

**Critical Race Approaches to Understanding Health Inequities Impacting Trans People of Color in
the United States**

by

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Abstract

This dissertation critically examines structural drivers of health inequities impacting trans people of color in the United States. To do so, I use theories that concern how the structural power dynamics that drive these inequities are produced and maintained: Critical Race Theory, the structural trauma framework, and the structural vulnerability framework. This research is an attempt to respond to community-identified priorities and support community-led initiatives to promote trans people of color's health and wellbeing by identifying, understanding, and working towards dismantling the systems that produce hardship and adverse health outcomes in trans communities of color.

In the first study, I used Behavioral Risk Factor Surveillance System data to examine differences in the prevalence of Adverse Childhood Experiences (ACEs) and their relationship with self-rated mental and physical health between trans people of color and multiple comparison groups using an intercategory approach to intersectionality. Findings revealed that trans people of color had higher probabilities of six ACEs in comparison to at least one other group and that the relationship between five ACEs and poor mental health was more pronounced than for at least one other group. Interpreted through the structural trauma framework, these findings underscore the need to restructure the interconnected systems that contribute to ACEs and mediate their health impacts in trans children of color.

In the second study, I use data from a large convenience sample of trans women to examine differences in the relationship between trans-related state policies (e.g., nondiscrimination laws, gender marker change laws) and self-rated health between trans women

of color and White trans women. I drew from Critical Race Theory's *critique of liberalism* to conceptualize this study, and the analysis used both intracategorical and intercategorical approaches to intersectionality. Findings indicated that multiple policies were associated with better self-rated health for White trans women and worse self-rated health for trans women of color. These results suggest that trans-related state policies may widen health inequities impacting trans women of color by increasing access to resources necessary for wellbeing more effectively for White trans women than trans women of color, highlighting a need for greater attention to race and racism in research and organizing efforts to promote health equity for trans people of color via policy change.

The third study uses qualitative methods and an intracategorical approach to intersectionality to explore how Black trans leaders of organizations serving Black trans communities cultivate Black trans joy and liberation. In partnership with the Black Trans Fund, I interviewed ten such leaders and used reflexive thematic analysis and Critical Race Theory's *counternarrative* methodology to develop three themes: envisioning joyful, liberated futures; laying groundwork through liberatory praxis; and prioritizing safety and healing. These themes emphasize the proactive, strategic, and values-driven nature of these leaders' work and offer insight into how efforts to achieve health and social equity within and beyond public health research can better align with Black trans communities' priorities and approaches.

Ultimately, findings from this dissertation demonstrate the utility of integrating multiple critical theories to examine health inequities. Applying these theories implicates the structures that drive health inequities among trans people of color, suggesting the need for continued evaluation and transformative restructuring of the systems that that impact safety for trans

children of color, develop state-level trans-related policies, and influence community-based organizations.

Chapter 1 Introduction

1.1 Health inequities impacting trans people of color in the United States

Inadequate population-level data on trans¹ people in the United States limits our understanding of the full extent to which trans populations of color² experience health inequities (National Academies of Sciences, 2022). Typical sources of health surveillance and demographic data including the National Health and Nutrition Examination Survey, National Health Interview Survey, and vital records do not collect information that allows for trans people to be identified in their datasets (Lett & Everhart, 2022). However, other existing data sources, though imperfect, have allowed for comparisons of health outcomes among different subsets of trans people of color to different control groups (Lett, 2023). Overall, these analyses suggest stark health

¹ I use “trans” as an umbrella term for people whose gender differs from that typically associated with their sex assigned at birth via Western, colonialist gender norms. This is intended to encompass people who identify as trans, people of trans experience, and nonbinary people.

² I use “people of color” to collectively refer the racial and ethnic groups White supremacy excludes and oppresses (Starr, 2022). This term therefore demarcates power relations rather than describes a shared identity. In recent years, some scholars have shifted towards using “racially minoritized” to reflect this distinction, arguing in some cases that “people of color” obscures power dynamics, reflects a belief that skin color confers pathology, and conflates the experiences of distinct racial and ethnic groups (Black, Cerdena, & Spearman-McCarthy, 2023; Starr, 2022; Wingrove-Haugland & McLeod, 2021). While acknowledging the legitimacy of these critiques, I have chosen to use “people of color” due to concerns that “racially minoritized” does not adequately address the problems with (over)use of “people of color,” perpetuates linguistic violence against the groups it aims to describe, and reduces White supremacy to a problem of numeric representation while simultaneously failing to acknowledge that people not solely of European descent are the global majority (Cummings, 2019; Zheng, 2022).

inequities across the life course and across multiple health domains impacting trans people of color, generally concentrated among Black and Latina³ trans women.

Two representative sources of health data on adult trans populations currently exist (National Institute of Health, 2023). First, the Behavioral Risk Factor Surveillance System (BRFSS) is annually administered in all 50 states, the District of Columbia (DC), Guam, Puerto Rico, and the US Virgin Islands (CDC, 2023). Beginning in 2014, states could elect to use an optional Sexual Orientation and Gender Identity (SOGI) module (Restar, Jesdale, Pederson, Durso, & Scout, 2019). In 2019, BRFSS added an optional Assigned Sex at Birth which allows for the identification of additional trans respondents (Lett & Everhart, 2022). A growing body of literature has pooled multiple years of this data to characterize health inequities impacting trans people of color or particular racial/ethnic groups more specifically. For example, these studies have found that that Latinx⁴ trans people have lower access to healthcare and poorer health-related quality of life than Latinx cisgender people and White trans people (Lett, Asabor, Beltran, & Dowshen, 2021) and that Black trans people are more likely to report psychological distress, longer periods of being physically or mentally unwell, and poorer self-rated health than

³ I follow recommendations from the Center for the Study of Social Policy to capitalize nouns designating racial and ethnic groups such as Black, White, and Indigenous (Nguyễn & Pendleton, 2020). Doing so is intended to acknowledge the histories and identities of the people grouped within these terms. For Black and other racial groups subsumed under the category of “people of color”, this is intended as a step towards linguistic conventions that acknowledge humanity rather than describe physical appearances or geographic origins outside the United States and Europe. Capitalizing White is intended to draw attention to how Whiteness has functioned and thrived in the United States and name “White” as a distinct racial category rather than an implicit human default.

⁴ Current recommendations for referring to people from ethnic backgrounds that can be traced to Latin America suggest using “Latinx” or “Latine” to acknowledge the often unmeasured gender diversity within these groups (Miranda, Perez-Brumer, & Charlton, 2023). In this dissertation, I have chosen to use Latinx because it is currently most common (Galarte, 2021a).

Black cisgender people and White trans people (Lett, Dowshen, & Baker, 2020). A more recent study using pooled BRFSS data found that trans people of color experience inequities in subjective cognitive decline in comparison to cisgender White people and cisgender people of color (Cicero, Lett, Flatt, Benson, & Epps, 2023).

Second, TransPop collected data from a nationally representative sample of trans adults in the United States from 2015-2016 (TransPop, 2015). Researchers have used this data alone and in combination with other data sources to examine health and social inequities impacting trans people broadly; however, only one study thus far has examined racial differences in health outcomes or their predictors using this data (TransPop, 2023). This study found that trans people of color were more likely than White trans people to meet eligibility recommendations for HIV testing and noted TransPop's small sample size as a limitation to more rigorous analyses of racial inequities within trans populations (Sevelius, Poteat, Luhur, Reisner, & Meyer, 2020).

The US Trans Survey (USTS) has also provided critical data on health and social inequities impacting trans people of color. Unlike BRFSS and TransPop, the US Trans Survey (USTS) is a large, nonprobability sample of trans adults. The latest publicly available data from this survey, formerly called the National Trans Discrimination Survey, were collected in 2015 from over 27,000 individuals (James et al., 2016). Because of USTS's large sample size, researchers have been able to make a variety of comparisons between trans people of color (and subgroups within) and White trans people. For example, these analyses have found that in comparison to White trans people, American Indian/Alaskan Native, Black, Latinx and multiracial participants were more likely to report polyvictimization (i.e., experiencing multiple of the following: lifetime intimate partner violence, nonpartner sexual assault, anti-trans family violence, anti-trans physical violence in K-12 school settings, past year anti-trans physical

violence) (Messinger, Guadalupe-Diaz, & Kurdyla, 2022); that trans people of color overall were more likely to avoid healthcare due to anticipated discrimination (Lerner, Martin, & Gorsky, 2020); and that American Indian/Alaskan Native, Latinx, and multiracial participants were more likely to report severe psychological distress (Lett, Abrams, Gold, Fullerton, & Everhart, 2022). While these type of intra-group comparisons are key to understanding racial/ethnic health inequities within the trans population, USTS data does not allow for comparisons to cisgender control groups.

More recently, efforts to understand trans health at a population level have drawn from large administrative datasets. These data sources, which include claims data from public and private health insurance and electronic healthcare records, typically have larger samples of trans people than both BRFSS and TransPop and include cisgender control groups (Zhang et al., 2020). However, identifying trans people within these datasets is logistically and ethically challenging as data on gender and sex are not self-reported, and the algorithms designed to identify trans people may better identify White trans people than trans people of color (Chyten-Brennan, Patel, Ginsberg, & Hanna, 2021; Kronk et al., 2022; Thomeer & Patterson, 2022). Few studies using these data sources have considered racial/ethnic dimensions of inequities impacting trans populations. In one study of Veterans Health Administration data, Black trans veterans had a greater probability of being diagnosed with alcohol use disorder, several indicators of poor cardiovascular health, HIV, serious mental illness, and kidney disease than White trans veterans (G. R. Brown & Jones, 2014). A more recent study of private insurance claims data reported stark inequities in mortality rates between Black trans women and nonbinary people assigned male at birth and seven other comparison groups (e.g., Black cisgender men, White trans men and nonbinary people assigned female at birth) (L. Hughes et al., 2022).

Because of the limitations of these data sources, most studies on the health status of trans populations of color stem from research relying on smaller convenience samples. Generally, this research has centered Black and Latina trans women and focused on HIV prevention and treatment, healthcare access and experiences, substance use, and mental health (Farvid et al., 2021). These studies often aim to identify correlates, test mechanisms, or document incidence of adverse health outcomes rather than document or explore health inequities between trans people of color and other groups. However, the high prevalence of many adverse health outcomes in these samples likely reflects underlying inequities. For example, a meta-analysis of HIV research found that 44% of Black trans women in the United States are living with HIV compared to 26% of Latina trans women and 7% of White trans women (Becasen, Denard, Mullins, Higa, & Sipe, 2018). While similar meta-analyses have not been conducted for other health domains, recent studies reporting the prevalence of health outcomes or behaviors by race/ethnicity and gender suggest similar patterns (Farvid et al., 2021). For example, recent studies have documented health inequities impacting trans people of color across conditions including depression and suicidality (Park et al., 2022), psychological distress (Millar & Brooks, 2022), tobacco and alcohol use (Operario et al., 2023), and intimate partner violence (Whitfield, Coulter, Langenderfer-Magruder, & Jacobson, 2021).

1.1.1 Prevailing explanations for health inequities impacting trans people of color

Public health research concerning trans populations overall and trans people of color more specifically commonly centers stigma⁵ as a cause of these inequities. In general, research

⁵ These studies generally conceptualize stigma as the deep discreditation of a personal attribute (Goffman, 1963). Stigma against trans people exists throughout the social-ecological model and can be defined as the systematic

has attended to how stigmatizing experiences related to gender including anti-trans discrimination, interpersonal rejection and non-affirmation, violence, and internalized or anticipated stigma drive adverse health outcomes and how individual- or community-level characteristics may modify this relationship (Drabish & Theeke, 2022; Poteat & Simmons, 2022; Sevelius, 2013; Tan, Treharne, Ellis, Schmidt, & Veale, 2020; Testa et al., 2017; White Hughto, Reisner, & Pachankis, 2015; Wirtz, Poteat, Malik, & Glass, 2020). These studies are commonly grounded in social-ecological models (Johns, Beltran, Armstrong, Jayne, & Barrios, 2018; White Hughto et al., 2015) and/or theories that descend from the Minority Stress Model (Brooks, 1981; I. Meyer, 1995) including the Gender Minority Stress and Resilience Model (Hendricks & Testa, 2012; Salomaa et al., 2023; Tan et al., 2020; Testa, Habarth, Peta, Balsam, & Bockting, 2015) and the Gender Affirmation Framework (Sevelius, 2013).

In the wake of the upswell of trans visibility and sociopolitical animosity towards trans people over the last several years (H. Thompson, Wang, Talan, Baker, & Restar, 2023), research has built upon this work to interrogate upstream factors of trans health inequities. These include trans-specific state and federal laws (Kline et al., 2023); practices in schools and the criminal-legal system (Jenness & Rowland, 2023; Rosentel, López-Martínez, Crosby, Salazar, & Hill, 2020); and healthcare systems and structures (van Eijk, 2017). This dissertation seeks to contribute to this literature by examining structural drivers of population health inequities disadvantaging trans people of color and benefitting White and/or cisgender people. To do so, it draws from three theoretical approaches to understanding inequity: Critical Race Theory, the structural trauma framework, and the structural vulnerability framework. These theoretical

devaluation and marginalization of people who challenge hegemonic ideas of gender and sex, including the Western colonial gender binary (King, Hughto, & Operario, 2020).

approaches originate from legal studies, philosophy, and sociology, respectively. While they were developed outside of public health, they are appropriate for this line of inquiry because they concern how power structures manufacture the material conditions in which marginalized people live. Therefore, their use generates implications for disrupting marginalizing social structures with the ultimate goal of prioritizing trans people of color's survival, wellbeing, and flourishing.

1.2 Critical Race Theory in Public Health

Critical Race Theory builds on critical legal studies, radical feminism, and radical and conventional civil rights thought to examine and transform the production and maintenance of racism in the United States (Delgado & Stefancic, 2017). Critical Race Theory's central project is uncovering and dismantling White supremacy; as such, sub-movements have developed intellectual traditions to apply Critical Race Theory to specific racial or ethnic groups (i.e., to Latinx people through LatCrit) and to groups subjugated by other forms of structural oppression (i.e., ableism through DisCrit) (Annamma, Connor, & Ferri, 2013; Delgado & Stefancic, 2017; Solorzano & Yosso, 2001). Scholars have also applied and developed the tenets of this movement across social science disciplines including education (Ladson-Billings, 1999), sociology (Yosso & Solórzano, 2007), and public health (Ford & Airhihenbuwa, 2018).

A unifying theme of this multifaceted intellectual tradition is concern for the *permanence and persistence of racism* in all political, economic, and social domains of the United States (DeCuir & Dixson, 2004; Delgado & Stefancic, 2017; Ladson-Billings, 1999). Critical Race Theory thus counters the dominant White liberal ideology of colorblindness by characterizing the process of White supremacist racial domination as ongoing, systemic, and socially ingrained rather than as a fleeting historical artifact of a pre-Civil Rights Movement era (Crenshaw, 1995). In other words, White supremacy is the foundation of structural racism, which can be understood

as a social order in which mutually reinforcing housing, education, employment, earnings, benefits, credit, media, healthcare, and criminal legal systems foster racial inequities (Z. Bailey et al., 2017).

Using Critical Race Theory to understand health inequities impacting trans people of color requires an intersectional approach that centers race and racism. *Intersectionality* as a tool for critical analysis originates from Critical Race Theory (Crenshaw, 1991) and has been widely applied across social science disciplines to uncover and transform how interlocking social structures create and maintain dynamics of power and marginalization (Carbado, Crenshaw, Mays, & Tomlinson, 2013). In public health, intersectionality analyzes how interlocking forms of oppression shape individuals' lived experiences and population health outcomes, driving health inequities (Agénor, 2020; Bowleg, 2021; Poteat, 2021). For example, empirical studies using intersectionality to understand health outcomes among trans people of color have found that measures of racism and cissexism are jointly associated with housing instability among trans women (Beltran et al., 2019) and with behaviors that can contribute to HIV incidence among trans young adults of color (Lett, Asabor, et al., 2022). These studies demonstrate fidelity to intersectionality's Black feminist roots by focusing on how structural power dynamics— not individuals' "multiple identities" — shape the conditions in which trans people of color are more likely to experience housing instability, participate in sex work, and use alcohol and other substances before sex (Beltran et al., 2019; Bowleg, 2021; Lett, Asabor, et al., 2022). As with other subgroups of people of color in the United States, applications of intersectionality to trans people of color that do not consider structural racism work to flatten, depoliticize, and disarm the activist intent of intersectionality (Bowleg, 2021; Gillborn, 2015).

Black and Latina feminist scholars have articulated the importance of understanding contemporary systems of gender-based oppression as tools of structural racism (Bernal, 2002; Dillard, 2000; Lugones, 2008). Like race, gender, sex, and sexuality are not universal or biological realities but increasingly global sociocultural constructions designed to serve White supremacist goals (Bohrer, 2020; Lugones, 2008). The modern system of gender was established by White Europeans via Christianity and spread globally through colonization, genocide, and slavery (el-Malik, 2013; O’Sullivan, 2021; Snorton, 2017). Hegemonizing the Western patriarchal male/female gender binary served to subjugate colonized populations and build economic systems that concentrate control of resources and wealth among White men (Connell, 2016). Examples of this include European colonizers seizing land by imposing laws that effectively removed native Hawaiian women’s right to property (Kauanui, 2018), creating a goldmining labor force by displacing concepts of masculinity tied to family and pastoralism in South Africa (Breckenridge, 1998), and dispossessing and exploiting Indigenous communities in North America by dismantling existing gender systems via residential schools (Arvin, Tuck, & Morrill, 2013; Margolis, 2004; M. Robinson, 2020). Though hegemonic conceptualizations of gender and gender dynamics have been constantly contested and revised since colonization, these efforts have not substantially shifted how this gender system serves to disrupt potential lines of solidarity and resistance among people of color and uphold White economic interests through imperialism, neoliberalism, and racial capitalism (Bohrer, 2020; P. Collins, 2000; Connell, 2016; Lugones, 2008).

More recently, trans scholars have explained how the spread of this racialized gender system forcibly introduced the gender binary as a tactic of domination, division, and control serving White colonial interests (Leo, 2020; B. Robinson, 2020; Snorton, 2017). Today,

gendered concepts such as masculinity, femininity, and androgyny; passing and nonconformity; binary and nonbinary, are constructed within the implicit norm of Whiteness (Beauchamp, 2009; Canli, 2018; Green & Bey, 2018; Plemons, 2018; Roen, 2006; Stewart & Nicolazzo, 2019). Consequently, despite the tokenizing hyper-visibility of Black trans women in popular media and lesbian, gay, bisexual, and trans (LGBT) activism, public discourse and mobilization around “queer issues” or “trans issues” marginalizes trans people of color by centering Whiteness and White people’s experiences (Bassichis & Spade, 2014; Green & Bey, 2018; Krell, 2017; Lamble, 2014; Peeples, 2023; Vitulli, 2010). This phenomenon is readily apparent in the proliferation of trans-exclusionary, cissexist feminisms that align themselves with explicitly White supremacist movements to protect (White, cisgender) womanhood while purporting to care about lesbians’ welfare (Bassi & LaFleur, 2022; Evang, 2022). Understanding how cissexism drives health inequities among trans people of color thus necessitates interrogating how cissexism works to uphold White supremacy.

1.3 Structural Trauma

While Critical Race Theory directs public health researchers to consider the primacy and ordinariness of racism and the social construction of race while conducting health equity research, it does not identify mechanisms through which structural racism drives health inequities (Ford & Airhihenbuwa, 2018). As a result, public health research utilizing Critical Race Theory must also draw from more applied theories of health inequities to explain how and why structural racism operates in relation to health outcomes (Mannor & Malcoe, 2022). In theorizing on health inequities impacting trans people of color, returning to scholarship on the conceptual relationship between racism and gender-based oppressions offers guidance.

In particular, the structural trauma framework provides the basis for a critical, philosophical explanation for how structural racism and cissexism affect trans people of color's health. Elena Ruiz's essay *Structural Trauma* conceptualizes trauma as intentionally distributed through populations. In the same vein as previous work tracing contemporary, violent systems of gender and gender oppression to colonialism and slavery (Lugones, 2008; Snorton, 2017), the structural trauma framework analyzes how the political, social, and economic structures that differentially harm, contain, and eliminate populations who transgress the colonial gender binary do so by creating conditions in which these populations are likely to experience trauma (Ruiz, 2020). Examples of these conditions include the hyper-surveillance and criminalization of communities of color, impunity policies for non-Natives who commit federal crimes on Native lands, and the de-politicization and de-racialization of gun violence (Ruiz, 2020).

Trans children and youth of color's experiences in K-12 education exemplify how structural racism and cissexism create the conditions in which trans people of color are disproportionately exposed to trauma. An extensive, multidisciplinary body of literature has documented the racist foundations of public education in the United States, connecting this history to students of color's contemporary experiences of inequitable treatment, discrimination, and violence in schools (Justice, 2023; Lynn & Parker, 2006; Martinez-Cola, 2022). The past few decades of education reform centering standardized test scores as the ultimate metric of school success has strengthened a system in which students of color are more likely to attend overcrowded institutions staffed by less experienced educators who are provided fewer resources for instruction in comparison to White students (Clotfelter, Ladd, & Vigdor, 2007; Darling-Hammond, 2007; T. M. Davis & Welcher, 2013; Jennings, Deming, Jencks, Lopuch, & Schueler, 2015).

Additionally, despite the shift towards restorative justice and positive behavior models, school discipline policies and practices that uphold Western colonial gender norms and disproportionately target students of color are commonplace (Davison, Penner, & Penner, 2022; Hines-Datiri & Carter Andrews, 2017; Muñiz, 2021). The policies and practices include enforcement of racialized and gendered dress codes (Aghasaleh, 2018; Glickman, 2016), bans on trans students accessing bathrooms and other sex-segregated spaces consistent with their gender identity (E. Meyer, Leonardi, & Keenan, 2022), and anti-bullying initiatives that ignore underlying school climate dynamics that lead to violence against LGBT students (Payne & Smith, 2018). Such policies contribute to inequitable rates of school suspensions among Black, Indigenous, and multiracial LGBT youth in comparison to White cisgender heterosexual youth (Snapp, Day, & Russell, 2022). Trans people of color have described how traumatic experiences of discrimination, bullying, and violent victimization in school settings disrupted their education, contributing to absenteeism and drop out (Graham, 2014; Simons, Grant, & Rodas, 2021; Snapp et al., 2022). This lack of equitable education opportunities contributes to economic hardship, engagement in criminalized economies (e.g., drug sales, sex work), and interaction with the criminal legal system, all of which also predispose individuals to trauma (Graham, 2014; Lacombe-Duncan et al., 2022; Nadal, Davidoff, & Fujii-Doe, 2014; Rogers & Rogers, 2020; Rosentel et al., 2020; Yarbrough, 2021).

Because of its specific attention to the distribution of trauma across categories of race and gender, Ruiz's structural trauma framing can be used to understand trauma as a deliberate tool of racism and cissexism meant to enact physical and mental suffering against trans people of color (Ruiz, 2020). In addition to the mental health impacts of trauma, a host of physical health outcomes including cardiovascular disease, gastrointestinal health, cellular aging, and health

related quality of life have been associated with exposure to traumatic events and onset of PTSD symptoms (Pacella, Hruska, & Delahanty, 2013; Schnurr, 2015; Scott et al., 2013; Sowder, Knight, & Fishalow, 2018; Wolf & Schnurr, 2016). Therefore, the high prevalence of trauma among trans people of color may underlie physical and mental health inequities impacting this population. However, the structural trauma framework does not suggest ways of identifying and intervening upon the conditions that precipitate traumatic events or on how oppressive logics maintain those conditions. Both are needed to develop a functional and actionable theoretical understanding of drivers of health inequities impacting trans people of color.

1.4 Structural Vulnerability

The structural vulnerability framework complements the structural trauma framework as both consider how material deprivation and threats to survival are unevenly distributed throughout the population and intentionally clustered to benefit dominant ranks of social hierarchies (Quesada, Hart, & Bourgois, 2011; Ruiz, 2020). The structural vulnerability framework examines how mutually reinforcing economic, political, cultural, and social insults become embodied in individuals who occupy subordinated positionalities, driving adverse health outcomes (Castaneda, 2013; Quesada et al., 2011). In this framework, “insults” are stimuli that predispose particular individuals or communities to ill health in relation to people in superior positionalities (Quesada et al., 2011). For example, applications of this framework have analyzed how systems of seasonal farm labor benefit White American’s economic interests by exposing Latinx migrants and their families to insults including poor living and housing conditions, violent victimization, social isolation, and financial hardship, ultimately leading to trauma and poor health (Holmes, 2011; Negi, Siegel, Calderon, Thomas, & Valdez, 2020; Quesada et al., 2011).

When integrated into the structural trauma framework, structural vulnerability can thus be conceptualized as the material and social conditions precipitating trauma.

As operationalized in health research, structural vulnerabilities are indicators of how occupying a subordinated positionality impacts an individual's ability to pursue a healthy lifestyle and avoid survival emergencies (Bourgois, Holmes, Sue, & Quesada, 2017; Castaneda, 2013; Footer et al., 2020; Friedman et al., 2020; Negi et al., 2020). Observable structural vulnerabilities include low educational attainment, poverty, housing deprivation, violent victimization, and involvement in the criminal legal system (Bourgois et al., 2017; Footer et al., 2020). The structural vulnerability framework can be used to identify sources of social inequality that can be ameliorated through policy change, reallocation of resources, and improved technology (Quesada et al., 2011). For example, previous applications of this framework to trans populations have called for efforts to support the housing and employment needs of trans young adults who migrate to urban enclaves in pursuit of gender affirmation (Gamarel, King, et al., 2020) and for allocating funding to community-led organizations addressing the economic needs of trans women of color (King, Jadwin-Cakmak, Trammell, & Gamarel, 2022).

Trans people of color are a structurally vulnerable population as measured by multiple indicators. For example, the overall poverty rate for trans adults in the United States is estimated at 29.4% and is significantly higher for Black trans adults (38.5%), Latinx trans adults (48.4%), and other trans people of color (35.2%) than for White trans adults (18.6%) (Badgett, Choi, & Willson, 2019). Trans people of color are significantly less likely than cisgender lesbian, gay, and bisexual (LGB) people and White LGBT people to own their homes and have repeatedly identified housing deprivation as a pressing community issue in qualitative studies (Glick, Lopez, Pollock, & Theall, 2019; Lacombe-Duncan et al., 2022; Romero, Goldberg, & Vasquez,

2020). Poverty and housing deprivation increase contact with the police, who enact structural violence against trans people of color through hyper-surveillance, arrest, and incarceration (Ezie, 2023; B. Robinson, 2020; Yarbrough, 2021).

Trauma is normative among structurally vulnerable populations. For example, cisgender women of color experiencing housing instability have described how multigenerational, interlocking cycles of homelessness and violence make trauma part of daily life (Brush, Gultekin, Dowdell, Saint Arnault, & Satterfield, 2018). For trans people of color experiencing housing deprivation, trauma may be even more common as systems designed to prevent or mitigate violence and housing challenges such as domestic violence shelters and emergency housing programs often perpetuate discrimination and abuse (Ezie, 2023; Guadalupe-Diaz & Jasinski, 2017; James et al., 2016; Lacombe-Duncan et al., 2022; Rogers & Rogers, 2020). Similarly, trans women of color have described experiencing gender-based violence from cisgender men as typical of their dating, romantic, and sexual lives, and are hyper-aware of their risk for experiencing lethal violence due to the high homicide rates in their communities (Gamarel, Jadwin-Cakmak, et al., 2020). The structural vulnerability framework thus connects broader systems of oppression to local community dynamics and individual health outcomes and suggests that intervening on these vulnerabilities will more effectively improve health outcomes for individuals experiencing them than biomedical or behavioral interventions alone (Bourgois et al., 2017).

1.5 Dissertation Overview

The primary purpose of this dissertation is to critically examine structural drivers of health inequities impacting trans people of color in the United States. Guided by the theoretical frameworks described above, this work is intended to be responsive to community-identified

priorities and supportive of community-led initiatives to address these inequities and otherwise support trans people of color's health and wellbeing. The dissertation is comprised of three studies with different populations of focus, data sources, outcomes considered, and methodologies. Together, they demonstrate the flexibility and potential of using intersectionality frameworks in trans health research (Wesp, Malcoe, Elliott, & Poteat, 2019).

Drawing from Leslie McCall's methodological guidelines for exploring the "complexity of intersectionality," I employ both intercategory and intracategory intersectionality approaches (McCall, 2005). Intercategory intersectionality strategically categorizes groups of people to document inequalities and interrogate the societal dynamics that contribute to inequality (McCall, 2005). This is arguably the most common approach to intersectionality in quantitative public health research because its reliance on comparisons across two or more researcher-defined characteristics (e.g., race and gender) allows for precise analysis of the social patterning of health inequities (Merz et al., 2023).

In contrast, intracategory intersectionality analyzes the complexity of experiences within single analytic categories defined by multiple traits (e.g., Black women) (McCall, 2005). This approach has been used in public health research to understand heterogeneity within groups of people commonly essentialized in biomedical research (Merz et al., 2023). By juxtaposing and, at times, combining intercategory and intracategory approaches to intersectionality, this dissertation aims to illuminate the structural dynamics that give rise to health inequities impacting trans people of color while recognizing the complexity of social experiences contained within the categories of "trans", "people of color", and "trans people of color."

1.5.1 Study 1

In Study 1 (Chapter 2), I seek to examine differences in the prevalence and health impact of Adverse Childhood Experiences (ACEs) between trans people of color and five comparison analytic categories: White cisgender men, White cisgender women, White trans people, cisgender men of color, and cisgender women of color. Data for this study comes from the 2019, 2020, and 2021 BRFSS. Guided by the structural trauma framework, I conceptualize ACEs as among the intended consequences of efforts to distribute trauma across populations in ways that uphold colonial gender norms. I therefore hypothesize that trans people of color will have a higher age-adjusted predicted probability of reporting each ACE included in this analysis in relation to each of the comparison groups. Moreover, I hypothesize that the relationship between ACEs and self-reported poor mental and physical health in adulthood will be stronger for trans people of color than comparison groups because of the effects of continued adversity across the life course.

This study takes an intercategorical approach to intersectionality by delineating and making comparisons across social categories. Using the structural trauma framework as a guide will allow me to contextualize any inequities documented through this analysis within the social, political, and economic structures that may influence ACEs' social patterning. In addition to addressing the dearth of literature on childhood adversity among trans populations, this study will have important implications for structural interventions to reduce harm and promote safety for trans children of color.

