 2009).

Despite these limitations, this study offers important findings that may inform future directions for the development of trans-specific HIV prevention interventions. While interventions aimed at eliminating transphobic discrimination may negate binge drinking episodes, they may have a limited impact on URAI. Conversely, interventions informed by racial equity and social justice to specifically target transwomen of color may be effective in preventing URAI.

Table 1. Demographics, gender minority stress events, binge alcohol use and unprotected receptive anal intercourse stratified by transwomen of color status in the San Francisco Bay Area, 2013.

	All (N=149)	Whites (n=38)	TWOC Status (n=111)	X^2	P-value
Age					
18-29	24 (16.1)	5 (13.2)	19 (17.1)		
30-39	27 (18.1)	3 (7.9)	24 (21.6)	8.003	0.046
40-49	49 (32.9)	11 (28.9)	38 (34.2)		
50+	49 (32.9)	19 (50.0)	30 (27.0)		
Race					
White	38 (25.5)	38 (100.0)	0 (0.0)		
Latina	50 (33.6)	0 (0.0)	50 (45.0)	149.00	0.0001
Black	34 (22.8)	0 (0.0)	34 (30.6)		
Other	27 (18.1)	0 (0.0)	27 (25.4)		
Education					
High school or less	82 (55.0)	14 (36.8)	68 (61.3)	6.821	0.009
More than high school	67 (45.0)	24 (63.2)	43 (38.7)		
Nativity					
US born	118 (79.2)	37 (97.4)	81 (73.0)	10.225	0.001
Monthly Income					
0-417	28 (18.8)	5 (13.2)	23 (20.7)		
418-833	24 (16.1)	6 (15.8)	18 (16.2)		
834-1250	57 (38.3)	14 (36.8)	43 (38.7)	2.807	0.744
1251-1667	10 (6.7)	4 (10.5)	6 (5.4)		
1668+	29 (19.5)	9 (23.7)	20 (18.0)		
Missing	1 (0.7)	0 (0.0)	1 (0.9)		
Health Insurance Status					
Insured	125 (83.9)	36 (94.7)	89 (80.2)	4.439	0.035
Ever been fired from a job due to GID					
Yes	47 (31.5)	14 (36.8)	33 (29.7)	0.663	0.415
Ever had trouble getting a job due to GID					
Yes	82 (55.0)	22 (57.9)	60 (54.1)	0.169	0.681
Ever been denied housing due to GID					
Yes	47 (31.5)	18 (47.4)	29 (26.1)	5.916	0.015
Ever had problems with medical care due to GID					
Yes	46 (30.9)	17 (44.7)	29 (26.1)	4.594	0.032
Ever been "clocked" or had GID questioned					
Yes	125 (83.9)	36 (94.7)	89 (83.2)	4.786	0.029
Ever been verbally abused due to GID					
Yes	128 (85.9)	36 (94.7)	92 (82.9)	3.285	0.070
Ever been physically abused due to GID					
Yes	101 (67.8)	31 (81.6)	70 (63.1)	4.444	0.035
Any binge drinking (last 6 months)					
Yes	49 (32.9)	11 (28.9)	38 (34.2)	0.359	0.549
Any URAI (last 6 months)					
Yes	53 (35.6)	7 (18.4)	46 (41.4)	6.546	0.011

Table 2. Binary logistic regression analyses: Binge Drinking and Unprotected Receptive Anal Intercourse among transwomen in the San Francisco Bay Area.

	Binge Drinking (last 6 months)			URAI (last 6 months)		
	OR	95% CI	P	OR	95% CI	P
Levels of Transphobic Discrimination						
Low	REF			REF		
Moderate	2.732	(0.987, 7.559)	0.053	1.414	(0.533, 3.755)	0.487
High	**3.590**	**(1.284, 10.034)**	**0.015**	2.057	(0.771, 5.489)	0.150
Transwomen of Color Status						
No	REF			REF		
Yes	1.325	(0.517, 3.398)	0.558	**2.979**	**(1.048, 8.464)**	**0.040**
Age						
18-29	2.186	(0.710, 6.728)	0.173	1.040	(0.309, 3.503)	0.949
30-39	1.254	(0.413, 3.803)	0.690	**6.368**	**(2.043, 19.852)**	**0.001**
40-49	1.73	(0.686, 4.363)	0.246	2.172	(0.832, 5.673)	0.113
50+	REF			REF		
Education						
HS or less	0.571	(0.272, 1.200)	0.139	0.623	(0.289, 1.343)	0.227
More than HS	REF			REF		
Nativity						
US Born	REF			REF		
Foreign Born	1.048	(0.392, 2.806)	0.925	0.454	(0.158, 1.303)	0.142
Insurance Status						
Uninsured	0.621	(0.217, 1.773)	0.373	1.537	(0.563, 4.200)	0.402
Insured	REF			REF		

III. Paper 2 – Sexual minority disparities in alcohol and substance use among young transwomen in the San Francisco Bay Area

1. Introduction

Transwomen are a gender minority group that experiences health disparities in a number of diseases areas, with much of the research focusing on HIV risk (Bockting, Miner, Swinburne Romine, Hamilton, and Coleman 2013; Wilson et al. 2015; Xavier, Honnold, and Bradford 2007). Numerous studies have found elevated rates of HIV among transwomen in combination with other HIV-related health and social risk factors (Baral et al.). For example, a study in Peru documented an HIV prevalence of 30% (Silva-Santisteban, Raymond, Salazar, Villayzan, Leon, McFarland, and Caceres 2012). Herpes simplex virus and syphilis were also endemic at 79% and 23% prevalence (Silva-Santisteban et al. 2012). A respondent-driven sampling study in San Francisco found an HIV prevalence of 39.5% among transwomen (Rapues et al. 2013). In that study, racial/ethnic minority status, injection drug use, and low educational attainment were associated with HIV acquisition (Rapues et al. 2013).

Transwomen also have elevated rates of substance use, mental health disorders and experiences of violence, which are all factors linked to engagement in sexual risk behavior and HIV. Recent studies have found high rates of alcohol, methamphetamine, injection drug and marijuana use among transwomen (Reback and Fletcher 2014; Santos et al. 2014). A three year prospective study in New York City found that gender abuse, in the form of psychological and physical abuse, and major depression were endemic among transwomen (Nuttbrock et al. 2014). The National Transgender Discrimination Study found that 47% of previously incarcerated transwomen were victimized while in jail or prison (Reisner, Bailey, and Sevelius 2014). A study in Colorado found that transgender people experienced greater lifetime intimate partner violence

compared to their cisgender, or non-transgender, lesbian, gay and bisexual (LGB) counterparts (Langenderfer-Magruder et al. 2014).

2. Minority stress frameworks, health disparities and gender minorities

Rooted in social stress theory, minority stress research has investigated the impact of stigmatization and chronic stress that sexual minorities experience within the context of living in a heterosexist society (Meyer 1995; Meyer 2003). Conceptualized as a social psychological process, research on sexual minority stress has furthered our understanding of the consequences of stigma, prejudice and discrimination on mental health. The sexual minority stress framework posits that sexual minorities are exposed to excess stress related to a variety of stigma-related experiences (Meyer 2003). These stigma experiences may include prejudice-related events such as being physically attacked or denied housing, everyday discrimination, self-devaluation and the anticipation of discrimination related to the internalization of homophobia and heterosexism (Meyer 2003).

Though early sexual minority stress research has focused on gay men, this work has grown to include other sexual minorities, such as lesbian and bisexual women (Meyer 2003), and intersecting minority status, primarily minority race/ethnicity and minority sexual orientation (Meyer 2010; Meyer, Schwartz, and Frost 2008). Compared to heterosexual women, sexual minority women are faced with higher rates of smoking and respiratory illnesses (Blosnich, Jarrett, and Horn 2010; Johns, Pingel, Youatt, Soler, McClelland, and Bauermeister 2013). Disproportionate rates of substance use and alcohol use have also been shown to impact sexual minority women (Rosario 2008; Rosario, Schrimshaw, and Hunter 2008). An HIV risk study found sexual minority women were two to three times more likely than their heterosexual

counterparts to engage in HIV risk behavior and experience suicide ideation (Cochran, Mays, Alegria, Ortega, and Takeuchi 2007; Lee and Hahm 2012). Risk classifications tend to omit sexual minority status among women and perpetuate sexual orientation-related health disparities among women (Marrazzo 2004). Left unaddressed, these health disparities have major ramifications for population health and perpetuate barriers to healthcare access for sexual minority women (Bernhard 2001; Dearing and Hequembourg 2014; McNair 2003; Molina, Lehavot, Beadnell, and Simoni 2014).

As literature on the physiology of stress has developed, research has established a link between sexual minority stress and poor physical health. One study of 396 lesbian, gay and bisexual individuals (LGBs) found greater odds of physical health problems among those who experienced a prejudice event compared to those who did not (Frost, Lehavot, and Meyer 2015). While much of the minority stress literature addresses sexual minority disparities among cisgender LGB populations, few studies have applied the minority stress framework to gender minorities. Growing evidence suggests that minority gender identity, like other minority statuses, is a source of minority stress (Gamarel et al. 2016; Gamarel et al. 2014; Reisner, Gamarel, Nemoto, and Operario 2014; Reisner, Greytak, Parsons, and Ybarra 2015; Reisner, Pardo, Gamarel, Hughto, Pardee, and Keo-Meier 2015; Seelman 2016). The National Transgender Discrimination Survey (n=2,578) assessed a gender minority stress model of substance use and found that discrimination by a medical provider was associated with substance use as a coping strategy (Reisner et al. 2015). Other studies have found that discrimination was associated with suicide ideation (Rood, Puckett, Pantalone, and Bradford 2015) and greater odds of smoking and unsuccessful cessation attempts (Gamarel et al. 2016).

