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From Trauma to Transformation: the Role of the Trauma Surgeon in the Care of Black Transgender Women

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Abstract

Purposeof Review To describe 4 primary areas of trauma experienced by black transgender women, resilience demonstrated by the community, and opportunities for trauma surgeons to better serve this community.

Recent Findings Transphobia, racism, and misogyny place black transgender women at high risk for mistreatment in the workplace, criminal legal system, and community spaces. These experiences of social exclusion and trauma facilitate social isolation and reduced engagement with necessary services, like healthcare. Furthermore, many black transgender women do not seek care due to experiences of racial and gender microaggressions. As such, it is necessary that medical professionals who engage this community provide culturally responsive care.

Summary Black transgender women seeking care will likely present after having experienced significant social rejection as well as mental and physical traumas. Accordingly, medical professionals who engage them must be considerate of the impacts of their unique experiences when providing them care.

Keywords Transgender women · Trauma · Intersectionality · Violence

Introduction

Black transgender women (people who were assigned male sex at birth but currently identify as women) in the USA navigate a world where they are impacted by intersecting experiences of marginalization [1–3]. At once, they navigate the experience of being a racial minority, a woman, and a transgender person. Although these identities are not in themselves negative, they are often marginalized in US society, and therefore, black transgender women (TW) must contend with transphobia, e.g., mistreatment and discrimination due to their transgender identity that is compounded by the impacts of sexism and racial discrimination [4–8]. Moreover, because the experience of being black is impacted by one's gender identity (i.e., black women and men experience both shared and unique forms of discrimination), trans individuals of color must adapt to changing perceptions of both their gender and racial identities when transitioning, along with the stigma these new perceptions bring [9]. To capture this complex co-constituted phenomenon, this experience has been termed *transmisogynoir*, a combination of the words "transphobia" and "misogynoir" (the discrimination experienced by black women) [2, 10•]. Transmisogynoir attempts to capture—in one word—the range of traumatic experiences black transgender women (TW) encounter due to the ways their identities are construed by society.

Transmisogynoir extends beyond interpersonal experiences of discrimination, pervading social structures, and institutions such as healthcare, education, housing, employment, imprisonment, and policing. Thus, it is not only that intersectional identities present multiple vectors of interpersonal marginalization, but intersecting, entangled, and intractable social structures work in tandem to produce vectors of trauma, violence, and marginalization respondent to these complex identities [11–14]. Despite structurally comparable social networks, black TW face greater sexual health and systemic burdens compared to black men who have

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sex with men [15]. In navigating these experiences, black transgender women are often more likely to be exposed to violence and trauma [12, 13, 16]. For example, a qualitative study focused on the familial experiences of black and Latina transgender women found that, while a subset of women had at least one relative respond with warmth, most of the interviewed women had experienced verbal and physical abuse from family after coming out as transgender [17].

Given that structural factors, like transmisogynoir, have significant impacts on the health of black TW and the experiences of trauma they encounter, a lens of structural competency lends itself well to improving the quality of care provided to this community. Structural competency posits that inequalities in health must be conceptualized in relation to the institutions and social conditions that determine health-related resources [18]. This lens presents an opportunity for trauma surgeons to better serve black TW by building a deeper understanding of the complex contexts in which they live. In the sections that follow, we will examine 4 primary areas of trauma for black TW: (1) economic precarity and unemployment, (2) the carceral state, (3) community and interpersonal violence, and (4) health and healthcare. Then we will explore the resilience demonstrated by black TW and recommendations for trauma surgeons serving this community.