1.5.2 Study 2

In Study 2 (Chapter 3), I aim to examine racial/ethnic differences in the relationship between trans-related state policies and self-rated health among trans women. I created a multilevel dataset combining information on 12 state trans-related policies with data previously

collected from a large convenience sample of trans women in 30 states. Drawing substantially from Critical Race Theory's critique of liberalism (Freeman, 1995), I distinguish between trans-related policies that promote inclusion of trans people in the existing neoliberal world order and those that govern access to resources necessary for trans people's wellbeing. I hypothesize that the former ("equality policies") will be less strongly associated with health status for trans women of color than White trans women in the sample and that the latter ("access policies") will be more strongly associated with health status for trans women of color than White trans women.

This study combines intercategory and intracategory approaches to intersectionality by focusing on racial/ethnic variation within the broad category of trans women (McCall, 2005). By testing whether race/ethnicity moderates the relationship between trans-related policies and health, I fulfill intercategory intersectionality's intent to reveal inequities and their potential causes via strategic comparisons between different social groups. Simultaneously, by analyzing data from trans women without a male, nonbinary, or cisgender comparison group, I fulfill intracategory intersectionality's purpose to unpack complexity within a single multidimensional social category. Ultimately, the results generated from combining these approaches to intersectionality will have important implications for whether and how these policies are conceptualized as a potential means of achieving health equity for trans people.

1.5.3 Study 3

In Study 3 (Chapter 4), I present a qualitative interview study that I conducted in partnership with the Black Trans Fund (BTF), a philanthropic organization founded to resource and support Black trans community-based organizations (Black Trans Fund, 2023b). This study aims to explore how Black trans leaders of these organizations promote BTF's ethos of Black trans joy and liberation through their work. I interviewed 10 Black trans leaders of organizations

servicing Black trans communities across the country and employed reflexive thematic analysis to craft themes from this data. Drawing from Critical Race methodologies, I position these themes as counterstories to dominant narratives of Black trans health inequities in public health research (Soloranzo & Yosso, 2002).

In this study, I take an intracategorical approach to intersectionality by centering one group: Black trans people. While the research aims do not explicitly concern understanding heterogeneity within this population or within the sample of research participants, this study fulfills intracategorical intersectionality's typically narrow methodological focus on a single, multiply marginalized group and departure from comparison as the basis of knowledge generation. The results of this work will have implications for how academic research in public health and allied fields can better align with and support Black trans people's priorities.

1.5.4 Overarching Aims

In an era characterized by increasing violence and animosity towards trans people (DuBois et al., 2023; Wirtz et al., 2020), research that explicitly aims to benefit trans communities is necessary to avoid contributing to this ongoing marginalization (Everhart et al., 2022; Minalga et al., 2022; Scheim et al., 2019). Buoyed by theories that critically examine how the structural power dynamics that drive inequities are produced and maintained, this dissertation aims to benefit trans communities of color by moving beyond documenting inequities and towards identifying, understanding, and dismantling the systems that produce them. This includes the systems that impact the safety of trans children of color (Study 1, Chapter 2), state-level trans-related policies (Study 2, Chapter 3), and the multitude of influences on community-based organizations servicing Black trans communities (Study 3, Chapter 4). The three studies outlined above traverse the spectrum of approaches to intersectionality from intercategorical to

intracategorical, responding to the need for trans health research that uses intersectionality frameworks to understand structural drivers of health inequities impacting trans people of color (Berke & Collins, 2023; Poteat & Simmons, 2022; Wesp et al., 2019). By exposing some of the intertwined structural dynamics driving health inequities, this dissertation will generate implications for policy, research, and public health practice efforts to promote health and wellbeing among trans people of color.

Chapter 2 Inequities in the Distribution of Adverse Childhood Experiences and their Association with Health among Trans People of Color

2.1 Introduction

Adverse Childhood Experiences (ACEs) are potentially traumatic events or living conditions occurring before age 18 that negatively impact a child's sense of safety, stability, and attachment (CDC, 2019). The following scenarios have long been recognized as ACEs: physical, emotional, and sexual abuse; divorce or parental separation; household domestic violence; living in a household with an adult with mental illness, or alcohol or other substance use disorder; and having anyone in the household be incarcerated (Felitti et al., 1998). ACEs are relatively common in the United States, with recent studies using nationally representative datasets suggesting that around 60% of adults experienced at least one ACE (Cole, Armstrong, Giano, & Hubach, 2022; Crouch, Probst, Radcliff, Bennett, & McKinney, 2019; Giano, Wheeler, & Hubach, 2020; Islam, Rashid, & Rashid, 2023; Merrick, Ford, Ports, & Guinn, 2018). Research on ACEs typically examines how the number, severity, or frequency of ACEs influences behavior, social functioning, and health over the life course (Kalmakis & Chandler, 2014). This research shows that ACEs are strong predictors of adult health behaviors and, to a lesser extent, mental and physical health outcomes (K. Hughes et al., 2017; Islam et al., 2023; Petrucci, Davis, & Berman, 2019).

The prevalence and health impact of ACEs vary by gender, race, and ethnicity. Existing literature with general adult samples suggests that women are more likely than men to report childhood sexual abuse, household mental illness, and household substance use (Merrick et al.,

2018), and men are more likely than women to report physical abuse and physical neglect (Mersky, Choi, Plummer Lee, & Janczewski, 2021). Furthermore, studies have found that ACEs have a greater impact on substance use and mental health outcomes for women than men (Cunradi, Caetano, Alter, & Ponicki, 2020; McCall-Hosenfeld, Winter, Heeren, & Liebschutz, 2014). Additionally, Black, Latinx, multiracial, and American Indian/Alaskan Native populations report a higher number of ACEs than non-Latinx White populations (Merrick et al., 2018; Mersky et al., 2021). Research examining racial and ethnic differences in the health impact of ACEs has shown less consistent results, with some studies suggesting ACEs better predict mental health and substance use outcomes for White people than people of color (Schilling, Aseltine, & Gore, 2007; Youssef et al., 2017) and others indicating that ACEs are more strongly associated with these outcomes for people of color (LaBrenz, O'Gara, Panisch, Baiden, & Larkin, 2020; Lam-Hine, Riddell, Bradshaw, Omi, & Allen, 2023; Lee & Chen, 2017; Srivastav, Stropolis, Kipp, Richard, & Thrasher, 2020).

An emerging body of literature examines the prevalence and health impact of ACEs on trans populations (Dosanjh, Hinds, & Cubbin, 2023). This research suggests that trans adults are more likely than cisgender adults to have experienced ACEs (Schnarrs et al., 2019; Tran, Mann, Cortez, Harrell, & Nettuno, 2023) and that trans children are at increased risk for physical, mental, and sexual abuse relative to their cisgender peers (A. Roberts, Rosario, Corliss, Koenen, & Austin, 2012; Thoma, Rezeppa, Choukas-Bradley, Salk, & Marshal, 2021; Tobin & Delaney, 2019). Among trans people, ACEs have been associated with intimate partner violence, sexual behaviors that may result in increased HIV incidence, and mental health outcomes including depression, suicidality, and post-traumatic stress in late adolescence and adulthood (Arayasirikul et al., 2021; Suarez, Peitzmeier, Potter, Samandur, & Reisner, 2021). However, no known studies

have examined how gender modality modifies the relationship between ACEs and adult health or investigated racial and ethnic variation in the prevalence or health impact of ACEs among trans populations.

Understanding the specific impact of ACEs on trans people of color may provide additional perspective on health inequities this population experiences. Trans people of color experience inequities across a variety of health behaviors and conditions that have been associated with ACEs or childhood trauma including substance use, sexually transmitted infections, cancer, cardiovascular disease, and mental health conditions (Becasen et al., 2018; K. Hughes et al., 2017; Lett et al., 2020; Reisner, Jadwin-Cakmak, Sava, Liu, & Harper, 2019; Rich, Scheim, Koehoorn, & Poteat, 2020; Valentine & Shipherd, 2018). Additionally, research with cisgender populations suggests that ACEs may impact adult health in part by increasing the likelihood of adversity in adulthood (Edalati et al., 2017; M. Jones, Peck, Sharp, & McLeod, 2021; T. Jones, Nurius, Song, & Fleming, 2018; Mersky, Janczewski, & Nitkowski, 2018). Trans people of color have described how racism and cissexism intersect to drive exposure to adverse conditions in adulthood including poverty, interpersonal violence, housing deprivation, and involvement in the criminal-legal system (Gamarel, King, et al., 2020; Lacombe-Duncan et al., 2022; Smart et al., 2020; Yarbrough, 2021). Examining the prevalence of ACEs and their relationship with adult health status among trans people of color may lay important groundwork for understanding how cumulative adversity may drive health inequities in this population.

2.1.1 Theoretical Framework

Recent ACEs research has considered how systems of power influence the distribution and health impact of ACEs. For example, Bernard et al. (2021) argued that racism should be conceptualized as both a driver of ACEs and an ACE itself by tracing how historical racism (e.g.,

slavery, Jim Crow laws) shapes the present day social and economic conditions in which Black children are raised. These conditions include financial, educational, and housing inequities impacting Black families, the mass incarceration of Black youth and adults, and anti-Black policing practices, all of which contribute to Black children's exposure to "traditional" ACEs and institutional and interpersonal racism (Bernard et al., 2021). Schnarrs et al. (2022) built upon this work to consider how heterosexism shapes exposure to ACEs for LGBT populations and how exposure to heterosexism is itself an ACE (Schnarrs et al., 2022). However, their work does not consider how cissexism influences ACEs among trans populations or how intersecting systems of power (e.g., racism and cissexism) drive exposure to or modify the health impact of ACEs. A structural analysis of ACEs among trans people of color requires shifting attention from ACEs as predictors of individual health outcomes and towards understanding the social, cultural, and political forces that drive inequities in both the distribution and health impact of ACEs (Metzler, Merrick, Klevens, Ports, & Ford, 2017; S. White, Edwards, Gillies, & Wastell, 2019).

Therefore, I draw from the structural trauma framework to guide my analysis. As explained in more detail in Chapter 1, the structural trauma framework conceptualizes trauma as deliberately distributed through populations through "organizational logics of domination" that create conditions in which marginalized groups are more likely to experience trauma (Ruiz, 2020). Conceptualizing ACEs as indicators of structural trauma draws attention to how ACEs are among the intended effects of the ongoing project of containing and eliminating people who transgress the colonial gender binary: women of color and nonbinary, trans, and two-spirit people (Ruiz, 2020). From this perspective, the significant racial, ethnic, and gender variation in the prevalence of nearly all ACEs stems from intentionally created adverse political, cultural, and socioeconomic conditions in which families raising girls, trans, and two-spirit children of

color live. This perspective counters prevailing narratives focused on families' failure to care for and protect children from harm that disregard contextual factors outside of parent and caregivers' control (S. White et al., 2019).

The structural trauma framework is inherently intersectional as it considers how the confluence of multiple systems of power differentially shapes health outcomes (Bowleg, 2012; Moradi & Grzanka, 2017). For trans people of color, structural racism and cissexism intersect to create conditions that predispose individuals to trauma. As an example, this phenomenon is readily observable in K-12 education. The widespread use of zero-tolerance disciplinary policies that uphold Western colonial gender norms combined with the lack of public investment in K-12 schools serving communities of color limits access to quality education for trans young people of color (Chmielewski, Belmonte, Fine, & Stoudt, 2016; Rosentel et al., 2020; Simons et al., 2021). Trans people of color have described how traumatic experiences of discrimination, bullying, and violent victimization in school settings disrupted their education (Graham, 2014; Simons et al., 2021). Recent work has identified school-based discrimination along with family rejection; discrimination in employment, healthcare, and housing; and interpersonal violence against trans people of color as key origin points of the “discrimination-to-incarceration” pipeline that this population must manage (Ezie, 2023). Inequitable education opportunities contribute to economic hardship, engagement in criminalized economies, and interaction with the criminal-legal system, all of which predispose individuals to trauma and adverse health outcomes (Graham, 2014; Lacombe-Duncan et al., 2022; Nadal et al., 2014; Rogers & Rogers, 2020; Rosentel et al., 2020; Yarbrough, 2021).

2.1.2 Aims

This study aims to document variation in the prevalence of ACEs between trans people of color and people who are White and/or cisgender and examine whether the relationship between ACEs and poor mental and physical health differs between these groups. I conceptualize *trans* and *people of color* as broad “categories of analysis” rather than essentialist, coherent units of identity (P. Collins, 1993). In other words, I view “trans people of color” as a heterogeneous population whose commonalities are made salient by shared subjugation at the intersection of White supremacy and cissexism rather than a community of shared identity or experience (P. Collins, 1993). Centering trans people of color in this way therefore necessitates delineating five comparison categories following an intercategorical approach to intersectionality: White cisgender men, White cisgender women, White trans people, cisgender men of color, and cisgender women of color (McCall, 2005). Throughout this study, I refer to these categories as race/ethnicity/gender groups.

Based on the structural trauma framework and the documented racial, ethnic, and gender differences among cisgender populations, I hypothesize that trans people of color will be more likely to report all forms of ACEs than other race/ethnicity/gender groups. Additionally, I hypothesize that ACEs will be more strongly associated with poor mental health and poor physical health for trans people of color compared to other groups. The structural trauma framework suggests that systems of power amplify the impact of potentially traumatic events (i.e., ACEs) on marginalized populations by creating perpetual conditions of precarity in which trauma is likely to recur (Ruiz, 2020).

2.2 Methods

2.2.1 Data

I combined data from the 2019-2021 Behavioral Risk Factor Surveillance System (BRFSS) surveys to achieve a sufficient sample size of trans individuals for this cross-sectional, matched control study (Cicero, Reisner, Merwin, Humphreys, & Silva, 2020; Lett & Everhart, 2022). The BRFSS is a national telephone survey of community-dwelling adults in the United States which collects data on health behaviors, health status and chronic conditions, access to healthcare, and use of preventative health services (CDC, 2023). States (including Puerto Rico, Washington, DC, and Guam) use stratified random digit dialing and trained interviewers to administer the survey, which produces representative samples of each state and, when combined, the United States (CDC, 2023). In addition to the core components of the survey, states can elect to add optional modules. These include the Sexual Orientation and Gender Identity (SOGI) module, the Assigned Sex at Birth (ASAB) module, and the ACEs module (CDC, 2023).

2.2.2 Sample Derivation

Following previous recommendations, I elected to use a matched control study design rather than traditional complex survey analysis (Cicero et al., 2020). Matched control designs do not rely on BRFSS sampling weights, which are calculated based on participants' sex. For trans participants, sampling weights bias estimates as interviewing procedures and survey items for determining participants' sex to be used in developing weights do not clearly ask about sex assigned at birth, current sex, or gender identity, leading to differential misclassification of trans respondents (Cicero et al., 2020; Lett & Everhart, 2022). As of 2016, the BRFSS requires interviewers to ask rather than assume participants' sex with the question "Are you male or female?" (Lett & Everhart, 2022). However, trans participants who share a sex assigned at birth or gender identity do not answer this question consistently (Tordoff, Andrasik, & Hajat, 2019). For example, of the 382 participants who identified as trans women in the 2021, 59.4% reported

answered ‘male’ to this question and 40.6% answered ‘female.’ These groups are thus assigned disparate weights in the raking algorithm.

Therefore, I followed recommendations designed to account for biased sampling weights by analyzing trans participants matched to four cisgender controls (two male, two female) on race, ethnicity, age, residence, survey year, and state (Cicero et al., 2020; Lett & Everhart, 2022). To create this analytic sample, I first combined the 2019-2021 BRFSS data and restricted the sample to participants living in states that administered the ACEs module and either the SOGI or ASAB module (n=276,266)⁶. The SOGI and ASAB modules both allow for identification of some trans respondents; the SOGI module will not identify people whose gender and sex assigned at birth are different but who do not identify with the term “trans”, and the ASAB module alone will not identify trans people who do not identify as men or women (e.g., nonbinary people) (Lett & Everhart, 2022). Respondents living in states that administered only the ASAB module were classified as trans if their reported sex at birth (male, female) differed from their reported current sex (male, female) and cisgender if there was no difference. Respondents living in states that administered only the SOGI module were classified as trans if they responded “yes” when asked if they identified as trans or classified as cisgender if they responded “no”. Respondents in states using both modules were considered trans if they were identified as such under either module.

⁶ 2019: Delaware, Florida, Iowa, Kansas, Missouri, Ohio, Oklahoma, New York, Pennsylvania Rhode Island, South Carolina, Tennessee, Virginia, West Virginia, Wisconsin
2020: California, Georgia, Hawaii, Idaho, Iowa, Kansas, Massachusetts, Montana, New Jersey, Oklahoma Rhode Island, South Carolina, Texas, Utah, Virginia, Wisconsin
2021: Alabama, Arizona, Iowa, Kansas, Mississippi, Ohio, New Jersey, Nevada, Virginia, Wisconsin

I further restricted the sample to participants who provided valid data on days of poor physical health, days of poor mental health, and at least one ACEs item (n=136,748). This allowed for identification of 609 eligible trans participants, 56,534 eligible cisgender male participants, and 68,154 eligible cisgender female participants. I used an algorithm to randomly select two cisgender men and two cisgender women for each trans participant, matched on race (White, Black, other or multiracial), ethnicity (Latinx, other), categorical age (18-24, 25-30, 31-35, 36-40, 41-45, 51-55, 56-60, 61-65, 66-70, 71-75, 75-79, 80+), residence (metropolitan county, non-metropolitan county), survey year, and state. Race and ethnicity were operationalized separately to match participants on both characteristics (e.g., White Latinx trans participants with White Latinx cisgender participants) due to the documented racial health inequities among Latinx adults in the United States (Cuevas, Dawson, & Williams, 2016). Only participants with valid data on the matching variables (i.e., who did not refuse or respond ‘don’t know’ to any items) were included in the final analytic sample. The algorithm matched 551 trans participants, resulting in a final analytic sample of 2,755 participants.

2.2.3 Measures

Demographics. Participants self-reported their age, race, and ethnicity. Because the degree to which imputed race and ethnicity data accurately assigns trans respondents is unknown, I only used participants’ self-reported data in the matching algorithm and further analysis. For the matching algorithm, race was coded as White only, Black only, or other/multiracial; participants who did not provide valid data on their race were excluded. Ethnicity was coded as Latinx if participants reported being of Hispanic, Latino/a, or Spanish origin and other if not. For the main analyses, participants were considered people of color if they identified as Latinx, Black, and/or other/multiracial and White if they identified as non-

Latinx White. Participants were then categorized into race/ethnicity/gender groups: White cisgender men, White cisgender women, White trans people, cisgender men of color, cisgender women of color, trans people of color. Finally, regarding residence, the BRFSS categorizes participants as living in a metropolitan county or non-metropolitan county based on whether their reported county of residence is in a Metropolitan Statistical Area.

ACEs. The ACEs module consists of 11 questions assessing the “core” or original ACEs (Felitti et al., 1998). Specifically, the items ask whether the following experiences occurred before age 18:

1. *Household mental illness*: living with anyone who was depressed, mentally ill, or suicidal
2. *Household alcoholism*: living with anyone who was a problem drinker or alcoholic
3. *Household drug use*: living with anyone who used illegal street drugs or who abused prescription medications
4. *Household incarceration*: living with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility
5. *Parental divorce*: having parents’ divorce or separate
6. *Domestic violence*: the frequency with which parents or adults in the home ever slapped, hit, kicked, punched, or beat each other up
7. *Physical abuse*: the frequency with which a parent or adult in the home ever hit, beat, kicked, or physically hurt the participant
8. *Verbal abuse*: the frequency with which a parent or adult in the home swore at, insulted, or put down the participant

9. *Sexual touch*: the frequency with which an adult or anyone 5 years or older than the participant ever touched them sexually
10. *Being made to sexually touch an adult*: the frequency with which an adult or anyone 5 years or older than the participant made the participant touch them sexually
11. *Forced sex*: frequency with which an adult or anyone 5 years or older than the participant forced them to have sex

Participants could respond yes or no to items 1-5 and never, once, and more than once for items 6-11. To maintain consistency with the other items, items 6-11 were dichotomized at least once vs. never. Additionally, due to the low prevalence and conceptual similarity of items 9-11, these were combined into a single dichotomous measure of any sexual abuse ($\alpha=.83$). Otherwise, ACEs were operationalized individually rather than as a composite or sum measure to avoid equating fundamentally different types of childhood adversity (McLennan, MacMillan, & Afifi, 2020).

Self-rated health. Participants were asked, “Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?” and “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” Participants were considered to be in poor physical health if they reported 14 or more days of ‘not good’ physical health and to be in poor mental health if they reported 14 or more days of ‘not good’ mental health (Moriarty, Zack, & Kobau, 2003).

2.2.4 Analysis

I first characterized the sample by calculating means and proportions for all variables used in the matching algorithm, all ACEs, and self-rated health. I then compared the distribution of all ACEs, poor physical health, and poor mental health across race/ethnicity/gender groups using Chi-square tests. To extend these analyses, I fit logistic regression models predicting each ACE by race/ethnicity/gender group and age and tested for differences in the predicted probability of each ACE between trans people of color and each other race/ethnicity/gender groups using Chi-square tests.

To test whether race/ethnicity/gender group modified the relationship between ACEs and poor health, I first fit a series of unconditional logistic regression models to determine the main effects of each ACE on poor mental and physical health controlling for race/ethnicity/gender groups and the matching characteristics (i.e., age, state, metropolitan residence, race, ethnicity, survey year). Unconditional regression models are appropriate in matched control study designs when participants are matched on demographic rather than health characteristics or the health outcome of interest (Kuo, Duan, & Grady, 2018). I then added a *race/ethnicity/gender x ACE* interaction term to each model and calculated the average marginal effect of each ACE on poor mental and physical health for each group (Norton, Dowd, & Maciejewski, 2019). I tested for differences in the average marginal effects between trans people of color and other groups using pairwise comparisons. All analyses were conducted in Stata 17.0.

2.3 Results

2.3.1 Sample Characteristics

Among the 2,755 participants included in this study, 78.0% (n=2,125) identified as White, 5.9% (n=160) as Black, and 16.2% (n=440) as another race or multiracial (Table 2.1). Within the latter group, 10.0% (n=44) identified as American Indian/Alaskan Native, 37.3%

(n=164) as Asian, 9.5% (n=42) as Native Hawaiian or other Pacific Islander, 15.5% (n=68) as some other race, and 27.7% (n=122) as multiracial. Further, 9.1% of participants (n=250) identified as Latinx. In total, 153 trans participants of color were matched with 306 cisgender men and 306 cisgender women of color, and 398 White trans participants were matched with 796 White cisgender men and 796 White cisgender women. Most participants (70.1%, n=1,930) lived in a metropolitan county. Around one third of participants each lived in the Midwest, South, and West census regions, with 3.5% of participants (n=95) representing the Northeast. Participants' mean age was 43.8 (SD=18.4), excluding those 80 and over whose exact age was not reported. Finally, the greatest proportion of participants (65.0%, n=1,790) completed the 2020 BRFSS, followed by 24.0% (n=660) for the 2021 BRFSS and 11.1% (n=305) for the 2019 BRFSS.

Table 2.1 Prevalence of variables used in matching among the final analytic sample, N=2,755

| | N | % |
|----------------------------|-------|-------|
| Gender | | |
| Cisgender Man | 1102 | 40.0 |
| Cisgender Woman | 1102 | 40.0 |
| Trans | 551 | 20.0 |
| Race | | |
| White | 2125 | 78.0 |
| Black | 160 | 5.9 |
| Other/Multiracial | 440 | 16.2 |
| Ethnicity | | |
| Latinx | 250 | 9.1 |
| Other | 2505 | 90.9 |
| Residence | | |
| Metropolitan County | 1930 | 70.1 |
| Non-Metropolitan County | 825 | 30.0 |
| Year | | |
| 2019 | 305 | 11.1 |
| 2020 | 1790 | 65.0 |
| 2021 | 660 | 24.0 |
| Census Region ^a | | |
| Northeast | 95 | 3.5 |
| Midwest | 815 | 29.6 |
| South | 925 | 33.6 |
| West | 920 | 33.4 |
| | M | SD |
| Age ^b | 43.75 | 18.41 |

^aParticipants were matched on state rather than census region.

^bAge was categorized into 5-year increments for matching participants ages 25-79; participants 18-24 were grouped together and participants at least 80 years old were grouped together. The mean presented here excludes 145 participants who were at least 80 years old as their exact age is not included in the dataset.

2.3.2 Race/Ethnicity/Gender Distribution of ACEs and Poor Health

Chi-square tests indicated eight of the nine ACEs varied statistically by race/ethnicity/gender group (Table 2.2). The prevalence of household mental illness ranged from 17.2% among cisgender men of color to 35.0% among White trans people ($p < 0.001$). Household alcoholism was least prevalent among White cisgender men (18.8%) and most prevalent among White trans people (27.9%, $p = 0.001$). Household incarceration was lowest among White

cisgender women (7.8%) and highest among trans people of color (17.8%, $p=0.001$). Parental divorce was the only ACE most prevalent among a cisgender race/ethnicity/gender group; the prevalence ranged from 25.6% among White cisgender women to 35.3% among cisgender women of color ($p<0.001$). The prevalence of domestic violence ranged from 12.6% for White cisgender men to 25.7% for trans people of color ($p<0.001$). The prevalence of both physical and verbal abuse was lowest among White cisgender men (22.4% and 36.4%, respectively) and highest among White trans people (35.0% and 53.1%, respectively; $p<0.001$ for both). White cisgender men reported the lowest prevalence of sexual abuse (7.5%), and trans people of color reported the highest (24.8%, $p<0.001$). Finally, the proportion of participants reporting poor physical health and mental health varied statistically by race/ethnicity/gender group ($p<0.001$ for each, Table 2.2). Among trans people of color, 19.1% reported poor physical health and 30.1% reported poor mental health, the highest among any group.

Table 2.2 Distribution of ACEs and self-rated health by race/ethnicity/gender group, BRFSS 2019-2021

| | Total Sample | | White Cisgender Men | | White Cisgender Women | | White Trans People | | Cisgender Men of Color | | Cisgender Women of Color | | Trans People of Color | | p-value |
|--------------------------|--------------|------|---------------------|------|-----------------------|------|--------------------|------|------------------------|------|--------------------------|------|-----------------------|------|---------|
| | n | % | n | % | n | % | n | % | n | % | n | % | n | % | |
| ACE | | | | | | | | | | | | | | | |
| Household Mental Illness | 659 | 24.2 | 140 | 17.7 | 232 | 29.4 | 134 | 35.0 | 52 | 17.2 | 62 | 20.5 | 39 | 25.8 | <0.001* |
| Household Alcoholism | 652 | 23.8 | 149 | 18.8 | 209 | 26.4 | 110 | 27.9 | 65 | 21.2 | 77 | 25.2 | 42 | 27.6 | 0.001* |
| Household Drug Use | 361 | 13.2 | 92 | 11.6 | 103 | 13.0 | 59 | 14.9 | 42 | 13.8 | 41 | 13.5 | 24 | 16.0 | 0.560 |
| Household Incarceration | 270 | 9.9 | 68 | 8.6 | 60 | 7.8 | 52 | 13.2 | 31 | 10.2 | 32 | 10.5 | 27 | 17.8 | 0.001* |
| Parental Divorce | 782 | 28.7 | 202 | 25.6 | 202 | 25.6 | 128 | 32.6 | 93 | 30.5 | 107 | 35.3 | 50 | 33.3 | 0.002* |
| Domestic Violence | 471 | 17.4 | 99 | 12.6 | 126 | 16.0 | 82 | 21.0 | 60 | 20.3 | 66 | 21.9 | 38 | 25.7 | <0.001* |
| Physical Abuse | 730 | 26.9 | 175 | 22.4 | 185 | 23.5 | 137 | 35.0 | 83 | 31.1 | 88 | 29.0 | 52 | 34.2 | <0.001* |
| Verbal Abuse | 1120 | 41.3 | 286 | 36.4 | 317 | 40.3 | 207 | 53.1 | 121 | 40.5 | 118 | 39.5 | 71 | 47.0 | <0.001* |
| Sexual Abuse | 392 | 14.5 | 59 | 7.5 | 141 | 18.1 | 78 | 20.2 | 23 | 7.7 | 54 | 18.1 | 37 | 24.8 | <0.001* |
| Self-Rated Health | | | | | | | | | | | | | | | |
| Poor Physical Health | 299 | 11.0 | 70 | 8.9 | 93 | 11.9 | 57 | 14.7 | 25 | 8.3 | 26 | 8.6 | 28 | 19.1 | <0.001* |
| Poor Mental Health | 473 | 17.5 | 72 | 9.1 | 146 | 18.7 | 117 | 29.9 | 42 | 14.1 | 50 | 16.8 | 46 | 30.1 | <0.001* |

2.3.3 Predicted Probabilities of ACEs by Race/Ethnicity and Gender

Chi-square tests detecting differences in the age-adjusted predicted probabilities indicated variation in the prevalence of all ACEs between trans people of color and other race/ethnicity/gender groups (Table 2.3). All cisgender race/ethnicity/gender groups had statistically lower probabilities of at least one ACE compared to trans people of color. Compared to trans people of color, White cisgender men had a statistically lower probability of household alcoholism (0.19 vs. 0.27, $p=0.043$), household incarceration (0.09 vs. 0.16, $p=0.012$), domestic violence (0.13 vs 0.25, $p=0.001$), physical abuse (0.22 vs. 0.34, $p=0.005$), and sexual abuse (0.03 vs. 0.13, $p<0.001$). White cisgender women had a significantly lower probability of household incarceration (0.08 vs. 0.16, $p=0.004$), domestic violence (0.16 vs. 0.25, $p=0.021$), and physical abuse (0.24 vs. 0.34, $p=0.013$). Among cisgender men of color, the probability of household mental illness (0.16 vs. 0.24, $p=0.033$), household incarceration (0.09 vs. 0.16, $p=0.032$), and sexual abuse (0.03 vs. 0.13, $p<0.001$) was statistically lower than for trans people of color. Cisgender women of color had a statistically lower probability of household incarceration compared to trans people of color (0.10 vs. 0.16, $p=0.042$). White trans people had a statistically higher probability of household mental illness (0.36 vs. 0.24, $p=0.003$) and verbal abuse (0.54 vs. 0.45, $p=0.049$) than trans people of color.