While many studies have aggregated transwomen with gay and bisexual men (Andrinopoulos, Hembling, Guardado, de Maria Hernandez, Nieto, and Melendez 2015; Chariyalertsak, Kosachunhanan, Saokhieo, Songsupa, Wongthanee, Chariyalertsak, Visarutratana, and Beyrer 2011; Kellogg, Clements-Nolle, Dilley, Katz, and McFarland 2001; Nemoto, Luke, Mamo, Ching, and Patria 1999; Solomon, Mayer, Glidden, Liu, McMahan, Guanira, Chariyalertsak, Fernandez, Grant, and iPrEx Study 2014) or high risk heterosexual cisgender women (Baral, Holland, Shannon, Logie, Semugoma, Sithole, Papworth, Drame, and Beyrer 2014), it is rare for researchers to stratify results on the basis of sexual minority status among transwomen. In one study, transwomen were analyzed together with LGB cisgender women, perpetuating the conflation between sexual orientation and gender identity (Logie, James, Tharao, and Loutfy 2012). In samples consisting of only transwomen, sexual minority transwomen are often lumped with heterosexual transwomen, primarily focused on heterosexual HIV risk (Nemoto, Bodeker, Iwamoto, and Sakata 2014; Nuttbrock et al. 2014). For example, a study conducted in New York City measured the lifetime exposure of HIV/STI infection among transwomen. While they found that heterosexual transwomen bore the brunt of HIV and STI infection risk, almost a third of their sample (32.6%) identified as lesbian or bisexual (Nuttbrock et al. 2014). The authors' analysis, however, did not examine exposures or outcomes specific to sexual minority transwomen. As a result, the risk profile of sexual minority transwomen is unclear.

3. Intersectionality

Intersectionality is a framework that allows for the study of multiple intersecting identities. Intersectionality has been described as a prism, a multidimensional lens through which

to analyze lived experiences socially located at the intersection of various axes of identity. It allows researchers to better understand how multiple forms of stigma, oppression, and power relations converge and work together to shape inequity. Intersectionality acknowledges that the overall organization of power in a society exists within a matrix of domination consisted of intersecting systems of oppression, organized through interacting of power domains: structural, disciplinary, hegemonic and interpersonal (Hill Collins 2000).

Kimberle Crenshaw, a legal scholar and critical theorist, coined the term intersectionality (Crenshaw 1991). Her work problematized identity politics as a failed attempt to look beyond difference, but rather conflated or ignored difference within groups. Her work in particular dealt with violence against women where she argued that women's experiences of violence are shaped by other dimensions of their identities such as race and class. She explains, "when the practices expound identity as woman or person of color as an either/or proposition, they relegate the identity of women of color to a location that resists telling" (Crenshaw 1991: 1242). She goes on to argue that because feminism and antiracism are structured to attend to identities in a mutually exclusive manner, women of color are marginalized within both contexts.

The application of intersectionality to health does not only shed light on social inequities but also explains how complexity and social unevenness is perpetuated at the intersection of multiple axes of identity (McGibbon 2011). For example, Agenor et al (2014) uses intersectionality to examine women's health, specifically the utilization of a Pap test, at the intersection of sexual orientation and race/ethnicity (Agenor et al. 2014). Women with only female sexual partners were less likely to have reported a Pap test in the last year compared to women with only male sexual partners. Nested within this finding, the authors found that this disparity is greater for Black women compared to White women. This study finds that sexual

minority disparities are exacerbated for those at the intersection of minority sexual orientation and ethnic-racial identity. Not only can intersectionality show how society is structured unevenly, it can also challenge explanatory frameworks. Viruell-Fuentes and co-authors (2012) argue for an intersectional approach rather than individual culture-based frameworks in explaining health disparities among immigrants. They explain that while individual culture-based frameworks organize around the problem of acculturation, that is, poor health as a result of having to replace their own culture with the cultural characteristics of the country they have immigrated to, intersectional approaches are critical to problematizing immigrant health (Viruell-Fuentes, Miranda, and Abdulrahim 2012). Rather than over relying on cultural explanations, research on immigrant health must employ intersectionality, undergo a conceptual shift and consider the meanings of structural racism, racialization and structural heirarchies, residential segregation, immigration policies and other determinants altogether (Viruell-Fuentes, Miranda, and Abdulrahim 2012). Other studies have found that structural and social factors over contextual factors alone are intricately linked to inequities in health (Krieger, Waterman, Gryparis, and Coull 2015; Seng et al. 2012; Veenstra 2011).

Transwomen are not often examined with an intersectional lens and it is critical to understanding their health. Lacombe-Duncan (2016) explains that the majority of quantitative studies on transgender health do not explicitly apply theory and few qualitative studies that have applied intersectionality to understand the experiences of transgender women living with HIV (Lacombe-Duncan 2016). One qualitative study of stigma among 104 women in Ontario, Canada of which 22% were transwomen, argued that these women experienced independent and mutually constitutive relationships between their marginalized identities and social inequities (Logie, James, Tharao, and Loutfy 2011; Logie, James, Tharao, and Loutfy 2012). One

psychological study used an intersectional approach integrating theories from sexual minority stigma, body objectification and HIV stigma to develop a framework for gender affirmation (Sevelius 2013).

Informed by intersectionality and the sexual minority stress framework, this analysis takes an "intersectionality-informed stance" and examines differences in demographic characteristics and alcohol and substance use between sexual minority and heterosexual transwomen (Bowleg 2012: 1270). It builds on both gender and sexual minority research by investigating the intersection of sexual minority disparities in a sample of gender minorities.

4. Materials and methods

4.1 Study sample and data collection

This study is a cross-sectional secondary analysis of baseline data from a longitudinal study of HIV risk and resilience among young transwomen in the San Francisco Bay Area. Recruitment for the study consisted of a mix of peer referral, outreach on social networking sites and at in-person community-based events. Recruitment procedures are described in previously published research (Arayasirikul, Chen, Jin, and Wilson 2015; Rowe, Santos, McFarland, and Wilson 2014). Inclusion criteria for the study were: being 16 to 24 years old, identifying as transgender or any gender identity other than that typically associated with their male sex assigned at birth, and living in the San Francisco Bay Area. After being screened for eligibility, participants provided informed consent. The behavioral survey was administered in-person by an interviewer using a tablet computer. Research procedures were approved by the Institutional Review Board at the University of California, San Francisco.

4.2 Independent Variables

Sexual minority status was determined by asking participants what was their sexual orientation. Participants who identified as anything other than heterosexual – or more specifically those who identified as lesbian, bisexual, queer, or pansexual – were coded as a sexual minority. Individuals who identified as asexual, questioning or unknown were excluded. Socioeconomic status was determined using self-reported monthly income. Age, race/ethnicity, highest level of education completed, and foreign-born status are reported. We assessed access to gender affirmative care through asking participants whether or not they are currently taking hormones and if they have ever had feminization procedures (FP) such as laser hair removal, breast augmentation, facial feminization surgery, or gender confirmation surgeries such as a penectomy, orchiectomy, or vaginoplasty.

4.3 Dependent Variables

Alcohol use was measured by assessing for heavy episodic drinking (HED). HED was measured as a dichotomous outcome indicating if participants reported any or no occasion of consuming 5 or more drinks in one episode during the past six months (Wechsler and Nelson 2006). We assessed use of methamphetamine, crack/cocaine, and illicit prescription drug use as dichotomous variables indicating whether or not participants reported any or no drug use during the past six months.

4.4 Statistical analysis

I used univariate and bivariate statistics to determine differences in demographic characteristics between sexual minority and heterosexual transwomen. We used logistic

regression models to examine the relationship between sexual minority status and alcohol and substance use, controlling for potential confounders such as age, race/ethnicity and socioeconomic status. Regression models were constructed for each outcome for which there was a statistically significant difference in demographic characteristics at the bivariate level between sexual minority and heterosexual young transwomen. Stepwise models were built to consider the effects of demographic and gender transition related variables on the other variables in the model.

5. Results

5.1 Sample characteristics

The sample for this secondary analysis included 259 young transwomen. Table 1 describes overall demographic characteristics and those for sexual minority and heterosexual participants. Nearly two-thirds of participants (64.9%) identified as a sexual minority. Overall, the sample was racially diverse with 39.8% whites, 28.6% Latina, 12.7% Black 8.5% Asian and 10.4% other race. A little over two-thirds of participants were aged 21-24 years. The majority of participants identified as female or transwoman (78.3%), had a high school diploma or less education (54.1%), were born in the United States (83.0%), made $1000 or less a month (72.2%), were currently taking hormones (57.5%) and had not undergone gender feminization procedures (69.5%).

