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ORIGINAL ARTICLE

Gender Affirmation: A Framework for Conceptualizing Risk Behavior Among Transgender Women of Color

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Abstract Experiences of stigma, discrimination, and violence as well as extreme health disparities and high rates of sexual risk behavior and substance use have been well-documented among transgender women of color. Using an intersectional approach and integrating prominent theories from stigma, eating disorders, and HIV-related research, this article offers a new framework for conceptualizing risk behavior among transgender women of color, specifically sexual risk behavior and risky body modification practices. This framework is centered on the concept of 'gender affirmation,' the process by which individuals are affirmed in their gender identity through social interactions. Qualitative data from 22 interviews with transgender women of color from the San Francisco Bay Area in the United States are analyzed and discussed in the context of the gender affirmation framework.

Keywords Transgender identity · Gender affirmation · Stigma · Race · Risk behavior · Sexuality

Introduction

Transgender women, or 'transwomen,' as a group have been found to experience stigmatization and discrimination in multiple arenas of life, in many different countries around the world (Barrientos et al. 2010; Grant et al. 2011; Lombardi et al. 2001a; Nemoto et al. 2011; Silva-Santisteban et al. 2011; Wilson et al. 2011; Winter 2010). 'Transwomen' are individuals who were assigned 'male' at birth but do not identify as men and instead identify as women, transgender, or other gender identity. 'Transwomen' as a broad category represents a multitude of diverse experiences, and these experiences can vary widely by culture. In this paper, I will be specifically examining reports of and data related to experiences of transwomen in the United States; thus all studies cited are based on U.S. samples unless otherwise noted. In the U.S., poverty, experiences of victimization, discrimination, and extreme health disparities (especially related to HIV rates and clinical outcomes) have all been well-documented among transwomen of color in particular (Clements-Nolle et al. 2001; Herbst et al. 2008; Lombardi et al. 2001a; Sevelius et al. 2010). Similar experiences of marginalization have been documented among transwomen in other countries around the world as well, such as Peru, Thailand, and Nepal, to name a few (Nemoto et al. 2011; Silva-Santisteban et al. 2011; Wilson et al. 2011).

The theoretical lens of intersectionality is a useful foundation for analyzing the ways in which social identities related to race, class, sexuality, and gender interact to generate unique cultural experiences, values, and power differentials that make transwomen of color as a group particularly vulnerable to engaging in behaviors that increase their risk for HIV and other negative health outcomes (Warner 2008). Estimates from urban centers across the United States suggest that HIV prevalence rates among transwomen are among the highest of all risk groups, especially among transwomen of color and African American transwomen in particular, ranging from 22 % to 68 % (Elifson et al. 1993; Garofalo et al. 2006; Herbst et al. 2008; Nuttbrock et al. 2009; Operario et al. 2011). Like other health disparities, HIV transmission and infection are inextricably linked to social and economic

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inequalities (Zierler and Krieger 1997). While such data are useful to assess the burden of HIV among transwomen, most studies are epidemiological with little theoretical development or attention to issues specific to gender.

In this paper, I use an intersectional approach to integrate relevant theories and examine how the social contexts of racism, sexism, and transphobia intersect to produce qualitatively unique cultural experiences and meanings for transwomen of color that often lead to risky health behaviors. Fundamental to an intersectional approach is understanding identity within a social structural context, acknowledging that identity is informed by institutional, political, and societal structures (Warner 2008). In order to situate my own perspective, I acknowledge that as a genderqueer-identified, female-bodied, White, gay, middle-class academic, this research is inherently informed by my own position within these social contexts. The purpose of this paper is to explore the role of gender affirmation in the context of a newly proposed theoretical model that integrates prominent theories from stigma, eating disorders, and HIV-related research as well as the existing literature related to transgender women, and posits that risk behavior among transgender women of color can be conceptualized as an outcome of unmet need for gender affirmation.

'Gender affirmation' refers to an interpersonal, interactive process whereby a person receives social recognition and support for their gender identity and expression (Bockting et al. 2006; Melendez and Pinto 2007; Nuttbrock et al. 2009). The concept and importance of gender affirmation have been acknowledged in previous research with transgender populations (Melendez and Pinto 2007), although investigators have used various terminologies such as 'gender validation' (Nemoto et al. 2004b), 'transgender identity affirmation,' 'identity support,' 'gender identity affirmation' (Nuttbrock et al. 2009a; Nuttbrock et al. 2002), and 'gender construction' (Rodriguez-Madera and Toro-Alfonso 2005). The need for gender affirmation is not unique to transgender individuals, but may take on a more prominent role in their lives due to their gender minority status. For non-transgender individuals whose gender identity and expression aligns with the gender they were assigned at birth, gender affirmation may come easily and without much thought, although societal pressures to conform to rigid notions of masculinity and femininity are pervasive and often untenable for many. For transgender individuals, gender affirmation is sometimes more complicated but is just as vital a confirmation of their sense of self, a confirmation that they are being seen for who they are and are being treated as they wish to be treated. Gender affirmation can include everything from family, friends, and strangers using the correct name and pronoun to 'being treated like a lady' to being accepted in all of one's various expressions of gender, depending on the context. While a number of investigators have observed this need for gender affirmation among transgender participants in their studies, its relationship to high risk behavior has rarely been directly investigated (Melendez and Pinto 2007; Nuttbrock et al. 2009a). If indeed the need for gender affirmation is related to high-risk behavior (and thus negative health outcomes), this finding could provide important implications for intervention strategies, lend insight into how rigid binary notions of gender can both directly and indirectly impact one's mental and physical health, and open up new directions for future research utilizing an intersectional approach to examining lived experiences of racism, sexism, and transphobia.