Table 2.3 Age-adjusted predicted probabilities and 95% confidence intervals of ACEs by race/ethnicity/gender group, BRFSS 2019-2021

| | White Cisgender Men | White Cisgender Women | White Trans People | Cisgender Men of Color | Cisgender Women of Color | Trans People of Color |
|--------------------------|----------------------|-----------------------|----------------------|------------------------|--------------------------|-----------------------|
| | Estimate (95% CI) | Estimate (95% CI) | Estimate (95% CI) | Estimate (95% CI) | Estimate (95% CI) | Estimate (95% CI) |
| Household Mental Illness | 0.18 (0.16-0.21) | 0.30 (0.27-0.33) | 0.36 (0.31-0.41)* | 0.16 (0.12-0.20)* | 0.19 (0.15-0.23) | 0.24 (0.17-0.30) |
| Household Alcoholism | 0.19 (0.16-0.22)* | 0.27 (0.24-0.30) | 0.28 (0.24-0.33) | 0.21 (0.16-0.25) | 0.25 (0.20-0.29) | 0.27 (0.20-0.34) |
| Household Drug Use | 0.12 (0.10-0.14) | 0.13 (0.11-0.16) | 0.15 (0.12-0.19) | 0.13 (0.09-0.16) | 0.13 (0.09-0.16) | 0.15 (0.09-0.20) |
| Household Incarceration | 0.09 (0.07-0.11)* | 0.08 (0.06-0.10)* | 0.14 (0.10-0.17)* | 0.09 (0.06-0.13)* | 0.10 (0.07-0.13)* | 0.16 (0.11-0.22) |
| Parental Divorce | 0.26 (0.23-0.29) | 0.26 (0.23-0.29) | 0.33 (0.29-0.38) | 0.29 (0.24-0.34) | 0.33 (0.28-0.38) | 0.31 (0.24-0.38) |
| Domestic Violence | 0.13 (0.10-0.15)* | 0.16 (0.14-0.19) | 0.21 (0.17-0.25) | 0.20 (0.15-0.24) | 0.21 (0.17-0.26) | 0.25 (0.18-0.32) |
| Physical Abuse | 0.22 (0.20-0.25)* | 0.24 (0.20-0.27)* | 0.35 (0.30-0.40) | 0.31 (0.25-0.36) | 0.29 (0.24-0.34) | 0.34 (0.26-0.41) |
| Verbal Abuse | 0.37 (0.34-0.40) | 0.41 (0.38-0.44)* | 0.54 (0.49-0.59)* | 0.39 (0.33-0.44) | 0.37 (0.32-0.43) | 0.45 (0.37-0.53) |
| Sexual Abuse | 0.08 (0.06-0.09)* | 0.18 (0.15-0.21) | 0.20 (0.16-0.24)* | 0.08 (0.05-0.11)* | 0.18 (0.13-0.22) | 0.25 (0.18-0.31) |

* Difference from trans people of color significant at $p < 0.05$ in Chi-square tests of equality of margins

2.3.4 Race/Ethnicity and Gender Differences in the Effects of ACEs

Poor mental health. Each ACE was associated with increased odds of poor mental health when adjusting for race/ethnicity/gender group, age, race, ethnicity, state, metropolitan residence, and survey year (Table 2.4). Odds ratios ranged from 1.41 (95% CI: 1.12-1.76, $p=0.003$) for parental divorce to 3.17 (95% CI: 2.52-4.00, $p<0.001$) for household mental illness. When including the *race/ethnicity/gender x ACE* interaction term, these associations persisted for all ACEs except parental divorce.

Table 2.4 Multivariate logistic regression models predicting odds of poor mental health

| Model 1: Main Effects | Household Mental Illness | | | Household Alcoholism | | | Household Drug Use | | |
|--|--------------------------|------------|---------|----------------------|------------|---------|--------------------|------------|---------|
| | OR | 95% CI | p-value | OR | 95% CI | p-value | OR | 95% CI | p-value |
| Race/Ethnicity/ Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.44 | 0.18-1.08 | 0.073 | 0.42 | 0.17-1.00 | 0.051 | 0.44 | 0.19-1.07 | 0.069 |
| White Cis Women | 0.91 | 0.38-2.20 | 0.838 | 0.93 | 0.39-2.20 | 0.864 | 1.05 | 0.44-2.47 | 0.917 |
| White Trans People | 1.58 | 0.65-3.85 | 0.317 | 1.73 | 0.72-4.14 | 0.219 | 1.98 | 0.83-4.73 | 0.125 |
| Cis Men of Color | 0.39 | 0.23-0.66 | <0.001* | 0.38 | 0.23-0.63 | <0.001* | 0.37 | 0.22-0.62 | <0.001* |
| Cis Women of Color | 0.46 | 0.28-0.76 | 0.002* | 0.44 | 0.27-0.72 | 0.001* | 0.47 | 0.29-0.77 | 0.003* |
| ACE | 3.17 | 2.52-4.00 | <0.001* | 2.29 | 1.83-2.89 | <0.001* | 2.17 | 1.66-2.84 | <0.001* |
| <u>Model 2: Interactions</u> | | | | | | | | | |
| Race/Ethnicity/ Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.53 | 0.20-1.44 | 0.214 | 0.53 | 0.21-1.37 | 0.190 | 0.54 | 0.21-1.38 | 0.196 |
| White Cis Women | 1.51 | 0.57-4.00 | 0.407 | 1.22 | 0.48-3.09 | 0.676 | 1.48 | 0.59-3.69 | 0.400 |
| White Trans People | 2.01 | 0.74-5.47 | 0.174 | 2.21 | 0.86-5.67 | 0.102 | 2.68 | 1.06-6.77 | 0.038* |
| Cis Men of Color | 0.40 | 0.20-0.80 | 0.009* | 0.43 | 0.23-0.82 | 0.010* | 0.39 | 0.21-0.71 | 0.002* |
| Cis Women of Color | 0.62 | 0.33-1.17 | 0.142 | 0.52 | 0.27-0.97 | 0.041* | 0.59 | 0.33-1.03 | 0.065 |
| ACE | 6.66 | 2.87-15.48 | <0.001* | 4.62 | 2.07-10.36 | <0.001* | 5.89 | 2.17-15.96 | <0.001* |
| ACE x Race/Ethnicity/ Gender | | | | | | | | | |
| White Cis Men | 0.62 | 0.23-1.66 | 0.339 | 0.44 | 0.17-1.16 | 0.097 | 0.49 | 0.16-1.56 | 0.227 |
| White Cis Women | 0.29 | 0.12-0.73 | 0.008* | 0.40 | 0.16-0.99 | 0.047* | 0.23 | 0.08-0.70 | 0.010* |
| White Trans People | 0.53 | 0.20-1.39 | 0.195 | 0.44 | 0.17-1.12 | 0.084 | 0.29 | 0.09-0.93 | 0.038* |
| Cis Men of Color | 0.91 | 0.30-2.80 | 0.871 | 0.72 | 0.24-2.14 | 0.555 | 0.70 | 0.20-2.48 | 0.580 |
| Cis Women of Color | 0.43 | 0.14-1.28 | 0.130 | 0.62 | 0.22-1.76 | 0.364 | 0.31 | 0.09-1.15 | 0.081 |

Table 2.4, continued

| Model 1: Main Effects | Household Incarceration | | | Parental Divorce | | | Domestic Violence | | |
|--|-------------------------|-----------|---------|------------------|-----------|---------|-------------------|------------|---------|
| | OR | 95% CI | p-value | OR | 95% CI | p-value | OR | 95% CI | p-value |
| Race/Ethnicity/Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.41 | 0.17-0.99 | 0.048* | 0.46 | 0.19-1.09 | 0.079 | 0.47 | 0.19-1.12 | 0.089 |
| White Cis Women | 1.00 | 0.42-2.35 | 0.992 | 1.09 | 0.46-2.57 | 0.845 | 1.10 | 0.46-2.62 | 0.825 |
| White Trans People | 1.83 | 0.77-4.37 | 0.173 | 2.00 | 0.84-4.79 | 0.118 | 2.05 | 0.85-4.93 | 0.108 |
| Cis Men of Color | 0.37 | 0.22-0.61 | <0.001* | 0.38 | 0.23-0.62 | <0.001* | 0.36 | 0.22-0.61 | <0.001* |
| Cis Women of Color | 0.47 | 0.29-0.76 | 0.002* | 0.45 | 0.28-0.74 | 0.001* | 0.45 | 0.27-0.73 | 0.001* |
| ACE | 1.80 | 1.33-2.44 | <0.001* | 1.41 | 1.12-1.76 | 0.003* | 1.97 | 1.54-2.52 | <0.001* |
| Model 2: Interactions | | | | | | | | | |
| Race/Ethnicity/Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.45 | 0.18-1.12 | 0.087 | 0.44 | 0.17-0.13 | 0.089 | 0.61 | 0.24-1.59 | 0.317 |
| White Cis Women | 1.14 | 0.45-2.77 | 0.772 | 1.22 | 0.49-3.04 | 0.664 | 1.54 | 0.61-3.91 | 0.365 |
| White Trans People | 2.14 | 0.87-5.27 | 0.099 | 1.90 | 0.75-4.83 | 0.176 | 2.76 | 1.07-7.12 | 0.036* |
| Cis Men of Color | 0.42 | 0.24-0.73 | 0.002* | 0.43 | 0.23-0.81 | 0.009* | 0.48 | 0.25-0.90 | 0.023* |
| Cis Women of Color | 0.53 | 0.31-0.92 | 0.024* | 0.38 | 0.19-0.74 | 0.005* | 0.52 | 0.28-0.97 | 0.041* |
| ACE | 3.12 | 1.26-7.75 | 0.014* | 1.64 | 0.77-3.50 | 0.203 | 4.41 | 1.92-10.13 | <0.001* |
| ACE x Race/Ethnicity/Gender | | | | | | | | | |
| White Cis Men | 0.70 | 0.23-2.17 | 0.535 | 0.95 | 0.38-2.37 | 0.915 | 0.43 | 0.15-1.22 | 0.112 |
| White Cis Women | 0.50 | 0.17-1.47 | 0.206 | 0.61 | 0.26-1.43 | 0.253 | 0.33 | 0.13-0.86 | 0.023* |
| White Trans People | 0.46 | 0.15-1.40 | 0.172 | 1.01 | 0.41-2.45 | 0.989 | 0.40 | 0.15-1.08 | 0.071 |
| Cis Men of Color | 0.59 | 0.16-2.19 | 0.433 | 0.72 | 0.25-2.04 | 0.534 | 0.43 | 0.14-1.33 | 0.141 |
| Cis Women of Color | 0.53 | 0.15-1.89 | 0.327 | 1.42 | 0.53-3.84 | 0.489 | 0.64 | 0.21-1.88 | 0.412 |

Table 2.4, continued

| Model 1: Main Effects | Physical Abuse | | | Verbal Abuse | | | Sexual Abuse | | |
|--|----------------|-----------|---------|--------------|------------|---------|--------------|-----------|---------|
| | OR | 95% CI | p-value | OR | 95% CI | p-value | OR | 95% CI | p-value |
| Race/Ethnicity/Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.45 | 0.19-1.10 | 0.081 | 0.41 | 0.17-1.004 | 0.050 | 0.44 | 0.18-1.10 | 0.078 |
| White Cis Women | 1.13 | 0.47-2.72 | 0.778 | 0.95 | 0.39-2.30 | 0.910 | 0.96 | 0.40-2.34 | 0.937 |
| White Trans People | 1.90 | 0.78-4.61 | 0.155 | 1.59 | 0.65-3.88 | 0.310 | 1.79 | 0.73-4.40 | 0.203 |
| Cis Men of Color | 0.35 | 0.21-0.59 | <0.001* | 0.36 | 0.21-0.60 | <0.001* | 0.40 | 0.24-0.67 | <0.001* |
| Cis Women of Color | 0.48 | 0.29-0.78 | 0.003* | 0.46 | 0.28-0.76 | <0.001* | 0.45 | 0.28-0.75 | 0.002* |
| ACE | 2.52 | 2.02-3.15 | <0.001* | 3.07 | 2.45-3.96 | <0.001* | 2.47 | 1.90-3.20 | <0.001* |
| Model 2: Interactions | | | | | | | | | |
| Race/Ethnicity/Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.43 | 0.17-1.14 | 0.090 | 0.66 | 0.23-1.93 | 0.450 | 0.49 | 0.19-1.27 | 0.142 |
| White Cis Women | 1.27 | 0.50-3.23 | 0.620 | 1.15 | 0.40-3.28 | 0.800 | 1.12 | 0.44-2.86 | 0.816 |
| White Trans People | 1.86 | 0.71-4.85 | 0.206 | 1.27 | 0.41-3.87 | 0.680 | 2.11 | 0.81-5.48 | 0.126 |
| Cis Men of Color | 0.31 | 0.15-0.63 | 0.001* | 0.36 | 0.15-0.88 | 0.024* | 0.46 | 0.25-0.83 | 0.010* |
| Cis Women of Color | 0.50 | 0.26-0.95 | 0.033* | 0.54 | 0.24-1.22 | 0.141 | 0.47 | 0.26-0.87 | 0.017* |
| ACE | 2.62 | 1.21-5.64 | 0.014* | 4.09 | 1.84-9.07 | 0.001* | 3.68 | 1.61-8.44 | 0.002* |
| ACE x Race/Ethnicity/Gender | | | | | | | | | |
| White Cis Men | 1.15 | 0.46-2.90 | 0.766 | 0.41 | 0.16-1.06 | 0.066 | 0.78 | 0.26-2.34 | 0.651 |
| White Cis Women | 0.73 | 0.31-1.75 | 0.481 | 0.71 | 0.29-1.71 | 0.440 | 0.59 | 0.23-1.51 | 0.268 |
| White Trans People | 1.08 | 0.44-2.66 | 0.868 | 1.28 | 0.49-3.37 | 0.618 | 0.55 | 0.24-1.49 | 0.242 |
| Cis Men of Color | 1.32 | 0.46-3.77 | 0.609 | 0.94 | 0.31-2.84 | 0.919 | 0.60 | 0.15-2.36 | 0.465 |
| Cis Women of Color | 0.91 | 0.33-2.49 | 0.849 | 0.75 | 0.27-2.13 | 0.590 | 0.89 | 0.30-2.66 | 0.832 |

Note: All models adjusted for age, race, ethnicity, state, metropolitan residence, and survey year

* p<0.05

Pairwise comparisons derived from the models including the interaction term indicated statistically significant differences in the average marginal effects of five of the nine ACEs on poor mental health between trans people of color and other race/ethnicity/gender groups (Table 2.5). In each case, the average marginal effect was greater for trans people of color. The average marginal effect of household mental illness on poor mental health was 0.35 (95% CI: 0.16-0.53) for trans people of color, indicating that trans people of color who experienced this ACE had a 0.35 higher predicted probability of poor mental health at the time of survey administration than those who did not experience this ACE. Pairwise comparisons indicated that this was statistically higher than the average marginal effect of household mental illness on poor mental health for White cisgender women (0.11, 95% CI: 0.04-0.18, $p=0.021$) and cisgender women of color (0.12, 95% CI: 0.01-0.23, $p=0.023$). The average marginal effect of household alcoholism on poor mental health for trans people of color was 0.28 (95% CI: 0.11-0.45) compared to 0.07 (95% CI: 0.01-0.14, $p=0.031$) for White cisgender men. The average marginal effect of household drug use on poor mental health was 0.33 (95% CI: 0.11-0.55) for trans people of color compared to 0.05 (95% CI: -0.04-0.14, $p=0.019$) for White cisgender women and 0.07 (95% CI: -0.04-0.18, $p=0.027$) for cisgender women of color. The average marginal effect of domestic violence was 0.26 (95% CI: 0.09-0.43) for trans people of color compared to 0.06 for both White cisgender women (95% CI: -0.02-0.15, $p=0.044$) and cisgender men of color (95% CI: -0.02-0.14, $p=0.029$). Finally, the average marginal effect of verbal abuse on poor mental health was 0.23 (95% CI: 0.09-0.37) for trans people of color compared to 0.05 (95% CI: 0.001-0.10, $p=0.022$) for White cisgender men.

Table 2.5 Predicted probabilities of poor mental health by ACE and race/gender/ethnicity group derived from adjusted unconditional logistic regression interaction models with pairwise comparisons of differences in the average marginal effects of each ACE on poor mental health

| ACE | White Cisgender Men | White Cisgender Women | White Trans People | Cisgender Men of Color | Cisgender Women of Color | Trans People of Color |
|---------------------------------|---------------------|-----------------------|--------------------|------------------------|--------------------------|-----------------------|
| Household Mental Illness | | | | | | |
| Without ACE | 0.07 (0.04-0.11) | 0.18 (0.13-0.24) | 0.23 (0.15-0.30) | 0.06 (0.02-0.09) | 0.09 (0.04-0.13) | 0.13 (0.05-0.21) |
| With ACE | 0.24 (0.16-0.32) | 0.30 (0.22-0.37) | 0.49 (0.39-0.59) | 0.26 (0.12-0.41) | 0.21 (0.08-0.33) | 0.48 (0.27-0.68) |
| AME | 0.17 (0.09-0.24) | 0.11 (0.04-0.18) | 0.26 (0.16-0.36) | 0.20 (0.07-0.34) | 0.12 (0.01-0.23) | 0.35 (0.16-0.53) |
| Pairwise p-value | 0.091 | 0.021* | 0.434 | 0.164 | 0.023* | - |
| Household Alcoholism | | | | | | |
| Without ACE | 0.09 (0.06-0.12) | 0.18 (0.13-0.23) | 0.28 (0.21-0.35) | 0.08 (0.03-0.12) | 0.09 (0.04-0.14) | 0.16 (0.07-0.24) |
| With ACE | 0.17 (0.10-0.23) | 0.29 (0.21-0.36) | 0.43 (0.33-0.53) | 0.21 (0.08-0.33) | 0.21 (0.09-0.33) | 0.44 (0.24-0.63) |
| AME | 0.07 (0.01-0.14) | 0.10 (0.03-0.17) | 0.15 (0.04-0.25) | 0.13 (0.02-0.24) | 0.12 (0.02-0.22) | 0.28 (0.11-0.45) |
| Pairwise p-value | 0.031* | 0.066 | 0.194 | 0.115 | 0.088 | - |
| Household Drug Use | | | | | | |
| Without ACE | 0.09 (0.06-0.13) | 0.21 (0.16-0.26) | 0.32 (0.25-0.39) | 0.07 (0.03-0.11) | 0.10 (0.05-0.15) | 0.16 (0.07-0.24) |
| With ACE | 0.22 (0.13-0.31) | 0.26 (0.17-0.36) | 0.43 (0.31-0.56) | 0.22 (0.09-0.36) | 0.17 (0.04-0.29) | 0.49 (0.25-0.73) |
| AME | 0.13 (0.04-0.21) | 0.05 (-0.04-0.14) | 0.12 (-0.01-0.25) | 0.15 (0.03-0.28) | 0.07 (-0.04-0.18) | 0.33 (0.11-0.55) |
| Pairwise p-value | 0.091 | 0.019* | 0.094 | 0.139 | 0.027* | - |
| Household Incarceration | | | | | | |
| Without ACE | 0.10 (0.06-0.13) | 0.21 (0.16-0.26) | 0.32 (0.25-0.39) | 0.09 (0.04-0.14) | 0.11 (0.05-0.17) | 0.19 (0.09-0.28) |
| With ACE | 0.19 (0.09-0.28) | 0.28 (0.17-0.40) | 0.40 (0.27-0.53) | 0.15 (0.03-0.28) | 0.17 (0.04-0.30) | 0.40 (0.19-0.62) |
| AME | 0.09 (-0.01-0.18) | 0.08 (-0.03-0.19) | 0.08 (-0.06-0.22) | 0.06 (-0.05-0.18) | 0.06 (-0.06-0.18) | 0.21 (0.02-0.41) |
| Pairwise p-value | 0.263 | 0.230 | 0.267 | 0.177 | 0.169 | - |
| Parental Divorce | | | | | | |
| Without ACE | 0.10 (0.06-0.13) | 0.22 (0.16-0.27) | 0.30 (0.22-0.37) | 0.09 (0.04-0.14) | 0.08 (0.03-0.13) | 0.19 (0.09-0.29) |
| With ACE | 0.14 (0.08-0.20) | 0.22 (0.15-0.29) | 0.40 (0.31-0.50) | 0.11 (0.04-0.18) | 0.17 (0.08-0.26) | 0.27 (0.12-0.42) |
| AME | 0.04 (-0.01-0.10) | 0.00 (-0.07-0.06) | 0.10 (0.01-0.21) | 0.01 (-0.05-0.08) | 0.09 (0.01-0.17) | 0.08 (-0.05-0.21) |
| Pairwise p-value | 0.612 | 0.271 | 0.780 | 0.366 | 0.943 | - |

Table 2.5, continued

| ACE | White Cisgender Men | White Cisgender Women | White Trans People | Cisgender Men of Color | Cisgender Women of Color | Trans People of Color |
|--------------------------|---------------------|-----------------------|--------------------|------------------------|--------------------------|-----------------------|
| Domestic Violence | | | | | | |
| Without ACE | 0.10 (0.06-0.13) | 0.21 (0.16-0.26) | 0.31 (0.24-0.38) | 0.08 (0.03-0.12) | 0.09 (0.04-0.13) | 0.15 (0.07-0.23) |
| With ACE | 0.17 (0.09-0.25) | 0.27 (0.18-0.36) | 0.43 (0.32-0.55) | 0.14 (0.04-0.23) | 0.20 (0.09-0.32) | 0.41 (0.22-0.60) |
| AME | 0.07 (-0.01-0.15) | 0.06 (-0.02-0.15) | 0.12 (0.01-0.24) | 0.06 (-0.02-0.14) | 0.11 (0.02-0.21) | 0.26 (0.09-0.43) |
| Pairwise p-value | 0.051 | 0.044* | 0.185 | 0.029* | 0.121 | - |
| Physical Abuse | | | | | | |
| Without ACE | 0.08 (0.05-0.11) | 0.19 (0.14-0.24) | 0.26 (0.19-0.33) | 0.06 (0.02-0.10) | 0.09 (0.04-0.14) | 0.16 (0.07-0.25) |
| With ACE | 0.20 (0.13-0.27) | 0.31 (0.22-0.39) | 0.47 (0.38-0.56) | 0.17 (0.07-0.27) | 0.18 (0.08-0.29) | 0.32 (0.16-0.48) |
| AME | 0.12 (0.05-0.19) | 0.11 (0.04-0.19) | 0.21 (0.12-0.31) | 0.11 (0.03-0.20) | 0.09 (0.01-0.18) | 0.16 (0.02-0.30) |
| Pairwise p-value | 0.625 | 0.565 | 0.527 | 0.539 | 0.406 | - |
| Verbal Abuse | | | | | | |
| Without ACE | 0.09 (0.05-0.12) | 0.14 (0.09-0.18) | 0.15 (0.08-0.22) | 0.05 (0.01-0.09) | 0.07 (0.02-0.12) | 0.12 (0.04-0.21) |
| With ACE | 0.13 (0.08-0.19) | 0.31 (0.24-0.37) | 0.46 (0.38-0.54) | 0.16 (0.07-0.26) | 0.19 (0.09-0.29) | 0.35 (0.19-0.51) |
| AME | 0.05 (0.001-0.10) | 0.17 (0.10-0.23) | 0.31 (0.22-0.40) | 0.11 (0.03-0.20) | 0.11 (0.03-0.20) | 0.23 (0.09-0.37) |
| Pairwise p-value | 0.022* | 0.467 | 0.349 | 0.115 | 0.128 | - |
| Sexual Abuse | | | | | | |
| Without ACE | 0.09 (0.06-0.13) | 0.19 (0.14-0.23) | 0.29 (0.22-0.36) | 0.09 (0.04-0.14) | 0.09 (0.04-0.14) | 0.17 (0.08-0.26) |
| With ACE | 0.22 (0.10-0.34) | 0.32 (0.23-0.41) | 0.44 (0.33-0.56) | 0.17 (0.01-0.33) | 0.24 (0.10-0.37) | 0.41 (0.21-0.61) |
| AME | 0.13 (0.01-0.24) | 0.13 (0.05-0.22) | 0.15 (0.03-0.27) | 0.08 (-0.06-0.23) | 0.15 (0.03-0.26) | 0.24 (0.06-0.41) |
| Pairwise p-value | 0.299 | 0.297 | 0.419 | 0.162 | 0.351 | - |

* Pairwise comparison versus trans people of color significant at p<0.05; AME = average marginal effect

Poor physical health. Seven ACEs were associated with higher odds of poor physical health when adjusting for race/ethnicity/gender and all covariates (Table 2.6). Odds ratios ranged from 1.45 (95% CI: 1.09-1.13, $p=0.010$) for parental divorce to 2.02 (95% CI: 1.50-2.71, $p<0.001$) for domestic violence. Household drug use and household incarceration were not associated with poor physical health. In the models including the *race/ethnicity/gender x ACE* interaction term, there were no statistically significant associations between ACEs and poor physical health. Additionally, there were no statistically significant differences in the average marginal effect of any ACE on poor physical between trans people of color and other groups (Table 2.7).

Table 2.6 Multivariate logistic regression models predicting odds of poor physical health

| Model 1: Main Effects | Household Mental Illness | | | Household Alcoholism | | | Household Drug Use | | |
|---|--------------------------|-----------|---------|----------------------|-----------|---------|--------------------|-----------|---------|
| | OR | 95% CI | p-value | OR | 95% CI | p-value | OR | 95% CI | p-value |
| Race/Ethnicity/ Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.43 | 0.14-1.33 | 0.143 | 0.38 | 0.12-1.14 | 0.085 | 0.39 | 0.13-1.18 | 0.096 |
| White Cis Women | 0.56 | 0.19-1.72 | 0.313 | 0.49 | 0.16-1.47 | 0.202 | 0.53 | 0.18-1.60 | 0.259 |
| White Trans People | 0.73 | 0.24-2.27 | 0.590 | 0.63 | 0.21-1.94 | 0.425 | 0.66 | 0.22-2.03 | 0.470 |
| Cis Men of Color | 0.38 | 0.21-0.71 | 0.002* | 0.37 | 0.20-0.67 | 0.001* | 0.37 | 0.20-0.68 | 0.001* |
| Cis Women of Color | 0.40 | 0.22-0.73 | 0.003* | 0.40 | 0.22-0.72 | 0.002* | 0.41 | 0.22-0.74 | 0.003* |
| ACE | 1.61 | 1.19-2.17 | 0.002* | 1.67 | 1.27-2.20 | <0.001* | 1.16 | 0.79-1.70 | 0.459 |
| Model 2: Interactions | | | | | | | | | |
| Race/Ethnicity/ Gender | | | | | | | | | |
| White Cis Men | 0.49 | 0.15-1.58 | 0.234 | 0.37 | 0.12-1.17 | 0.090 | 0.42 | 0.13-1.33 | 0.142 |
| White Cis Women | 0.58 | 0.18-1.87 | 0.357 | 0.43 | 0.14-1.33 | 0.142 | 0.59 | 0.19-1.85 | 0.367 |
| White Trans People | 0.79 | 0.24-2.63 | 0.705 | 0.66 | 0.21-2.09 | 0.477 | 0.76 | 0.24-2.42 | 0.641 |
| Cis Men of Color | 0.39 | 0.19-0.80 | 0.010* | 0.32 | 0.15-0.68 | 0.003* | 0.43 | 0.22-0.82 | 0.010* |
| Cis Women of Color | 0.42 | 0.21-0.88 | 0.021* | 0.44 | 0.22-0.89 | 0.023* | 0.49 | 0.26-0.93 | 0.029* |
| ACE | 1.94 | 0.75-5.02 | 0.171 | 1.45 | 0.57-3.69 | 0.432 | 1.54 | 0.49-4.80 | 0.461 |
| ACE x Race/Ethnicity/ Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.57 | 0.18-1.87 | 0.358 | 1.04 | 0.34-3.14 | 0.946 | 1.14 | 0.30-4.38 | 0.848 |
| White Cis Women | 0.94 | 0.33-2.69 | 0.903 | 1.54 | 0.54-4.36 | 0.418 | 0.89 | 0.24-3.31 | 0.864 |
| White Trans People | 0.79 | 0.26-2.43 | 0.677 | 0.91 | 0.29-2.81 | 0.869 | 0.72 | 0.17-3.02 | 0.656 |
| Cis Men of Color | 1.04 | 0.26-4.13 | 0.951 | 1.51 | 0.40-5.60 | 0.542 | 0.22 | 0.02-2.29 | 0.207 |
| Cis Women of Color | 0.79 | 0.21-3.02 | 0.732 | 0.72 | 0.19-2.67 | 0.620 | 0.16 | 0.02-1.66 | 0.125 |