Compared to heterosexuals, a greater proportion of sexual minority transwomen identified as white (50.0% vs. 20.9%; Chi-square = 25.337, p-value = 0.0001), and genderqueer or questioning (25.0% vs. 2.2% and 7.1% vs. 0.0%, respectively; Chi-square = 32.870, p-value < 0.0001). Greater proportions of sexual minority transwomen were born in the United States

(88.1% vs. 73.6%; Chi-square = 8.763, p-value = 0.003) and had some college or a Bachelor's degree (40.5% vs. 27.5% and 15.5% vs. 0.0%, respectively; Chi-square = 28.4210, p-value = 0.0001). Additionally, a greater proportion of sexual minority transwomen were not currently taking hormones compared to their heterosexual counterparts (50.0% vs. 28.6%; Chi-square = 11.093, p-value = 0.001).

5.2 Alcohol use and substance use outcomes

Table 2 describes overall alcohol and substance use and differences by sexual minority status. A little over half of participants (54.1%) reported any heavy episodic drinking episodes in the last six months. 13.5% of participants reported any methamphetamine use. 16.6% of participants reported any crack/cocaine use and 20.8% reported any illicit prescription drug use. Statistically significant differences between sexual minority transwomen and heterosexual transwomen were found in alcohol use and illicit prescription drug use. Significantly greater proportions of sexual minority transwomen reported any heavy episodic drinking episodes (61.3% vs. 40.7%; Chi-square = 10.135, p-value < 0.001) and any illicit prescription drug use (28.0% vs. 7.7%; Chi-square = 14.717, p-value < 0.0001) in the last six months compared to their heterosexual counterparts.

5.3 Multivariable analysis

The results of the multivariable analyses are summarized in Tables 3. Sexual minority transwomen had more than two fold greater odds of engaging in heavy episodic drinking in the past six months as compared to heterosexual transwomen [AOR, 2.294 (95% CI, 1.212-4.232; p-value = 0.008)], independent of race/ethnicity, age, income, nativity, hormone status and history

of feminization procedures. Additionally, sexual minority transwomen had 3.6 fold greater odds of recent illicit prescription drug use compared to heterosexual transwomen [AOR, 3.617 (95% CI, 1.438-9.098; p-value = 0.006)].

6. Discussion

Health at the intersection of sexual orientation among gender minorities is understudied. To address this gap, the current study examines sexual minority health disparities among a sample of young transwomen. Transwomen are not a homogenous population and, like other populations, their intersecting identities shape their health outcomes (Watkins-Hayes 2014). In this analysis, we found that sexual minority young transwomen were significantly more likely to report recent heavy episodic drinking and illicit prescription drug use compared to their heterosexual counterparts. While the majority of research with transwomen has taken on a heterosexist lens to understand HIV risk by failing to disaggregate samples by sexual identity, these findings support investigating sexual minority status as a source of health disparities among transwomen.

Our findings on alcohol and substance use among sexual minority transwomen are consistent with research conducted among sexual minority cisgender women (Kerby, Wilson, Nicholson, and White 2005; Trocki, Drabble, and Midanik 2009). Research from the National Alcohol Survey, a national population-based survey of adults in the United States, found that sexual minority cisgender women had lower alcohol abstention rates, greater odds of alcohol dependence and greater reporting of an alcohol-related social consequence compared to heterosexual cisgender women (Drabble, Midanik, and Trocki 2005; Drabble and Trocki 2005). These findings have persisted through three waves of the National Alcohol Survey (Drabble,

Trocki, Hughes, Korcha, and Lown 2013). A study on drinking context among bar patrons in Northern California found that sexual minority status among cisgender women was associated with higher risk of excessive alcohol consumption (Trocki and Drabble 2008).

While these findings suggest that sexual minority transwomen are at elevated risk for hazardous drinking and substance use, it is important to interrogate heterosexuality among transwomen and understand the context and mechanisms embedded within heterosexuality that may be protective against risk. Exploring these factors may offer potential explanations as to why sexual minority transwomen in this study experienced greater risk for hazardous drinking and substance use. A qualitative study conducted with sexual minority and heterosexual cisgender women found that the meaning of alcohol consumption in fostering community connection was more salient for sexual minority cisgender women and similar meanings may help understand alcohol and substance use in sexual minority transwomen (Drabble and Trocki 2014). Are there specific environments and conditions – physical, relational, community-level, familial, discursive, or ideological – embedded within hegemonic heteronormativity that protect heterosexual transwomen from the sexual minority health disparities identified in this study? For example, social network ties among transwomen may be stratified by sexual minority status. If sexual minority transwomen have greater affinity toward other sexual minority transwomen rather than heterosexual transwomen, they may also share normative beliefs and behaviors that might lead to greater hazardous drinking or substance use. Additionally, if sexual minority transwomen do find greater affinity with each other and their sexual fluidity is such that their sexual networks are similar to or the same as their friendship networks, hazardous binge drinking and substance use may play a role in facilitating social and sexual interactions in their specific networks. The overlapping or mixing of social, sexual and substance using networks has been

shown in studies of men who have sex with men (Schneider, Cornwell, Ostrow, Michaels, Schumm, Laumann, and Friedman 2013); however, there have been no published studies on the social networks of transwomen.

Intersectionality makes space for the co-constitution of many types of risk along different axes of identity (Berger 2004). Intersectionality increases diversity in the types of positionalities that can be reflected in research (Bowleg 2012). Future studies from an intersectionality-informed stance are needed to better understand social inequality and how multiple minority identities synchronistically influence health behaviors and outcomes. Furthermore, this study underscores the importance of disaggregation of transwomen by sexual orientation. Lumping sexual minority with sexual majority (or heterosexual) transwomen potentially perpetuates an ecological fallacy in transwomen's health research, where health outcomes specific to heteronormativity at the aggregate level are then inferred at the individual level independent of sexual orientation and applied erroneously to sexual minority transwomen. For this reason, we recommend future research studies collect sexual minority status data separate from and in addition to gender identity data and that transgender health care providers and interventionists screen for sexual minority status as an indicator of heavy episodic drinking and substance use.

This study is not without limitations. This study did not employ probability-based sampling and was limited to the San Francisco Bay Area. Therefore, these findings are not generalizable to all transwomen or those in other geographic regions. Sexual minority status in this study was operationalized using sexual identity as a measure rather than a measure of same sex behavior. Previous research among cisgender populations has found that for sexual minority cisgender men, alcohol use did not vary by identity or behavior measures of sexual minority status; however, for sexual minority cisgender women, use of behavior measures alone provided

lower estimates of alcohol related outcomes (Midanik, Drabble, Trocki, and Sell 2007). There are no established best practices specific to the measurement of sexual minority status among gender minorities, especially with regard to identities that are non-binary (e.g. pansexual, queer) and additional research is needed. Moreover, identity stability over time and into adulthood for young transwomen remains unexplored.

How to best sample and the representativeness of RDS studies among transwomen is unclear. Bauer and Scheim published their concern over selection bias in studies of transwomen reported in Baral et al.'s systematic review and meta-analysis which found a pooled HIV prevalence of 19.1 % worldwide (Baral et al. 2013; Bauer and Scheim 2013). In response to Bauer and Scheim, Baral et al. explained, ''sampling strategies that are most pragmatic in most settings tend to oversample high risk transgender women,'' subsequently calling for improved sampling strategies (Baral, Poteat, Guadamuz, and Beyrer 2013). This study implemented RDS in combination with online social network strategies and we found that sampling approach introduced important diversity this sample of young transwomen, in particular diversity in age and HIV risk (Arayasirikul, Chen, Jin, and Wilson 2015). At the same time, youth, adolescents and young adults are underrepresented in HIV research, especially due to HIV-related perceived stigma and negative social (DiClemente, Ruiz, and Sales 2010). Racial, gender, and sexual minorities are especially vulnerable to medical fear of authority, mistrust, stigma, mistreatment, and exploitation (Bonevski, Randell, Paul, Chapman, Twyman, Bryant, Brozek, and Hughes 2014; Brawner, Volpe, Stewart, and Gomes 2013; Miller, Wickliffe, Jahnke, Linebarger, and Dowd 2014; Valaitis 2002) [39–42]. Methodological developments in RDS studies

to include the use of the Internet may help to address these challenges and make research more accessible and youth-friendly (Bauermeister, Zimmerman, Johns, Glowacki, Stoddard, and Volz 2012; Wejnert 2008).

Despite limitations, this study is the first to demonstrate sexual minority health disparities in alcohol and substance use in a gender minority group of transwomen and suggests that sexual minority stress may play an important role in disparities among transwomen. However, we caution merely reproducing conceptions of sexual minority stress based on cisgender populations; instead, robust qualitative research is necessary to understand not only how sexual minority stress is framed among gender minorities but also how gender minority identity intersects with sexual minority identity. Future work must address measurement of gender minority stress as well as its relationship to sexual minority identity and sexual minority stress.

Table 1. Overall sample demographics stratified by heterosexual or sexual minority status among young transwomen aged 16-24 in the San Francisco Bay Area, 2012-2014.