Economic Precarity and Unemployment

Black TW encounter substantial barriers to stable employment. Of the black TW who participated in the 2015 US Transgender Survey, 22% were unemployed, 26% reported having lost their jobs due to their gender identity, and 47% reported being fired, denied promotion, or rejected from a job due to their gender identity, the largest proportion of any racial group [6]. Due to workplaces that are either overtly transphobic (e.g., unwilling to hire trans individuals; staff who harass trans individuals) or implicitly unsafe for trans employees (e.g., no supports for trans employees, like cultural competency training for staff, acknowledgment of gender pronouns, repercussions for mistreatment of trans employees), many black TW transition between jobs quickly, never having the opportunity for vertical progression, or are relegated to informal economies which may have less stability, e.g., doing hair or makeup outside of a salon setting; sex work [6, 19–21].

Given that sex work is illegal across most of the USA and sex workers are often held in low esteem by the public [22], sex work places black TW at elevated risk for encountering physical harm. These women may be confronted by violence from clients and often cannot trust the police to protect them if they experience physical or sexual assault, as some police are violent clients or engage in gender-based harassment when encountering sex workers [6, 19, 21, 23]. Among black TW, research has demonstrated associations between engagement in sex work and higher depression, hormone misuse, misuse of silicone fillers for body modification, condomless sex, and substance use [24, 25]. However, additional research is needed to understand the pathways of these relationships. Nonetheless, despite the potential for these negative outcomes, some black TW leverage their participation in sex work to find social and economic networks of support among other sex workers [21, 26, 27]. Furthermore, engagement with clients is also an opportunity for gender affirmation [26]. Accordingly, economic precarity necessitates sex work for many black TW, but the experience is also more complex and layered, with the potential for beneficial and detrimental consequences.

For many black TW, difficulty achieving stable employment and the challenges of navigating limited income are compounded by housing instability. The 2015 US Transgender Survey found that 51% of black TW participants had experienced homelessness in their lifetime, the largest for any racial group [6]. Although economic instability is one factor in housing instability, black TW have also attributed their difficulty obtaining stable housing to discrimination from landlords and social rejection from friends or family who might otherwise have provided housing [6, 28, 29]. Currently, there is limited legal recourse when black TW experience such discrimination, given the legal protections against anti-LGBTQ discrimination are limited. For example, the federal Fair Housing Act and Equal Credit Opportunity Act do not prohibit discrimination based on gender identity [30]. Furthermore, only a minority of states and localities prohibit discrimination based on gender identity in housing services. These barriers to housing reinforce barriers to economic stability, given that homeless job applicants experience significant discrimination in their pursuit of work [31]. Put in concert with the discrimination which could be experienced due to a name that is read as black [32] and/or a name that is discordant with the stated gender/name [33], black TW may be caught in an intractable cycle of economic and housing instability. This cycle places these women in a desperate situation which may further incentivize engagement in behavior that is not legal to provide for basic needs. This precarity may further create opportunities for increased interactions with police, including harassment, arrest, and incarceration.

The Criminal Legal System

Epidemiological data detailing the prevalence of imprisonment among trans individuals is sparse, but existing data suggests that trans people are incarcerated at higher rates

than other communities, with black TW incarcerated at higher rates than any other racial group [34–36].

However, even before incarceration, black TW report high levels of negative interactions with police, including unwarranted stops, harassment, and arrests [36, 37]. A report conducted by the National Center for Transgender Equality and the National LGBTQ Task Force found that black trans individuals reported being disrespected in police encounters 47% of the time [13]. Thirty-eight percent of black trans respondents reported having been harassed by police, as compared to 22% of the overall sample. Across studies, black TW report being profiled as sex workers and then being subjected to aggressive and abusive policing [38, 39]. Furthermore, when these women need the help of the police, they may be dismissed or criminalized. In a qualitative study of transgender individuals' experiences with police, one black TW described having been followed and propositioned by a police officer driving aside her as she walked home [37]. The respondent attempted to ignore his advances, but found that he became more persistent as she tried to get away from him. Only after she called a friend who came to meet her in his car did the officer leave. This same respondent reported that her only previous encounter with police had been after having been robbed the year prior. When the police came to meet her, they decided not to investigate the crime and accused her of being a sex worker. Furthermore, there have been multiple recent high-profile cases (e.g., CeCe McDonald, Ky Peterson) when black transgender people have been arrested and found guilty of murder when they have had to harm an attacker in self-defense [40]. These experiences make precarious what should be a positive relationship with professionals tasked with serving and protecting the public. However, these interactions often lead to incarceration, increased marginalization, and trauma.