Table 2.6, continued

| | Household Incarceration | | | Parental Divorce | | | Domestic Violence | | |
|--|-------------------------|-----------|---------|------------------|-----------|---------|-------------------|-----------|---------|
| Model 1: Main Effects | OR | 95% CI | p-value | OR | 95% CI | p-value | OR | 95% CI | p-value |
| Race/Ethnicity/ Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.38 | 0.13-1.15 | 0.088 | 0.39 | 0.13-1.19 | 0.098 | 0.44 | 0.15-1.34 | 0.150 |
| White Cis Women | 0.54 | 0.18-1.61 | 0.268 | 0.55 | 0.18-1.66 | 0.285 | 0.59 | 0.20-1.80 | 0.356 |
| White Trans People | 0.68 | 0.22-2.07 | 0.495 | 0.69 | 0.22-2.13 | 0.517 | 0.73 | 0.24-2.24 | 0.582 |
| Cis Men of Color | 0.36 | 0.20-0.66 | 0.001* | 0.37 | 0.20-0.68 | 0.001* | 0.37 | 0.20-0.68 | 0.001* |
| Cis Women of Color | 0.40 | 0.22-0.72 | 0.002* | 0.40 | 0.22-0.74 | 0.003* | 0.37 | 0.20-0.68 | 0.001* |
| ACE | 1.03 | 0.66-1.60 | 0.907 | 1.45 | 1.09-1.93 | 0.010* | 2.02 | 1.50-2.71 | <0.001* |
| Model 2: Interactions | | | | | | | | | |
| Race/Ethnicity/ Gender | | | | | | | | | |
| White Cis Men | 0.44 | 0.14-1.39 | 0.163 | 0.33 | 0.11-1.06 | 0.062 | 0.35 | 0.11-1.12 | 0.077 |
| White Cis Women | 0.64 | 0.21-1.99 | 0.441 | 0.52 | 0.17-1.64 | 0.269 | 0.46 | 0.15-1.46 | 0.188 |
| White Trans People | 0.82 | 0.26-2.60 | 0.739 | 0.63 | 0.19-2.01 | 0.430 | 0.61 | 0.19-1.96 | 0.406 |
| Cis Men of Color | 0.44 | 0.23-0.86 | 0.016* | 0.29 | 0.13-0.63 | 0.002* | 0.33 | 0.16-0.97 | 0.002* |
| Cis Women of Color | 0.48 | 0.25-0.92 | 0.027* | 0.37 | 0.18-0.79 | 0.010* | 0.32 | 0.16-0.65 | 0.002* |
| ACE | 2.17 | 0.78-6.05 | 0.140 | 1.01 | 0.39-2.60 | 0.985 | 1.07 | 0.70-2.87 | 0.900 |
| ACE x Race/Ethnicity/ Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.59 | 0.15-2.28 | 0.443 | 1.83 | 0.62-5.46 | 0.276 | 2.24 | 0.69-7.26 | 0.180 |
| White Cis Women | 0.41 | 0.10-1.69 | 0.219 | 1.21 | 0.40-3.55 | 0.726 | 2.41 | 0.79-7.39 | 0.124 |
| White Trans People | 0.37 | 0.09-1.55 | 0.174 | 1.50 | 0.49-4.60 | 0.477 | 1.81 | 0.55-5.90 | 0.326 |
| Cis Men of Color | 0.20 | 0.02-2.00 | 0.172 | 1.91 | 0.53-6.93 | 0.326 | 1.41 | 0.35-5.78 | 0.629 |
| Cis Women of Color | 0.32 | 0.05-2.00 | 0.224 | 1.29 | 0.36-4.57 | 0.695 | 1.72 | 0.45-6.63 | 0.431 |

Table 2.6, continued

| Model 1: Main Effects | Physical Abuse | | | Verbal Abuse | | | Sexual Abuse | | |
|---|----------------|-----------|---------|--------------|-----------|---------|--------------|-----------|---------|
| | OR | 95% CI | p-value | OR | 95% CI | p-value | OR | 95% CI | p-value |
| Race/Ethnicity/ Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.43 | 0.14-1.31 | 0.136 | 0.41 | 0.13-1.26 | 0.121 | 0.43 | 0.14-1.31 | 0.136 |
| White Cis Women | 0.59 | 0.20-1.80 | 0.358 | 0.56 | 0.18-1.70 | 0.304 | 0.59 | 0.19-1.80 | 0.351 |
| White Trans People | 0.68 | 0.22-2.11 | 0.508 | 0.68 | 0.22-2.10 | 0.500 | 0.73 | 0.24-2.28 | 0.592 |
| Cis Men of Color | 0.35 | 0.19-0.65 | 0.001* | 0.39 | 0.21-0.73 | 0.003* | 0.41 | 0.22-0.77 | 0.006* |
| Cis Women of Color | 0.42 | 0.23-0.76 | 0.005* | 0.43 | 0.23-0.79 | 0.007* | 0.43 | 0.23-0.79 | 0.006* |
| ACE | 1.74 | 1.33-2.27 | <0.001* | 1.74 | 1.34-2.27 | <0.001* | 1.70 | 1.24-2.34 | 0.001* |
| Model 2: Interactions | | | | | | | | | |
| Race/Ethnicity/ Gender (ref=trans people of color) | | | | | | | | | |
| White Cis Men | 0.36 | 0.11-1.15 | 0.084 | 0.40 | 0.12-1.41 | 0.155 | 0.46 | 0.14-1.47 | 0.188 |
| White Cis Women | 0.47 | 0.15-1.51 | 0.206 | 0.52 | 0.15-1.80 | 0.302 | 0.61 | 0.19-1.95 | 0.401 |
| White Trans People | 0.58 | 0.18-1.93 | 0.376 | 0.68 | 0.19-2.47 | 0.562 | 0.77 | 0.23-2.51 | 0.661 |
| Cis Men of Color | 0.28 | 0.13-0.62 | 0.002* | 0.27 | 0.10-0.72 | 0.009* | 0.40 | 0.19-0.82 | 0.013* |
| Cis Women of Color | 0.38 | 0.18-0.81 | 0.012* | 0.58 | 0.25-1.34 | 0.202 | 0.53 | 0.26-1.07 | 0.078 |
| ACE | 1.06 | 0.42-2.65 | 0.907 | 1.74 | 0.71-4.30 | 0.229 | 1.94 | 0.74-5.08 | 0.176 |
| ACE x Race/Ethnicity/ Gender | | | | | | | | | |
| White Cis Men | 1.72 | 0.59-5.02 | 0.325 | 0.97 | 0.34-2.74 | 0.953 | 0.75 | 0.21-2.73 | 0.668 |
| White Cis Women | 2.00 | 0.71-5.63 | 0.191 | 1.09 | 0.40-2.99 | 0.864 | 0.97 | 0.33-2.89 | 0.956 |
| White Trans People | 1.60 | 0.54-4.80 | 0.398 | 0.93 | 0.32-2.73 | 0.896 | 0.92 | 0.28-2.96 | 0.885 |
| Cis Men of Color | 1.76 | 0.48-6.43 | 0.391 | 1.90 | 0.53-6.86 | 0.327 | 1.57 | 0.34-7.29 | 0.567 |
| Cis Women of Color | 1.25 | 0.35-4.41 | 0.732 | 0.51 | 0.14-1.77 | 0.287 | 0.39 | 0.09-1.73 | 0.217 |

Note: All models adjusted for age, race, ethnicity, state, metropolitan residence, and survey year

* p<0.05

Table 2.7 Predicted probabilities of poor physical health by ACE and race/gender/ethnicity group from adjusted logistic regression interaction models with pairwise comparisons of differences in the average marginal effects of each ACE on poor physical health

| ACE | White Cisgender Men | White Cisgender Women | White Trans People | Cisgender Men of Color | Cisgender Women of Color | Trans People of Color |
|---------------------------------|---------------------|-----------------------|--------------------|------------------------|--------------------------|-----------------------|
| Household Mental Illness | | | | | | |
| Without ACE | 0.09 (0.06-0.12) | 0.10 (0.07-0.14) | 0.13 (0.08-0.19) | 0.07 (0.01-0.13) | 0.08 (0.01-0.14) | 0.16 (0.04-0.28) |
| With ACE | 0.10 (0.10-0.23) | 0.17 (0.10-0.23) | 0.19 (0.10-0.27) | 0.13 (0.01-0.26) | 0.11 (0.01-0.22) | 0.27 (0.07-0.46) |
| AME | 0.01 (-0.05-0.07) | 0.07 (0.01-0.12) | 0.05 (-0.03-0.14) | 0.06 (-0.05-0.17) | 0.04 (-0.05-0.13) | 0.10 (-0.06-0.27) |
| Pairwise p-value | 0.283 | 0.667 | 0.596 | 0.650 | 0.457 | - |
| Household Alcoholism | | | | | | |
| Without ACE | 0.08 (0.05-0.11) | 0.09 (0.06-0.12) | 0.13 (0.09-0.18) | 0.07 (0.01-0.13) | 0.09 (0.02-0.17) | 0.19 (0.06-0.32) |
| With ACE | 0.12 (0.06-0.18) | 0.18 (0.12-0.24) | 0.17 (0.09-0.25) | 0.14 (0.02-0.27) | 0.10 (0.01-0.19) | 0.25 (0.06-0.44) |
| AME | 0.04 (-0.02-0.09) | 0.09 (0.03-0.15) | 0.03 (-0.05-0.12) | 0.07 (-0.03-0.17) | 0.01 (-0.08-0.08) | 0.06 (-0.10-0.22) |
| Pairwise p-value | 0.773 | 0.752 | 0.775 | 0.922 | 0.528 | - |
| Household Drug Use | | | | | | |
| Without ACE | 0.08 (0.06-0.11) | 0.11 (0.08-0.15) | 0.14 (0.09-0.19) | 0.09 (0.02-0.15) | 0.10 (0.03-0.17) | 0.18 (0.05-0.30) |
| With ACE | 0.14 (0.05-0.22) | 0.15 (0.07-0.23) | 0.15 (0.05-0.26) | 0.03 (-0.03-0.10) | 0.03 (-0.03-0.08) | 0.24 (0.03-0.46) |
| AME | 0.05 (-0.03-0.13) | 0.03 (-0.04-0.11) | 0.01 (-0.10-0.12) | -0.05 (-0.13-0.02) | -0.07 (-0.14-0.01) | 0.07 (-0.13-0.26) |
| Pairwise p-value | 0.891 | 0.756 | 0.626 | 0.260 | 0.200 | - |
| Household Incarceration | | | | | | |
| Without ACE | 0.09 (0.06-0.11) | 0.12 (0.08-0.15) | 0.15 (0.10-0.20) | 0.09 (0.02-0.15) | 0.09 (0.02-0.19) | 0.17 (0.05-0.29) |
| With ACE | 0.11 (0.02-0.19) | 0.11 (0.02-0.20) | 0.12 (0.02-0.22) | 0.04 (-0.04-0.12) | 0.07 (-0.04-0.17) | 0.30 (0.07-0.54) |
| AME | 0.02 (-0.06-0.10) | -0.01 (-0.10-0.08) | -0.02 (-0.13-0.08) | -0.05 (-0.13-0.04) | -0.03 (-0.12-0.07) | 0.13 (-0.07-0.33) |
| Pairwise p-value | 0.314 | 0.202 | 0.173 | 0.120 | 0.167 | - |
| Parental Divorce | | | | | | |
| Without ACE | 0.08 (0.04-0.10) | 0.11 (0.08-0.15) | 0.13 (0.08-0.18) | 0.07 (0.01-0.12) | 0.08 (0.02-0.15) | 0.19 (0.06-0.32) |
| With ACE | 0.13 (0.07-0.19) | 0.13 (0.08-0.19) | 0.18 (0.10-0.26) | 0.12 (0.02-0.22) | 0.11 (0.01-0.20) | 0.19 (0.03-0.36) |
| AME | 0.05 (-0.01-0.11) | 0.02 (-0.04-0.08) | 0.05 (-0.03-0.13) | 0.05 (-0.03-0.14) | 0.02 (-0.05-0.10) | 0.01 (-0.14-0.14) |
| Pairwise p-value | 0.496 | 0.799 | 0.536 | 0.533 | 0.799 | - |

Table 2.7, continued

| ACE | White Cisgender Men | White Cisgender Women | White Trans People | Cisgender Men of Color | Cisgender Women of Color | Trans People of Color |
|--------------------------|---------------------|-----------------------|--------------------|------------------------|--------------------------|-----------------------|
| Domestic Violence | | | | | | |
| Without ACE | 0.08 (0.05-0.11) | 0.10 (0.07-0.13) | 0.13 (0.08-0.18) | 0.08 (0.01-0.14) | 0.07 (0.01-0.13) | 0.19 (0.06-0.32) |
| With ACE | 0.17 (0.08-0.25) | 0.22 (0.13-0.30) | 0.22 (0.12-0.32) | 0.11 (0.001-0.22) | 0.12 (0.01-0.23) | 0.20 (0.03-0.37) |
| AME | 0.09 (0.01-0.17) | 0.12 (0.04-0.20) | 0.09 (-0.01-0.19) | 0.09 (-0.06-0.12) | 0.05 (-0.04-0.14) | 0.01 (-0.14-0.16) |
| Pairwise p-value | 0.372 | 0.217 | 0.390 | 0.793 | 0.644 | - |
| Physical Abuse | | | | | | |
| Without ACE | 0.08 (0.05-0.10) | 0.10 (0.07-0.13) | 0.12 (0.07-0.11) | 0.06 (0.01-0.11) | 0.08 (0.02-0.15) | 0.18 (0.05-0.32) |
| With ACE | 0.13 (0.07-0.19) | 0.18 (0.12-0.25) | 0.18 (0.11-0.26) | 0.11 (0.01-0.20) | 0.10 (0.01-0.20) | 0.10 (0.04-0.35) |
| AME | 0.05 (-0.01-0.11) | 0.09 (0.02-0.15) | 0.06 (-0.01-0.14) | 0.05 (-0.03-0.12) | 0.02 (-0.05-0.10) | 0.01 (-0.13-0.14) |
| Pairwise p-value | 0.555 | 0.314 | 0.480 | 0.634 | 0.853 | - |
| Verbal Abuse | | | | | | |
| Without ACE | 0.07 (0.05-0.10) | 0.09 (0.06-0.12) | 0.11 (0.07-0.16) | 0.05 (0.01-0.10) | 0.10 (0.02-0.18) | 0.10 (0.03-0.28) |
| With ACE | 0.11 (0.07-0.16) | 0.15 (0.10-0.21) | 0.17 (0.11-0.23) | 0.14 (0.03-0.26) | 0.09 (0.01-0.17) | 0.24 (0.07-0.40) |
| AME | 0.04 (-0.003-0.09) | 0.07 (0.02-0.11) | 0.06 (-0.01-0.13) | 0.09 (-0.001-0.19) | -0.01 (-0.08-0.06) | 0.08 (-0.06-0.22) |
| Pairwise p-value | 0.590 | 0.819 | 0.737 | 0.885 | 0.243 | - |
| Sexual Abuse | | | | | | |
| Without ACE | 0.08 (0.05-0.11) | 0.10 (0.07-0.14) | 0.13 (0.08-0.17) | 0.07 (0.01-0.13) | 0.09 (0.02-0.16) | 0.16 (0.03-0.20) |
| With ACE | 0.11 (0.03-0.20) | 0.18 (0.11-0.25) | 0.20 (0.11-0.30) | 0.19 (-0.01-0.38) | 0.07 (-0.01-0.16) | 0.26 (0.06-0.47) |
| AME | 0.03 (-0.05-0.11) | 0.07 (0.005-0.14) | 0.08 (-0.02-0.17) | 0.11 (-0.06-0.29) | -0.02 (-0.10-0.06) | 0.10 (-0.06-0.27) |
| Pairwise p-value | 0.456 | 0.737 | 0.778 | 0.936 | 0.193 | - |

* Pairwise comparison against trans people of color significant at $p < 0.05$; AME = average marginal effect

2.4 Discussion

Our findings partially supported our hypotheses that ACEs would be more prevalent and have a stronger association with poor health for trans people of color than other race/ethnicity/gender groups. Trans people of color in our sample reported the highest prevalence of 8 of the 9 ACEs. In age-adjusted models, trans people of color had a greater probability of reporting household alcoholism, household mental illness, domestic violence, household incarceration, sexual abuse, and physical abuse than at least one cisgender race/ethnicity/gender group. However, White trans people had a greater probability of reporting household mental illness and verbal abuse than trans people of color. Additionally, I found a greater association between household mental illness, household alcoholism, household drug use, domestic violence, and verbal abuse on poor mental health for trans people of color than for at least one other race/ethnicity/gender group. These results align with previous work suggesting that systemic racism and cissexism shape the population distribution and impact of ACEs (Bernard et al., 2021; Schnarrs et al., 2022).

However, there were no detected race/ethnicity/gender differences in the relationship between ACEs and poor physical health. This finding may reflect the generally weaker relationship between ACEs and physical health outcomes compared to behavioral or psychosocial outcomes reported in other studies (Petruccelli et al., 2019). Previous research has hypothesized that ACEs affect physical health outcomes by increasing allostatic load (Finlay et al., 2022; Soares, Rocha, Kelly-Irving, Stringhini, & Fraga, 2021). Our sample skewed young, limiting the timespan over which ACEs possible impacts on allostatic load could emerge into race/ethnicity/gender differences perceptible via a self-report measure of general physical health.

2.4.1 Distribution of ACEs

Interpreted through the structural trauma framework, the higher prevalence of most ACEs among trans people of color can be understood as a result of deliberate efforts to subjugate this population to maintain White colonial hegemony (Ruiz, 2020). This lens directs attention towards the interlocking systems that perpetuate ACEs with specific consequences for trans children of color, such as the child welfare system. Black, Native, and Latinx children are over-represented in child welfare investigations and foster care (AFCARS, 2020; Edwards, Wakefield, Healy, & Wildeman, 2021). Children removed from their families by the child welfare system are at increased risk of abuse, violence, neglect, and discrimination (Gypen, Vanderfaeillie, De Maeyer, Belenger, & Van Holen, 2017; Landers, Danes, Campbell, & White Hawk, 2021; Morton, 2015; D. Roberts, 2022), and emerging work suggests that this risk is especially pronounced among trans children of color (Grooms, 2020; Mountz, Capous-Desyllas, & Pourciau, 2018; Robinson, 2018). Trans former foster youth of color have described how other youth, institution staff, and caregivers in home-based placements targeted visible aspects of their gender and racial identities through, for example, destroying clothing and hormones, cutting or soiling their hair, physical violence, sexual harassment, and corrective rape (Mountz, 2019; Robinson, 2018).

The child welfare system's surveillance and punishment tactics such as family separation, forced compliance with government "service plans" (e.g., parenting classes, random drug tests), and gender segregation are contemporary versions of the tactics used to colonize Indigenous nations and maintain enslavement and economic exploitation of Black people (D. Roberts, 2022). These practices link child welfare to an array of other institutions that structure adversity for trans people of color including education, policing, healthcare, and the criminal-legal system (Daum, 2015; Ezie, 2023; Howard et al., 2019; D. Roberts, 2022; Rosentel et al., 2020; Simons

et al., 2021; M. White et al., 2020). For example, trans people of color have described how their attempts to resist violence in foster care placements resulted in psychiatric institutionalization, homelessness, and incarceration in juvenile facilities, exemplifying the discrimination-to-incarceration pipeline (Ezie, 2023; Mountz, 2019).

Understanding the inequitable distribution of ACEs as an intended product of how these interlocking systems have historically evolved necessitates prevention efforts centered upstream from families, parents, or children (Bethell et al., 2017). Public health researchers and practitioners have increasingly recognized policy's potential to prevent ACEs by strengthening nutrition and housing assistance programs, tax credits, childcare subsidies, family-friendly work policies, and other economic supports (Forston, Klevens, Merrick, Gilbert, & Alexander, 2016; Metzler et al., 2017). In addition, laws implicating how trans youth are treated in schools, healthcare, and social services such as anti-bullying policies, gender-affirming name and pronoun regulations, and training requirements for service providers (e.g., school counselors) can potentially reduce adversity for trans youth specifically (Philbin et al., 2023).

However, states have recently enacted policies with serious implications for adverse impacts on trans youth (Barbee, Deal, & Gonzales, 2022). As of this writing, 22 states ban best-practice medical care for trans youth, with child welfare investigations and loss of custody as potential consequences for parents who seek this care for their children (MAP, 2023a). In 2023 alone, an additional 15 state legislatures advanced bills introducing or strengthening these bans (ACLU, 2023). Furthermore, 11 states have legislation either promoting or requiring school staff to out trans youth to their families regardless of risk to the child (MAP, 2023b). Repealing these laws and introducing policies and programs that support families, schools, and healthcare

systems to fulfill trans children's social, legal, and medical gender affirmation needs may prevent some of the adversity trans children experience and mitigate its impacts (Ashley, 2019).

Furthermore, abolition movements that seek to dismantle the systems that perpetuate criminalization of people of color, queer and trans people, and poor people including policing, immigration enforcement, child welfare, and prison systems and the carceral logics undergirding them (Nourie, 2021; Ritchie, 2017; D. Roberts, 2022; Spade, 2015d) have argued that eliminating state surveillance, control, and punishment would promote children's access to equitable education, family networks, and safe, nurturing environments, all of which are key to ACEs prevention (Dettlaff, Abrams, & Teasley, 2023; D. Roberts, 2022). For example, abolition would directly reduce the prevalence of ACEs by ending incarceration of parents and children's exposure to ACEs through the child welfare system (A. Jones, Buntman, Ishizawa, & Lese, 2022; Ritchie, 2017; D. Roberts, 2022). More broadly, abolitionist policies would reduce inequities in ACEs by mitigating educational, employment, and income inequities, increasing access to family-centered healthcare and social services, and eliminating the discrimination-to-incarceration pipeline (Brewer & Heitzeg, 2008; Ezie, 2023; Khan, Iwai, & DasGupta, 2022; Ritchie, 2017).

2.4.2 Relationship between ACEs and Adult Health

The structural trauma framework also helps elucidate why ACEs may have a stronger relationship with poor mental health for trans people of color than groups that benefit from White supremacy, patriarchy, and/or cisnormativity (e.g., White cisgender women, cisgender men of color). This framework's characterization of trauma as a political tool is manifested in colonial notions of appropriate responses to trauma demand individual-level acceptance, coping, and resilience and pathologize or circumvent collective continuance (i.e., intergenerationally

transmitted survival strategies) and other political “strategies of refusal” (Anderson, 2019; Ruiz, 2020). Because of their depreciated social status, trans people of color are less likely than other race/ethnicity/gender groups to have access to resources that effectively mitigate the traumatic impacts of ACEs and cumulative adversity across the life course. These resources include social support and socioeconomic assets (e.g., income, education, health insurance), which are among the strongest buffers against the impact of ACEs on adult health (T. Jones et al., 2018; Nurius, Green, Logan-Greene, Longhi, & Song, 2016; Nurius, Logan-Greene, & Green, 2012).

Additionally, trans people of color, including youth, have described intracommunity connections and support as crucial to their health and wellbeing (Lacombe-Duncan et al., 2022; Singh, 2012; Stone, Nimmons, Salcido, & Schnarrs, 2019). However, these networks may be generally less able than White or cisgender people’s networks to provide the material, financial, and information social support needed to ameliorate ACEs’ impacts. For example, transmisogyny and racism intersect to drive housing deprivation among trans women of color, limiting this community’s ability to support each other in accessing permanent, safe housing solutions in times of crisis (Glick et al., 2019; Glick, Lopez, Pollock, & Theall, 2020).

Furthermore, adverse experiences in adulthood may exacerbate the relationship between ACEs and poor adult health (Nurius et al., 2012; Ports, Ford, & Merrick, 2016). As trans adults of color are more likely than other groups to report adversities such as homelessness, criminal-legal system contact, and violent victimization, the race/ethnicity/gender differences in the relationship between ACEs and poor mental health that I found may therefore reflect ACEs’ starting role in a cascade of cumulative adversity (Glick et al., 2019; Gonzalez et al., 2022; Reisner, Bailey, & Sevelius, 2014; Rogers & Rogers, 2020; Staples & Fuller, 2021).

Longitudinal and qualitative research engaged with critical theories and methodologies is needed

to better understand these dynamics with the goal of identifying structural-level interventions that decrease adversity across the life course among trans people of color.

2.4.3 Limitations

Findings from this study should be interpreted in light of several important limitations. First, the results are not generalizable at the population level because the SOGI, ASAB, and ACEs modules were only administered to a subset of states each year, and I did not perform a weighted analysis. However, the matched control study design did allow for analysis of a diverse sample of trans and cisgender adults, which is a notable strength of this study. Although I combined three years of BRFSS data, I was not powered to analyze more granular categories of trans people (e.g., trans men, trans women) and people of color (e.g., Latinx, Asian, Black), obscuring variation within these groups. Future studies seeking to examine differences in the prevalence or health impact of ACEs between several groups should consider adjusting for multiple comparisons in their analyses to avoid overstating the implications of any statistically significant findings. A second notable strength of this study is the operationalization of 8 of the 11 ACEs as single items. In contrast to approaches that rely on a total count of ACEs or create broad ACE categories, this operationalization allows for specific estimates of the prevalence of distinct ACEs and their relationship to adult health (Krinner, Warren-Findlow, Bowling, Issel, & Reeve, 2021).

However, measurement validity may underlie the null findings regarding race/ethnicity/gender group differences in the relationship between ACEs and poor physical health. First, the degree to which documented racial and ethnic differences in the validity of self-rated health reports among cisgender populations manifests in trans populations is unknown, limiting my ability to draw inferences as to whether self-reported poor mental or physical health

reflect “objective” morbidity (Assari, Lankarani, & Burgard, 2016; Erving & Zajdel, 2022). Future research should consider using less subjective measures of health status. Furthermore, as is typical in ACEs research, self-report and recall bias may have led to underreporting of ACEs (Reuben et al., 2016). Finally, the BRFSS does not include measures of childhood socioeconomic status, an established predictor of ACEs (Walsh, McCartney, Smith, & Armour, 2019). Future research on ACEs among trans populations should extend our work drawing from structural theories of health inequities to carefully consider the role of childhood socioeconomic status in their analyses (Metzler et al., 2017; Taylor-Robinson, Straatmann, & Whitehead, 2018).

2.4.4 Conclusion

Our findings provide preliminary evidence that ACEs inequitably impact trans people of color in comparison to other race/ethnicity/gender groups. Guided by the structural trauma framework, these results reflect the need to examine and restructure the interlocking systems that drive adversity among trans children of color including schools, child welfare, the criminal-legal system, and healthcare and exacerbate the effects of ACEs among adults. I echo calls for public health and allied fields to increase attention to preventing ACEs and childhood trauma among trans populations (Kroppman, Kim, Zaidi, Sharma, & Rice, 2020). Theoretical frameworks compatible with intersectional thinking such as the structural trauma framework should guide future research to center trans people of color and identify effective structural loci for ACEs prevention.

Chapter 3 Racial/Ethnic Differences in the Association between Trans-Related State Policies and Self-Rated Health of Trans Women

3.1 Introduction

In the United States, policies with particular relevance for trans populations have been in flux over the past decade. Policy surveillance organizations have noted the erosion of state-level protections for trans populations (Hughto, Meyers, Mimiaga, Reisner, & Cahill, 2021; Movement Advancement Project, 2020; Pacey et al., 2021), a trend with direct implications for trans population health. State-level protective policies, such as nondiscrimination laws and requirements that private and public health insurance cover medical gender affirmation, are consistently associated with better health among trans populations (Du Bois, Yoder, Guy, Manser, & Ramos, 2018; Goldenberg, Reisner, Harper, Gamarel, & Stephenson, 2020a, 2020b; McDowell, Raifman, Progovac, & Rose, 2020). In contrast, exclusionary policies, such as those that allow healthcare providers to deny care to trans patients on religious grounds, have been linked to adverse health outcomes, including non-prescribed hormone use, healthcare avoidance, violent victimization, suicidality, and physical distress (Drakeford, 2018; L. Hughes et al., 2021; Ledesma & Ford, 2020; Reisner et al., 2015). Further, public debates surrounding adoption of trans-related policies may heighten depression, anxiety, and PTSD symptoms among trans populations (Hughto et al., 2021; Pacey et al., 2021; Tebbe, Simone, Wilson, & Hunsicker, 2021).

Little research has examined the relationship between policies and health among different subgroups of trans populations. In particular, the health effects of trans-related policies on trans

people of color is largely unknown as many studies examining the health effects of trans-related policies had samples that were upwards of 80% White or only included race/ethnicity as a control variable (Goldenberg et al., 2020b; L. Hughes et al., 2021; Hughto et al., 2021). Accumulating evidence suggests racial inequities in health outcomes within trans populations. For example, Black and Latina trans women experience inequities across HIV prevention and HIV continua compared to their White counterparts (Becasen et al., 2018). Additionally, trans people of color have reported worse self-rated health, more mental health symptoms, and lower access to gender-affirming healthcare and have a greater probability of chronic diseases and mortality when compared to White trans people (L. Hughes et al., 2022; Lett, Abrams, et al., 2022; Lett et al., 2021; Lett et al., 2020; Park et al., 2022; Seelman, Young, Tesene, Alvarez-Hernandez, & Kattari, 2017). Thus, understanding which populations benefit from trans-related policies is crucial to understanding structural solutions to health inequity within trans populations.

3.1.1 Theoretical Framework

This study draws from Critical Race Theory's *critique of liberalism* to explore racial differences in the relationship between trans-related state policies and health among trans women. As described in Chapter 1, this critique holds that policies based in race-blind neoliberal frameworks of inclusion and rights expansion primarily benefit populations that are the least vulnerable to the harms of racism and intersectional oppression (Bonilla-Silva, 2015; Freeman, 1995). For example, affirmative action policies were first introduced to higher education in the mid-1960's; by 1980, as a result of these policies, White women surpassed White men in admission to and graduation from college while both Black men and Black women remained behind (Cortese, 1991). The same trend has been observed for receipt of small business loans,

government contracts, and private sector employment (Goodwin, 2013). Accordingly, affirmative action policies function in ways that allow White institutions to cultivate reputations for diversity and inclusion while sustaining systems in which White people thrive at the expense of people of color (Aguirre, 2010).

Like affirmative action, many trans-related policies are based on the liberal ideal of equal opportunity and may function to exacerbate social and health inequities (Ashley, 2018; Spade, 2015c). For example, the 2020 *Bostock v. Clayton County, Georgia* decision resulted in trans inclusion in employment nondiscrimination policies nationwide; prior, 22 states had state-level employment nondiscrimination protections for trans people (Movement Advancement Project, 2023). Nonetheless, anti-trans employment discrimination remains highly prevalent in the presence of trans-inclusive nondiscrimination policies, and the actual enforcement of these laws does not provide redress for most trans people who experience workplace discrimination (M. Davis & Wertz, 2010; Rosich, 2020; Spade, 2015c). Employment nondiscrimination laws require complainants to prove employers' discriminatory intent, a task which is difficult for those who have financial access to appropriate legal counsel and effectively impossible for those who do not (Spade, 2015c). Given documented economic inequities between White trans people and trans people of color, and specifically Black and Latina trans women, Critical Race Theory's *critique of liberalism* would therefore suggest that trans-inclusive employment nondiscrimination laws are more likely to benefit White trans women than trans women of color (Badgett et al., 2019; Irving & Hoo, 2020; Rosentel, VandeVusse, & Hill, 2019).