	Overall (N=259)	Heterosexual Transwomen (n=91)	Sexual Minority Transwomen (n=168)	X^2	P-value
Race					
White	103 (39.8)	19 (20.9)	84 (50.0)	25.337	0.0001
Latino	74 (28.6)	39 (42.9)	35 (20.8)		
Black	33 (12.7)	16 (17.6)	17 (10.1)		
Asian	22 (8.5)	7 (7.7)	15 (8.9)		
Other	27 (10.4)	10 (11.0)	17 (10.1)		
Age					
16-17	18 (6.9)	8 (8.8)	10 (6.0)	0.976	0.614
18-20	65 (25.1)	24 (26.4)	41 (24.4)		
21-24	176 (68.0)	59 (64.8)	117 (69.6)		
Gender identity					
Female	119 (45.9)	48 (52.7)	71 (42.3)	32.87	0.000
Trans woman	84 (32.4)	41 (45.1)	43 (25.6)		
Genderqueer	44 (17.0)	2 (2.2)	42 (25.0)		
Questioning or Other	12 (4.6)	0 (0.0)	12 (7.1)		
Education					
Some high school or less	52 (20.1)	29 (31.9)	23 (13.7)	28.421	0.0001
High school diploma or GED	88 (34.0)	37 (40.7)	51 (30.4)		
Some college	93 (35.9)	25 (27.5)	68 (40.5)		
Bachelor's degree or more	26 (10.0)	0 (0.0)	26 (15.5)		
Nativity					
Foreign born	44 (17.0)	24 (26.4)	20 (11.9)	8.763	0.003
US born	215 (83.0)	67 (73.6)	148 (88.1)		
Monthly Income					
$1000 or less a month	187 (72.2)	64 (71.1)	123 (74.1)	0.264	0.607
More than $1000 a month	69 (26.6)	29 (28.9)	43 (25.9)		
Missing	3 (1.2)				
Currently taking hormones					
No	110 (42.5)	26 (28.6)	84 (50.0)	11.093	0.001
Yes	149 (57.5)	65 (71.4)	84 (50.0)		
Ever had feminization procedures					
No	180 (69.5)	60 (65.9)	120 (71.4)	0.841	0.359
Yes	79 (30.5)	31 (34.1)	48 (28.6)		

Table 2. Differences in alcohol and substance use by sexual minority status among young transwomen in the San Francisco Bay Area, 2012-2014.

	Overall (N=259)	Heterosexual Transwomen (n=91)	Sexual Minority Transwomen (n=168)	X^2	P-value
Alcohol Use (Last 6 mo)					
Heavy Episodic Drinking	140 (54.1)	37 (40.7)	103 (61.3)	10.135	0.001
Substance Use (Last 6 mo)					
Methamphetamine Use	35 (13.5)	14 (15.4)	21 (12.5)	0.420	0.517
Crack/Cocaine Use	43 (16.6)	12 (13.2)	31 (18.5)	1.182	0.277
Illicit Prescription Drug Use	54 (20.8)	7 (7.7)	47 (28.0)	14.717	0.0001

Table 3. Binary logistic regression analyses: alcohol and substance use outcomes by sexual minority status among young transwomen in the San Francisco Bay Area.

	Heavy Episodic Drinking			Illicit Prescription Drug Use		
	OR	95% CI	p	OR	95% CI	p
Sexual Minority Status						
No	REF			REF		
Yes	**2.294**	**(1.212, 4.232)**	**0.008**	**3.617**	**(1.438, 9.098)**	**0.006**
Race						
White	REF			REF		
Latino	1.625	(0.767, 3.443)	0.205	0.563	(0.228, 1.391)	0.213
Asian	0.361	(0.118, 1.101)	0.073	0.420	(0.101, 1.755)	0.234
Black	0.683	(0.282, 1.652)	0.397	0.229	(0.049, 1.076)	0.062
Other Race	0.679	(0.273, 1.690)	0.405	0.787	(0.270. 2.291)	0.661
Age						
16-17 years old	**0.161**	**(0.041, 0.627)**	**0.009**	0.345	(0.041, 2.913)	0.328
18-20 years old	0.654	(0.353, 1.213)	0.178	0.540	(0.235. 1.241)	0.147
21-24 years old	REF			REF		
Monthly Income						
$1000 or less	0.612	(0.328, 1.140)	0.121	0.635	(0.309, 1.308)	0.218
$1001 or more	REF			REF		
Nativity						
US Born	REF			REF		
Foreign Born	0.760	(0.329, 1.759)	0.522	0.725	(0.226, 2.320)	0.588
Current HRT Status						
No	1.270	(0.687, 2.347)	0.446	0.755	(0.348, 1.637)	0.477
Yes	REF			REF		
History of FP						
No	0.984	(0.533, 1.815)	0.958	1.283	(0.586, 2.810)	0.533
Yes	REF			REF		

IV. Paper 3 – Intersectional Oppression: Examining transmisogyny and stress among young transwomen

Introduction

Minority stress frameworks have provided a theoretical platform for investigating the impact of stigmatization and chronic stress that minorities, in particular sexual minorities, experience within the context of living in a heterosexist society (Meyer 1995; Meyer 2003). Research on minority stress has furthered our understanding of the consequences of discrimination, or enacted stigma, on mental health in particular (Meyer 2010). The minority stress framework posits that sexual minorities are exposed to excess stress related to a variety of stigma-related experiences (Meyer 2003). These stigma experiences may include prejudice-related events such as being physically attacked or denied housing, everyday discrimination, self-devaluation and the anticipation of discrimination related to the internalization of heteronormativity and heterosexism (Meyer 2003). Minority stress researchers have gone on to argue that multiple minority statuses, for example minority sexuality and racial identity, exacerbate discrimination and stress and its deleterious effect on health (Meyer 2010).

Meyer's work (2003) explains how the social environment shapes minority status and minority identity. While all people experience general stressors, sexual minorities experience greater stress due to living in a heterosexist society. Sexual minorities experience internalized homophobia, expectations of rejection and the need to conceal one's identity as a proximal stress process, linked to discrimination and violence distally. Meyer explains that potential points of intervention might lie in changing how sexual minorities cope with sexual minority stress through the provision of social support on both a community level and individual level and changing the characteristics of being a sexual minority in a homophobic society. An example of

the latter is attributing a positive valence on sexual minority identity; instead of associating sexual minority identity with negative stereotypes, reclaiming sexual minority identity. Another example is reducing the prominence of sexual minority identity through foregrounding other identities (e.g. "I am not only a lesbian woman, I am also a strong Black woman" or "Being LGB is a small part of my life.").

Minority stress frameworks have been widely adopted by sexual minority researchers and are beginning to be applied an explanation of health disparities among transwomen. Studies have shown high rates of alcohol, methamphetamine, injection drug and marijuana use among transwomen (Reback and Fletcher 2014; Santos et al. 2014). A three-year prospective study in New York City found that gender abuse, in the form of psychological and physical abuse and major depression were endemic among transwomen (Nuttbrock et al. 2014). In another study, transwomen, compared to transmen, exhibited lower self-esteem which was associated with greater lifetime internet sexual partners (Benotsch et al. 2014). The National Transgender Discrimination Study found that 47% of transwomen who have ever been incarcerated reported being victimized while being incarcerated (Reisner, Bailey, and Sevelius 2014). Minority stress may be useful in thinking about the social production of gender minority stress among transwomen as a result of transphobia in society; however, current work does not adequately describe the social process or intersectional oppression and stress that transwomen face that shape these health disparities. Few researchers have attempted to simply substitute gender minority stress for sexual minority stress (Gamarel et al. 2014; Reisner, Gamarel, Nemoto, and Operario 2014). This work assumes few theoretical difference between gender and sexual minorities, falling short in attending to the specific social location of transwomen. Moreover, this research doesn't attend to the specific social forces and social processes at work that shape these

disparities in health. Instead, this work crudely assumes that transphobia is the main driver of gender minority stress, without characterizing how transphobia and other social forces intersect to shape the social location of transwomen. This paper seeks to examine a distinct source of intersectional oppression and stress at the specific intersection of sex and gender.

Transmisogyny as a Form of Intersectional Oppression and Stress

This study uses intersectionality as a theoretical framework to analyze the social forces that reinforce the social location of transwomen. Intersectionality allows for the study of multiple intersecting identities. Often described as a prism through which to analyze lived experiences socially located at the intersection of various axes of identity, intersectionality allows us to understand how multiple forms of oppression and power relations converge and work together to shape inequity. Intersectionality acknowledges that the overall organization of power in a society exists within a matrix of domination consisted of intersecting systems of oppression, organized through interacting of power domains: structural, disciplinary, hegemonic and interpersonal (Hill Collins 2000). Intersectionality argues that social inequalities and health cannot be understood through a single axis understanding of identity (Berger 2004; Crenshaw 1991; Dworkin 2005). Research that attends to the simultaneity of multiple axes of identity can better explain social locations, lived experiences, and health outcomes than any single identity can alone (Bowleg 2012).

Sociological work not only provides an understanding of the lived experiences of trans people but also allows us to shine light on societal forces that operate at the macro level. An example of this is Schilt and Westbrook's (2009) work with trans and cisgender narratives, in particular focused on interactions with "gender normals" (Schilt and Westbrook 2009:441).

Schilt interviewed over fifty transmen out at the workplace and Westbrook analyzed the discourse that framed media reports of trans murders. Drawing from two case studies, their comparative analysis reveals the process by which the doing of gender by trans people is intricately linked to heteronormativity. They show that trans people do gender in public and in private relationships to pass as the gender with which they identify, foregrounding the preservation of heteronormativity through these social interactions in both public and private relationships.