The Gender Affirmation Framework: Overview

The gender affirmation framework proposed and explored here is based on the existing body of literature related to transgender women of color and integrates objectification theory, a theory that has been primarily explored in the context of women's body image and eating disorders research (Fredrickson and Roberts 1997; Moradi and Huang 2008) with the Identity Threat Model of Stigma from social psychology literature (Major and O'Brien 2005). Objectification theory suggests that experiences related to gender socialization and sexual objectification lead to women being defined by others as well as defining themselves by their bodies and appearance. Although any explorations of this theory and its hypothesized applications to transwomen's experiences are unknown to the author as of the writing of this paper, some of the concepts offered under the purview of objectification theory are useful for understanding some of the commonalities often reported by transwomen (Moradi 2010). The second theory that informs the gender affirmation framework, the Identity Threat Model of Stigma, posits that when a person with a stigmatized identity confronts a situation that seems to threaten one's identity and the person does not have the resources to cope with that threat, that person will respond by attempting to decrease the threat or increase one's coping resources. The gender affirmation framework also draws on Diaz's HIV-related research with Latino gay and bisexual men, which examines sexual risk and psychological distress as outcomes of social oppression (Diaz et al. 2001, 2004).

The intersection of the social contexts of racism, transphobia, and sexism results in extreme marginalization, where a high need for gender affirmation among transwomen of color generally does not get met. Due to pervasive stigma, early socialization experiences for transgender women of color often include childhood harassment for gender nonconformity (Mallon & De Crescenzo 2006), family rejection (Koken et al. 2009), experiences of discrimination and violence (Lombardi et al. 2001b), and experiences of being sexually objectified, including sexual violence (Lombardi et al. 2001b; Risser et al. 2005). Certain religious traditions with

which families of color are often affiliated may value more rigid notions of gender and espouse the "immorality" of sexual minorities and transgender identity, possibly leading to higher levels of family rejection of gender non-conforming children (Koken et al. 2009), and gender affirmation has been shown to be more likely to come from friends than family (Nuttbrock et al. 2009a). Being rejected from their families at a young age often leads to school dropout, homelessness, and a persistent cycle of sex work, substance use, incarceration, and poverty among transwomen (Cochran et al. 2002; Wilson et al. 2009). This cycle is even more intense for African American transwomen (Lombardi 2009), emphasizing the interconnectedness of racism, transphobia, poverty, and violence. Experiences of transphobia have consistently been found to be associated with depression, anxiety, and low self-esteem (Lombardi 2009; Melendez and Pinto 2007; Nuttbrock et al. 2010).

Transwomen also report being sexually objectified from a young age (Garofalo et al. 2006). Because they are objectified in ways that mirror the sexual harassment of non-transgender women, objectification experiences may be one of the few areas in life where transwomen experience some form of gender affirmation, and sex work in particular may be one arena where gender affirmation is most readily accessible (Nuttbrock et al. 2009a). Sexual objectification experiences, as described by objectification theory, are those experiences that reduce a woman to the appearance or function of her body and/or body parts (Fredrickson and Roberts 1997). This includes experiences of and/or anticipation of the male gaze, objectifying interpersonal encounters, appearance evaluations, cat calls, or other sexual gestures and comments, all experiences commonly reported by transgender women. Objectification theory also proposes that sexual objectification experiences lead to self-objectification, a process in which women internalize the concept of themselves as sexual objects and consistently monitor and measure their bodies against dominant cultural standards of beauty (operationalized as 'body surveillance' and 'body comparison,' respectively) (Moradi 2010). This self-objectification process then leads to body shame and increased anxiety, both of which are also commonly reported among transwomen (Ålgars et al. 2010; Kraemer et al. 2008; Moradi 2010).

Self-objectification, body surveillance, and body shame are generally associated with lower body esteem, lower self-esteem, and fewer health-promoting behaviors (Bockting et al. 1998; Lowery et al. 2005). The objectified body consciousness framework adds 'body control beliefs' to the objectification theory framework (McKinley and Hyde 1996). Body control beliefs support the view that bodily appearance can and should be controlled to comply with cultural standards of attractiveness, i.e. through medical intervention. Like body surveillance and body shame, body control beliefs arise from the internalization of cultural standards of attractiveness, but body control beliefs may be associated with a healthy sense of agency and competence as well as with risky body modification behaviors (McKinley and Hyde 1996). In transwomen, this may manifest as taking control of one's transition process in healthy ways, such as seeing a doctor for prescription hormones and pursuing information about one's options for gender-related health care, but may also result in risky body modification practices such as using hormones obtained on the street, taking a higher dosage of hormones than prescribed, or using injection silicone, a dangerous (and illegal) practice that can lead to serious health consequences.

The Identity Threat Model of Stigma explains that anxiety and maladaptive coping strategies can result from stigma-related stressors that threaten one's identity and exceed one's coping resources (Major and O'Brien 2005). Thus, when the need for gender affirmation is high (due to psychological distress) and access to gender affirmation is low (due to social oppression), identity threat may result. Thus, for transgender women, stigma, social rejection, and body shame create a high need for gender affirmation while stigma and discrimination can prevent access to gender affirmation. This discrepancy creates identity threat, resulting in anxiety and depression in addition to attempts at reducing the threat. Transgender women may attempt to reduce identity threat by either attempting to increase their access to gender affirmation or decrease their need for gender affirmation, and these coping strategies may be adaptive or maladaptive. Initial evidence suggests that transgender women may seek to fulfill unmet needs for gender affirmation in ways that increase risk for HIV and other negative health outcomes (i.e. engaging in sex work, pursuing dangerous silicone injections, having sex to obtain gender affirmation) (Bockting et al. 1998; Sausa et al. 2007; Wiessing et al. 1999). According to an identity threat model of stigma, those with the highest need for gender affirmation and the lowest access will be at the highest risk for negative health outcomes.

In a number of studies with Latino men who have sex with men, Diaz found that self-reported experiences of discrimination were highly correlated with psychological distress and risky sex practices (Diaz 1998; Diaz et al. 2004). He proposed a framework for understanding how oppressive social and cultural forces might influence a variety of risk behaviors in marginalized populations, and his theory is useful in understanding how social marginalization may contribute to increased sexual risk. He proposed that the anxiety produced by stigma and discrimination increases the likelihood of engagement in high-risk contexts (e.g. sex while under the influence of substances or sex work) which in turn increases risk (Diaz et al. 2004).