Black TW who are incarcerated women are often housed within male facilities, which places them at elevated risk of experiencing violence from other incarcerated individuals [41, 42]. This may include verbal abuse, physical attacks, and sexual assault/exploitation. In addition, studies also have found that incarcerated transgender women also experience physical violence from prison staff [43]. For example, Ashley Diamond, a black transgender woman, sued the Georgia Department of Corrections in 2015 for being held in male prisons, denying her hormone therapy, and subsequently being sent to solitary confinement [44]. After her suit, Ms. Diamond was released on parole and reached a settlement in her lawsuit. Furthermore, the Georgia Department of Corrections reported they would revise their policies to ensure transgender women received hormone therapy during incarceration. However, Ms. Diamond was returned to prison after a parole violation in 2020, where she was again housed with men, denied hormone therapy, and, per her report, sexually assaulted more than a dozen times [45]. Ms. Diamond's case illustrates the continued victimization of black TW at the state and criminal legal system levels.

Further illustrating the impact of transmisogynoir in jail and prisons, analysis of data from the National Transgender Discrimination Survey has found that black, Latina, and multiracial transgender women experienced significantly higher odds of being victimized or mistreated while incarcerated relative to their white transgender peers [41]. Despite the negative health and psychological effects of solitary confinement [46, 47], transgender women are also often placed in solitary confinement for long periods of time [43]. Though this decision is often framed through the lens of "protective custody," it may also be used as a punishment for gender expression, sexual activity, or requesting gender-affirming care. Studies have shown that hormone therapy is often discontinued while incarcerated, and gender-affirming surgeries are usually uniformly denied during incarceration [48, 49]. As such, incarceration places these women at heightened risk for physical harm, psychological harm, and discontinuation of healthcare.

Interpersonal and Community Violence

In addition to the increased risk for sexual assault and violence among black TW sex workers from clients and in carceral settings, black TW face multiple forms of violence across multiple social settings and relationships [19]. Estimates of intimate partner violence (IPV) routinely suggest that a majority of black TW will experience IPV [50, 51]. Various factors—such as a lack of economic autonomy, a system built to prioritize white victimization and ignore racially-motivated violence, and the isolating size of increasingly marginal communities—have been theorized as contributing to the high rates of IPV among trans individuals of the color [52]. The fetishization of non-white TW also contributes to the dehumanization of black TW that enables greater IPV and sexual assault [19, 53]. IPV itself is associated with higher rates of depression, condomless sex, HIV vulnerability, and worse HIV viral suppression [14, 50, 54, 55], in addition to persistent psychological and emotional distress [14, 56, 57].

Furthermore, racially motivated gender-based violence and murder have both disproportionately affected black TW [16, 58–60]. A recent review of the CDC's National Violent Death Reporting System data found, relative to cisgender victims of homicide, transgender victims were more likely to be Black (54% vs 41%), have a mental health condition (27% vs 11%), report being homeless (5% vs 2%), or report being a sex worker (10% vs < 1%) [61]. Furthermore, there was a disproportionate number of transgender victims of homicide in US states in the West and Midwest.

In cases of violence against black TW, it is not merely the victims' status as trans or black that explains the violence but their intersectional identity as black, trans, and women that situates them as a marginalized other [16, 52, 53]. As previously stated, attempts to guard against such violence have often been met by punishment from the criminal legal system [62]. However, black TW activists have shone a light on this mistreatment to push for systemic reform and shifts in how black TW are construed. Campaigns like #GirlsLikeUs have been devised to make black TW real beings rather than a flattened "other" [63]. This campaign initially focused on transgender women voicing support for one another and then grew into a social media visibility movement, wherein transgender women could share their stories and experiences. As such, this activist work has served to contest the violence they experience and attempt to make room for solidarity and intra-community support.