A great deal of scholarship involving transgender people is concerned with gender conformity or alignment of one's gender expression and gender identity. From Garfinkel's study of Agnes as the to the coming out of Christine Jorgensen, passing as cisgender has been held as a gold standard, rationalizing one's transition from one gender to another (Vidal-Ortiz 2008). Passing has been studied as a way to manage stigma (Kando 1972), mitigating the stigmatization and transphobic discrimination from society, and as an act of resistance (Kanuha 1999). Doing gender outside of society's gender ideals may lead to being ostracized from society, reinforcing the necessity for gender conformity (Pfeffer 2010).

Gender conformity stigma has been linked to inequities in health. A study examining gender non-conformity among a large national sample of trans people was conducted using the National Transgender Discrimination Survey (Miller and Grollman 2015). Miller and Grollman (2015) draw from the sociology of gender, symbolic interactionism, Goffmanian stigma and the minority stress theory, a social psychological framework for understanding the impact of discrimination on mental health among sexual minorities of color. The authors hypothesized that gender non-conformity, a visible marker of trans identity, was associated with greater discrimination. They found that compared to gender conforming trans people, gender non-

conforming trans people face more discrimination and are more likely to engage in negative health behaviors, specifically attempted suicide, drug and alcohol abuse and smoking.

Transwomen are particularly vulnerable to transmisogyny (Serano 2007). Transmisogyny is extremely understudied and has been used to describe interlocking forms of gender oppression (Serano 2007) and associated with barriers to health care access, self-esteem and safety (Vidal-Ortiz 2008). Transmisogyny is the product of the overlap of both cissexism and sexism. Cissexism and sexism are oppressive ideologies, the former privileges cisgender identity as the dominant norm and the latter privileges men in societal power relations. Cissexism produces transphobia and sexism produces misogyny, systematic marginalization and stigmatization of trans people and women in society, respectively. Cissexism and sexism, transphobia and misogyny synchonistically work together to create transmisogyny as a form of intersectional stress that transwomen experience. This study aims to describe the contours of transmisogyny, how is transmisogyny socially reinforced and through what processes, and what the social consequences are.

Method

This study is a secondary analysis of qualitative data from a sub-sample of adolescent and young adult transwomen who were recruited to participate in the Transgender Research Youth Project (TRYP), a 2-year mixed methods research study of the HIV risk behaviors of transwomen in Los Angeles and Chicago (Wilson et al. 2009). The TRYP study surveyed 151 transwomen, 16–24 years of age, who were recruited from service organizations and street locations in Los Angeles (n = 75) and Chicago (n = 76). Individual in-depth semi-structured face-to-face interviews were conducted with 43 transwomen who were recruited from the

original survey sample of 151 youth. Interviews were conducted in Spanish and English, tape-recorded, translated and transcribed. Interviews were conducted by one cisgender male and one cisgender female interviewers with extensive experience working with trans communities. Interviews were not matched on race. For this analysis, I analyze the 34 interviews conducted in English. Participants were given an incentive of $50 for a 2-hour interview. Human subjects' approval was obtained from the Committee for Protections of Human Subjects at the University of California, Berkeley. Data for this secondary analysis were de-identified and approved by the Adolescent Medicine Trials Network.

Interview Guide

Community members in Los Angeles were invited to serve as a Transgender Advisory Committee (TAC) and participated in the design and development of the qualitative instrument used for this study (Wilson et al. 2009). The final interview guide was developed in collaboration with the TAC. The in-depth interview guide explored six conceptual domains: gender identity, social support, transgender community, discrimination, sex work and sex. This analysis does not focus on sex work or sexual risk behavior as these domains were analyzed previously (Wilson et al. 2009). Moreover, the remaining domains, in particular gender identity and discrimination, provided rich description of identity and interaction with social structure that made analyzing intersectional oppression possible. Next, I present the specific open-ended interview questions by domain.

Gender identity: 1) How do you describe yourself? 2) What does it mean to you to identify this way? 3) What are some of the things that you like about identifying in this way? 4) What are some of the challenges of identifying in this way? 5) What do you think it means to be

a man? A woman? 6) What does it mean to be transgender? 7) What are your feelings about how you look?

Social support: Try to think of a time in the recent past where you had a really hard time (e.g. lost a job, a friend died, struggled with drugs, got kicked out of school). In general, walk me through that situation and how it happened. Then, I'm going to ask you a few questions about who you turned to for support and why. 1) Describe this hard time. 2) Who did you turn to for support during this hard time? 3) Please describe your relationship with that person or those people. 4) How did this person or these people support you? 5) People have various ways of being open about their gender identity. What are the attitudes of those that are closest to you when it comes to this part of your life?

Transgender community: 1) How were you introduced to the transgender community? 2) How would you describe the transgender community?

Discrimination: Some people have challenges in their day-to-day lives that are related to their gender identity. I'd like to talk about some of the challenging experiences you may have had in your life. Specifically, I'm going to ask you some questions to find out if you have had any challenges in school, work and life that are related to your gender identity. 1) Describe your experiences at school? 2) What have been your experiences with getting jobs? 3) In was setting or environment do you feel most accepted and why?

Analysis

This grounded theory study interrogates the social etiology of gender minority stress among young transwomen. This paper aims to examine transmisogyny as a critical social process at the intersection of sex and gender and a source of intersectional social stress. I explore the

ways in which sex and gender intersect in shaping oppression that transwomen face. I argue that transmisogyny is a specific source of gender minority stress in the transition experiences of young transwomen.

Grounded theory is a method of analyzing qualitative data through the use of coding and memoing, constantly comparing data toward theoretical saturation. Grounded theory involves developing categories of information (open coding), interrelating these categories (axial coding), constructing analytical narratives about these categories (selective coding), and developing theoretical propositions. This process continues iteratively until theoretical saturation is reached, or no new data or patterns are revealed (Charmaz 2006; Strauss and Corbin 1997). Grounded theory methods provide an analytic lens through which the experiences and lives of individuals can be better understood and offers tools to examine and think about qualitative data in order to generate a substantive theory on a social phenomenon.

Findings

Reading the cis(tem): The social etiology of transmisogyny and how cissexism and misogyny conditions the possibilities of gender identity

Participants discussed the types of sensitizing concepts that have gendered their disposition on gender identity and their gender transition. In this process, ideal types of gender roles and embodied practices emerge, explaining how these cisgender archetypes have tangibly and actively shaped their lives. This makes hegemonic cis-sexism visible, demonstrating how transmisogyny is structured. Participants acknowledged the distinction between sex and gender gender as socially constructed. They rejected male cisgender binary identity through a process of

being aware of masculinity, patriarchy and misogyny, their distance from it, and the negativity they associated with it. One participant explained,

> *"I have never seen myself as a man and I could never see myself as ever being a man. People call me a man and I think it's really offensive. I think men are ruining the world. I think - I mean I am friends with men, but … But inside me, deeper, it brings up all these really negative connotations."*

Not only does male cisgender binary identity not fit within her conceptualization of herself, but she associated negative social roles with "man" as a gender identity, reinforcing her rejection of that identity as not her own. Another participant shared,

> *"Men, in general, like to assert their dominance over things … men tend to be aggressive and less caring. But maybe these are just stereotypes in my head. I have, you know, so many other people I've encountered have proven these stereotypes wrong. But then again, there's many people that I deal with in my life that prove them right."*

Similarly, this participant goes on to extend the negative social role she associates with men. While she acknowledges that she may be making a generalization about all men, she perceives that her own experiences have proven her right.

Participants understand cisgender, hegemonic masculinity also through interpreting notions of femininity, demonstrating how misogyny is structured. One participant explained that, "To be a woman means to be feminine, polite and dainty, you know. Kind and warm hearted, loving, pretty." Another participant added,

"The way she smells or the way she washes, the way she dresses. Everything. But morals would probably be the first one, because a certain kind of a woman didn't just do anything. Everything is done a certain kind of a way."

Both of these participants explain being a woman is to embody a specific feminine ideal from bodily comportment and slight mannerisms and how to feel and smell.

Other participants discussed that as a result of interacting with a social system that privileged masculinity and maleness, women are oppressed. One explained:

"For some reason, I feel like women, since they're relatively oppressed in our society and treated unfairly, I don't think they're given the recognition they deserve. I mean, I almost feel like women are treated as inferior and that makes me really angry. And it means to have to deal with a lot of oppression. And to deal with unnecessary struggle."

Hegemonic patriarchy conditioned the possibilities of young transwomen's gender identities through their perceptions of ideal relationships with men. Once participant stated, "A woman is to be passive … She knows her place with her man as well as she knows her place with herself." Participants went on to describe,

"I think men are more aggressive. They are more dominating. Less opinionated. Women tend to be more opinionated or outspoken about their opinions to different people. And they may feel a certain way, but they won't like always go over and say this and that. They keep their opinions to themselves. Women tend to gossip more and, you know, and be more catty and cut up more."

"I have to be more careful now because women are most likely to be taken advantage of by sexual predators, by robbers or whatever. So it is more so I have to be more cautious now of a lot of things."

"Men don't talk with you as much with respect. Like there have already been a few situations where if I'm in an argument with someone - like with a guy, or a discussion and it's apparent in the way they're speaking that my opinion isn't as important, you know. There is kind of like an unspoken sense that women's feelings aren't as important."