Some samples of transwomen report high levels of engagement in unprotected receptive anal sex with multiple

partners, sex under the influence of drugs and alcohol, sex work, and sharing needles for injection drugs, hormones, silicone, and other substances for body modification purposes (Kenagy 2002; Nemoto et al. 2004; Operario et al. 2011; Sausa et al. 2007). Some transwomen report that receptivity during sex is experienced as affirming of their female gender identity (Bockting et al. 1998), and since very few transwomen have access to (and many do not desire) genital surgery, receptivity during sex for transwomen usually means receptive anal sex (Nuttbrock et al. 2009b). In addition, studies have shown that experiences of stigma and discrimination increase transwomen's need for gender affirmation from their male sexual partners, thus increasing their willingness to engage in risky sexual behavior and reducing their self-efficacy to negotiate condom use and/or substance use during sex (Bockting et al. 1998; Melendez and Pinto 2007; Reisner et al. 2009; Rodriguez-Madera and Toro-Alfonso 2005; Sausa et al. 2007; Sugano et al. 2006). One meta-analysis found that almost half (44 %) of transwomen reported unprotected receptive anal intercourse, with the highest rates being reported with sex work clients (39 %) and primary partners (37 %) (Herbst et al. 2008). Similar to other at-risk populations, sex under the influence of drugs and/or alcohol is one of the most commonly cited sexual risk factors among transwomen as it is often used as method of coping with stigma, loneliness, and/or the demands of sex work, and can lead to unprotected sex (Nemoto et al. 2004a; Xavier et al. 2005).

The Present Research

This paper will describe a qualitative study that examines the intersection of gender with racial and ethnic identity among 22 transwomen of color to explore associations proposed by the gender affirmation framework. Qualitative methods have specific advantages in the assessment of issues of intersectionality, due to allowance for complexities and multiplicities of experience, and the creation of space for unanticipated results that come from groups that are underrepresented in theory (Marecek et al. 2001). The strength of this methodology lies in its ability to generate a nuanced understanding of the phenomena of interest from the perspective of the participant. However, there are also limits to this methodology in that it is inherently exploratory, cannot unequivocally provide support for or refute hypotheses, and may not be generalizable to other groups of transgender women.

The primary research questions were: How do the intersecting experiences of transphobia, racism, and sexism shape how transgender women of color describe their need for gender affirmation and access to gender affirmation? What is the relationship of gender affirmation to behavior, and what happens when gender affirmation needs go unmet? Additional research questions that drove the data analysis were: How might intersecting experiences of transphobia, racism, and sexism lead to self-objectification (and the accompanying body surveillance, body comparison, and body shame) among transwomen of color? For transwomen of color who experience the identity threat that results from high need for gender affirmation and low access to gender affirmation, how do they attempt to resolve this threat? What happens when attempts at resolving identity threat occur in high risk contexts?

Method

Participants and Recruitment

The data reported here were collected as part of two separate but similar qualitative studies. The first study, conducted between January 2008 and August 2008, specifically recruited self-identified transwomen over the age of 18 who had recent experiences of incarceration. The second study, conducted between August 2009 and December 2009, was conducted to describe the influence of transwomen's unique cultural context on HIV-related risk behaviors and was open to all adult self-identified transwomen, with a specific emphasis on recruitment of transwomen of color. The data were combined for the purposes of this analysis because the samples were not significantly different on any demographic dimension (due primarily to the high rates of incarceration among transwomen of color) and the interview guides were designed around similar research questions. Participants for both studies were recruited in the San Francisco Bay Area through direct street outreach from locations frequented by transwomen that were identified based on previous research, such as transgender-specific community-based agencies, health service organizations, street locations, and trans-friendly social spaces. Participants were informed that the research sought transgender women who were willing to share their experiences to help us learn more about ways to reduce HIV risk for transgender women and their partners. Snowball sampling was also utilized, where participants recruited other eligible transwomen by word of mouth. Transwomen who were interested in participating called a phone number listed on flyers and business cards to receive further information about the study and to determine eligibility. Those who met the following criteria were considered eligible for the study: assigned 'male' gender at birth and currently identify as 'female' or 'transgender' or some variation indicating the person does not identify with her birth gender (e.g. transsexual, gender variant, male-to-female, MTF, etc.), 18 years of age or older, able to speak English and able to provide informed consent.

The data reported here include 22 qualitative interviews with participants who self-identified as transgender women of color. The mean age of the sample was 35.3 (SD=7.01, range 23–53) and self-reported racial/ethnic composition of the sample was 11 African American, six Latina, two Asian/Pacific Islander, one Native American, and two mixed race participants (see Table 1). When asked about HIV status, 16 of the 22 participants (72.7 %) reported being HIV-positive, and one stated that her recent test results were inconclusive. All of the participants reported being currently sexually active within the previous 3 months and exclusively attracted to men.

Although all participants self-identified as transgender women for the purposes of inclusion in the study, it was clear that not all participants had a fixed and uncomplicated sense of identification with the term 'transgender.' Many participants (n=12, 55 %) described a clear female gender identity, others (n=5, 23 %) identified with the term 'transsexual,' and some (n=2, 10 %) described a more fluid gender identity and expression that depended on social context or life circumstances. Two participants (10 %) who both identified as 'transsexual females' stated that they had not heard the term 'transgender' until they moved to San Francisco, highlighting the contextual nature of these terms.

Procedures

Potential participants were screened by telephone or in-person to determine eligibility. Eligible transwomen were interviewed by the researcher in a private location for approximately 60–90 min. The participants were reimbursed $40 upon completion of the interview. Interviews were digitally recorded and professionally transcribed, and all computer files were encrypted and handled according to protocols for confidential and sensitive materials. All procedures for both studies were reviewed by the University of California, San Francisco Committee on Human Research and received Institutional Review Board approval.

Table 1 Participant demographics

	N	%
Race/Ethnicity		
African-American/Black	11	50
Latina	6	27
Asian/Pacific Islander	2	9
Native American	1	5
Multiracial	2	9
Age		
20–29	6	27
30–39	9	41
40–49	5	23
50–59	2	9
HIV status		
Positive	16	73
Negative	5	23
Don't know/Indeterminate	1	5

[a]Numbers may not equal exactly 100 % due to rounding

Interview Content

Both studies used cross-sectional, semi-structured qualitative interviews to elicit descriptions of the unique cultural context of transwomen's experiences and the influence of this context on behaviors. The first study also included specific questions about transwomen's experiences of incarceration, especially regarding sexual risk behaviors, drug use, reasons for incarceration, and experiences of violence while incarcerated. Data related specifically to incarceration have been presented at a scientific meeting (Sevelius 2009a) and will be explored in a separate manuscript currently in preparation.