Furthermore, employment discrimination, hate crime laws, and other currently debated trans-related policies do not address structural vulnerability among trans people (Spade, 2015c). Structural vulnerability as described in greater detail in Chapter 1 refers to a depreciated social

position created through discrimination and economic exploitation and marked by social, economic, and material hardships (e.g., poverty, violence) (Bourgois et al., 2017; Quesada et al., 2011). Large-scale national studies indicate that employment inequities impacting trans adults have increased despite the expansion of nondiscrimination policies (Grant et al., 2011; James et al., 2016). Similarly, growing lists of states have added gender identity as a protected class in hate crime laws and eliminated “trans panic” defenses (i.e., defendants’ use of discovery of a trans person’s gender as exculpatory or mitigating evidence) in criminal proceedings. Nonetheless, annual accounts of fatal violence against trans women of color continue to grow (Human Rights Campaign, 2021).

Responding to the noted inadequacies of liberal reforms based on ideals of inclusion and equality, trans activists have proposed policy agendas focused on building coalitions across axes of oppression to transform or abolish the legal and administrative systems that directly control the lives of the most marginalized trans people: prisons, welfare programs, job training centers, foster care, housing authorities, and healthcare (Spade, 2015c). In particular, trans women of color have identified potentially effective focal points for trans-related policies. These include providing equitable access to public and private housing; cultural and structural competence in education, employment, and healthcare settings; and programs that promote safety and recovery from interpersonal violence and other traumas (Bradford & Stephens, 2021; Lacombe-Duncan et al., 2022; Simons et al., 2021; Yarbrough, 2021).

These issues align with several existing trans-related policies, namely those that govern insurance coverage for gender affirming medical care, institutional sex segregation (e.g., in domestic violence programs), and identity document changes (Spade, 2015c). In this study, I refer to these policies as *access policies* because they have direct implications for trans people’s

access to resources critical for wellbeing. In contrast, I use the term *equality policies* to refer to policies that signal recognition of trans people within the existing neoliberal order but without altering their lived experiences, such as nondiscrimination policies and hate crime laws.

3.1.2 Current Study

This study seeks to examine the relationship between access and equality policies and self-rated health among trans women. Due to the lack of population-level data that adequately captures gender identity (Lett & Everhart, 2022), I pursued my research aims using a large convenience sample of trans women. Though my results do not generalize to all trans people of color in the United States, I view this study as an initial effort to critically examine how race and racism operate within trans health policy evaluation research. Additionally, trans women of color experience a e high prevalence of interpersonal violence, economic precarity, and adverse health outcomes across a range of conditions including mortality (King et al., 2022; Lacombe-Duncan et al., 2022; Smart et al., 2020; Swartz et al., 2019; Wirtz et al., 2023). Accordingly, centering this population aligns with our theoretical focus on structurally vulnerable trans communities.

Overall, I expect that access policies will be more consistently associated with better self-rated health than equality policies because they have more direct implications for trans women's material conditions and social experiences (Spade, 2015c). Additionally, trans women of color are more structurally vulnerable than White trans women due to their positionality at the intersection of racism, cissexism, and misogyny (Badgett et al., 2019; Lacombe-Duncan et al., 2022; Reisner et al., 2014; Rosentel et al., 2020; Yarbrough, 2021). Accordingly, I hypothesize that race will moderate the relationship between policies and self-rated health. More specifically, I hypothesize that in comparison to White trans women, access policies will more strongly impact the health of trans women of color while equality policies will less strongly impact their

health (Spade, 2015c). Finally, I hypothesize that any observed relationships between policies and self-rated health will persist when controlling for measures of structural vulnerability and individual- and state-level demographics.

3.2 Methods

3.2.1 Study Design

Data for this analysis were collected through the Leading Innovation for Transgender Women's Health and Empowerment (LITE) study. Between March 2018 and October 2020, 1,614 trans women were enrolled in either a 2-year prospective cohort study designed to characterize HIV incidence and risk factors for HIV acquisition or a cross-sectional comparison group of trans women living with HIV (Wirtz et al., 2019). LITE initially enrolled participants at six physical study sites in Boston, MA; New York, NY; Baltimore, MD; Washington, DC; Atlanta, GA; and Miami, FL. Beginning in June 2018, participants living in Eastern and Southern cities in the United States could enroll online. Eligibility criteria for participation in the baseline survey included being at least 18 years old, speaking English or Spanish, identifying as a woman or with a feminine gender identity, and being assigned male sex at birth (Wirtz et al., 2021; Wirtz et al., 2019). Data for this cross-sectional analysis comes from the baseline survey of all participants. Individuals were included in this analysis if they provided a valid United States zip code of their residence and data on self-rated health, race, and ethnicity, resulting in an analytic sample of 1,585 participants. Study procedures were approved by the Johns Hopkins School of Medicine single Institutional Review Board.

3.2.2 Measures

Trans-Related State Policies

Policy data were extracted from reports published by the Movement Advancement Project and cross-referenced with state legal texts (Movement Advancement Project, 2023). Trans-related state policies were selected based on (1) their applicability to trans adults, (2) variation across the states represented in the dataset, and (3) their ability to be categorized as access or equality policies, resulting in seven access policies and five equality policies. Each of the access policies govern trans adults' ability to receive either medical care or legal gender affirmation. Each of the equality policies reflect trans people's inclusion in nondiscrimination or criminal justice laws. For ease of interpretation, all policies were coded dichotomously such that 1 represents the theoretically most favorable policy environment for trans people and 0 represents all other environments (Table 3.1). States in which legal authorities (e.g., human rights commissions, state supreme courts) have interpreted nondiscrimination laws covering sexual orientation and/or sex to include gender identity were coded as '1'. Additionally, I created composite measures totaling all access policies ('access policy index', $\alpha=0.86$) and all equality policies ('equality policy index', $\alpha=0.86$). The average distribution of these measures across the study period is presented in Figure 3.1.

Figure 3.1 Average distribution of access policies and equality policies among states represented in the LITE Cohort, March 2018-October 2020

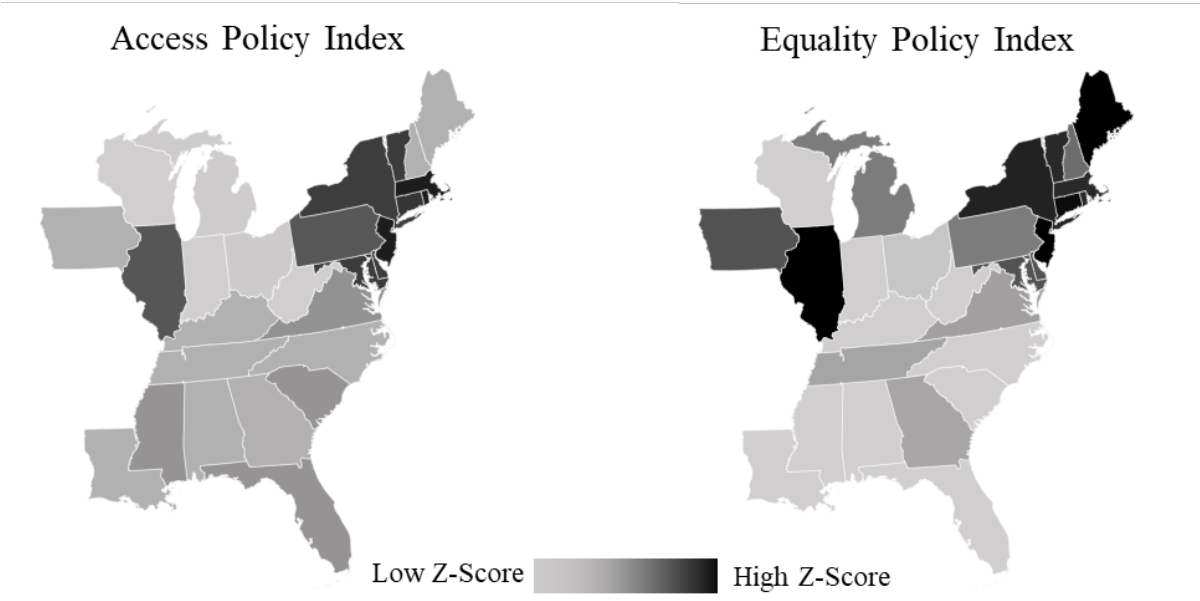


Table 3.1 Trans-related state policies included in analysis

| Access Policies | Scoring |
|---|---|
| Trans Enrollment in Private Insurance | 1 – private insurers are prohibited from denying coverage based on gender identity 0 – no explicit prohibitions on private insurers deny coverage based on gender identity |
| Private Insurance Coverage of Gender Affirming Care | 1 – private insurers are required to cover gender affirming care 0 – private insurers are not required to cover gender affirming care |
| Medicaid Coverage of Gender Affirming Care | 1 – Medicaid policy explicitly covers gender affirming care 0 – Medicaid policy does not explicitly cover gender affirming care |
| Name Change Publication Requirements | 1 – Publication of a name change is never required 0 – Publication of a name change is required in at least some circumstances, or the law is unclear |
| Name Change Legal Status Requirements | 1 – Name change requirements are the same for all 0 – At least some people with a criminal record are required to undergo additional steps or are not allowed to change their name |
| Driver’s License Gender Marker Change Requirements | 1 – Requires a simple form completed only by the applicant 0 – Has additional requirements such as certification by a medical or psychological provider or court order |
| Birth Certificate Gender Marker Change Requirements | 1 – No surgery or court order required 0 – Requires surgery, a court order, or is prohibited |
| Equality Policies | Scoring |
| Housing Nondiscrimination | 1 – Gender identity is a protected class 0 – Gender identity is not a protected class |
| Public Accommodations Nondiscrimination | 1 – Gender identity is a protected class 0 – Gender identity is not a protected class |
| Credit Nondiscrimination | 1 – Gender identity is a protected class 0 – Gender identity is not a protected class |
| Trans Panic Defense | 1 – Inadmissible 0 – Permitted |
| Inclusion in Hate Crime Laws | 1 – Gender identity is a protected class 0 – Gender identity is not a protected class |

Outcome

Self-Rated Health. I chose self-rated health as a study outcome because it is a robust predictor of morbidity and mortality at the population level (Loren, Cook, Leon, Emaus, & Schirmer, 2020; Schnittker & Bacak, 2014). Self-rated health was assessed with a single item asking whether participants considered their health to be excellent, very good, good, fair, or poor. I converted this to a 4-point scale, combining poor and fair health, in which higher numbers indicated better self-rated health to account for skewed data.

Participant Level Covariates

Demographics. Participants self-reported their race, ethnicity, age, citizenship, and whether they immigrated to the United States. For the purposes of this analysis, participants were considered people of color if they selected any race other than or in combination with White or indicated that they were Hispanic/Latina. Participants also reported the zip code of where they currently live, which was used to assign their state of residence and calculate local population density in number of people per square mile using Zip Code Tabulation Area data from the 2016-2020 American Community Survey (ACS) (US Census Bureau, 2022).

Structural Vulnerability Indicators. Fifteen indicators were selected to reflect Bourgois et al.'s (2017) eight domains of structural vulnerability: financial security, residence, risk environments, food access, social network, legal status, education, and discrimination. The structural vulnerability framework conceptualizes such indicators as the individual-level consequences of a structurally subordinated positionality (Bourgois et al., 2017).

Financial Security. Participants were asked to indicate their current sources of income or financial support. Those who did not report having a full- or part-time job were considered unemployed. Any participants who were unemployed and reported receiving income from

unregulated or criminalized forms of employment (e.g., sex work, ‘under the table’ jobs, drug sales) were considered to have informal employment. Finally, participants reported their total income over the past 30 days, which was dichotomized at \$1,000 or less, which approximates the federal poverty level for an individual during the study period (US Department of Health and Human Services, 2022).

Residence. Participants were considered to have unstable housing if they reported currently living anywhere other than housing they owned or rented; this included, for example, living in a homeless or domestic violence shelter, doubling up with friends or family, and living in hotels. Participants also reported the number of days during the last 3 months (site-based participants) or 6 months (online participants) they had difficulty finding a safe place to sleep, which was dichotomized as any vs. none.

Risk Environments. In the structural vulnerability framework, risk environments refer to potential for bodily harm, including interpersonal violence (Bourgois et al., 2017). Participants completed an adapted version of the intimate partner violence scale from the World Health Organization Multi-country Study on Women’s Health and Domestic Violence Against Women; items were modified to ask about violence from all perpetrators (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Emotional abuse was assessed with four items asking whether participants had been insulted, humiliated, intimidated, or threatened to be outed ($\alpha=0.91$). For example, participants reported whether someone had ever “belittled or humiliated [them] in front of other people” and, if so, whether this had happened in the past 3 months (site-based participants) or past 6 months (online participants). Lifetime and recent physical violence were assessed with six items asking whether participants had been slapped, pushed, punched, kicked, choked, or attacked with a weapon ($\alpha=0.96$). A sample physical violence item is “Has anyone

ever... hit you with a fist or something else that could hurt you?" Finally, lifetime and recent sexual violence were assessed with four items asking whether participants had been physically forced to have sex, had been degraded or humiliated during sex, had unwanted sex out of fear, or had unwanted sex because someone told them it was their right ($\alpha=0.95$). A sample sexual violence item is "Has anyone ever... had sexual intercourse or did something sexual you did not want to because you were afraid of what they might do?" Each type of interpersonal violence was considered an indicator of risk environment if participants reported any experience within each category within the past 3 months (site-based participants) or past 6 months (online participants).

Food Access. Participants were considered food insecure if they reported running out of food or money for food by the end of the month sometimes, most of the time, or almost always (Coleman-Jensen, Rabbitt, Hales, & Gregory, 2020). Additionally, SNAP/EBT reported as a source of income or support in the past 3 months (site-based participants) or 6 months (online participants) was also considered an indicator of food access.

Social Network. Participants completed the 5-item California Health Interview Survey social support measure, which assessed general social support with items such as "Thinking about the last 6 months, how often have you had someone available to understand your problems?" (California Health Interview Survey, 2011). Participants rated items on a 4-point scale, which were then summed for an overall score ($\alpha=0.91$). To create an indicator reflecting Bourgois et al. 2017's conceptualization of absence of social support as a structural vulnerability, participants with a mean score in the bottom quartile of the sample (7 out of a possible 20) were considered socially isolated (Bourgois et al., 2017).

Legal Status. Participants reported whether they had ever been held in prison, jail, juvenile detention, or immigration custody at any point in their lives. Those that had were considered to have been incarcerated. Additionally, participants rated the extent to which their legal forms of identification (e.g., driver's license) list their name and gender. Those who reported that none of their forms of identification listed either were considered to not have any of their legal gender affirmation needs met. Finally, not having United States citizenship was considered a marker of structural vulnerability.

Education. Participants selected one of the following options to report their educational background: did not complete 8th grade, completed 8th grade, some high school, completed high school (received a diploma or GED), some college or associate degree, completed college (Bachelor's degree), technical/vocational school, some graduate school, or completed graduate school. Participants were considered educationally structurally vulnerable if they reported completing less than high school.

Discrimination. Discrimination was assessed with the 9-item Intersectional Discrimination Index: Anticipated Discrimination subscale (Schein & Bauer, 2019). Participants rated items like "I may be denied a bank account, loan, or mortgage because of who I am" on a 4-point scale ($\alpha=0.94$). To create an indicator reflecting Bourgois et al.'s (2017) conceptualization of discrimination as a form of structural vulnerability, those in the top quartile of the sample (27 out of a possible 36) were considered to have high anticipated discrimination.

State-level Covariates

State-level covariates were selected based on their potential confounding influence on self-rated health. The proportion of the state population identifying as Black, the proportion identifying as Latinx, the percent of each state's population with a bachelor's degree, and state's

household income inequality was derived from 2016-2020 ACS data (US Census Bureau, 2022). States' overall unemployment rate for 2019 was taken from Bureau of Labor Statistics data (US Bureau of Labor Statistics, 2021).

3.2.3 Analyses

Analysis began by calculating descriptive statistics for all variables of interest to categorize the sample by individual-level demographics, structural vulnerability indicators, and self-rated health. ANOVA and chi-square tests were used to determine if there were significant differences between White participants and participants of color across these variables.

Multilevel Modeling

Subsequent analyses used multilevel models to account for participant clustering by state. Participants represented 29 states and Washington, DC: Alabama, Arizona, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, and Wisconsin. Participants were assigned to 46 state-time clusters based on their state of residence and the time at which they completed the survey. This clustering accounted for changes in laws that occurred during the period over which participants completed their baseline surveys. For example, there were 14 participants from Connecticut, 10 of whom completed the survey prior to Connecticut updating requirements for gender marker changes on driver's licenses, and 11 of whom did so prior to Connecticut's prohibition of trans panic defenses. Therefore, participants from Connecticut were assigned to three different state-time clusters. Because this approach created small clusters, I conducted sensitivity analyses using state as the clustering variable for all multilevel regression models.

Operationalizing Structural Vulnerability. Multilevel latent class analysis (LCA) was performed in MPlus 8.8 using all structural vulnerability indicators. Beginning with a single-class model, models with up to 5 classes were evaluated using Bayesian information criterion (BIC), sample-size adjusted BIC, and Lo-Mendell-Rubin likelihood ratio tests (Nylund, Asparouhov, & Muthen, 2007). All models adjusted for whether participants completed study procedures online or at a study site. Participants were assigned to latent classes based on their highest posterior predicted probability of class membership.

Regression Models. I fit multilevel ordinal regression models in Stata 17.0 to test the association between policy variables and self-rated health. First, each policy variable was entered as the only independent variable in models accounting for clustering at the state-time level. Brant tests indicated that none of the policy variables violated the parallel regression assumption. Then, I fit adjusted models including person-level covariates (i.e., age, race, local population density, online vs. site-based participation, immigration history, and structural vulnerability class membership) and state-level covariates (i.e., racial demographics, proportion of adults with a bachelor's degree, income inequality, and unemployment rate). Adjusted models used complete case analysis as missingness was less than 1% across all variables. Finally, I added *policy x person of color* interactions terms to each model to determine if relationships between policy and self-rated health were consistent across White participants and participants of color.

3.3 Results

3.3.1 Sample Characteristics

Structural vulnerability indicators were highly prevalent in the sample. For example, 37.5% of participants reported housing instability and 22.4% had a history of incarceration (Table 3.2). In LCA, a two-class model best fit the data (Table 3.3). The predicted probabilities

of most structural vulnerability indicators were substantially higher in Class 2 than Class 1. For example, the predicted probability of being currently unemployed was 0.748 in Class 2 compared to 0.239 in Class 1, and the predicted probability of food insecurity was 0.364 in Class 2 compared to 0.065 in Class 1. Therefore, Class 2 was labeled “High Vulnerability,” and Class 1 was labeled “Low Vulnerability.” Slightly over half of participants were assigned to the Low Vulnerability class (55.3%).

Table 3.2 Prevalence of structural vulnerability indicators within the sample

| | Sample Prevalence | | Predicted Probability | |
|----------------------------------|-------------------|-----|----------------------------|-----------------------------|
| | % | n | Class 1: Low Vulnerability | Class 2: High Vulnerability |
| Currently Unemployed | 45.7 | 715 | 0.239 | 0.748 |
| Monthly Income <\$1000 | 37.6 | 588 | 0.136 | 0.799 |
| Informal Employment | 29.6 | 464 | 0.198 | 0.434 |
| Unstable Housing | 36.9 | 578 | 0.302 | 0.460 |
| Recently Lacked Safe Housing | 13.9 | 218 | 0.050 | 0.246 |
| Emotional/Psychological Violence | 36.3 | 568 | 0.345 | 0.404 |
| Physical Violence | 12.1 | 189 | 0.067 | 0.191 |
| Sexual Violence | 7.7 | 121 | 0.051 | 0.113 |
| Food Insecurity | 20.1 | 314 | 0.065 | 0.364 |
| SNAP/EBT Use | 30.4 | 476 | 0.055 | 0.607 |
| Social Isolation | 26.9 | 421 | 0.181 | 0.396 |
| History of Incarceration | 22.2 | 347 | 0.102 | 0.377 |
| No Legal Gender Affirmation | 39.5 | 619 | 0.416 | 0.371 |
| Not a US Citizen | 7.3 | 115 | 0.036 | 0.124 |
| Less than High School Education | 12.6 | 198 | 0.019 | 0.255 |
| High Anticipated Discrimination | 25.9 | 406 | 0.271 | 0.275 |
| | % Assigned (n) | | 56.1 (878) | 43.9 (688) |

Table 3.3 Goodness of fit for latent class models of structural vulnerability

| Number of Classes | BIC | Adjusted BIC | Lo-Mendell-Rubin LRT | |
|-------------------|-----------|--------------|----------------------|---------|
| | | | Value | p-value |
| 1 | 28529.318 | 28472.136 | - | - |
| 2* | 25033.608 | 24925.597 | 1416.986 | 0.0816 |
| 3 | 24594.583 | 24429.389 | 567.378 | 0.6403 |
| 4 | 24567.091 | 24344.715 | 158.924 | 0.6328 |
| 5 | 24573.438 | 24293.880 | 125.339 | 0.4426 |

* Selected model

Over half of the analytic sample was comprised of participants of color (54.7%, n=867). Among participants of color, 37.6% (n=326) were Black, 37.0% (n=320) were Latina (any race), 4.0% (n=35) were Asian/Pacific Islander, 0.7% were American Indian/Alaskan Native, and 20.9% were multiracial or reported another race. There were statistically significant differences between participants of color and White participants across most individual-level variables (Table 3.4). More participants of color immigrated to the United States (18.7%) than White participants (2.7%) ($p<0.001$). Over half of White participants completed study procedures online (60.5%) compared to 17.2% of participants of color ($p<0.001$). The mean local population density for White participants was 9566.7 individuals per square mile compared to 21471.6 for participants of color ($p<0.001$). Additionally, participants of color were more likely to be assigned to the High Vulnerability class than White participants (64.7% vs. 20.6%, $p<0.001$). Finally, the distribution of participants across self-rated health categories differed across race/ethnicity ($p<0.001$); for example, 23.3% of participants of color described their health as “excellent” compared to 13.5% of White participants.

Table 3.4 Characteristics of participants by race

| | Full Sample | | White Participants | | Participants of Color | | p-value |
|--|-------------|-------|--------------------|-------|-----------------------|-------|---------|
| Age (M, SD) | 33.0 | 12.05 | 31.1 | 11.5 | 34.5 | 12.3 | 0.050 |
| Birthplace (% , n) | | | | | | | <0.001 |
| United States | 88.6 | 1397 | 97.4 | 698 | 81.3 | 699 | |
| Outside United States | 11.4 | 180 | 2.7 | 19 | 18.7 | 161 | |
| Site (% , n) | | | | | | | <0.001 |
| Baltimore | 8.1 | 129 | 2.9 | 21 | 12.5 | 108 | |
| Boston | 11.1 | 176 | 14.9 | 107 | 8.0 | 69 | |
| New York | 15.7 | 249 | 9.1 | 65 | 21.2 | 184 | |
| Atlanta | 7.3 | 115 | 3.1 | 22 | 10.7 | 93 | |
| Miami | 9.7 | 154 | 2.5 | 18 | 15.7 | 136 | |
| DC | 11.3 | 179 | 7.1 | 51 | 14.8 | 128 | |
| Online | 36.8 | 583 | 60.5 | 434 | 17.2 | 149 | |
| Local Population Per Square Mile (M, SD) | 139645 | 20303 | 9567 | 17842 | 17602 | 21472 | <0.001 |
| Structural Vulnerability (% , n) | | | | | | | <0.001 |
| Low | 55.3 | 876 | 79.4 | 507 | 35.3 | 306 | |
| High | 44.7 | 709 | 20.6 | 148 | 64.7 | 561 | |
| Self-Rated Health (% , n) | | | | | | | <0.001 |
| Fair/Poor | 22.5 | 356 | 23.8 | 171 | 21.3 | 185 | |
| Good | 30.7 | 486 | 34.3 | 246 | 27.7 | 240 | |
| Very Good | 28.5 | 451 | 29.4 | 211 | 27.7 | 240 | |
| Excellent | 18.4 | 292 | 13.5 | 90 | 23.3 | 202 | |

3.3.2 Trans-related Policies and Self-Rated Health

In unadjusted models, several access and equality policies and both policy indices were associated with better self-rated health (Table 3.5). The access policies that were associated with better self-rated health included requirements that private insurers cover gender-affirming care (OR=1.43, 95% CI: 1.08-1.90), Medicaid coverage of gender-affirming care (OR=1.37, 95% CI: 1.05-1.78), name change requirements not being dependent on applicants' criminal records (OR=1.58, 95% CI: 1.26-1.99), and accessible birth certificate gender marker change requirements (OR=1.40, 95% CI: 1.05-1.88). Equality policies associated with better self-rated health included gender identity protections in credit nondiscrimination law (OR=1.43, 95% CI:

1.06-1.94) and hate crime law (OR=1.59, 95% CI: 1.20-2.11). In models with indices, each additional access policy and equality policy was associated with a 10% increase in the odds of being in the next highest self-rated health category (95% CI: 1.04-1.16 and 1.02-1.18, respectively). None of these associations persisted when adjusting for individual- and state-level covariates.

In the sensitivity analyses using state as the clustering variable, Medicaid coverage of gender affirming care, accessible birth certificate gender marker change requirements, gender identity protections in credit nondiscrimination laws, and the equality index were not associated with self-rated health in the unadjusted models (Table 3.6). Otherwise, there were no differences in which policy variables were associated with self-rated health or in the direction of associations between the main analyses and sensitivity analyses.

Table 3.5 Odds of better self-rated health by trans-related state policies and race

| | Unadjusted Models | | Adjusted Models ² | | | |
|---|-------------------|--------------|------------------------------|-----------|-----------------|-------------|
| | Policy | | Policy | | Person of Color | |
| Access Policies | OR | 95% CI | aOR | 95% CI | aOR | 95% CI |
| Private insurers can't deny coverage on the basis of gender identity | 1.33 | 0.98-1.81 | 1.10 | 0.80-1.52 | 1.35 | 1.08-1.69** |
| Private insurers required to cover gender-affirming care | 1.43 | 1.08-1.90* | 1.13 | 0.87-1.46 | 1.35 | 1.09-1.69** |
| Medicaid covers gender-affirming care | 1.37 | 1.05-1.78* | 1.05 | 0.82-1.35 | 1.35 | 1.09-1.69** |
| Publications not required for name change | 0.99 | 0.70-1.39 | 0.90 | 0.70-1.17 | 1.35 | 1.08-1.68** |
| Name change requirements not dependent on criminal record | 1.58 | 1.26-1.99*** | 1.08 | 0.82-1.43 | 1.35 | 1.08-1.69** |
| Accessible driver's license gender marker change requirements | 1.28 | 0.94-1.75 | 1.03 | 0.73-1.45 | 1.35 | 1.09-1.69** |
| Accessible birth certificate gender marker change requirements | 1.40 | 1.05-1.88* | 1.09 | 0.79-1.50 | 1.35 | 1.09-1.69** |
| Equality Policies | | | | | | |
| Gender identity protected in housing and public accommodations nondiscrimination law ¹ | 1.28 | 0.96-1.71 | 1.10 | 1.84-1.45 | 1.35 | 1.08-1.69** |
| Gender identity protected in credit nondiscrimination law | 1.43 | 1.06-1.94* | 1.08 | 0.68-1.72 | 1.35 | 1.08-1.69** |
| Trans panic defense inadmissible | 1.09 | 0.71-1.69 | 1.12 | 0.80-1.58 | 1.35 | 1.08-1.69** |
| Gender identity protected in hate crime law | 1.59 | 1.20-2.11** | 1.11 | 0.82-1.51 | 1.35 | 1.08-1.69** |
| Indices | | | | | | |
| Access Index | 1.10 | 1.04-1.16** | 1.02 | 0.95-1.09 | 1.36 | 1.09-1.69** |
| Equality Index | 1.10 | 1.02-1.18* | 1.03 | 0.95-1.12 | 1.35 | 1.08-1.69** |
| Race | | | | | | |
| Person of Color | 1.39 | 1.13-1.71** | | | | |

¹All states that included gender identity protects in housing law also included them in public accommodations law

²Models adjust for structural vulnerability class membership, age, study modality, migration history, local population density and state unemployment, income inequality, percent Black, and percent Latinx

* p<0.05; **p<0.01; ***p<0.001

Table 3.6 Sensitivity analysis of odds of better self-rated health by trans-related state policies and race using state as the clustering variable

| | Unadjusted Models | | Adjusted Models ² | | | |
|---|-------------------|------------------|------------------------------|------------------|------|---------------------------|
| | OR | Policy 95% CI | aOR | Policy 95% CI | aOR | Person of Color 95% CI |
| Access Policies | | | | | | |
| Private insurers can't deny coverage on the basis of gender identity | 1.26 | 0.91-1.75 | 1.09 | 0.79-1.51 | 1.35 | 1.09-1.69** |
| Private insurers required to cover gender-affirming care | 1.38 | 1.01-1.90* | 1.13 | 0.87-1.46 | 1.46 | 1.09-1.70** |
| Medicaid covers gender-affirming care | 1.34 | 0.98-1.83 | 1.05 | 0.82-1.34 | 1.36 | 1.09-1.69** |
| Publications not required for name change | 1.04 | 0.72-1.52 | 0.89 | 0.69-1.15 | 1.35 | 1.08-1.68** |
| Name change requirements not dependent on criminal record | 1.55 | 1.22-1.99*** | 1.10 | 0.83-1.45 | 1.36 | 1.09-1.69** |
| Accessible driver's license gender marker change requirements | 1.37 | 0.98-1.91 | 1.02 | 0.72-1.44 | 1.36 | 1.09-1.69** |
| Accessible birth certificate gender marker change requirements | 1.36 | 0.98-1.89 | 1.08 | 0.77-1.51 | 1.36 | 1.09-1.70** |
| Equality Policies | | | | | | |
| Gender identity protected in housing and public accommodations nondiscrimination law ¹ | 1.23 | 0.88-1.71 | 1.10 | 0.83-1.44 | 1.46 | 1.09-1.69** |
| Gender identity protected in credit nondiscrimination law | 1.34 | 0.96-1.87 | 1.08 | 0.68-1.71 | 1.36 | 1.09-1.69** |
| Trans panic defense inadmissible | 0.99 | 0.66-1.46 | 1.11 | 0.79-1.56 | 1.36 | 1.09-1.69** |
| Gender identity protected in hate crime law | 1.53 | 1.15-2.04** | 1.13 | 0.83-1.53 | 1.35 | 1.09-1.69** |
| Indices | | | | | | |
| Access Index | 1.10 | 1.03-1.16** | 1.02 | 0.95-1.09 | 1.36 | 1.09-1.70** |
| Equality Index | 1.08 | 0.99-1.17 | 1.03 | 0.95-1.12 | 1.36 | 1.09-1.69** |
| Race | | | | | | |
| Person of Color | 1.36 | 1.10-1.67** | | | | |

¹All states that included gender identity protects in housing law also included them in public accommodations law

²Models adjust for structural vulnerability class membership, age, study modality, migration history, local population density and state unemployment, income inequality, percent Black, and percent Latinx

* p<0.05; **p<0.01; ***p<0.001

Models including *policy x person of color* interaction terms indicated that the relationship between five policies varied significantly by race/ethnicity. In each case, the interaction term indicated a statistically weaker association with better self-rated health for participants of color than White participants. The specific policies included prohibitions on private insurers denying coverage on the basis of gender identity (OR=0.51, 95% CI: 0.35-0.76), requirements that private insurers cover gender affirming care (OR=0.64, 95% CI: 0.43-0.95), gender identity protections in housing and public accommodations (OR=0.67, 95% CI: 0.45-1.01) and credit nondiscrimination laws (OR=0.59, 95% CI: 0.40-0.88). Finally, the access policy index (OR=0.91, 95% CI: 0.83-0.99) and the equality policy index (OR: 0.89, 95% CI: 0.80-0.99) were also statistically significant. The sensitivity analysis produced the same pattern of statistical significance and directionality of associations as the main analysis (Table 3.8).