Young transwomen take part in a process of conceptualizing and actualizing their selves, attempting to read legitimacy in their being through society's binary cis-sexist lens. Actively organizing the ways in which their own gender identity does not fit scripts and roles defined by heteronormative masculinity, young transwomen understand their own positionality outside of what is traditionally gendered male and closeness with that which is gendered female. They begin to see and feel the systemic cis-sexism or "cistem" that structures their social world, including their relationships with men and masculinity, left to make sense of, anticipate and cope with transmisogyny as a result.

Clocked and Spooked: Passing as an interlocking system of oppression, transmisogyny and transition work

Participants experience gender minority stress as a social process shaped by transmisogyny. Embodying trans identity is a continual practice, comprised of transition-related work that is structured by transmisogyny, which in turn shapes ideals and conditions of passing.

Passing refers to the practice of embodying the gender with which one identifies as; for this study, specifically binary cisgender women. As a result of one's transition-related work, participants experience both degrees of passing privilege and a constant threat of not passing or being "clocked" or "spooked." The tenuousness of the experience of passing privilege and threat is a motor for gender minority stress that reaches a zenith during adolescence and young adulthood but persists across the life course.

Contrary to gender conceived as a natural process, gender and transitioning is work. Participants describe transition-related work or transition work using the concept of "full-time," or living as a woman full-time, to signify a "significant" dedication to their transition and consequently trans identity. The starting point for the type and severity of transition work varies, dependent on the on-going practice of assessing the extent to which one's current gender presentation fits their ideal gender presentation. These ideals, as previously stated, are shaped and exacerbated by transmisogyny. Transition work encompasses a diverse variety of efforts aimed at achieving one's gender identity ideal and includes work done on one's identity, emotions and gender presentation. For most participants, it involves actively seeking out information, resources, and support to socially and medically transition. One participant describes this process,

> *"I learned about the black market, how bad for it is for the girls. I learned about the top doctors and the pump parties. I learned about - okay, when I started my transitioning, I started doing research on my own. I was on the computer and I did a lot of research on certain things and found out more and more. I mean, I asked transgender people, but they will only tell you so much and then they won't tell you the important things, because what I've learned about certain*

transgender people, they don't want to see the next up and coming transgender person outdoing them."

For this participant, her transition work included navigating a sea of transition-related resources on the Internet and potentially harmful informal economies, or a "black market" of transition-related resources, one of which she mentions – "pump parties." Pump parties are informal gatherings of people who through word of mouth have sought the injection and filler services of a lay transition provider. A "pumper" will pump areas of the body where a more curvaceous appearance is desired (i.e. hips, buttocks, cheeks, lips, and chin). Transwomen who get pumped often are unaware of the specific substance they are being pumped with which can vary from cooking oil to Fix-A-Flat. Moreover, this participant discusses having to work against the sense of competition among the trans community. As a result, gatekeeping practices selectively filter access to transition resources as those who have undergone a great deal of transition work want to not be "outdone" in terms of their passability. This is an effort to protect one's own transition success against other transwomen at the beginning stages of their transition.

While transition work and passing are foregrounded social processes, the anticipation of being clocked is omnipresent. Gender minority stress is the co-creation of transition work and the anticipation of being clocked. Imagine the stress of having to play to an audience on stage and seek respite backstage to only be surprised that there is a second audience there whose gaze is solely focused on you. This vigilant surveillance is central to and productive of gender minority stress. One participant discussed this stress saying,

"There's all this self-consciousness, worries about self-appearance and worries that, you know, if they did find out, or if I end up telling them something, and I

wish I had not told them it is going to be on all these things. So there are more things to consider now than before."

Passing is not a discrete checklist of things to do, get done, wear, act, or think. Transition work is on-going and processual. Not only is one's presentation and the body subject to its regime, but one's mind is also entangled with it. One participant who is full-time said, "There's still work to be done, because I'm still learning to accept myself." Passing is not merely a state to occupy; it is conditional, changing with the social context, and so transition work must be adaptable. While transition work varies by the individual, many share the common goal of blending in with society. One participant explained,

"I would have to say I'm a chameleon. I could go to a gay function and I get so many lesbians hitting on me because they don't know that I'm transgendered. And I get accepted more because they are like, oh you're a fish, you are hot, and you're so pretty. But when I go to the straight side, it is the same thing, because they - oh you're so gorgeous. I love the way you dress and you are so classy. I mean, it is just - I can really blend in with any type of group. I mean, I don't have no particular one that makes me feel my acceptance more."

Passing is conditioned by transmisogyny through surveillance/measurement and continually defining what and who is passable and how to pass. Measuring whether or not a transwoman is passable is a complex social interaction, a joint action, enveloping members of society and the trans individual through the lens of transmisogyny. A participant explained, "I could be more curvaceous. I think that my face can be more feminine, but I'm very confident and comfortable in the way I look." While she has come to accept her gender presentation, she acknowledges the ways in which she "could be more," closer to the misogynist ideal of

femininity. Other participants discussed similar sentiments about their own gender presentation, especially in the context of biomedical intervention or medical transition. One participant remarked,

> *"I'm really worried that when I start medically transitioning that I won't look feminine enough, and that I won't pass. But I mean I'm okay with how I look. And you know, kind of okay with my body. I wish it was more feminine, so I'm going to take hormones to change that."*

> *"I think it [passing] affects me because I'm not feminine enough, like for the type of guys that I would date. I wouldn't be feminine."*

In these women's accounts of passing and the worries embedded there within, the subtle distrust in the promise of passing begins to reveal itself. It is here in this liminal space of interpreting how to pass and enacting transition work while acknowledging the distance between their passing potential and seemingly unattainable transmisogynist ideals that degrades the promise of passing. These passing threats, or experiences where transwomen question their own gender identity and ability to pass in context of their social environment, are varied but heightened while navigating gendered spaces, especially restrooms. One participant describes the difficulty of using the restroom that is concordant with their gender identity, eventually acquiescing to use the men's restroom prioritizing the comfort of others over her own and questioning her passing in the gendered space. She explains,

> *"Last week, you know, I went to school and I asked the secretary, where is the restroom? And she said, okay past the water fountain will be to your right. But as I was walking before I hit the water fountain, there was a guy's rest room. So I*

guess she was sending me to the female's rest room. And sometimes I'm like I don't know where to go. Like I want to go to the girl's but I'm like maybe, you never know they would feel offended, you know. So I usually just go into a guy's rest room. And there's been a few times, you know, some guys are like, are you in the wrong rest room? You know, that type of things.

Others develop strategies to minimize their passing threat. When forced to use the men's restroom, one participant describes her attempt to visit the restroom only in times when traffic will be low. She said,

"I had to use the men's room, which made me very uncomfortable. I wouldn't go in there if it was men up in there. I wouldn't go up in there during break times. When there was class changing times. I would go up in there only when I knew that class was going on. Because when class was going on you won't really too much find anyone in the bathroom. So I struggled with that a lot. And I was afraid to go into the female's room, because I was scared I would be called something for being a freak."

Navigating other gendered spaces, gym class or the women's department in a clothing store, was met with similar passing threat. Passing threats quickly become opportunities for social reinforcement and disciplining of one's gender identity. One woman explained,

"During gym I didn't feel comfortable in going to gym, because I didn't want to do the boys side and the girl's side. I didn't want to be separated like that, because I knew that I would be on the side that I didn't want to be on. And then I felt that I wasn't supposed to be there because I had my teachers calling me by my boy name, which that's what they were supposed to do because that was for my

records. And I was being called a male, and it just wasn't - I think because of my identity is why I wasn't comfortable and I felt that I was in the wrong place."

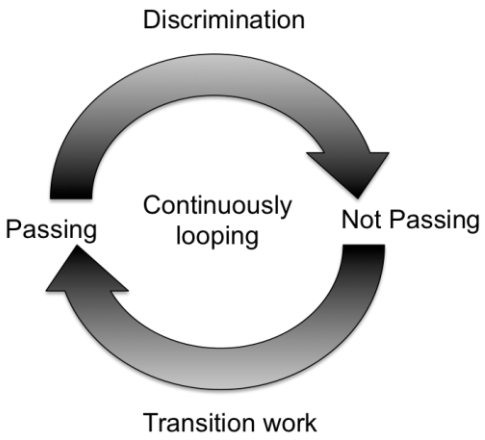
Her teachers' logic was rooted in the legal structure's definition of gender, not acknowledging her for who she is but rather what her legal name was. Misgendering is an example of a microaggression, a covert, subtle form of transphobic discrimination and an act of interpersonal violence. Misgendering and other forms of transphobic discrimination are ways society polices the boundaries of gender. In addition to gendered spaces, another contentious space where passing threats create opportunities for transphobic discrimination is at the workplace. One participant describes being misgendered at work,

"Well, I don't know, you know, you've got stupid customers who call me 'he,' even though I've got a name tag that says Samantha. And that impacts me very significantly; because it's telling me I can't pass. I still can't pass … [It] is like throwing a hatchet on my self-appearance. It [gives] me little self- esteem, you know, throwing a hatchet about it. It's like, you know, 'sir'. Just go [sound] whack me in the back why don't you, you know?"