In general, the interviews began with broad questions, using probes only as needed in order to elicit a narrative rather than brief answers. Interview prompts were open-ended (i.e. "Tell me about your sexual relationships") to encourage expansive responses. Probes were included in the interview guide to elicit specific information about sexual risk behaviors, substance use, access to hormones and other health care services, experiences of violence and harassment, romantic relationships, social and familial support, and coping. Gender affirmation issues, both need for and access to gender affirmation, were explored in depth along with any perceived connections to risk behaviors. Specific probes were included for certain participants when relevant, such as questions about perceived risks and benefits of sex work, contexts of substance use, and issues related to race/ethnicity and how those issues intersect with transgender identity and gender affirmation issues.

Analytic Strategy

Transcripts were analyzed with Atlas.ti using template analysis, a standard qualitative technique for identifying and organizing themes through the development of a coding template (Crabtree and Miller 1999). This technique is useful for analysis of qualitative data when some *a priori* themes are defined based on theory and/or the research questions of interest. In this case, the *a priori* themes were based on the theories and culturally relevant concepts and data described in the introduction of this paper and the primary research questions. The use of *a priori* themes can expedite the initial coding phase of qualitative data analysis, which is often extremely time-consuming. Data that did not relate to the *a priori* themes were not disregarded however, as this material often suggested other useful ways of categorizing the themes and codes as they related to the theoretical model (King 1998). As suggested by experts in

template analysis, the number of *a priori* themes were restricted to as few as possible to allow for new and related themes to emerge (Crabtree and Miller 1999; King 1998). Once the *a priori* themes were defined, initial coding of the data consisted of reading the transcripts and identifying sections of the text that corresponded to the *a priori* themes. If the data highlighted issues that were not included among the *a priori* themes, an existing theme was modified or a new theme was created. The themes were broken down into codes and modified as needed to reflect the language that the participants used to describe the constructs of interest (e.g. need for gender affirmation) to ensure that the coding template included culturally relevant language. After a subset of the transcripts was coded in this way, an initial coding template was created to reflect the emergent ideas. The coding template was a list of all themes and codes, organized in a hierarchical fashion with broader themes broken down into more specific codes. In addition, template analysis allows for the same text to be coded using two or more codes, so some quotations were coded using multiple codes. Two senior researchers with expertise in qualitative research methods reviewed the coding process, the coding template, and two coded interviews each. Multiple meetings over the course of several months were convened to systematically discuss these elements of the analytic process and for the senior researchers to provide their interpretations of the data. All minor discrepancies were resolved with further discussions and refinement of the definitions of coding themes, and reviews of subsequent iterations of the coding template. Once these steps were taken to help establish reliability, this initial coding template was then used to code the remaining transcripts. As the remaining transcripts were coded, the initial coding template was modified as needed, as new themes were identified or existing ones were refined. Previously coded interviews were then re-coded with the modified template. This iterative process continued until the analysis was no longer improved by modification of the coding template and the decision to deem the coding template 'final' was made in consultation with one of the aforementioned senior researchers with expertise in qualitative research methods. The final coding template (condensed for parsimony) and code definitions are provided in Table 2, along with counts for the number of times each theme was mentioned by the participants in order to provide an indication of their relative frequency. The validity of the template analysis was established through the methods recommended by Crabtree and Miller (1999), which included consulting with fellow researchers in the field, verification with two transgender women of color who were not participants in the study, and presentation of the findings and solicitation of feedback at the World Professional Association for Transgender Health in Atlanta (Sevelius 2011). Additional validation of the coding process was conducted by having a different senior researcher (who was not involved in the initial development and validation of the coding template) code two of the interviews. Overall percent agreement was 89 %. The percent agreement for each of the individual codes is reported in Table 2. Quotes that exemplify each theme will be provided to illustrate the theoretical concepts explored here along with the quoted participant's self-reported race/ethnicity and age.

Results

Stigma and Social Oppression

Transphobia and Rejection

Participants (n=22, 100 %) described the pain and feelings of loneliness that resulted from rejection by their families of origin at a young age. They described how they internalized the transphobia they encountered from their families and society, and how this often led to low self-esteem and a sense of shame. Some participants (n=7, 32 %) described having at least one parent or other family member (i.e. sibling, aunt, cousin, grandparent, etc.) who was supportive of her, which felt crucial when the rest of the family was not supportive.

> When you have to face this world alone and you feel like your family don't support you, it's a very lonely, touchy hurting feeling. (African American, 53)

Participants who did not "pass" discussed the pain of facing stigma on an almost daily basis (n=9, 41 %). Those who felt they had more access to gender affirmation through passing mentioned the anxiety that comes with passing due to the stress of information control (n=5, 23 %), as well as intense fear for their own emotional and physical safety associated with being 'outed' as transgender (n=5, 23 %):

> Once you go out in society…if you not the prettiest one, the most passable thing then everybody is laughing everywhere you go. That hurts. Everybody has feelings, no matter what you are. (African American, 35)

> Even if you have the operation, you're still going to always be classified as male, no matter what…That's the problem I have [even though I pass]. Once you get a sex change, you're still living a lie. And hopefully you don't get killed. A guy who finds out might forgive you, or he might just leave you. Or he might just set you up and have you killed. (African American, 35)

> It is a struggle. No matter how good you are at what you do, it's never going to be easy. If you live in a

Table 2 Condensed coding template used in this study, along with counts and definitions