Table 3.7 Adjusted odds of better self-rated health by trans-related state policies, race, and their interaction

| Access Policies | Policy | | Person of Color | | Policy x Person of Color | |
|---|--------|------------|-----------------|--------------|--------------------------|-------------|
| | aOR | 95% CI | aOR | 95% CI | aOR | 95% CI |
| Private insurers can't deny coverage on the basis of gender identity | 1.35 | 0.96-1.91 | 1.92 | 1.42-2.59*** | 0.51 | 0.35-0.76** |
| Private insurers required to cover gender-affirming care | 1.37 | 1.01-1.87* | 1.82 | 1.30-2.56** | 0.64 | 0.43-0.95* |
| Medicaid covers gender-affirming care | 1.21 | 0.90-1.64 | 1.64 | 1.19-2.28** | 0.73 | 0.50-1.08 |
| Publications not required for name change | 0.76 | 0.53-1.08 | 1.24 | 0.97-1.59 | 1.39 | 0.89-2.18 |
| Name change requirements not dependent on criminal record | 1.14 | 0.82-1.58 | 1.47 | 1.03-2.10* | 0.88 | 0.58-1.33 |
| Accessible driver's license gender marker change requirements | 1.17 | 0.80-1.70 | 1.55 | 1.16-2.06** | 0.75 | 0.51-1.11 |
| Accessible birth certificate gender marker change requirements | 1.19 | 0.82-1.71 | 1.62 | 1.07-2.43* | 0.80 | 0.52-1.24 |
| Equality Policies | | | | | | |
| Gender identity protected in housing and public accommodations nondiscrimination law ¹ | 1.31 | 0.95-1.81 | 1.77 | 1.25-2.52** | 0.67 | 0.45-1.01* |
| Gender identity protected in credit nondiscrimination law | 1.28 | 0.79-2.07 | 1.77 | 1.31-2.38*** | 0.59 | 0.40-0.87** |
| Trans panic defense inadmissible | 1.24 | 0.80-1.93 | 1.38 | 1.10-1.75** | 0.79 | 0.42-1.50 |
| Gender identity protected in hate crime law | 1.16 | 0.81-1.67 | 1.46 | 0.98-2.18 | 0.90 | 0.58-1.41 |
| Indices | | | | | | |
| Access Index | 1.06 | 0.98-1.14 | 1.97 | 1.30-3.00** | 0.91 | 0.83-0.99* |
| Equality Index | 1.08 | 0.99-1.18 | 1.84 | 1.27-2.66** | 0.89 | 0.80-0.99* |

¹All states that included gender identity protects in housing law also included them in public accommodations law

All models adjust for structural vulnerability class membership, age, study modality, migration history, local population density and state unemployment, income inequality, percent Black, and percent Latinx

* p<0.05; **p<0.01; ***p<0.001

Table 3.8 Sensitivity analysis of adjusted odds of better self-rated health by trans-related state policies, race, and their interaction using state as the clustering variable

| Access Policies | Policy | | Person of Color | | Policy x Person of Color | |
|---|--------|------------|-----------------|--------------|--------------------------|-------------|
| | aOR | 95% CI | aOR | 95% CI | aOR | 95% CI |
| Private insurers can't deny coverage on the basis of gender identity | 1.34 | 0.95-1.89 | 1.92 | 1.42-2.60*** | 0.51 | 0.34-0.76** |
| Private insurers required to cover gender-affirming care | 1.38 | 1.01-1.88* | 1.82 | 1.30-2.56** | 0.64 | 0.43-0.95* |
| Medicaid covers gender-affirming care | 1.20 | 0.89-1.63 | 1.64 | 1.18-2.27** | 0.74 | 0.50-1.08 |
| Publications not required for name change | 0.76 | 0.54-1.08 | 1.25 | 0.98-1.60 | 1.45 | 0.86-2.12 |
| Name change requirements not dependent on criminal record | 1.15 | 0.83-1.61 | 1.46 | 1.02-2.09* | 0.89 | 0.59-1.34 |
| Accessible driver's license gender marker change requirements | 1.15 | 0.78-1.68 | 1.54 | 1.16-2.06** | 0.76 | 0.51-1.12 |
| Accessible birth certificate gender marker change requirements | 1.18 | 0.81-1.73 | 1.65 | 1.09-2.49* | 0.78 | 0.50-1.22 |
| Equality Policies | | | | | | |
| Gender identity protected in housing and public accommodations nondiscrimination law ¹ | 1.31 | 0.95-1.82 | 1.78 | 1.25-2.52** | 0.67 | 0.45-0.99* |
| Gender identity protected in credit nondiscrimination law | 1.28 | 0.79-2.07 | 1.78 | 1.32-2.39*** | 0.59 | 0.40-0.87** |
| Trans panic defense inadmissible | 1.25 | 0.80-1.94 | 1.40 | 1.11-1.76** | 0.76 | 0.40-1.44 |
| Gender identity protected in hate crime law | 1.17 | 0.81-1.68 | 1.44 | 0.97-2.16 | 0.92 | 0.59-1.44 |
| Indices | | | | | | |
| Access Index | 1.06 | 0.98-1.14 | 1.98 | 1.30-3.01** | 0.91 | 0.83-0.99* |
| Equality Index | 1.08 | 0.99-1.18 | 1.84 | 1.27-2.67** | 0.89 | 0.80-0.99* |

¹All states that included gender identity protects in housing law also included them in public accommodations law

All models adjust for structural vulnerability class membership, age, study modality, migration history, local population density and state unemployment, income inequality, percent Black, and percent Latinx

* p<0.05; **p<0.01; ***p<0.001

To aid interpretation of these results, I present predicted probability plots for each general health outcome category by race (White vs. people of color) for the Access Policy Index (Figure 3.2) and Equality Policy Index (Figure 3.3) and the distribution of predicted probabilities of each general health outcome category by race (White vs. people of color) and each policy with a statistically significant interaction term (Figure 3.4). For both indices, the probability of reporting ‘very good’ and ‘excellent’ health increases as each index increases for White trans women but decreases for trans women of color. As follows, the probability of reporting ‘fair/poor’ and ‘good’ health decreases as each index increases for White trans women but increases for trans women of color. A similar trend is evident when examining each of the individual policies with significant interaction terms. For example, as shown in Figure 3.2, Panel A, White participants living in states in which private insurers are prohibited from denying coverage on the basis of gender identity have a higher predicted probability of ‘very good’ and ‘excellent’ health than those in other states whereas the reverse is true for participants of color.

Figure 3.2 Sample distribution of predicted probabilities of self-rated general health categories by select trans-related state policies and race

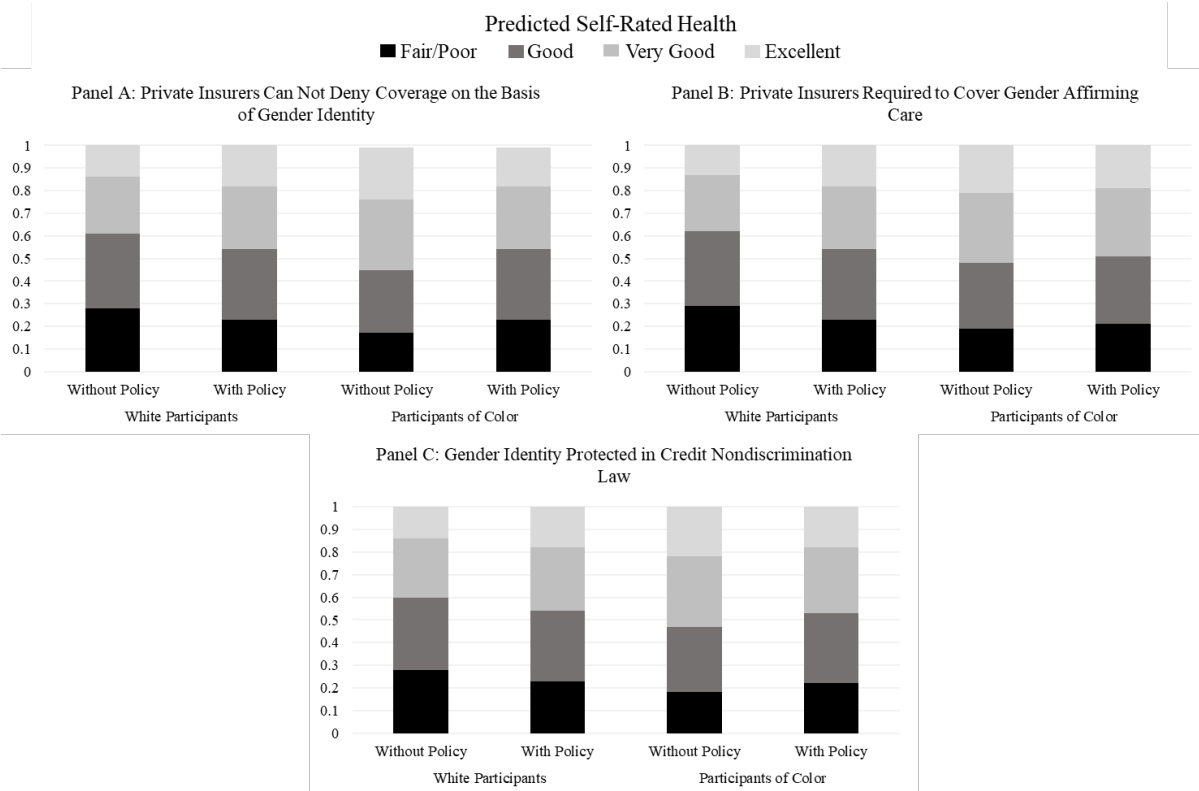


Figure 3.3 Predicted probabilities of self-rated general health categories by access policy index and race/ethnicity

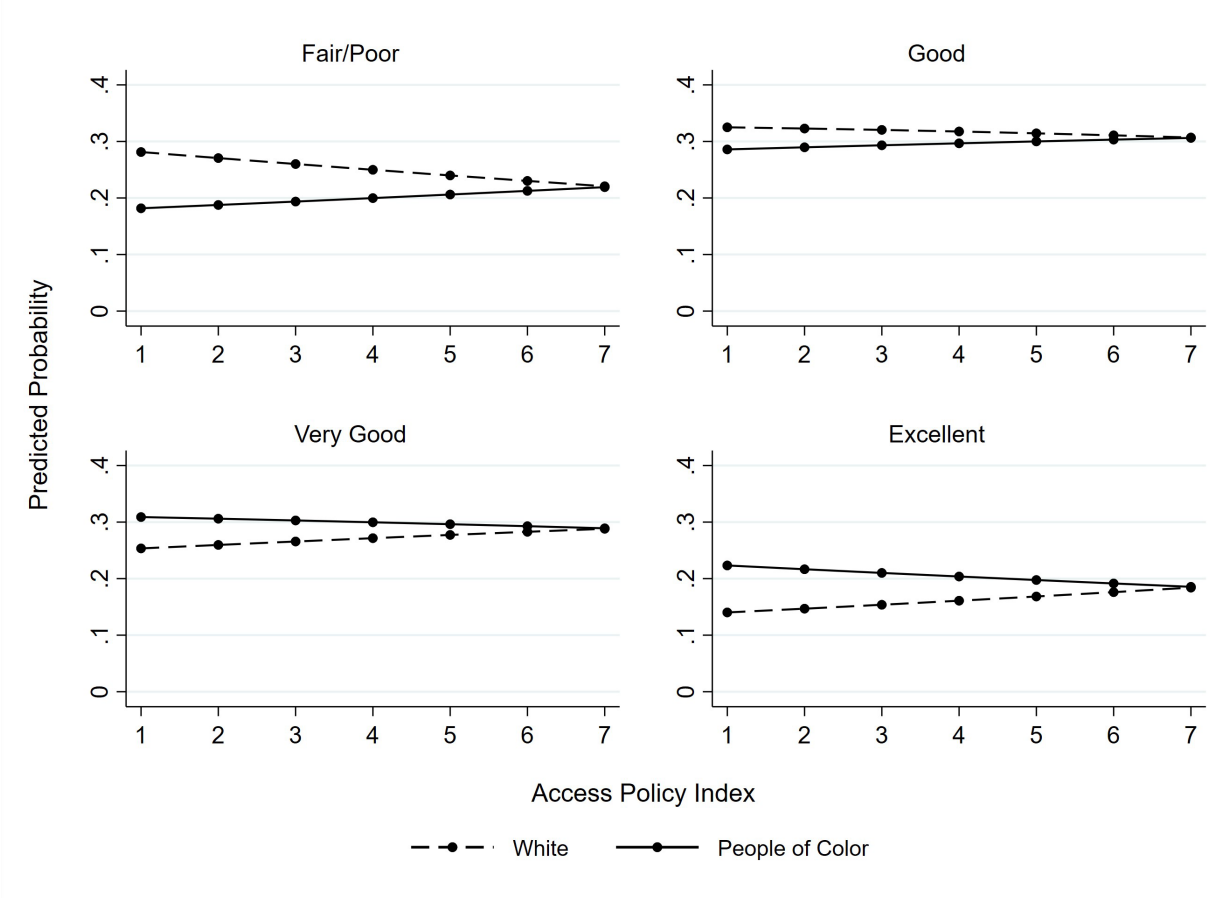
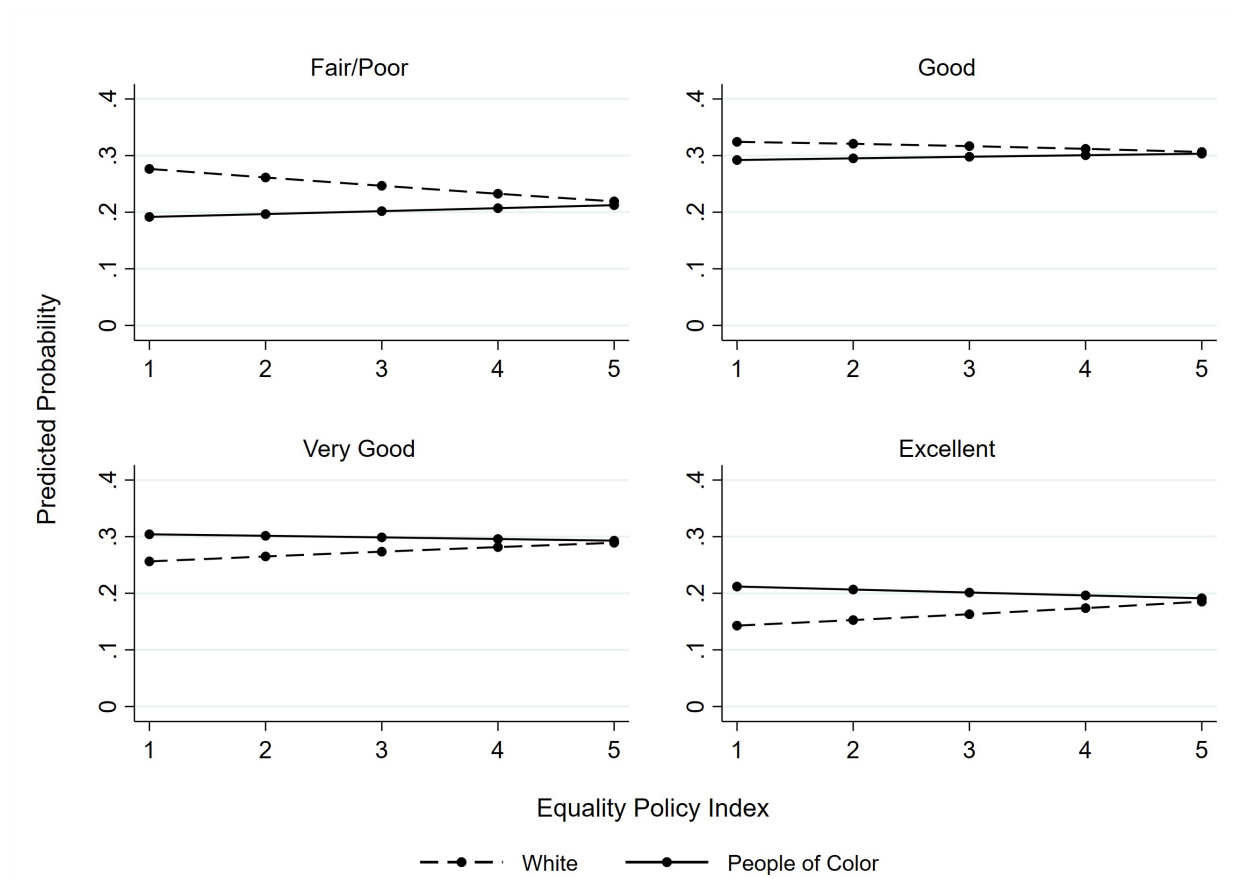


Figure 3.4 Predicted probabilities of self-rated general health categories by equality policy index and race/ethnicity



3.4 Discussion

This analysis of adult trans women in the United States found that several trans-related state policies governing access to resources and equality under the law were associated with better self-rated health in bivariable regression models. When adjusting for individual- and state-level covariates including structural vulnerability, these associations did not persist. However, adding *policy x person of color* interaction terms to the adjusted models revealed that race/ethnicity moderated the relationship between several trans-related state policies and self-rated health. Specifically, the odds of better self-rated health were higher for White trans women and lower for trans women of color. Contrary to my hypotheses, this finding was true for both access and equality policies. These findings suggest that trans-related state policies may have a beneficial impact on health for White trans women and a potentially detrimental impact on health for trans women of color, consistent with critical race theory's critique of liberalism (Bonilla-Silva, 2015; Freeman, 1995).

All policies included in this analysis are nonracial in that they do not contain language about race or racism (Bonilla-Silva, 2015). This colorblindness disregards how violence, discrimination, and access to resources are qualitatively different for trans women of color than White trans women due to the centrality of race and racism in the hegemonic ideology undergirding political, economic, and cultural structures in the United States (Bonilla-Silva, 2015; Krell, 2017; Ladson-Billings & Tate, 1995). For example, I found that the relationships between two policies regarding private health insurance and self-rated health was positive for White trans women and negative for trans women of color. This may be because White adults are more likely to have private insurance than Black or Latinx adults due to their greater access to employer subsidies and greater ability to afford purchased insurance (Buchmueller, Levinson,

Levy, & Wolfe, 2016). Trans-related policies regarding private insurance coverage are therefore potentially more relevant to White trans women's access to healthcare.

The distinction between access and equality policies was based on previous critical trans studies highlighting how nondiscrimination and hate crime laws strengthen the carceral state and fail to redistribute resources from those in power to structurally vulnerable trans people (Ashley, 2018; Spade, 2015c; Vitulli, 2010). I hypothesized that access policies would be more strongly associated with better self-rated health for trans women of color than White trans women because these policies aim to eliminate barriers to important social determinants of health for "all" trans people, agnostic to racial differences: medical and legal gender affirmation and health insurance (Reisner, Radix, & Deutsch, 2016). However, the access policies examined in this study may be ineffective for addressing barriers specific to trans women of color. These include structural, institutional, and interpersonal gendered racism in healthcare settings, schools, and the criminal-legal system that may influence their health status and drive racial health inequities within trans populations (Agénor et al., 2022; Howard et al., 2019; Rosentel et al., 2020; Yarbrough, 2021).

Moreover, the policies I analyzed in this study may serve to worsen trans women of color's health via predatory inclusion. Predatory inclusion occurs when access to goods, services, or opportunities is extended to members of a marginalized or formerly excluded group under conditions that threaten the advantages of access (Seamster & Charron-Chénier, 2017). Examples of predatory inclusion include the expansion of microcredit programs, payday loans, subprime mortgages, student loans, online and for-profit higher education programs, and individually operated financial technology (e.g., cryptocurrencies, electronic trading platforms) (Charron-Chénier, 2020; Gott, 2022; McMillan Cottom, 2020; Ridgeway & Wason, 2023;

Seamster & Charron-Chénier, 2017; Taylor, 2018). These schemes purport to democratize access to credit, capital, education, entrepreneurship, wealth, and housing, yet they result in inequitable financial losses, debt accumulation, and receipt of lower quality services for structurally vulnerable people and people of color. The trans-related policies included in this study may be functioning similarly in that they may increase trans women of color's access to systems that perpetuate racial health inequities; specifically, private health insurance, housing, public accommodations, and credit.

Policies that structure the distribution of and access to social, economic, and political resources for all people of color may be more relevant to the lives of trans women of color than the specifically trans-related 'access policies' that I analyzed (Agénor et al., 2021). Structural-racism related policies may have unique impacts on trans women of color as intersectional racism, cissexism, and misogyny impact how they are enforced. For example, compared to cisgender, heterosexual people, trans women are disproportionately subject to police contact, harassment, and arrest for "walking while trans" under the pretext of enforcing solicitation laws, and police hyper-surveillance of low-income communities of color compounds this risk (Daum, 2015). Critical legal scholars have described how solicitation laws and other policies used to justify 'quality-of-life' or 'broken windows' policing function to intimidate, control, and financially exploit people of color with intersecting marginalized identities, including trans women of color (R. Collins, 2007; Oberman & Johnson, 2016; Ritchie, 2017; Stewart-Winter, 2015). These laws include laws criminalizing behaviors deemed signifiers of disorder or immorality under hegemonic White supremacy and cisheteropatriarchy (e.g., loitering, vagrancy), laws criminalizing engagement in survival economies (e.g., sex work), laws governing law enforcement conduct (e.g., stop-and-frisk, racial and ethnic profiling), and laws

structuring the legal systems through which those charged with de minimis offenses are sentenced (Agénor et al., 2021; Howell, 2016; Kurdyla, 2022; Martin, Sykes, Shannon, Edwards, & Harris, 2018; Ritchie, 2017; J. Thompson, 2015). How the full scope of these laws are enacted and enforced against trans women of color remains poorly documented (Ritchie, 2017), and their impact on population level health outcomes or health inequities is understudied (Poteat & Simmons, 2022).

Overall, these results indicate that both access and equality policies are more effective at improving the health of White trans women as compared to trans women of color. These findings suggest that existing trans-specific policies serve to create paths for less marginalized trans women (e.g., White) to navigate existing oppressive structures such as health insurance and healthcare, housing, and credit systems (Spade, 2015c). Policies that effectively promote justice and liberation for trans people would instead reorder, disrupt, or dismantle these systems to effectively redistribute resources critical to structurally vulnerable trans people's wellbeing (Spade, 2015c). For example, many of the policy demands in the Trans Agenda for Liberation concern abolition of the criminal-legal system in ways that would increase trans people of color's—specifically Black trans women's—access to employment, housing, and other economic resources and decrease their exposure to interpersonal violence (Bradford & Stephens, 2021). Such demands include decriminalizing sex work; ending practices such as monetary sanctions, cash bond, pretrial detention, and solitary confinement; removing immigration restrictions and eliminating immigrant detention; and redistributing public safety funds from policing to community-based alternatives based in restorative/transformational justice practices (Bradford & Stephens, 2021). The results of this study highlight the need for policy research pertaining to trans health that uses intersectionality frameworks to understand how both trans-specific and

non-trans specific laws differentially impact health for trans women of color (Poteat & Simmons, 2022; Rosentel, Fuller, Bowers, Moore, & Hill, 2021; Wesp et al., 2019).

3.4.1 Limitations

These findings and their implications must be interpreted in light of several limitations. First, the data came from a convenience sample of trans women participating in a study focused on HIV, and 21 states were not represented in the data. I chose this data source because national health surveillance systems do not allow for the identification of large enough samples of trans people of color to adequately power analyses. Consequently, my findings lack generalizability to other geographies and trans populations (e.g., trans men). Additionally, although this study is among the first to decompose policy effects on health among White and trans people of color, I acknowledge that my analyses were not powered to explore the diversity within the latter category by attending to the experiences of particular racial groups (i.e., Black, Latina, Asian).

Furthermore, while my use of LCA to operationalize and adjust for structural vulnerability is a notable strength of this study, surveys administered to the online and site-based participants had different recall windows for some variables. Site-based participants may therefore have been more likely to be misclassified as Low Vulnerability as their recall windows for the items regarding risk environment, income sources, and difficulty finding a safe place to sleep were three months shorter than online participants. I attempted to mitigate this issue by adjusting for study modality in the LCA and all multivariable models. Additionally, the null findings regarding birth certificate gender marker changes likely reflect that these laws pertain to state of birth rather than current residence; future studies should consider mobility and migration among participants in evaluating this policy. Finally, the cross-sectional study design precludes any conclusions regarding causation, and I did not consider the length of time prior to data

collection in which states had enacted these policies. Future research should consider quasi-experimental approaches to evaluating trans-related policies' health impact.

3.4.2 Conclusion

Policies that promote trans people's access to resources and inclusion in existing legal and socioeconomic systems may have differential benefits on White trans women's health compared to trans women of color's health. Future evaluations of trans-related policies must consider the role of race and racism in the function, enforcement, and health impact of these policies (Agénor et al., 2021). Trans health research and political advocacy efforts must extend their focus beyond policies and practices that only implicate trans identity or gender affirmation and towards those that impact trans people of color's material conditions to effectively promote health equity.

Chapter 4 Cultivating Black Trans Joy and Liberation: Lessons from Community Leaders

4.1 Introduction

Black trans people experience inequities across a wide range of health domains including HIV prevention and care (Becasen et al., 2018), mental health symptoms (Lett et al., 2020), violent victimization (Gyamerah et al., 2021), and overall mortality (L. Hughes et al., 2022). As described throughout this dissertation, Black trans people are also subject to structural vulnerability, which refers to a subordinated social positionality characterized by political, cultural, and economic insults (Quesada et al., 2011). Black trans structural vulnerability is a consequence of both historical and ongoing impacts of anti-Black racism and cissexism which differentially expose this population to economic exploitation, discrimination, and violence (Fischer, 2021; Page, 2022; Quesada et al., 2011). Previous work has documented and described how structural vulnerabilities such as poverty, incarceration, food insecurity, unemployment, and housing deprivation are often co-occurring and mutually reinforcing among trans communities of color (Clark et al., 2023; Lacombe-Duncan et al., 2022; Rosentel et al., 2020; Yarbrough, 2021). Further, these multiple, synergistic structural vulnerabilities have been linked to poor mental health and substance use among trans women of color (King et al., 2022).

4.1.1 Public Health Narratives

Public health research focused specifically on trans populations has grown rapidly over the past two decades (Riselay, Ivanitskaya, & Haidar, 2023). Research with Black trans populations overwhelmingly focuses on HIV prevention and care among Black trans women

while other genders and health domains are poorly represented in the literature (Farvid et al., 2021). This research has perpetuated majoritarian narratives explaining health inequities and, to a lesser extent, structural vulnerability among Black trans populations. *Majoritarian narratives* are explanations for social inequities that derive from, uphold, and normalize White supremacy (Dixson & Rousseau Anderson, 2017). This term was coined in reference to prevailing narratives of racial differences in educational outcomes in the United States which fail to account for and obscure how White supremacy in education practices and policies (e.g., school funding) shapes the conditions in which children live and learn. Instead, majoritarian narratives identify children, communities, or cultures as the drivers of inequities in educational outcomes (Soloranzo & Yosso, 2002).

One prevailing majoritarian narrative of health inequities among Black trans populations characterizes Black trans people as inherently prone to behaviors (i.e., ‘risk behaviors’) that harm health and thus in need of outside intervention. This explanation is a variation of deficit narratives that blame people of color and the environments, communities, and cultures in which they live for the adverse effects of systemic racism and other forms of oppression (L. P. Davis & Museus, 2019). For example, majoritarian narratives underlie research that compares sexual behaviors (Ezell, Ferreira, Duncan, & Schneider, 2018), substance use (Vance, Boyer, Glidden, & Sevelius, 2023), and healthcare engagement (e.g., STI screening) (Lelutiu-Weinberger et al., 2020) between Black trans populations and other groups or are used as a rationale to modify these behaviors (Arrington-Sanders et al., 2020; Kaufman et al., 2020; Meussig et al., 2020). Behavior-focused research frequently identifies anti-trans stigma and racism as distal determinants of health inequities using theories such as the Gender Affirmation Framework (Sevelius, 2013) or Gender Minority Stress Theory (Hendricks & Testa, 2012). Although these

theories acknowledge structural vulnerabilities that Black trans communities experience through a social-ecological lens (White Hughto et al., 2015), the research focus remains on understanding and modifying individuals' behavior.

A variation of deficit narratives focuses on factors that protect individuals from adverse health outcomes. Protective factors are used to explain or mitigate health inequities impacting people of color and other marginalized groups. For example, the Transgender Resilience Intervention Model posits that “group resilience” and “individual resilience” buffer the impact of minority stressors trans people experience (e.g., anti-trans discrimination, internalized transphobia) and thereby reduce mental health inequities (Matsuno & Israel, 2018). Often referred to as a “strengths-based approach,” the resilience majoritarian narrative claims to subvert deficit-based narratives. However, the resilience majoritarian narrative fails to do so because it advocates changing individuals and their immediate circumstances rather than on the structural power dynamics that drive inequities (Anderson, 2019; Gray, 2018). Examples of this thinking in research conducted with Black trans women have suggested that individual resilience in the form of empowerment and motivation may increase pre-exposure prophylaxis adherence (PrEP) among trans women (Storholm et al., 2022) and that group resilience in the form of interactions with Black trans peers may mitigate the impact of interpersonal violence on mental health (Sherman et al., 2022). While less overtly stigmatizing than research concerned with documenting and modifying “risk behaviors”, such studies ultimately rehash deficit narratives by suggesting health inequities result from a lack of resilience rather than unacknowledged structural power dynamics (L. E. Davis, 2014).