These experiences highlight the fragility of passing, leaving transwomen in the wake of its broken promise. They also demonstrate how transmisogyny is co-constituted through the promise-making work of passing and its shortfalls, reinforced by experiences of transphobic discrimination and violence. Passing becomes a complex set of enactments and individuals continually move between states of passing and not passing. While transition work moves from states of not passing to passing, experiences of discrimination disrupt the continuum of passing which involves states of passing on one and not passing on the other. Transmisogyny is the

motor that keeps this passing complex continually looping. The passing complex (Figure 1) is an interlocking structure of oppression (Hill Collins 2000), producing gender minority stress.

Figure 1. The Passing Complex



Social Consequences of Transmisogyny and Passing

Being cisgender or not forms a type of social stratification, and passing acts as a lever to sustain and contest the cistem. In addition, passing becomes influenced by intersectional privileges and inequalities to amplify or dampen disparities. The most prominent example of an amplification of social location disparities related to passing is economic. Transition work requires one to work, or at least have access to financial resources. Not only are there social and emotional costs, the cost of transitioning is financially burdensome. One participant explains,

> *"This lifestyle is really expensive. Especially for a person that is not doing it just to do something. It is actually who you are and more of what it is that you're trying to become. It becomes quite overbearing. Medication is quite expensive for things. It's expensive for everyone. And it's like in this in this lifetime there are different things that come and will be changing your gender. Like if you have a medical card you can get laser from certain doctors. There's a lot of different*

things that are an advantage, see like me personally, every time I buy a prescription it's $200 almost. And that's like every month."

While the financial burden of transitioning is significant, transphobic employment discrimination further exacerbates financial hardships and the ability to successfully transition and pass. One participant described how her inability to pass was central to her unemployment,

"I have applied it to a few places and there is just kind of a general sense that people who look better get jobs. And this is not supposed to be the case. And officially it is definitely not the case. Legally it can't possibly be the case, but in reality it is. And so my consciousness about my self-appearance if you have less confidence, will apply to this. And when I was doing applications in general, I feel like there's always this block here, because I'm not fully transitioned yet. Like if I was fully transitioned I could just explain myself to them as who I am with the skills I have and so forth. And it seems like there's always this appearance thing."

In this description, she distilled her experiences of employment discrimination to being "not fully transitioned yet." Passing is desirable in order to better "explain" and legitimize her identity to potential employers, again, smoothing over any unwanted attention focused on her trans identity.

Not only are transmisogyny and passing threat deeply connected with employment so is the anticipation of trans discrimination from strangers and social institutions. One participant described her anticipation and her perceived eventuality of being confronted with transphobic verbal and physical violence from strangers. She said,

"I mean I'm fine with it until I start having some serious problems with it, with people attacking me. And it actually hasn't happened yet. But I'm waiting for it to happen. I'm just waiting and I know it's going to happen any day now… Verbally,

I mean any sort of attack, I'm sure it'll start off with verbal. I don't know if people are going to try to, you know, destroy my bike or throw things at me or what. But I always expect the worst. Just in case it comes."

Having to navigate and cope with the corporeal consequences of transmisogyny, transwomen anticipate discrimination vicariously. She later discussed that she anticipates discrimination from medical institutions vicariously through friends' experiences, explaining,

"My friends have had problems with, specifically insurance. And them not wanting to cover trans, being unwilling to cover transgender issues, which is really difficult. And I haven't started hormones yet, but I imagine once I do that this is going to be a big problem for me."

When probed about the role of her support system in dealing with the discrimination she faced, she shared,

"I think they're worried about my safety, and they're worried about the challenge of having a friend that is transgender and you know, if people give them shit. You know, they're going to have to step up and defend me as well. And that they're going to, you know, it's going to be a challenge for them as well. And I think they're nervous about that."

Her response underscores the anticipation of discrimination impacting those that may be situated around her. Not only does transmisogyny victimize transwomen, it may also negatively put their social support networks at risk of indirect violence as well.

Conclusion

These findings address the gap in knowledge and lack of substantive theoretical work on gender minority stress. This analysis describes the process of how transmisogyny conditions the possibilities of gender identity for young transwomen. Participants were socialized and raised with specific ideals around gender roles, which were reinforced by their interactions with cisgender peers. They rejected male cisgender binary identity through a process of being aware of masculinity, patriarchy and misogyny, their distance from it, and the negativity they associated with it. At the same time, they identified with the oppression of women in society and begin to bring systemic cissexism or what I refer to as the "cistem" into view. Socially located at the intersection of cissexism and sexism, transwomen are presented with the challenge of passing as cisgender in society. They begin to engage in the process of transition work. Transition work requires interacting with and mobilizing support from the social, legal and medical systems. While transition work trajectories vary by individual contexts and is on-going and processual, the goal of transition work is blending in with society or passing. Passing is also not a static construct, it is dynamic and in flux. This flux in passing is largely driven by navigating spaces where transwomen encounter passing threats, especially in gendered spaces such as restrooms. Passing threats may lead to macro and micro forms of transphobic discrimination. As a result, I argue that passing becomes a complex set of enactments and interactions where individuals move between states of passing and not passing. While transition work moves from states of not passing to passing, experiences of transphobic discrimination disrupts states of passing to not passing. Transmisogyny is the motor that keeps this passing complex continually looping and is an interlocking structure of oppression, producing a specific form of gender minority stress.

This study is not without its limitations. The interview instrument was part of a larger quantitative study of young transwomen at risk for HIV and not specifically designed for

eliciting data specifically on transmisogyny. In addition, the study design does not incorporate repeated interviews with participants. For example, in the case that a specific question become salient in the middle of interviewing a number of participants, the researcher would be able to schedule additional interviews with those already interviewed but were not asked that specific question of emerging importance. Techniques to ensure validity also were not operationalized. For instance, member checking and triangulation of various data were not utilized to maximize methodological rigor. With regard to methodology, other theoretical-methods packages would have fore grounded different aspects of the lived experiences of these participants. Although not exactly a critique of the selection of grounded theory as a method for this study, it is important to note that by incorporating or "trying on" different lenses and methods, such as ethnography for example, it may have brought to light different actors into the analysis, which would benefit our understanding of the dynamic time these participants lived through.

Despite these limitations, there is much to be gained from these data. These data provide a critical window into the history and evolution of transgender identity in the United States. They also provide an important insight into the theorization of transmisogyny and the process of passing. Passing becomes a form of social stratification, an intersectional prism that amplifies disparities, especially in employment. Employment discrimination is a specific form of anticipated stress. Transmisogyny and passing are situated within important questions about agency and constraint. On one hand, passing becomes a strategy to insulate against transphobic stigma and discrimination. Similar identity politics have been shown in research with HIV+ women where women leveraged other aspects of their identity – race, sexual orientation and class – to shape their perception as "victims" as opposed to "deviant," escaping blame and being discredited (Grove, Kelly, and Liu 1997). However, passing as an interlocking system of

oppression offers a way through, but no way out of a society driven by transmisgyny. As Patricia Hill Collins (2000) stated, "Racist and sexist ideologies, if they are disbelieved, lose their impact" (Hill Collins 2000: 284). Emancipation free of transmisogyny lies in the belief that there are many ways of existing as a woman that are not contingent on sex, gender, and gender presentation aligning in such a way that maintains sexist, cissexist, and gender conforming norms. Sex and gender are embedded in and constitutive of social structure (Springer, Hankivsky, and Bates 2012). West and Zimmerman explain that "the 'doing' of gender is undertaken by women and men whose competence as members of society is hostage to its production" (West and Zimmerman 1987: 126).

The sociology of gender deconstructs social differences attributed to sex, a biological construct. Lorber argues that social practices transform bodies to fit the categories of "female" and "male" and "women" and "men" (Lorber 1993). Passing among transwomen is one social practice that can transforms trans bodies to fit binary categories of cisgender identity with little variation within that social category. It is important to consider how these social categories intermingle, especially among trans people, and how individuals and groups vary within these social categories (Lorber 1996). All individuals within a social category (e.g. sex, gender, etc.) are not homogenous, and the differences between social categories blurred. Future studies deconstructing these dichotomies in sex and gender are critical to understanding the complexity in the social construction and meanings of sex and gender for cisgender and trans people alike.

V. Conclusion / Implications

Discrimination and health research has largely focused on race, class and gender. This work has just begun to address sexual and gender minorities. Although public health literature on race-based discrimination has raised the visibility of racial minority identity as an axis of difference, more can be done to promote advancements in sociological inquiry and theory focused on sexual and gender minorities. Work to date that has involved sexual and gender minorities has been largely descriptive, showing the many health needs of transwomen as a whole; the application of a sociological lens may better explain how intersecting minority identities may influence the social production of health and health disparities. Conceptually, understanding the health of transwomen has the potential of broadening conceptually how we treat examine and understand gender, race and sexuality.

Summary of the Research

My dissertation research uses intersectionality to examine how race, sexual orientation and gender influence transwomen's health. I intentionally examine diverse cross-sections of transwomen that include a sample of adult transwomen and a sample of young transwomen in the San Francisco Bay Area during the same time period. In thinking through these quantitative data, the significance of examining intersectional oppressions specific to the social location of transwomen became clear to me. To do this, I chose to examine qualitative data in my third study that involved young adult transwomen, aged 24 and younger in 2007. My analysis of transmisogyny as an intersectional oppression is an effort to foreground salient social processes that relate to transwomen today. Altogether, my dissertation offers a unique look into a community across age, and in some ways, time, that has furthered my theorization of the

complex, linked, intersectional oppressions transwomen face. Next, I summarize what each of these studies found.