Code	Definition	Count	% Agreement[a]
Stigma/Social oppression			
- rejection	Family rejection, social isolation, rejection by potential sex/ relationship partners	40	83
- transphobia	Harassment, violence, experiences of being stigmatized and/or discriminated against due to trans status	76	92
- sexual objectification	Being regarded as a sex object by others, having one's self and one's body reduced to its sexual function	21	89
- racism	Harassment, violence, experiences of being stigmatized and/or discriminated against due to one's race/ethnicity	12	100
Psychological distress			
- self-objectification	Regarding one's own body as an object, internalization of sexual objectification	14	100
- body comparison	Comparing one's own body to those of others' for judgment purposes	16	100
- body surveillance	Self-monitoring of one's own body and its parts	19	89
Gender affirmation			
- need for	Desire to pass or live "stealth", importance of passing, desire to be affirmed as female	102	92
- access to	Access to support and affirmation from family, peers, society, and/or lovers and sex partners, ability to pass or not pass, access/barriers to gender-specific health care, hormone use/access to hormones	148	83
High risk contexts			
- sex work	Sex in exchange for money, drugs, food, and/or shelter or other needs	78	90
- sex to obtain gender affirmation	Sex to fulfill gender affirmation needs	26	89
- sex under the influence of substances	Sex while using drugs and/or alcohol	14	100
Risk behavior			
- unprotected sex	Receptive or insertive anal sex without a condom	33	100
- unhealthy body modification practices	Injection silicone use, use of street hormones	16	100
- heavy substance use	Chronic and/or excessive use of drugs and/or alcohol	46	94

[a] Between two coders on a subset of transcripts

> heterosexual society and you're trying to blend in and somehow you have been outed by someone or they've figured it out, they are going to tell you in your face that they don't have a problem with you. But they do have a problem with you. I have faced that. (Mixed race, 28)

Sexual Objectification

Participants (n=19, 86 %) described at length some of the experiences they had with being sexually objectified, and often felt that men only valued them for sex:

> My thing is that he figures he can go to the picnics with his [non-transgender] girlfriend, take her around to his parents, his family, take her to the movies, and then I would be on the back burner. He's only going to want to have sex with me. (African American, 35)

This type of objectification was described as frustrating, but many participants (n=15, 68 %) also described receiving a certain amount of much-needed gender affirmation from it as well. The objectification experiences were described as affirming in the sense that they felt validated as women through these experiences, but validation came with the price of feeling that they were not being valued as unique human beings with something beyond sex to offer the world.

> You walk down the street after you done turned the trick and you feel like you're the grand diva 'cause somebody stopped 'cause you're pretty. But see what I realize is that it's not the beauty on the inside that they see. All they see you for is a piece of ass…All they think that transgenders are good for is sex and drugs. (African American, 23)

Another participant described how she attempts to take back some of the power that she feels she loses as a result of being sexually objectified by asking for money after sex:

> I have all kind of profiles on the Internet, and guys think you're a female. Then when you disclose your gender to them, they just think, you know, do you want to come over and kick it, and that means come to your house and have sex. I screw some of them and I ask them for money after I screw them. I tell them I need to go buy a new outfit or this and that. My thing is because I feel like that gives me the empowerment, the power, you know 'cause everyone, people just think of you as a sex object. (African American, 35)

Intersections of Race and Transgender Identity

When discussing sexual objectification, standards of beauty, and how they felt about their bodies, participants' responses were often (n=11, 50 %) shaped by their particular socio-cultural perspective as a transwomen of color.

One participant commented on the African American community's appreciation for her more voluptuous physique:

> Everybody thinks my butt implanted. But it ain't. Not silicone neither. That's natural, baby. That's from eatin'. Some are like, 'Damn! She got a big ass! Oh, damn, she got a big ass booty!' And then they're like, 'Man, that's a dude!' And they're like, 'No! That ain't no dude! That's a woman! Ain't no dude got no booty like that!' That's my main attraction is my butt…When I went back home, I was, like, the talk of the town. The talk of the project. I was like a celebrity. (African American, 30)

Another participant described her experience of being a Latina transgender woman and the pressure she feels to strive to pass in order to avoid stigma and increase her access to gender affirmation:

> It's part of our culture. Our transgender culture. Latina transgender culture. The more passable we look, the better for us. We don't get stigmatized that much. And we get more…you know, we get more attraction and attention from the men. (Latina, 39)

Psychological Distress

Self-Objectification

To the extent that they felt they were valued only for their bodies, some participants (n=9, 41 %) also described how they internalized this objectified sense of their self-worth:

> If and when I do ever get the surgery, I'm going to be really stingy and selfish with that, because my thing is, not only is it expensive and stuff, it's more of a commodity, you know so then it's really going to make [men] chase and desire, but its not going to be issued out like I issue out my body now, so then it will really give me a better clientele and class of guys that come my way. (African American, 35)

Body Comparison and Body Surveillance

Almost all participants (n=21, 95 %) talked about their desire to look more like a non-trans woman, their envy of transwomen who pass, and their intense self-monitoring of their bodies and facial features with a critical eye toward what makes them appear more masculine or feminine.

> I want [the men I date] to say, damn that's a badass bitch. I know what she may have been, but, man, she giving females a run for they money. (African American, 36)

> It's all about hormones, you know. When I was on hormones, full-fledged, I would never get clocked [i.e. identified as trans]. Six months off hormones, the masculinity starts coming back. You can feel the change, not only. Your face changes, you get kind of masculine features coming back. And that really affects my confidence. (Mixed race, 28)

Gender Affirmation

Participants (n=22, 100 %) described what made them feel affirmed in their gender. Many participants (n=18, 82 %) discussed how this affirmation often comes from the attention of men, but many also aspired to have this affirmation come from within:

> Instead of just getting into life and forgetting about men and getting into myself and loving myself, it's just always about men, always a man, you know, because they feed your ego and tell you that you're so pretty, (African American, 35)

One participant described how her need for gender affirmation has lessened over time, as she has become more comfortable in her body and gained self-esteem, but that she still seeks this affirmation from others and experiences receiving it as a very positive boost to her self-esteem:

> A lot of times I'll be like, oh my god, I hope they don't clock it. [But] once you become comfortable in your

> own skin and really start loving who you are inside, it doesn't matter about the outside and once you come to that acceptance and you start really loving yourself—because for a long time, I didn't love myself. You know? I didn't feel like I was worthy of really anything to really be living. Now if they do [clock me as transgender], I'll be like, 'okay, it's fine', but I'll be worried… If I know I'm passing, I know I'm good. And then certain men be like, 'Oh, yes' and 'little mama' this and that. Okay. I'm good! [claps]. I'm good! You get that warm feeling inside. Like, what I'm doing is paying off! (African American, 36)

Many participants (n=17, 77 %) described feeling affirmed in their gender by being the receptive partner during sex, while others (n=5, 23 %) reported feeling comfortable during sex (including being the insertive partner or having their penises touched) as long as they felt they were being loved and respected as women:

> I don't like boys that want girls with titties to ride they backs. I think that's gross. But then again, to each his own. I ain't done it before, because I have tricks that wanted to do me, but it's like, it's ruining the illusion of being a woman. (African American, 30)
>
> What's important is does this person care about me, and do they respect me as a woman?… for them to make sure that I felt I was important and loved, every part of my body, that meant more to me than just playing the bottom role. (African American, 36)

One participant described how excited she was when she first started taking hormones and imagined how this would affect her access to gender affirmation from men:

> When you start taking hormones, it was just a jolt, like a rush. It was like, oh, I'm going to grow breasts, and I'm going to get a big butt and hips and stuff, and I'm going to look more like a woman. So you get so excited, so it's almost like a sigh of relief. Oh, but if I'd had this when I was 13 years old, I'd be so pretty now, so pretty… just to look totally like a woman… I wouldn't even hardly need surgery, I'd be so convincing to guys, they don't care what you got, you're just so pretty and so sly to them. And you're so real, that they just want you, you know, they just want you. (African American, 35)

Some participants (n=7, 32 %) discussed the competition they feel among transwomen, often related to appearance and competition for validation through the attention of men:

> If the transgenders are not as passable as you are you get a lot of animosity from them. Cause they guys will come by and always give me that extra attention. It's not that I wanted it, but it was flattering sometimes and sometimes I was happy cause I knew that I could get what I want from them. And I made a lot of enemies like that. (African American, 33)

Participants often (n=14, 64 %) discussed body control beliefs and how access to gender affirmation was often tied up with access to gender affirming health care, such as hormones and surgery.

> Yeah, I got the booty. Need a little smaller waistline. [laughs] A little more tits. I want a pair of inserts, but I'm afraid. But I get into it. If I get it, I'll get the saltwater saline bag. I don't want no silicone. (African American, 30)

Two participants (10 %) who had comparatively high access to gender affirmation described how being affirmed in their gender also affirmed their sense of self and even their sense of being human:

> I meet men off the streets or women off the streets and they'll just talk in passing, and that makes me feel more alive, I guess. More human. Because there's people that actually can converse with me, that I'm approachable enough for people to converse with me. Yeah. So I guess that it does make me feel more like a woman, it makes me feel more human. (API, 29)

> When you go out in public, and people have no clue or they call you miss or ma'am. I think that's the biggest time when you feel good about yourself. You can go get an ice-cream. You can do normal things that any woman would do, or your girlfriend would do, a sister would do. You say, 'Oh my god, I've made it.' Like, instead of someone hollering at you and saying, 'Oh, look at that, that's a dude.' Or some kind of slur or something. (Mixed race, 28)

Participants often brought up the issue of expenses related to transitioning, and the disparities in access to gender affirmation between transwomen that can afford expensive procedures and those that cannot. One participant lamented that transwomen do not all have the same level of access to gender-related health care due to differences in access to resources:

> Yeah, if I got the money to go have surgery and have it all done in less than a months' time, yeah, I'd have surgery to feminize my body. Your average girl don't have that choice. And to get to where the girl [with money] did it in 2 to 3 months, it takes another girl a few years, some of us a lifetime, to get to that point. (African American, 41)

High Risk Contexts

Sex Work and Sex to Obtain Gender Affirmation

Participants (n=18, 82 %) described how being rejected by their families often forced them to leave their homes to try to survive on the street. For some participants (n=16, 73 %), this quickly led to an introduction to survival sex work and seeking love and support where they could get it. In addition to being a means of survival, sex work was also described as a means of obtaining gender affirmation:

> The money is really good, and easy. And when a guy is paying you to have sex, it can make you feel like a real hot commodity, a sexy lady. It can be fun. (API, 29)
>
> I think that my happiness comes from validation. And I think that's another reason that transsexuals are so promiscuous. And, because it's like, oh my god, if a straight man is banging me, it's like, I guess I made it as a woman. You know? It's like reassurance. Over and over again. And [non-transgender] women, they don't spread their legs in front of everybody because they don't have to. You know, they're not trying to get validated by a guy. They know who they are. (Mixed race, 28)
>
> We lean on certain people for support and love in this life. And if you're not getting it from your own blood, it hurts. That's why a lot of us go out into the streets and look for that love and affection and respect that we would have probably been fine if we got that at home. (African American, 53)

Many participants (n=14, 64 %) described how lack of access to gender affirming healthcare keeps many transwomen involved in sex work. One participant described it this way:

> I have some beautiful, beautiful, beautiful friends who look totally [like a non-transgender] woman. And I'm like, 'God, I wish I could look like her!' But that takes money. They been involved in prostitution. They get the money, they save the money, they keep doing it and doing it. Until they achieve what they wanted to see. (Latina, 37)

Sex Under the Influence of Substances

Half of the participants (n=11, 50 %) reported that sex and drug use often went hand-in-hand. Often drugs were used as a means of coping with sex work and requests for sexual practices that the women did not feel comfortable with:

> [Transgender women] know that there's no money for them [because of employment discrimination], to be getting food or anything else. So, it's like, I may as well go to the streets, at least at the end of the day, I'll have money. The only problem with that is, I have to deal with my drug addiction in order to able to deal with dealing with this guy that I'm going to be making this money from. So, you take a chance on spending all your money on drugs, and coming out of both places with nothing. (Native American, 36)

Some participants (n=9, 41 %) reflected on how using drugs during sex might affect their ability to negotiate condom use. One participant described how getting drugs from her sex partner made her feel that he was in control of the decision to use condoms or not:

> I would get free crack from people that I was dating. I've been really lucky but I haven't been really safe as far as using protection and stuff. And I think there may be some correlation with substance use because I've always just kind of let the guy decide if he wants to wear protection or not. (African American, 33)

Risk Behavior

Unprotected Sex

Almost all participants (n=21, 95 %) discussed having had unprotected sex at some point in their lives. Participants attributed the decision not to use condoms to various motivations, such as enjoying sex more without condoms, feeling uncomfortable about insisting on condom use, feeling that being 'in love' meant not using condoms, and worrying that their partner might think they were not 'clean' if they insisted on condom use. One young participant reported that many men have misconceptions about the need for condoms during sex with a transwoman:

> Some guys are so dumb and naïve, they think you can't get anything from anal sex because it's not a vagina. And if they do, they figure, oh, well you can't get pregnant, so I don't have to use no condoms with you. (African American, 24)

Risky Body Modification Practices

All participants (n=22, 100 %) were currently using hormones or had used hormones in the past. Most participants (n=18, 82 %) reported starting hormone therapy by obtaining hormones from friends, the Internet, or going to Mexico to buy them without a prescription:

> I went down to Tijuana to buy my prescription by the cases. An older queen taught me how to inject myself and everything. Actually, a lot of times I would have her do it. It's a hassle when you're buying them on the

streets. And, you don't know exactly what you're buying. You have to be very careful. (Native American, 36)

Participants who reported using injection silicone (n=7, 32 %) often had mixed feelings about their experiences. For example, one transwoman reported being happy with the results of the procedure, but was aware of and anxious about the possible negative health consequences:

> Silicone was an experience in Mexico. Scary, back alley. I went to Mexico and did the Latina thing, because all my Latina friends were doing it, all of my friends have big asses and hourglass figures and I wanted it too. It's okay. I mean, I'm happy I got it, but if I could turn things, I probably shouldn't have… It's just, you never know what can go wrong, you never know how your body can react. I sometimes regret it. I feel scared sometimes. (Mixed race, 28)

Heavy Substance Use

Participants who reported heavy substance use (n=13, 59 %) often expressed a sense that their need to use was a way of coping with rejection and transphobia and/or avoiding dealing with the difficult issues that they faced during their transition.

> From marijuana, I jumped to coke. And then coke, it wasn't doing it [for me] no more, and that's when I got introduced to meth. And that's when all hell break all loose. I didn't realize the harm that I was doing to myself until I hit rock bottom. I was very, very depressed and I was putting a lot of my issues on the back burner and wasn't addressing them. Because I didn't have nowhere to go, I didn't have no therapy, nothing. I just used drugs as a scapegoat for me to relieve the pain. I OD'ed once… And then [another time] I almost killed myself. (Latina, 35)

Discussion

Gender affirmation, or being affirmed in their identity by others, was characterized as a highly important source of social support for participants. The gender affirmation framework was developed from an intersectional perspective based on the existing literature on transwomen of color and integrates relevant theories to clarify how social oppression decreases access to gender affirmation while psychological distress increases the need for gender affirmation, which is associated with identity threat. Attempts to decrease the threat then happen in high risk contexts, where risk behavior is more likely (Diaz 1998; Major and O'Brien 2005).

The results presented here support the gender affirmation framework, illustrated in Fig. 1, by demonstrating that in the context of social oppression (including sexual objectification), a high need for gender affirmation coupled with low access to gender affirmation among transgender women is associated with identity threat. Participants reported attempts to reduce the threat by seeking gender affirmation in high risk contexts in ways that increase risk to their health. In addition, the anxiety produced by stigma and discrimination is related to increased likelihood of engagement in high-risk contexts (e.g. sex while under the influence of substances or undergoing risky body modification procedures), and may increase the risk of engagement in high-risk contexts by increasing the need for gender affirmation.

Transwomen in this study reported that having their gender identity affirmed by other people is decidedly important, although there is variability in how vital this affirmation is to each individual. A very high level of access to gender affirmation is often referred to as "passing" for transwomen who wish to be perceived as a non-trans woman. While some transwomen were comfortable identifying openly and being perceived as transgender, many transwomen strive to avoid being "clocked" or "read" as transgender by others and instead prefer to be perceived as simply a woman. Thus, there was a degree of variability in this sample in participants' levels of need for gender affirmation.

Just as transwomen's need for gender affirmation varied, their access to gender affirmation also varied. Some participants reported passing as non-trans women quite easily due to their naturally small physique and delicate facial features and bone structure. This phenomenon was also observed in one sample of Asian and Pacific Islander transgender women and has been suggested as one possible explanation for their lower rates of HIV risk behavior and higher socioeconomic status, compared to other transgender women of color (Operario and Nemoto 2005). Other transwomen did not naturally pass, but due to their socioeconomic status may have had access to gender-related health care (also called 'sex reassignment' or 'gender confirmation' procedures), such as hormones and surgeries that assist one's physical transition and feminize the face and body. Those who do fully pass and are usually not "clockable" as transgender have been referred to in the literature as having "passing privilege", in that when they interact with strangers who read them as a non-transgender female, they are being affirmed in their gender identity and are able to avoid the negative effects of stigma (Xavier 1999). In fact, a number of studies have found that increased access to gender affirmation does result in increased quality of life for transgender people (Ainsworth and Spiegel 2010; Gerhardstein and Anderson 2010; Kraemer et al. 2008; Newfield et al. 2006). Transwomen in this study also reported that beginning their gender transition eased their depression and reduced their

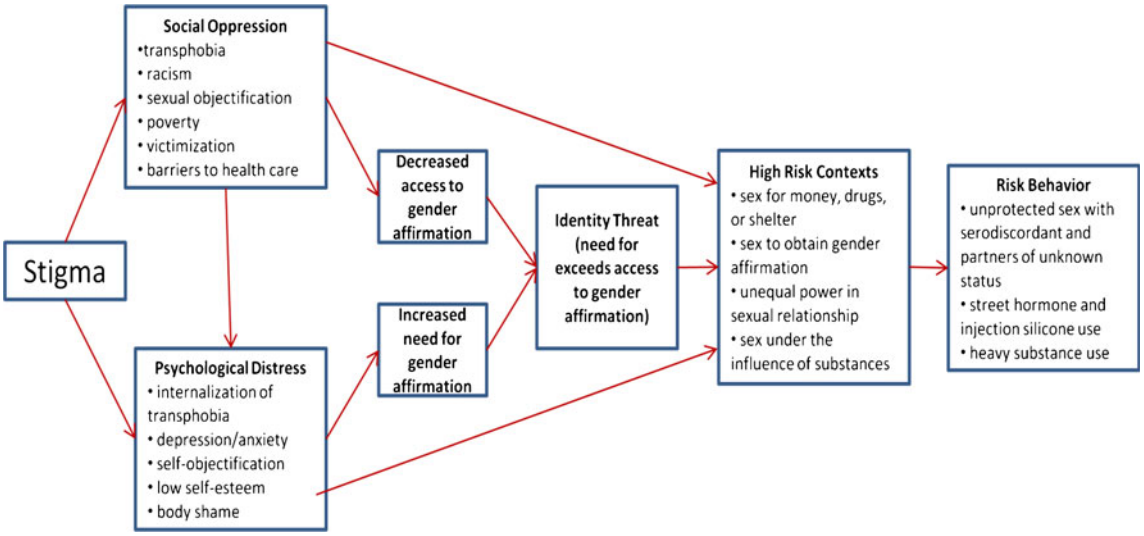

Fig. 1 Gender affirmation framework for conceptualizing risk behavior among transwomen of color