Both variations of the deficit narrative thus imagine the ideal Black trans person as capable of adaptively coping with extreme and unremitting oppression, stress, and adversity

through health-promoting behaviors rather than advancing an ideal future in which Black trans people are not disproportionately subject to these harms (Suslovic & Lett, 2023). Imagining such a future is a central project of BlackCrit, a critical theory of Blackness developed within and in response to Critical Race Theory (Dumas & ross, 2016). According to the originators of BlackCrit, Black liberatory fantasy, “resist[s] a revisionist history that supports dangerous majoritarian stories that disappear Whites from a history of racial dominance” (Dumas & ross, 2016). Using Black liberatory fantasy to approach the problem of health inequities and structural vulnerabilities impacting Black trans people thus requires directly attending to White supremacy and other structural power dynamics—not Black trans people’s identities, behaviors, or communities.

4.1.2 Structural Trauma

The structural trauma framework, described in detail in Chapter 1, provides an appropriate viewpoint from which to approach this work. The structural trauma framework analyzes how “organizational logics of domination” (e.g., colonialism, structural racism) strategically create conditions in which populations who exist outside of the Western, colonial gender binary are likely to experience trauma (Ruiz, 2020). These conditions include gender-based interpersonal violence, institutionalized violence (e.g., deportation), dispossession, and economic exploitation, which mirror the conditions that define structural vulnerability (Bourgois et al., 2017; Ruiz, 2020). Ruiz illustrates the phenomenon of structural trauma by highlighting how violence against Indigenous women in North America upholds (neo)colonial political and economic structures benefiting White men (Berenstain, Dotson, Paredes, Ruíz, & Silva, 2021; Ruiz, 2020). This violence and the subsequent traumatic impacts for those exposed are not random or accidental but rather sanctioned through policy and its enforcement (Ruiz, 2020).

Placing Ruiz's (2020) work in conversation with Black, trans, and Black trans feminisms demonstrates its applications for understanding structural vulnerability and health inequity among Black trans populations. Colonialism and racism are the organizational logics of domination responsible for violence against Indigenous women and manifested in hegemonized White notions of gender and sex through genocide and slavery. The same organizational logics simultaneously create and condemn the category of people now labeled "transgender" (Meyers, 2022; Snorton, 2017). The conditions that currently shape Black trans life including political attacks on reproductive freedom, access to gender-affirming healthcare, freedom of movement, education, and voting rights are the contemporary manifestation of these forces (Richardson et al., 2022). Viewed through the structural trauma framework, the structural vulnerabilities and health inequities impacting Black trans populations are the intended effects of the ongoing effort to contain and eliminate people who exist outside the colonial gender binary (Ruiz, 2020).

4.1.3 Counternarratives and Community Participation

The structural trauma framework thus provides a starting place for the development of counternarratives to the majoritarian narratives of Black trans structural vulnerability and health inequity. Counternarratives (also called counter-stories) are accounts of those "on the margins of society" that reveal, analyze, or contest majoritarian narratives (Soloranzo & Yosso, 2002). Black liberatory fantasy is a specific type of counternarrative that centers the "wondrous possibilities" of eradicating White supremacy (Dumas & ross, 2016). Though Black liberatory fantasy has been primarily applied in education research (Toliver, 2023), public health and medical research have used other forms of counternarrative to interrogate structural racism in patient care (Olszewski, 2022), in epidemiological methods (Petteway, 2022), and in theorizing about race as a risk factor for disease (Ford & Airhihenbuwa, 2018; C. Jones, 2000).

Counternarrative-as-methodology is deeply concerned with power and voice as it seeks not just to represent the experiences of marginalized people but to transform accounts of these experiences into tools of resistance (Soloranzo & Yosso, 2002).

On a practical level, community-engaged public health research likewise grapples with power and voice when considering how academic researchers can engage, collaborate, and share control with community members and community leaders given inherent power differentials (J. Alexander, Comfort, Weiner, & Bogue, 2001; Duran et al., 2019; Trapence et al., 2012; Wallerstein & Duran, 2017). This type of research pertaining to Black trans people and other trans people of color tends to involve community members primarily in participant recruitment, in community health worker roles, or as key informants for study design, intervention development, or evaluation (Hirshfield et al., 2019; Magnus et al., 2020; Operario et al., 2017; Poteat et al., 2019; Sevelius et al., 2022; Sevelius, Neilands, Dilworth, Castro, & Johnson, 2020; Wesp et al., 2019). While this is a welcome departure from extractive research involving community members only as participants, research efforts to guide effective public health interventions often do not involve learning from Black trans community leaders' experiences with organizing and creating change within and for their communities (Lacombe-Duncan et al., 2022).

Black trans communities have an extensive history of community building, activism, advocacy, and political organizing. These include organized and spontaneous protests in response to police violence, most notably in 1966 at Compton's Cafeteria in San Francisco, CA and 1969 at the Stonewall Inn in Greenwich Village, NY (Armstrong & Crage, 2006; Mulholland, 2020). Additionally, Black trans communities form cohesive intra- and intergenerational kinship structures that provide crucial social support often in the absence of

family of origin (Graham et al., 2014; Lundy-Harris, 2022; Shange, 2019; M. White et al., 2020). In some Black trans communities, these structures are formalized through House and Ball culture, which Black and Latinx trans women and queer cis men developed in the 1970s to provide avenues for entertainment, artistic expression, and social connection separate from White-dominated trans and queer spaces (M. Bailey, 2011; Monforte, 2010). More recently, the increasing professionalization of activism has seen a proliferation of Black trans-led and Black trans-serving nonprofit and philanthropic organizations (Greene, 2021; Spade, 2015b). Many of these organizations work within a city or local community to organize advocacy efforts, support artistic or cultural endeavors, or provide clients direct services such as healthcare, food assistance, financial assistance, and housing while others operate more broadly to distribute resources nationally or globally (Willis, 2020).

Engaging Black trans community leaders in crafting counternarratives regarding the health inequities and structural vulnerabilities impacting Black trans communities may provide insights that have greater community relevance and potential for effective social change than research that involves Black trans people without acknowledging leaders' expertise (Krieger, 2020). Community relevance is especially important given the disconnect between Black trans communities' stated priorities and the focal topics of research conducted about them (Lett, 2023). Trans activists and organizations have long called for research, policy, and programming that improves housing, employment, income, education, healthcare, and safety for structurally vulnerable trans populations and reduces stigma, violence, and criminalization (Bradford & Stephens, 2021; Fischer, 2021; Grullón Paz & Astor, 2020; MacNeill & Smith, 2021; Spade, 2015a; Tagonist, 2009). Despite their relevance, these structural issues are poorly represented in

public health research with trans samples overall and for Black trans populations particularly (Farvid et al., 2021; Marshall et al., 2019).

4.1.4 Research Aims

This study seeks to elicit, interpret, and disseminate Black trans community leaders' counternarratives regarding Black trans communities' health inequities and structural vulnerability in the effort to inform public health research involving Black trans populations. This work is a partnership between researchers at the University of Michigan and community leaders connected to the Black Trans Fund (BTF). BTF is the first philanthropic organization to center Black trans joy and liberation in their grantmaking work, which resources and supports Black trans social justice leaders (Black Trans Fund, 2023a). More concretely, this qualitative study aims to understand how Black trans community leaders cultivate Black trans joy and liberation through their work. We are interested in better understanding leaders' goals in serving their communities, visions for Black trans futures, and challenges they have encountered in pursuing their work.

4.2 Methods

4.2.1 Partnership

I initially approached BTF's leadership with the concept for this study. Bré Rivera, BTF's director, had previously been involved with and supportive of trans health research my mentor and colleagues conducted at the University of Michigan. This established relationship facilitated BTF's interest in the proposed collaboration and promoted trust, understanding, and shared decision making during the planning of this study. Along with HunterDae Little-Goodridge, a program manager at BTF, we collaboratively developed the aims and procedures

for this qualitative study. Ultimately, BTF had final decision-making power over the study's specific aims, eligibility criteria, recruitment procedures, participant incentive structure, topics covered in the interview guide, and plans to disseminate findings. They also provided feedback on recruitment materials and multiple iterations of the results. University of Michigan researchers were solely responsible for navigating institutional review board procedures, conducting interviews, and analyzing data. All study procedures were approved by BTF leadership and deemed exempt from review by the University of Michigan Health Science and Behavioral Sciences Institutional Review Board (IRB).

4.2.2 Participants and Recruitment

Eligibility criteria for this study were aligned with BTF's eligibility criteria for their grantmaking work. Individuals needed to be at least 18 years old; identify as Black, African American, or as part of the African diaspora; identify as trans, nonbinary, or a person of trans experience; and hold a director or equivalent position in an organization that predominantly serves Black trans people. BTF initially identified ten individuals representing eight organizations from their pool of grantees as potential study participants. BTF leadership sent individual emails explaining the purpose of the study, encouraging participation, and facilitating introductions to me. Additionally, BTF leadership introduced me to two of the potential participants via text. Ultimately, all ten individuals expressed interest in the study and were scheduled for a phone call screener. During this phone call, I explained the purpose and procedures of the study, answered questions, and verbally administered a brief survey to ensure they met eligibility criteria. I then scheduled eligible participants for their initial interview.

4.2.3 Data Collection

As this study was part of my dissertation research, I performed all data collection and analysis. Immediately prior to each interview, I conducted a verbal informed consent process with each participant, during which they could opt to receive an emailed version of the informed consent. All participants gave permission for the interview to be audio recorded on an external device. Interviews followed a semi-structured interview guide with open-ended questions prompting participants to provide background information on their organizations and the communities they serve, describe barriers and facilitators to achieving their organizations' goals, and envision the future of their organization, communities, and Black trans people in general. Participants also answered a brief set of questions to provide demographic data for themselves (i.e., race/ethnicity, age, gender, pronouns, work history) and characterize their organization (i.e., number of staff, number of individuals served, time since establishment). Participants received \$400 via prepaid debit card or check for completion of this interview. Audio recordings were uploaded to a password-protected folder and transcribed verbatim using a third-party online transcription service.

Additionally, I conducted follow-up interviews with 8 of the 10 participants. One participant could not be contacted due to a medical issue, and another was unavailable for a second interview due to shifting work schedules. At the beginning of these interviews, participants completed a revised informed consent process to confirm whether and how they wanted their names or pseudonyms to appear in products derived from this research. This process was instated through consultation with the IRB and based on feedback from participants who wanted to be credited for their contributions rather than anonymized. All participants who completed a second interview asked for their real names to be used in all dissemination products. The other two participants are referred to by pseudonyms they selected at the end of their

interviews. Second interviews covered topics that emerged during initial interviews and development of preliminary themes. I shared quotes taken from the initial interviews (both from the participant being re-interviewed and other participants) and asked questions that prompted participants to interpret, extend, or clarify the ideas within these quotes. These interviews were audio recorded and transcribed as the first interviews, and participants received \$100.

4.2.4 Analysis

I chose reflexive thematic analysis to understand, interpret, and develop results from the data. Reflexive thematic analysis is a qualitative method that centers and encourages interrogation of researcher subjectivity in relation to the aims, participants, and process, making it appropriate for research concerning social and political power dynamics (Braun & Clarke, 2022). While the research aims do not directly concern racism, cissexism, or other forms of oppression, I anticipated that participants would explicitly acknowledge and share experiences shaped by these social power structures. Furthermore, given my theoretical grounding in Critical Race Theory, BlackCrit, and the structural trauma framework and aim to conduct research that promotes Black trans joy and liberation, it was essential to choose a qualitative method that allows for theory-informed, deductive analysis. Reflexive thematic analysis encourages researchers to recognize how they are oriented towards their data along the spectrum from inductive (data-driven) to deductive (researcher- or theory-driven) and acknowledges that this orientation can shift over the research process (Braun & Clarke, 2022).

My reflexive thematic analysis process began during data collection. Immediately following each interview, I journaled about the process and content, which included describing arising emotions for myself and the participant, noting expected and unexpected topics of conversation, and documenting points of confusion, tension, and interest for future consideration.

After transcription, I began familiarizing myself with the data by listening to each recording and checking the transcript for errors. I then read each transcript twice and journaled to document the content of each interview, reflect on participants' apparent and latent understandings of how their organizations' missions and practices promote Black trans joy and liberation, and draw connections between topics and observations different participants shared.

I then began a systematic coding process to continue interpreting the data. Originally, I planned to begin with semantic, inductive codes capturing the meaning readily apparent within the data. However, participants often explicitly discussed concepts closely related to the theoretical basis of this study including structural racism, intersectionality, joy, and liberation. As a result, codes quickly became more deductive as I moved through the dataset to capture these theoretical constructs and the meaning they held for participants. Codes also became more latent as relating participants' answers to the theoretical constructs underlying the study's aims took priority. All transcripts were coded once in their entirety. Additionally, when coding every transcript but the first, I relied on my knowledge of the dataset to return to specific places of previously coded transcripts and apply newly developed codes as applicable.

After reviewing the transcripts, list of codes, and notes, I began drafting themes with the aim to connect, interpret, and extend codes rather than summarize the content of the interviews. I organized these initial themes into a table alongside brief explanations and supporting data excerpts. This table was revised repeatedly through continued review of the data, codes, and journal entries and discussion with the research team. This included presenting five potential themes and eight potential subthemes to BTF leadership, who provided feedback on their importance, usefulness, clarity, and organization in relation to the research aims. After conducting the follow-up interviews, I reviewed the resultant transcripts in relation to the

candidate themes with specific attention to how participants confirmed, refuted, extended, or modified the ideas within these themes. During this stage of analysis, I combined, eliminated, and revised the candidate themes and subthemes to incorporate findings from the follow-up interviews and develop a coherent set of final results that speak to the research aims.

4.3 Results

As summarized in Table 4.1, there was substantial variation in participants' age, gender, and years working in the field. On average, the organizations participants led had been active for 8.4 years (range: 3-19). Seven of the eight organizations focused at least in part on specific local communities. These were based in: the Bronx, New York (2 organizations); Birmingham, Alabama (2 organizations); Tucson, Arizona; Atlanta, Georgia; and San Francisco, California. The remaining organization works throughout the U.S. and offers the majority of their programming virtually. Though a few organizations focused on a singular community need, most offered a wide range of services, opportunities, and resources to Black trans people. Examples include support groups, retreats, and community building events; emergency financial assistance; housing referrals, emergency housing, and semi-permanent housing; political and spiritual education; and re-entry services for people returning from substance use or mental health treatment and incarceration. Five of the organizations had 501c3 nonprofit status.

I developed three themes that focused on the central research question of how Black trans leaders cultivate Black trans joy and liberation through their community-based work. First, “envisioning joyful, liberated futures in contrast to survival mode” highlights participants’ often revolutionary imaginings for Black trans futures. The subtheme “connection with self, community, and broader social movements” connects these futures to organizations’ current programming. The second theme, “laying groundwork through liberatory praxis” analyzes

organizations’ standard practices and their underlying values. The subtheme “selectively navigating available resources and networks” focuses particularly on decisions participants make around funding and professional collaborations. Finally, “prioritizing safety and healing” concerns how participants explained the importance of the supports they provide communities.

Table 4.1 *Characteristics of participants*

| Name or Pseudonym | Race/Ethnicity | Gender Identity | Age | Years in Field | Organization Location |
|------------------------|---|---------------------------|-----|----------------|-----------------------|
| Alex Santiago | Black | Trans male | 55 | 20 | Atlanta, GA |
| Brianna Coleman | Black | Woman of trans experience | 25 | 5 | Bronx, NY |
| Dane Edidi | Black, Indigenous, Latina | Trans woman | 40 | 15 | National/virtual |
| Daroneshia Duncan-Boyd | Black | Transgender | 39 | 13 | Birmingham, AL |
| Devin Lowe | Black | Transmasculine | 30 | 9 | New York, NY |
| Donnell | Black | Transmasculine | 38 | 9 | National/virtual |
| Josiah Ramos | African, Taino, Puerto Rican, Dominican | Man of trans experience | 24 | 4 | Bronx, NY |
| Logan Boyd | African American | Transmasculine | 32 | 5 | Birmingham, AL |
| Monica Jones | Black | Trans woman | 38 | 19 | Tuscon, AZ |
| Priscilla | Black | Trans-identified female | 58 | 27 | San Francisco, CA |

4.3.1 Theme 1: Envisioning joyful, liberated futures in contrast to survival mode

Participants imagined ideal futures for Black trans people characterized by autonomy, peace, and comfort. Several participants expressed desire to build and sustain physical

communities or spaces centered on Black trans people. When asked what her organization would do with unlimited resources, Brianna Coleman said, *“We would buy the hugest amount of land and try to create a damn town for Black trans people. And I know that might sound like some segregation shit, but I’m with it, like create a whole town for me and my brothers and my sisters and my siblings.”* Other participants were working towards similar goals by, for example, constructing tiny homes for Black trans women in Tucson, Arizona; funding motorbikes for Black trans-led shelters in Uganda; and designing a retreat space for Black trans leaders in Birmingham, Alabama.

Participants framed these current projects as steps towards broader visions for Black trans futures. Expanding on the tiny home project, Monica Jones said, *“But then our bigger vision is that we can renovate these old hotels we see on the highway and turn those into long-term or short-term housing and have a trans housing community. A village where it is not just you just gonna stay here, but it’s like, oh, we have a garden, we have access to a gym, we have access to a pool.”* By including amenities that promote relaxation, health, and enjoyment, her future vision extends beyond a world in which Black trans people only have their basic needs met and towards Black trans joy and liberation.

While envisioning Black trans futures, participants consistently defined Black trans joy and liberation as an absence of scarcity and threat. Many participants conceptualized joy and liberation in contrast to personal experiences of hardship. For example, Brianna Coleman said, *“I never wanna have to swing or defend myself again from anyone, and I never wanna be hungry again. I never wanna be cold and I never wanna see my friends outside, and I never wanna be in positions where I know I shouldn’t have to be, but I am there strictly for survival. I don’t wanna live my life in survival, I don’t want my sisters to live our lives in survival. I want us to live our*

life in joy.” For Brianna, violence, food insecurity, housing deprivation, and other threats to survival are antithetical to a joyful life.

Participants described how difficult developing and sustaining a state of joy can be for those living in survival mode because of the internal and external resources required. Specifically, participants identified time, money, housing, mental wellness, and gender affirmation as critical facilitators of joy. Priscilla spoke about expanding case management and holistic wellness services (e.g., life coaching, mindfulness training) to address the needs of her clients who had experienced abuse as children in foster care. When asked how this impacted these individuals, she said, *“Quite a number of them are doing well. They’ve moved out from the SRO [single room occupancy] into a permanent housing. They’ve advanced, some have found employment. Quite a number of people have found employment, are working with other organizations, are also still supporting the communities that they’ve had relationships with when they were unhoused and... participating in different things that could bring joy.”* With some of the pressures of survival mode relieved through the services Priscilla’s organizations offer, these clients can more easily access opportunities for joy.

Participants were clear that anti-Black racism and cissexism are the ultimate barriers to Black trans joy and liberation and the root causes of the violence and trauma that places Black trans people in survival mode. They discussed how liberation requires dismantling the systemic physical, emotional, sexual, spiritual, political, and economic violence that creates the conditions in which Black trans people experience trauma. For instance, in discussing the importance of their organization’s political education initiatives, Devin Lowe said, *“Black trans liberation, the fight for Black trans lives, is a fight for bodily autonomy, right? And it is a political movement. So, when we’re talking about these huge structures that are in place, when we’re talking about*

transphobia and anti-Blackness, this is systematic violence that Black trans people are navigating that has us in the positions that we're in today-- dealing with housing insecurity, job insecurity, health disparities, violence within the medical industry.” Devin contextualizes the situations that threaten Black trans people’s survival within structural transphobia and anti-Blackness to unequivocally name structural violence as the fundamental obstacle to liberation.

Subtheme 1A: Connecting with self, community, and broader social movements.

While acknowledging the existence and impacts of structural violence against Black trans people, participants identified multiple sources of joy for themselves and their communities including practicing mindfulness and spirituality, making art, traveling, deepening community connections, and civic engagement. Dane Edidi described her vision for Black trans futures as a world in which Black trans people have the resources they need to, *“live their most expansive and humane dreams. If you wanna be a doctor, you get to be a doctor... You wanna be an artist, you're an artist. Lives of innovation. I see a world in which geniuses are not starving physically, are now able to have what they need in order to create lifesaving and affirming medical innovations, lifesaving and affirming technologies.”* Her vision acknowledges the multiplicity of ways Black trans people access joy and liberation and contribute to joy and liberation for others.

In many cases, expanding sources of joy was central to the programming, resources, and opportunities organizations offered Black trans communities. Programmatic efforts to promote Black trans joy and liberation strengthened clients’ understanding of their inner experiences, connection to other Black trans people, and engagement with the world around them. For example, Alex Santiago shared how a combined legal gender affirmation clinic and voting registration drive impacted his community: *“This comes into the joy and liberation type thing, because a lot of people had never voted before. We had this particular problem. And just for*

people to call, and we got letters, and we got emails, "Oh my God. I felt in power for the first time in my life," is what one person said. Inherent to this initiative is an underlying vision of a liberated future in which Black trans people have meaningful political power.

In this vein, several participants described how building and strengthening connections with other Black trans people through their work provided a major source of joy in their own lives. When asked what was currently bringing them joy at the start of their first interview, Devin Lowe said, *"Lately, doing more international work with Black trans communities has been bringing me a lot of joy... [International work] has just been feeling really rewarding in a way that it just hits different than doing the work here in the US."* They went onto explain how their collaborations with Black trans organizers and communities in Uganda, Kenya, Cuba, and Jamaica were working towards a future in which Black trans people interdependently provided each other with the skills, resources, and support needed to achieve Black trans joy and liberation globally.

Though most participants were not working internationally, many described similar feelings of joy in building community connections by, for example, developing mentoring and coaching programs for young Black trans leaders; hosting educational community events such as workshops and panels; and sponsoring community dinners, kiki balls, and celebrations. Many organizations operated drop-in spaces or hosted regular casual events to foster joy through community building. For example, Logan Boyd explained how Black trans men in his community in Birmingham, Alabama, are often reluctant to enter trans-only physical spaces where they could be outed and preferred virtual meetings. He shared how these meetings created space for men to let their guards down and be seen and appreciated for their authentic selves adding, *"People who have never been in the same space together, once they do get [on the Zoom*

*call], it's not awkward. You know, it's like, 'I don't know you, but I **know** you.'* Many participants described how these types of Black trans community spaces provide an important source of affirmation that can foster a deeper sense of belonging and security. Brianna Coleman described the connection to joy by saying, *"Real joy, not momentary value things, like my hair makes me feel good, but joy, peace, 'I'm safe.' I can be here and be okay and I'm trans and I love that."* Her comments reflect participants' understandings of Black trans joy as a generative, sustainable tool for personal development and community organizing rather than as a fleeting emotional experience.

4.3.2 Theme 2: Laying groundwork through integrous, liberatory praxis

The choices participants made regarding the internal structures and practices of their organizations were intended to build a foundation for their visions of joyful, liberated Black trans futures. Participants' organizations acted in alignment with the values they espoused such as economic justice, coalition building, and accessibility. They expressed the importance of maintaining integrity on a personal and organizational level. As Monica Jones explained, *"Integrity, I think it's just means... standing by our beliefs and how, if we as an organization believe in social justice, and we wanna hold everybody else up to the standards, that we have to be held up to those standards too. That our work within our own community must be held to those standards."*

Participants demonstrated organizational integrity through decisions such as becoming a 501c3, determining pay scales, defining the scope of their demographic served, and creating pipelines to employment within the organization for those receiving services. For instance, while explaining the choice to not pursue nonprofit status, Donnell said, *"The answer to Black trans thriving is not to have everyone be represented by a 501c3. That doesn't make sense. Because*

that's more government oversight for your life... Why do y'all think this is liberation?" For Donnell and other participants critical of the nonprofit industrial complex, honoring his conviction that state surveillance is incompatible with Black trans joy and liberation was more important than any benefits gained from nonprofit status.

Several participants were leaders of nonprofit organizations, and in general, they shared skepticism about the liberatory potential of nonprofits. Daroneshia Duncan-Boyd said, *"I do think that nonprofit, the infrastructure, is not the actual freedom to Black trans liberation. It does help in a way, but it's not the permanent answer...nonprofits should be a temporary fix to get Black trans folks to the level of achievement for liberation."* For Daroneshia, nonprofits such as hers play a role in attaining Black trans liberation but are not the end goal. She and other participants were critical of nonprofit organizations working in similar arenas whose practices did not align with their stated values, contrasting these organizations with their own organizational practices of transparency, community engagement, and reflection.

Participants also displayed integrity as community leaders through hiring decisions. Several who ran larger organizations with direct social service components emphasized the importance of providing their clients with employment opportunities within their organization. For example, Alex Santiago said, *"[We] just hired one of the clients that lives in the shelter. So we give you a place to stay, but then we give you jobs to help you be able to build and get out on your own."* Alex viewed employment as key to addressing housing challenges among his clients. Other participants emphasized the benefits of hiring current or former clients and framed their histories as strengths. Daroneshia said, *"Those are the same people that can reach the community and they can also appreciate the work because they have received the services and grown with the organization."* For Alex, Daroneshia, and participants operating similar organizations, hiring

from their client base was beneficial for both the organizations' goals and the communities they serve.

Participants also discussed adhering to values of equity and economic justice when deciding whether and how much of a salary to take for their work. After sharing an anecdote about an executive director of another Black trans-led organization taking a six-figure salary while paying staff members poorly, Donnell said, *"I can't have so much that it takes from the mouths of other people that I love and care about and respect."* Donnell's comment demonstrates a commitment to the other Black trans people his organization pays through employment and contract work and a distaste for community leaders that prioritize personal profit.

Subtheme 2A: Selectively navigating available resources and networks. In addition to consciously holding values while designing and growing their organization, participants demonstrated commitments to Black trans joy and liberation when engaging with external entities including funders, fiscal sponsors, and collaborators. Participants expressed strong preferences for working with external entities whose practices were oriented around shared values. For Devin Lowe, one of the key considerations when transitioning from a donation-based model to becoming fiscally sponsored was finding a sponsoring organization whose work also centered Black trans people. He explained, *"When [we] did finally become a fiscally sponsored project, we went with... another Black trans-led organization. And so I was very intentional about trying to make sure that all the money that we were receiving that's meant for Black trans people was continuing to be moved and held by other Black trans people."* As fiscal sponsors routinely take a percentage of grants given to their sponsored organizations, Devin's decision

ensures all grant money his organization receives goes towards serving Black trans people either through his own work or his sponsoring organizations' main projects.

Overall, participants desired mutually beneficial, relational connections built on understanding and trust. Recounting experiences as a BTF grantee, Josiah Ramos said, *“When I apply, I know they’re going to have joy in supporting the work I do. Other organizations, I just know you’re funding us. I don’t know how you feel. You’re just going to ask us to fill out some paperwork about our fiscal sponsorship and the bank information.”* Josiah’s discomfort with the mechanistic nature of most financial proceedings reflects participants’ overall disinterest in purely transactional collaborations. Participants wanted to know that the individuals, organizations, and institutions they collaborated with valued their work and experience. When recounting a recent speaking engagement at a prestigious university, Priscilla shared, *“They want me there because I am a Black trans woman... [The university] knows exactly who I am. They know I don't have no academia background. I don't have no college background, but they were specifically like when we were doing this thing, everybody wanted you.”* The relationship she and the university built with each other allowed her to feel comfortable entering academic spaces—generally inaccessible, often hostile environments for Black trans people— as a respected leader.

Furthermore, participants were not hesitant to end professional relationships that were patronizing, dishonest, or compromised their commitments to their organizations’ values. For example, Alex Santiago shared: *“I actually turned down funding from this one particular organization when I researched them and I saw what they were about... I reached out to somebody else who is familiar with that organization. They was like ‘They want you to be their token. It makes them look good if they have this Black organization as part of their [grantees].”* Other participants shared about refusing efforts to change organizations’ programming or

missions to be more aligned with funders' goals. Daroneshia Duncan-Boyd advised, *"You have to be mindful, and you have to be ready to give pushback because at any given chance, these funders will try to manipulate your organization into something they want it to be."* For these participants, maintaining their organization's integrity took precedence over securing all available funding for their work.

4.3.3 Theme 3: Prioritizing safety and healing

Though the organizations that participants led varied considerably in their demographic served, resources, capacity, and programming, they showed a common focus on Black trans people's safety and healing as a path towards joy and liberation. Some organizations prioritized safety and healing by focusing specifically on Black trans populations with an extreme burden of trauma. For example, Priscilla shared that all people her organization serves have been incarcerated, experienced police or correctional officer violence, and been in physically abusive relationships. She continued, *"Quite a number have been kicked out of many organizations because people are angry, and if you hear those stories and their narratives, their anger is valid. The thing that we have to do is try to help them minimize that anger so they don't be left out."* Priscilla's commitment to this population necessitates a trauma-informed approach to services that validates people's prior experiences and creates a safe, healing environment.

Other participants approached safety and healing from trauma rooted in racism and cissexism from a broader angle. For example, Dane Edidi's organization works to counter White supremacist Christian ideology by advancing Black trans liberation theology. She shared how the healing workshops they offer are, *"some of the first places in which some trans folks are told that they are divine and that they do have the right to love. And that all the transphobic shit that's been said about them [in religious contexts] are lies. And that whether they believe in God or*

not, they have the right to thrive. And I think that when people know they deserve more, they demand more.” The focus on healing from religious trauma and spiritual violence builds Black trans people’s capacities for self and community advocacy. Healing is achieved in part by envisioning thriving Black trans futures as the goal rather than persistence or resistance.