Examining the effects of transphobic discrimination and race on HIV risk among transwomen in San Francisco

This first study is a cross-sectional analysis of data from a sample of 149 HIV-negative adult transwomen in San Francisco. The data for this analysis was collected in 2013 from the TEACH 2 study, a respondent-driven sampling study of HIV risk behavior and HIV prevalence. This study found that compared to low levels, a high level of transphobic discrimination was associated with recent binge drinking. This study also found that transphobic discrimination was not significantly associated with unprotected receptive anal intercourse. However, race was independently associated with unprotected receptive anal intercourse. These findings suggest that while transphobic discrimination and race may indeed have independent deleterious effects on trans health, their impact differs across types of HIV risk behaviors.

Sexual minority disparities in alcohol and substance use among young transwomen in the San Francisco Bay Area

The second study is a cross-sectional analysis of data from a sample of 259 young transwomen. The data for this analysis was collected in 2012-2014 from the SHINE study, a longitudinal study of HIV risk and resilience among young transwomen ages 16-24 in the San Francisco Bay Area. The study examined sexual minority health disparities among young transwomen. This research showed that sexual minority young transwomen were significantly more likely to report recent heavy episodic drinking and illicit prescription drug use compared to their heterosexual counterparts. While the majority of research with transwomen has taken on a

heterosexist lens to understand HIV risk by failing to disaggregate samples by sexual identity, these findings support investigating sexual minority status as a source of health disparities among transwomen.

Intersectional Oppression: Examining transmisogyny and stress among young transwomen

The third study is a secondary analysis of qualitative, in-depth interview data from the Transgender Research Youth Project (TRYP). These data were collected from 34 young transwomen in Chicago and Los Angeles and transcribed in 2006. In this study, I take an intersectional approach to analyzing the lived experiences of young transwomen. I examine how transmisogyny conditioned the possibilities of gender identity and the process of passing as an interlocking system of oppression. I also describe the social consequences of transmisogyny, especially on socioeconomics, employment and the anticipation of discrimination. I argue that minority stress researchers should increasingly take up intersectionality in order to understand sex and gender and cissexism and misogyny collide and corroborate transmisogyny in the lives of young transwomen.

Contributions to Extant Literature

Discrimination and health research has largely focused on race, class and gender. This work has just begun to address sexual and gender minorities. Although public health literature on race-based discrimination has raised the visibility of racial minority identity as an axis of difference, more can be done to promote advancements in sociological inquiry and theory focused on sexual and gender minorities. Work to date that has involved sexual and gender minorities has been largely descriptive, showing the many health needs of transwomen as a

whole; the application of a intersectional lens may better explain how multiple minority identities influence the social production of health and health disparities. Conceptually, understanding the health of transwomen has the potential of broadening conceptually how we treat examine and understand gender, race and sexuality, adding to the literature on stigma and intersectionality and health. For example, Baca-Zinn and Dill (1991) discuss the ways intersectionality pushes feminist scholarship beyond the simple recognition of differences among women along the lines of race, class and sexuality They also argue that multiracial feminism as an analytic framework helps not only understand experiences of women of color but also of all women and men as well (Zinn and Dill 1996). This is because analyses that take into consideration oppressive structures are both about the oppressed and oppressors alike. While difficult methodologically, intersectionality scholars urge to not wait for these challenges to be resolved "to incorporate intersectionality into their theoretical frameworks, designs, analyses, and interpretations" (Bowleg 2012). The studies in this dissertation are attempts to move forward with an intersectionality-informed stance, examining different axes of identity and health among transwomen.

Remaining Questions / Further Research

While these three studies contribute to the field's understanding of the intersectional inequities in health that transwomen face, a number of questions remain. The research presented here showed that transwomen of color are at greater risk for unprotected receptive anal intercourse in the last six months compared to White transwomen. While this study sought to examine the relationship between transphobic discrimination and racial disparities, findings led to important questions that merit additional research. For example, at the bivariate level greater

proportions of White transwomen had experienced more gender minority stress events and therefore greater transphobic discrimination, compared to transwomen of color. Future studies of transphobic discrimination ought to measure racial discrimination and assess the interaction between these two sources of discrimination. I also discuss how different conceptions of ideal body types might influence how some transwomen are able to navigate social spaces without being identified as transgender, or pass as cisgender, and how these ideal body types might be shaped by race. A future study to examine how ideal body type might vary among transwomen and shape transition trajectories is needed.

The research presented here also showed that sexual minority transwomen are at greater risk for heavy episodic drinking and illicit prescription drug use compared to heterosexual transwomen. While the current study is one of the first studies to examine sexual minority disparities among transwomen, these results pose important questions as to how sexual minority stress among gender minorities substantively differs from that among cisgender populations. I discuss the potential significance of examining social network ties among transwomen to better understand this phenomenon. If indeed social networks of transwomen are constrained by sexual minority status, understanding the mixing or lack thereof between social, sexual and substance using networks might extend an understanding of the findings in my research.

The third study examined transmisogyny as a source of intersectional stress for young transwomen. While this analysis focused on how transmisogyny is enacted through social process of passing, agency and resistance are important concepts to consider. How do transwomen contest and subvert transmisogyny? Additionally, I am interested in exploring specific health behaviors driven by transmisogyny such as illegal filler use and its consequences. In future research, my work may seek to examine the opportunities for emancipatory ideology to

disrupt and unravel the interlocking system of oppression known as transmisogyny. How and for whom does the promise of passing holds and what lies in the wake of the broken promise of passing?

Methodologically, many other research questions remain. The question of measuring gender identity and its stability over time is especially important as trans visibility increases. In less than a decade of research, transgender began as a binary unidirectional conception of gender transition. However, as trans identified people increasingly embrace gender expansive, gender non-conforming and non-binary identities, in what ways must LGBT researchers evolve to produce relevant knowledge? Related to measurement, I use hazardous drinking or binge drinking to measure alcohol use. While this approach to defining harmful alcohol consumption is widely applied in alcohol research, this measure is gendered. For cisgender men, episodic hazardous drinking is defined as five or more drinks in one episode. For cisgender women, binge drinking is four or more drinks in one episode. Physiologists and medical practitioners might cite the difference in generalized conceptions of sex, body mass index and the ability of certain bodies over to metabolize a given amount of alcohol as the reason for these different definitions of binge drinking. While I used five or more in an effort to operationalize a more conservative measure, there is no best practice for which measure to use with trans populations. With early initiation of hormone replacement therapy, trans youth can delay the adolescence associated with their assigned sex. For young transwomen, this means that they might able to avoid puberty-related growth and muscle development, maintaining pre-pubescent body size and stature. This destabilizes the medical explanation for gendered definitions of binge drinking as body mass index loses its salience in describing trans bodies. In this way, trans research has the potential to shed light on how measures and their assumptions are gendered. Uncovering this bias within our

current standard practices is an important opportunity to interrogate the validity and intention of measures like binge drinking. Is binge drinking alone important? Is it simply the number of drinks consumed in a given period of time or drinking with the intention of intoxication? Are there social dimensions of alcohol use that are more salient in explaining a particular phenomenon than the about of alcohol a person with a particular body mass index is able to metabolize without diminishing cognitive function? Engaging these questions are crucial to trans health and eliminating disparities and inequality.

Not all methods are created equal. Interaction terms in linear statistical models are but only one way to analyze data (Purdie-Vaughns and Eibach 2008; Reidpath and Chan 2005; Sen, Iyer, and Mukherjee 2009; Veenstra 2011). Some methods account for intersectionality and social structure better than others. Two methods that can extend intersectionality in public health research are social network analysis and multi-level modeling. Social networks analysis can account for social structure through social ties and the measurement of important social dynamics such as group affinity, or the extent to which any one actor forms ties with either similar or dissimilar others (also referred to as homophily or assortativity), or network centrality, how influential a particular actor or group of actors is within a network. Multi-level modeling attends to social structure by explicitly accounting for social context in statistical models. Both of these methods shift the unit of analysis from the individual to social structure and offer meaningful ways to understand transwomen's health. However, while these methods may reveal important insight into the social production of health and illness among transwomen, they also require specific types of data to be measured. These data could be difficult to ascertain in secondary datasets if studies did not intend for these research questions to be asked of the data. This emphasizes the importance of bolstering intersectionality in public health research. While

traditional public health research is intended for largely descriptive purposes, intersectionality can push for the extension of our understanding of how health and illness are social produced. In addition to diversifying methodology and analysis, another example of the importance of intersectionality is in mixed methods. Mixed methods can stimulate innovation in the types of research questions and explanations possible. In my dissertation research, I was often left with the desire to explore qualitative research questions to better explain quantitative findings; and at the same time, my qualitative work gave way to new insight on how emerging social phenomena might be measured quantitatively.

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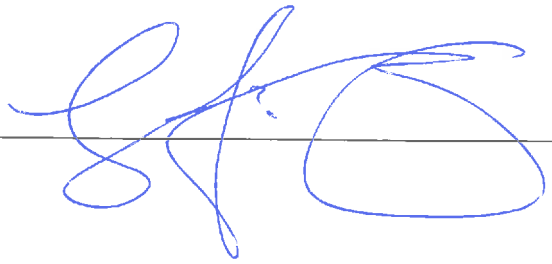
Author Signature 

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