need for alcohol and drugs. Xavier (1999b) conceptualizes transwomen's desire to pass as "stigma management," which is analogous to attempting to increase resources in the identity threat model of stigma, and supports the idea of increasing transgender women's access to gender affirmation as a means of reducing identity threat. However, even passing sometimes generated anxiety and stress for transwomen in this sample, due to the need to control information that may lead to being "outed" as transgender.

When seeking increased access to gender affirmation through body modification, participants often reported that they face multiple barriers to obtaining health care, especially health care related to gender transition. Not only do they face disparities in access to care that are shared by people of color in general, they are also confronted with a medical system that pathologizes their identity, sets up a gatekeeping system to restrict their access to gender-related care, and does not adequately train health care providers to meet their needs with compassion and respect (Bauer et al. 2009). Thus, transwomen in this sample reported that they often must turn to hormones purchased on the street and illegal "pumping parties" where silicone and other substances are injected into their body for feminization purposes.

Access to gender affirmation also includes social support from people who understand and support one's female and/or transfemale identity and communicate this through language (e.g. using the correct pronoun 'she' to refer to a transgender female, using her chosen name, or overtly expressing support) and/or body signals (e.g. engaging with her physically as a woman). Transwomen in this sample reported varying levels of access to this type of gender affirmation, depending on their family's level of acceptance and support, their connection to transgender community, and other factors. Other studies have shown high levels of social isolation among transwomen, who often report avoiding social contact out of fear of rejection and ridicule, especially when they do not pass and have faced a great deal of stigma-related stressors (Bockting 2008).

Sexual objectification experiences are a form of social oppression intended to communicate to women that they are primarily valued for the way they look and the function of their bodies (i.e. to serve as sexual objects). Dominant cultural standards of beauty include traditionally gendered ideas about what women should look like (e.g. height, weight), as well as unique pressures related to race and ethnicity, such as skin tone, hair color and texture, facial features, and shape and size of body parts. Transwomen of color in this study reported social pressures and expectations as well as personal desires to express a certain type of femininity that is shaped by culturally informed notions of womanhood that are often narrow and difficult to attain. By self-objectifying and internalizing dominant, racialized standards of beauty, transwomen of color in this study reported the tendency to constantly monitor and compare their body to that of other trans and non-trans women. Among transwomen, comparing one's body to non-trans women as well as other transwomen may predict higher levels of engaging in risky body modification procedures, such as street hormone use and injection silicone use.

Limitations

The conclusions derived from this data are a product of the characteristics of this particular sample of transwomen of color. These conclusions may not generalize to transwomen who are White, have not or do not engage in sex work and/or substance use, and do not have a history of incarceration. While the recruitment procedures for this study included

language specific to 'transgender women', a multitude of diverse gender identities were represented in the sample. This suggests that although participants often had unique and specific ways of describing their gender identity, they also demonstrated a sense of belonging under the umbrella term 'transgender women', as indicated by their self-selection for the study. This phenomenon may be particular to the San Francisco Bay Area, where 'transgender' may be a term that is more highly recognized and utilized than in other parts of the United States and elsewhere.

This research was limited to English-speaking transgender women of color, and thus is not likely to be generalizable to transwomen of color who do not speak English and may be recent immigrants. In addition, by analyzing the interviews of transwomen of color instead of separating them out by race, there may have been important differences between racial groups that are not explored here.

Implications

These findings point to a unique opportunity to build upon research that has been conducted with non-trans women by developing and testing interventions for transwomen that are grounded in objectification theory and designed to reduce body surveillance and body shame. Such interventions should focus on increasing access to gender affirmation while simultaneously decreasing the need for gender affirmation. Interventions may increase access to passing through gender confirmation procedures as stigma management, but may also increase pride in being transgender to increase self-esteem and reduce reliance on validation from sex partners to receive gender affirmation (Sevelius et al. 2009). Such interventions could be aimed at increasing group identification among transwomen, as group identification has been found to be positively correlated with self-esteem among African Americans (Branscombe et al. 1999). Data in the current study did suggest some potential challenges to building transgender group identification, including competition among transwomen and fears about potential "outing," which suggest areas for further exploration in the development of interventions.

The gender affirmation framework was developed with the unique social context of transgender women of color in mind, is formulated from a perspective that considers the intersecting experiences of transphobia, racism, and sexism, and is supported by results drawn from this particular sample. However, it is useful to think about how this framework might or might not generalize to be applicable with White transgender women, transgender men, or other gender-variant individuals. The powerful effects of testosterone often afford transmen a higher level of access to gender affirmation than transwomen, and this may account for some of the group differences found in employment and health status between transmen and transwomen (Clements-Nolle et al. 2001; Xavier et al. 2005). But to the extent that transmen internalize dominant cultural standards of masculinity, such as muscularity, height, and even penis size, gender affirmation needs may also affect transgender men's self-esteem and willingness to take risks. Also, some transmen report low need for gender affirmation (or even a strong desire to be seen as trans or queer) but high access to gender affirmation, or passing, where they are readily recognized as male and bypass the stigma associated with being transgender, even when they have a high level of group identification (Sevelius 2009b). The application of the gender affirmation framework to the multiple social identities experiences by transmen, especially transmen of color, presents an opportunity for interesting future research that could elucidate how these intersections manifest in unique experiences and outcomes for transmen. Future research is needed to test the pathways proposed in the gender affirmation framework by using quantitative measures of the constructs of interest with a larger sample of transgender individuals.

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