Both Priscilla and Dane’s work addresses needs commonly overlooked by other health and social services. Unique needs other organizations addressed included physical safety while traveling, reproductive justice, and navigating masculinity for Black trans men. Logan Boyd explained the importance of dedicated community spaces for Black trans men saying, *“We don't have all transmasculine spaces, especially all Black transmasculine spaces and healing spaces, where we can go and just pull down the mask, reveal who you really are and just be yourself and work through some stuff... A lot of it is just embedded in us through our trauma, you know what I'm saying? Just for being Black, for spending a large part of your life being a Black woman in America and then transition to... being a Black man in America.”* Logan’s implicit understanding of how racism, sexism, and cissexism increase the likelihood of experiencing trauma for Black trans men in America motivated him to create safe, affirming environments and opportunities for members of his community to acknowledge and process their experiences.

Participants discussed safety and healing as foundational to all aspects of Black trans futures including health, economic security, and cultural development on a community level. Brianna Coleman used her own experiences to explain the impacts of intergenerational community trauma. When asked what she wished for her younger self, she said, *“I wish that I had [older] Black trans women that were safe...since they wasn't safe, there was things that they installed into me that I have adopted as safety, but now that I am older, I no longer want that and I no longer want to teach that to other girls.”* She later clarified that she wanted her community

to value interdependence over self-sustainability and gender self-determination over passability, observing how these values are the community-level responses to violence against Black trans people. Paths towards Black trans joy and liberation therefore require interrogating, unpacking, and addressing communally held trauma.

4.4 Discussion

This study aimed to understand how Black trans community-based organizations cultivate joy and liberation through their work by centering Black trans community leaders' expertise. As such, this research recognizes participants as authorities in understanding and mitigating the health inequities and structural vulnerabilities impacting their communities. The resultant themes exemplify Black liberatory fantasy and provide guidance on how to reach joyful, liberated Black trans futures. Therefore, our findings offer public health and allied fields an opportunity for critical reflection on whether, how, and to what end Black trans people and Black trans futures are conceptualized, involved, and prioritized in our work.

The findings from this study reflect the potential of counternarratives for health equity research (Ford & Airhihenbuwa, 2018). Across themes, the results demonstrate how Black trans leaders use counternarratives based in Black liberatory fantasy to define and pursue their goals for their organization and Black trans communities overall. Participants' dreams for Black trans futures are strategically disengaged from ideas of resistance, struggle, suffering, and death that underlie dominant narratives about Black trans existence (Mack, 2023; Snorton & Haritaworn, 2022). This is not to say participants dismissed how structural violence impacts their communities; rather, their deep awareness of this violence and radical hope for its end informed all aspects of their work. This was particularly evident in participants' common focus on safety and healing from trauma. Prioritizing safety and healing both acknowledges the root causes of

the literal and symbolic violence impacting Black trans communities (e.g., the prison-industrial complex, White Christian nationalism, transmisogynoir) and disrupts the intended impacts of this violence. Ultimately, these counternarratives have important implications for research and intervention development that seeks to promote health equity among Black trans people.

First, the counternarratives elicited through these interviews subvert majoritarian deficit narratives about Black trans people, including those sustained by public health research and practice. A future in which Black trans experiences are characterized by autonomy, peace, and comfort expands beyond what majoritarian public health scholarship imagines for Black trans people: lives of resiliently enduring hardship, resisting oppression, and behaving in ways unlikely to lead to or transmit disease and mental illness (Li, Fabbre, & Gaveras, 2023; Scheim, Baker, Restar, & Sell, 2022; Suslovic & Lett, 2023). More broadly, the themes generated in this study position Black trans people as active participants in the making of Black trans futures rather than targets of White supremacy and cissexism. This study thus invites public health and allied fields to likewise consider Black trans joy and liberation as a critical means of and narrative frame for understanding and pursuing health and social equity (Krieger, 2020).

These counternarratives also lend credence to use of the structural trauma framework to understand health inequities impacting Black trans people. On the surface, the structural trauma framework may seem incongruous with centering Black trans joy and liberation as it is primarily concerned with how structural forms of oppression socially pattern trauma (Ruiz, 2020). However, the themes generated in this study demonstrate the importance of understanding the historical roots of contemporary barriers to Black trans joy and liberation. For example, participants described how a degree of critical distrust in philanthropic relationships was necessary to their work, and they expressed strong preferences for working with funders whose

values aligned with their own. Viewed through a rationalist performance mindset, participants' selectivity regarding the funding they would accept could be interpreted as financially inefficient and socially irresponsible to communities 'in need' (Mirabella, 2014). However, viewed through the structural trauma framework, this high degree of discernment can be interpreted as a logical response to the historical legacy of White supremacy in philanthropy and non-profit organizations, which functions to depoliticize Black and trans organized movements and preserve extant social hierarchies benefitting White and cisgender people (Ojeda & Wall, 2021; Redwood, 2023; Spade, 2015b). Participants' commitments to liberatory praxis thus cultivates Black trans liberation by countering the neo-liberalization of community organizing that demands adherence to business, bureaucratic, and entrepreneurial values over community values (Thibault, 2007).

Furthermore, the themes generated in this study have important implications for developing structural interventions to reduce health inequities impacting Black trans populations. In particular, Black trans leaders' prioritization of safety and healing aligns well with recommendations for structural interventions to be disease agnostic (A. F. Brown et al., 2019). Definitions and conceptualizations of safety and healing are expanding beyond the individual and interpersonal levels of the social ecological model to encompass broader structural elements of safety (Cowan, Dill, & Sutton, 2022; Rodriguez, Rakes, Healy, & Ben-Moshe, 2022; Slavich et al., 2023). While little research has examined the relationship between health outcomes and safety or healing at more macro levels, recent theoretical work posits that social safety influences behavioral, mental, and physical health outcomes through multiple biopsychosocial pathways (Diamond & Alley, 2022). This suggests that structural interventions to promote Black trans

people's safety in their families of origin, schools, communities, and the political sphere may have impacts on health equity across multiple health domains.

Finally, our findings suggest that intervention development must move beyond the concept of “authentic engagement” with Black trans communities. Many recommendations for developing structural interventions include some aspect of community engagement (Agurs-Collins et al., 2019; A. F. Brown et al., 2019). Findings from this study suggest that community leadership or participatory action approaches may be better suited to developing promising structural interventions. This is in contrast to typical partnership approaches that do not acknowledge and actively destabilize the inherent power differential between Black trans community members and academic researchers, public health practitioners, and policy makers regardless of identity (McCloskey, Aguilar-Gaxiola, & Michener, 2011; Wallerstein, 2020). Each of the participants in this study demonstrated expertise in understanding and addressing inequities their communities face. Because public health has both neglected and stigmatized Black trans people (Lacombe-Duncan et al., 2022; Poteat, van der Merwe, Sevelius, & Keatley, 2021; Singer, 2015), acknowledging this expertise by supporting community-led initiatives with research infrastructure, skills, and funding may more effectively work towards health equity than researcher-initiated projects (Krieger, 2020).

4.4.1 Strengths and Limitations

The primary strengths of this research lie within the community partnership between BTF and academic researchers. This partnership was critical to developing research aims, study protocols, and themes with relevance to both Black trans communities and public health as a field. Importantly, this partnership also facilitated trust and relationship building between the academic researchers and participants. As an example, one Black trans leader said she would not

have been interested in participating without BTF's endorsement of the study, and many remarked on how they were pleasantly surprised by the content of the interviews. However, because the participants were selected from BTF's pool of grantees, these results do not reflect the ideas or experiences of Black trans leaders outside of BTF's networks.

Conducting second interviews ensured that participants had the opportunity to review and provide feedback on study findings, enhancing credibility. However, these results should be interpreted within the context of the interviews. That is, the data collected contained only what participants were willing to and felt was important to share with a White graduate student. Given that academic research has a long and continuous history of exploited, mischaracterizing, and ignoring the concerns of Black people, trans people, and Black trans people, it is likely that participants tailored their answers to avoid this.

Finally, the results presented in this paper reflect a portion of the insights gleaned through these interviews. I chose to present three themes that spoke directly to the primary research aims to ensure they had adequate consideration. We plan to conduct and disseminate further analyses to develop additional themes that relate to other aspects of Black trans leaders' work not represented here.

4.4.2 Conclusion

In partnership with BTF, I used counternarrative as a critical methodology to understand how Black trans leaders envision and cultivate Black trans joy and liberation. The themes that I constructed directly contest majoritarian deficit narratives (e.g., individual risk behaviors, resiliency) regarding health inequities impacting Black trans communities. Centering Black trans joy and liberation makes apparent both the structural vulnerabilities Black trans communities experience and community-led initiatives to address and eliminate them. The results of this study

support continued efforts to shift public health and academic research towards understanding and intervening upon the structural determinants of inequities impacting Black trans populations and to support Black trans leaders' initiatives to prioritize safety and healing for their communities. Efforts to promote health equity and overall wellbeing among Black trans populations may be most effective if they are informed by and aligned with communities' values and planned, implemented, and evaluated via Black trans leadership.

Chapter 5 Conclusion

This dissertation sought to critically examine structural drivers of health inequities impacting trans people of color in the United States. Together, the three studies detailed in Chapters 2-4 demonstrate how integrating critical theories from multiple disciplines to pursue this goal directs attention to the historical roots of health inequities and the contemporary systems that maintain them. By moving from intercategory intersectionality (Study 1, Chapter 2) to intracategory intersectionality (Study 3, Chapter 4), this dissertation reveals numerous mechanisms through which structural racism and cisgenderism intersect to manufacture the social, economic, and political conditions that foster health inequities. In this concluding chapter, I summarize the major findings and contributions of each study. I then discuss this dissertation's overall contributions to trans health research, directions for future research, and noteworthy limitations. Finally, I conclude by reflecting on the broader significance of this work for public policy efforts to promote health equity for trans people of color.

5.1 Dissertation Summary

In Study 1 (Chapter 2), I examined differences in the prevalence of adverse childhood experiences (ACEs) and the association between ACEs and poor health between trans people of color and 5 comparison groups: White cisgender men, White cisgender women, White trans people, cisgender men of color, and cisgender women of color. The findings partially supported my hypotheses that trans people of color would have a significantly higher prevalence of all ACEs than comparison groups and that the association between ACEs and self-reported physical and mental health would be stronger among trans people of color than comparison groups. I

found that trans people of color had an elevated age-adjusted predicted probability of 6 ACEs in relation to at least one comparison group: household alcoholism, household incarceration, domestic violence, physical abuse, verbal abuse, and sexual abuse. Furthermore, the average marginal effect of 5 ACEs on self-reported poor mental health was stronger for trans people of color than at least one comparison group. These ACEs included household mental illness, household alcoholism, household drug use, domestic violence, and verbal abuse. However, there were no race/ethnicity/gender differences in the relationship between ACEs and poor physical health.

This study demonstrates intercategorical intersectionality's potential for documenting inequities impacting groups marginalized along multiple axes of identity such as trans people of color (McCall, 2005). The inequities documented in this work may not have been detected in analyses using more broadly defined comparison groups (e.g., collapsing cisgender participants, collapsing White participants). For example, in comparison to trans people of color, cisgender men of color had a significantly lower age-adjusted predicted probability of three ACEs (i.e., household mental illness, household incarceration, and sexual abuse) while White cisgender men had a significantly lower predicted probability of five ACEs (i.e., household alcoholism, household incarceration, domestic violence, physical abuse, and sexual abuse). Combining these comparison categories into a "cisgender men" category while statistically controlling for race/ethnicity may have masked these differences. Thus, the level of specificity inherent to intercategorical intersectionality more precisely identifies inequities than comparisons across a single axis of identity.

Additionally, interpreting these multiple comparisons through a structural trauma framework directs attention to systems that perpetuate surveillance, control, and punishment for

trans children and emerging adults of color and their families. The structural trauma framework extends recent theorizing on ACEs, which calls for greater attention to how historical and contemporary structural racism influences their distribution by implicating the Western colonial gender system (Bernard et al., 2021). Structures that enforce this gender system include child welfare, education, healthcare, and the criminal-legal system. The results of this study therefore suggest that trans children of color's experiences within these systems deserve greater attention and that restructuring and/or dismantling these systems may promote safety for trans children of color.

In Study 2 (Chapter 3), I moved towards intracategorical intersectionality by examining racial/ethnic differences in the association between trans-related state policies and the self-rated health of trans women in 29 U.S. states. I hypothesized that access policies would have a stronger association with health for trans women of color than for White trans women and that the reverse would be true for equality policies. While race/ethnicity did moderate the relationship between these policies and health, both types of policies were associated with worse health for trans women of color and better health for White trans women. These unexpected findings suggest that access and equality trans-related policies may widen racial/ethnic health inequities within the trans population.

Comparing racial/ethnic differences within a single gender category complicates existing narratives regarding the relationship between trans-related policies and health. Most previous research on this topic suggests that policies designed to protect trans people improve trans people's health on a population level while exclusionary policies worsen health, lending support to liberal policy agendas that purportedly attempt to address inequality by expanding legal rights (Drakeford, 2018; Du Bois et al., 2018; Goldenberg et al., 2020a, 2020b; L. Hughes et al., 2021;

Ledesma & Ford, 2020; McDowell et al., 2020; Reisner et al., 2015). However, the results of this study suggest that policy efforts to reduce health inequities impacting trans people of color will not be effective if they are oriented around rights expansion or fail to remove barriers to needed resources (e.g., healthcare) for structurally vulnerable trans populations (Spade, 2015c). Rather, access and equality policies may perpetuate health inequities by differentially benefiting White trans people. This study therefore demonstrates how combining intercategorical and intracategorical approaches to intersectionality lends critical nuance to seemingly established understandings about the relationship between trans-related policies and health.

In Study 3 (Chapter 4) I partnered with the Black Trans Fund (BTF) to conduct a qualitative study exploring how Black trans leaders of community-based organizations cultivate Black trans joy and liberation through their work. The themes that I constructed from interviews with community leaders via reflexive thematic analysis counter majoritarian narratives rooted in deficit understandings of Black trans communities. Findings highlight Black trans leaders' use of liberatory fantasy to envision and orient their work towards autonomous, comfortable, and peaceful Black trans futures.

This study employed intracategorical intersectionality. While participants represented a diverse array of racial, ethnic, and gender identities, they were all categorized as “Black” and “trans” for the purposes of this study and BTF’s grantmaking work. Unlike either quantitative study, this study did not aim to compare across categories of identity or positionality. Rather, the singular focus on Black trans people highlights some of the ways Black trans communities and organizations evade and contest White supremacy and cissexism. In addition to liberatory fantasy, this included strategic disengagement with deficit thinking, distrust of neoliberal and capitalistic economic and political systems, and prioritization of safety and healing. For example,

participants explicitly critiqued the nonprofit industrial complex and philanthropy, describing how these systems allow entities which are not authentically invested in Black trans joy and liberation to funnel resources from and exploit Black trans organizations. Aiming to better understand how Black trans leaders cultivate Black trans joy and liberation thus exposed how systems not often interrogated in public health research perpetuate racism and cissexism with unique consequences for Black trans communities.

5.2 Research Contributions

Collectively, these studies contribute to the theoretical and methodological foundations of trans health research with implications for health equity research more broadly. All three studies used conceptual tenets of and analytic approaches to Critical Race Theory, demonstrating the utility of applying this intellectual tradition in public health research (Ford & Airhihenbuwa, 2018; Graham, Brown-Jeffy, Aronson, & Stephens, 2011). Though trans studies scholars in the humanities have long drawn from and extended Critical Race Theory for inquiries into trans people of color's lived experiences and positionality (Radi, 2019; Richardson & Meyer, 2011), the studies comprising this dissertation are among the first to use multiple tenets of Critical Race Theory to ground public health research on health inequities impacting trans people of color.

First, these studies demonstrate the value of using multiple analytic intersectionality approaches when researching health inequities impacting structurally vulnerable populations (Bowleg, 2021; Merz et al., 2023). Study 1 (Chapter 2) and Study 2 (Chapter 3) take quantitative approaches to intercategory intersectionality. The methods rely on statistical analysis typically associated with positivism and occasionally deemed incompatible with Critical Race epistemologies (Ford & Airhihenbuwa, 2018). I broach this divide by interpreting the results using theoretical frameworks concerning the structural production of inequities: structural trauma

and structural vulnerability (Quesada et al., 2011; Ruiz, 2020). Applying these theories to quantitative intercategorical analysis centering race and racism aligns with Critical Race Theory's overarching purpose of revealing and undoing the permanence, ordinariness, and persistence of structural, systemic racism (Delgado & Stefancic, 2017). More specifically, the results of these studies draw attention to how racism embedded in the systems intended to protect children from harm (i.e., education, child welfare, healthcare, social services) and trans-related state policies may drive health inequities impacting trans people of color across the life course.

Placing the findings from Study 3 (Chapter 4) in conversation with the two quantitative studies illustrates the capabilities of intracategorical approaches to intersectionality. In interviews, Black trans leaders of organizations serving Black trans communities expounded on specifics of how the systems implicated in Study 1 (Chapter 2) manufacture Black trans suffering. For example, Priscilla shared about how her organization had recently expanded case management and holistic wellness services to address the traumatic effects of institutional abuse impeding her clients' abilities to live safe, joyful lives, naming foster care and prisons as key sites of violence against Black trans people. Regarding the findings on the relationship between trans-related state policies and self-rated health from Study 2 (Chapter 3), it is notable that participants' visions for Black trans futures and their organizations' approaches to achieving them bore little relation to the policies included in this analysis. This could be because I did not ask all participants to share their perspectives on how trans-related policies could cultivate Black trans joy and liberation, but it may also indicate that these leaders do not consider trans-related policies to be the most critical pathways for addressing their communities' priorities or structurally vulnerabilities. Their organizations' efforts were instead focused on promoting safety and healing. Thus, this intracategorical intersectionality approach adds detail to the conclusions

drawn from the intercategorical analyses and insight into what community leaders may consider effective avenues through which to pursue health equity for Black trans people.

In addition to intersectionality, these studies demonstrate how tenets of Critical Race Theory less commonly transferred to public health can support health equity research. In particular, Study 2 (Chapter 3) showcases how Critical Race Theory's critique of liberalism (Freeman, 1995) can be empirically applied via public health methods for policy evaluation. Previous studies evaluating the associations between trans-related policies and health have based hypotheses in assumptions that "protective" trans-related policies will benefit trans population health and "exclusionary" trans-related policies will harm trans population health (Drakeford, 2018; Du Bois et al., 2018; Goldenberg et al., 2020a, 2020b; L. Hughes et al., 2021; Ledesma & Ford, 2020; McDowell et al., 2020; Reisner et al., 2015). This study demonstrates how questioning the liberal logic inherent to these hypotheses shifts inquiry from *whether* trans-related policies influence health to *how* and *for whom* they influence health. Given Study 2 (Chapter 3)'s findings that supposedly protective trans-related policies were associated with worse health only for trans women of color in the sample, trans health research must make this shift to avoid perpetuating health inequities. Additionally, these findings suggest that trans health research should attend to how policies that most strongly uphold White supremacy by shaping the criminal-legal system, economic systems (e.g., credit, employment) immigration, education, and housing relate to racial health inequities within trans communities (Agénor et al., 2021).

Furthermore, Study 3 (Chapter 4) demonstrates how Critical Race Theory's methodology of counternarrative can elicit and develop alternative frameworks for understanding health inequities (Ford & Airhihenbuwa, 2018; Petteway, 2022; Solorzano & Yosso, 2001). In particular, the results of this study suggest that intentional distancing from deficit narratives may

help public health better align with community-led efforts to achieve equity for Black trans communities. Developing public health initiatives centered on Black trans joy and liberation through community-led research partnerships may be more acceptable and more effective than those concerned with resilience and behavior change. Ultimately, this study demonstrates how counternarrative's potential to expand, shift, critique, and improve theoretical and material approaches to promoting health equity.

5.2.1 Future Directions

The contributions this dissertation offers suggest that further research guided by critical theory can continue to uncover, interrogate, and dismantle structural drivers of health inequities impacting trans people of color. In addition to Critical Race Theory and the structural trauma and structural vulnerability frameworks underlying this work, existing theories that grapple with how social hierarchies, structures, and histories explain health inequities that may be useful to integrate into this work include ecosocial theory, structural violence, and the political economy of health (Harvey, 2020). Additionally, trans scholars of color in the humanities and social sciences have amassed a large body of literature applying, extending, and developing new critical theories through analysis of topics adjacent to trans health, trans medicine, and trans population studies including media depictions of Chicana trans death (Galarte, 2021b), Whiteness and transnormativity in trans political organizing (Hsu, 2024), and the historical medical archive of Black transness (J Gill-Peterson, 2018). Integrating applicable lessons from this work into trans health research may fortify the intellectual and historical basis from which researchers conceptualize and conduct studies.

This dissertation also provides specific methodological suggestions for future research endeavors. Foremost, future research should resource, support, and learn from community

leaders and existing community-led initiatives to uplift trans communities of color. Study 3 (Chapter 4) provides one example of how such research could be conducted. Importantly, this study deeply engaged with Black trans epistemology by orienting around BTF's ethos of Black trans joy and liberation. While qualitative methods facilitated this type of community engagement, quantitative studies grounded in critical theories and conducted in partnership with community leaders may also achieve this goal. For example, as population health initiatives expand their use of validated methods for collecting gender identity data, community leaders can guide researchers in developing research questions, analysis plans, and interpretation of findings that will produce insights that can facilitate their work and hold meaning for their communities.

Findings from this dissertation as a whole highlight the need for better understandings of trans people of color's experiences in schools, the child welfare system, the criminal-legal system, public benefits systems, and nonprofits (as both employees and service users), how these experiences influence population health, and what role government policies play. Cohort studies are particularly needed to provide evidence for causality in the relationship between features of these macro-level systems and health. Partnering with community leaders will aid development of specific research questions and feasible study protocols that can address these sizeable gaps in the literature on health inequities impacting trans people of color.

5.3 Limitations

In addition to the limitations present in the design of each study detailed in Chapters 2-4, notable limitations permeate throughout this dissertation and provide additional opportunities for future research. First, I attempt to speak to health inequities impacting trans people of color on a population level while lacking population-representative data. The BRFSS data used in Study 1 (Chapter 2) is intended to be nationally representative of the community-dwelling adult

population of the United States (CDC, 2023). However, because only a subset of states used the SOGI, ASAB, and ACEs modules each survey year, the results cannot be generalized beyond the analytic sample. The LITE data used in Study 2 (Chapter 3) is a large convenience sample of trans women living only in the Eastern and Southern U.S. Therefore, the results lack geographic generalizability and do not represent other trans populations. The qualitative method and research aims forming the basis of Study 3 (Chapter 4) do not demand generalizability or representativeness; however, narratives from Black trans leaders of organizations supporting Black trans communities likely do not resonate with those of other communities of trans people of color. While each study makes important contributions to public health's understanding of structural drivers of health inequities impacting trans people of color, better collection of gender identity data in large health surveillance projects is needed to strengthen the evidence base for many of the claims I make in this dissertation (Kronk et al., 2022; Lett & Everhart, 2022).

In part due to limitations of existing data, a second major limitation of this dissertation is the overgeneralization of racial, ethnic, and gender categories. In both Study 1 (Chapter 2) and Study 2 (Chapter 3), I use “people of color” as an analytic category, obscuring participants' specific racial and ethnic identities and homogenizing White supremacy's disparate impacts on distinct racial and ethnic groups. In Study 1 (Chapter 2), I treat gender similarly by combining trans women, trans men, and trans gender non-conforming participants into a singular “trans” category. To a lesser extent, I also did this in Study 2 (Chapter 3) by categorizing all participants as trans women rather than analyzing the data on their specific gender identities (i.e., trans feminine, woman of trans experience). My decisions around operationalizing race, ethnicity, and gender throughout this dissertation were intended to uncover mechanisms of racism and intersecting oppressions. However, these decisions also risk strengthening the use of these

categories as a means of producing rather than critiquing inequality (McCall, 2005). With advances in gender identity data collection, future research using intercategorical intersectionality approaches will be better positioned to avoid this limitation, sharpening understandings of health inequities among trans people of color and better tailoring recommendations for remedying them.

A final major limitation of this study is the use of self-reported general health measures as the primary outcomes in Study 1 (Chapter 2) and Study 2 (Chapter 3). These measures are established predictors of many clinical outcomes and mortality, and they are widely used as outcomes in studies assessing the impact of social determinants of health (DeSalvo, Bloser, Reynolds, He, & Muntner, 2006; Wind et al., 2023). Because self-reported general health measures reflect a range of potentially underlying health conditions, their use is also appropriate for research examining structural determinants of health. Recommendations for designing structural interventions to reduce health inequities suggest using a disease-agnostic evaluation approach, which addresses many conditions at once by altering common antecedents (A. F. Brown et al., 2019). However, no studies have validated use of these measures in trans health research. Research on the burden and structural drivers of more specific health outcomes including cardiovascular disease, metabolic diseases, mental health conditions, and cancer among trans populations of color is urgently needed (Farvid et al., 2021).

5.4 Implications

The findings from the studies contained in this dissertation have important implications for structural efforts to address health inequities impacting trans people of color. The implications detailed below center on public policy change via government action. I have aimed to maintain alignment with the transformative goals of critical trans politics and critique,

especially those Black and Latinx trans people have articulated within and outside of the academy (Q. D. Alexander, 2023; Bradford & Stephens, 2021; Hwang, 2022; Jenkins, 2023; Spade, 2015c). I draw these implications cognizant of these intellectual movements' shared understanding that increased government surveillance, regulation, and recognition of trans people upholds racialized neoliberalism under the guise of inclusivity (Galarte, 2021c; Spade, 2015c).

First, the findings across this dissertation highlight how the criminal-legal system interlocks with multiple other systems that structure trans people of color's lives beginning in childhood. The overall findings from Study 1 (Chapter 2) implicated systems charged with protecting children in the inequitable distribution of ACEs, all of which have direct ties to the criminal-legal system: schools, child welfare, and healthcare. Links between these systems foster policing, family and community separation, and incarceration for trans people of color and their families, likely contributing to the disproportionate prevalence of ACEs and stronger association between ACEs and adult mental health. Of note, trans people of color had a significantly higher predicted probability of having a member of their household incarcerated during childhood than any other race/gender/ethnicity group. Dismantling the carceral logic underpinning these systems through reparative policy change could reduce the prevalence of ACEs and lessen their mental health repercussions among trans people of color.

Policies that promote safety, wellbeing, and community care for trans children of color align well with Black trans community leaders' focus on safety and healing described in Paper 3 (Chapter 4). Participants described various strategies their organizations use to address trauma stemming from childhood experiences of religious and spiritual violence, domestic violence, foster care, and family rejection. Policies indicated to prevent these forms of childhood adversity

include publicly funded nutrition and housing assistance programs, tax credits, childcare subsidies, and school-based policies that promote social gender affirmation and shield trans students from violence, harassment, and outing (Forston et al., 2016; Metzler et al., 2017; Philbin et al., 2023). With the exception of the school-based policies, strengthening these programs would have broad reverberations for multiple other structurally vulnerable groups including people living in poverty, immigrants, disabled people, and Indigenous people (Spade, 2015a).

Participants in Study 3 (Chapter 4) also identified structural vulnerabilities facing Black trans communities across the life course that could be addressed in part by many of the same policies that foster safe, nurturing environments for children. Structural vulnerabilities participants' communities faced included housing deprivation, joblessness, poverty, food insecurity, violence, and lack of access to medical and legal gender affirmation. Alleviating these vulnerabilities was a central focus of several organizations' work. Therefore, effective policy change would lessen demand for the services currently oriented towards supporting Black trans people in "survival mode," allowing leaders and organizations greater space to proactively work towards their visions of joyful, liberated Black trans futures.

Results from Study 3 (Chapter 4) indicate that existing public services intended to address survival needs are not adequately reaching Black trans communities. Like the trans-specific "access policies" analyzed in Study 2 (Chapter 3), the policies structuring public programs granting housing, food, employment, and income support differentially uplift White beneficiaries (Kolivoski, Weaver, & Constance-Huggins, 2018; Limbert & Bullock, 2016; Sledge, 2022). Furthermore, several participants described how other organizations—usually larger nonprofit organizations—likewise fail the most structurally vulnerable Black trans people. For example, participants discussed challenges associated with meeting the needs of Black trans

people who had been denied access to other organizations' services due to behavioral health challenges stemming from trauma. While increased funding and resource provision to public and third-sector programs may address social determinants of health for many trans people, results of this dissertation support the need for continued evaluation and transformative restructuring of these systems to ensure they mitigate rather than perpetuate health and social inequities impacting structurally vulnerable trans people of color.

5.5 Closing Remarks

I don't actually need intersectionality in the sense of 'let me bring a trans perspective.' In fact, I need us to set aside the specialness of bringing a trans perspective and go back to the long tradition through which we can critique and understand minutely the racial and colonial logic of this system.
Jules Gill-Peterson (Shah, Shon, Reder, & Gill-Peterson, 2022)

The above quote comes from a roundtable discussion in which four scholars of color representing different disciplines reflected on contemporary uses and relevance of Critical Race Theory. Gill-Peterson, a self-described "rare trans woman of color in the academy" (Jules Gill-Peterson, 2023), posits in this quotation and throughout her contributions that trans studies research concerned with trans people of color needs to ground itself in existing intellectual traditions examining racism and colonialism (Shah et al., 2022). In this dissertation, I have attempted to do so by approaching research questions concerning health inequities affecting trans people of color using Critical Race Theory as a theoretical and methodological guide.

The conclusions from this dissertation implore trans health research to intellectually engage with and disrupt the structural determinants of health inequities impacting trans people of color. The studies comprising this work demonstrate some possible ways to pursue this goal: intercategory and intracategory approaches to intersectionality that center race and racism, use of counternarrative as methodology, and community-academic partnerships that seek to learn from and give power to community leaders' expertise. Such approaches are needed for public

health research to become truly accountable to trans communities of color and avoid protecting Whiteness by prioritizing issues of recognition and inclusion in existing neoliberal systems (Shah et al., 2022).

Finally, this research serves as a reminder of the importance of engaging with the critical discourses around root causes of health inequities in the United States when making epistemological and methodological decisions for health equity research more broadly (Bowleg, 2017). Such engagement will result in research that more meaningfully contributes to dismantling the political, social, and economic systems that precipitate health inequities than research based on unexamined assumptions, which often reflect a White racial frame (Bowleg, 2017, 2023; Feagin, 2020). Building equitable partnerships between academic researchers and community members, leaders, and organizations in tandem with critical analysis of the interplay between scientific evidence and political power to drive recommendations for sustainable change (Freudenberg & Tsui, 2014; Nnaji, Smith, Daffin, Wallace, & Hopkins, 2022).

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