Such solidarity is necessary given the pervasiveness of transmisogynoir. The experiences of black TW in adulthood are often more familiar. However, violence is an expected experience for many black TW, even from a young age. The US Transgender Survey reports that, among students in K-12 schools, 67% will experience verbal harassment, 55% will experience physical assault, and 38% will be sexually assaulted on the basis of their transgender identity, the highest percentages for any racial group [6]. Much like violence is used as a means of social control in prison settings, young black trans girls may encounter violence from peers and adults in attempts to stop behavior which defies gender norms. Such experiences may make the school or home environment hard to endure. They also set the stage for later negative outcomes, including runaway, school attendance problems, behavioral difficulties, school drop-out, engagement with the criminal legal system, and even suicide [64, 65]. Furthermore, as institutions and spaces such as schools or family homes intended to support young black TW become sites for harassment and physical harm [12, 14], trust in systems more broadly can be eroded, setting the stage for social isolation and underutilization of needed services.

Health and Healthcare

Black TW may underutilize needed services for many reasons, including a lack of access to affirming and culturally sensitive care [66]. The lack of access to affirming care has repercussions for accessing gender-affirming procedures, disease prevention services, and treatment. More specifically, many black TW seek procedures like facial feminization and breast augmentation to decrease dysphoria and increase comfort [67]. Given that black TW tend to begin medical aspects transition later than their white peers [68], the potential utility of such procedures to affirm their gender identity may be that much greater. Furthermore, despite stable rates of HIV transmission among Black Americans and signs of slowing HIV transmission among young transgender women of color, black TW continue to have the highest prevalence of HIV in the nation [69, 70]. Affirming and culturally sensitive healthcare environments facilitate greater engagement in care [67]. Given that black TW often come into care with a high degree of unmet need and have experienced a range of traumas, creating an environment wherein they can receive care without additional trauma is critical.

Part of ensuring that care is not traumatic requires providers understanding that healthcare experiences preceding the clinical encounter may have been traumatic. Specifically, a combination of personal and historical instances of discrimination in healthcare has resulted in a distrust of medical systems within many black communities, damaging the relationship between healthcare professionals and the black patients they serve [71, 72]. Similar to reports from black cisgender women, some black TW report the care they receive is of inconsistent or poor quality [71], while others report delaying medical services due to both the fear and experience of stigma, discrimination, and mistreatment by providers [71, 73, 74]. This mistreatment includes racial and gender microaggressions, as well as stigmatizing language related to living with HIV, drug use, and/or sex work [66]. These experiences make it challenging for these women to commit to engagement in care, even when there is a pressing need.

Furthermore, the experience of economic precarity impacts healthcare experiences, just as it does other aspects of black TW's lives. Many black TW report difficulty securing health insurance [74, 75]. One study of transgender women of color in Chicago, Houston, and LA County found that 62% of the women lacked health insurance [75]. Fear of accruing debt due to pursuing care may limit black TW's willingness to engage in care. However, delaying care may also mean more expensive care becomes necessary given that medical problems can become more complex over time. Accordingly, mitigation of financial burden or, at least, an understanding of how finances may impact care engagement is critical.

While some aspects of the clinic visit itself may be sites of trauma, the geographic context of the clinic may also be relevant. Some black TW report concerns about safety when seeking healthcare, especially for geographically inaccessible clinics [66, 76]. These women describe concern about being noticed in public en route to these clinics and associated concerns that they might be harmed [75]. In addition, some women reported only presenting in ways congruent to their gender "part-time" (generally in trans-inclusive social spaces or at night) in order to avoid harm [76].

Given these healthcare experiences, it is critical that healthcare providers who serve black TW are sensitive to

the potential difficulties that may precede their showing up for care. Furthermore, it is imperative that providers are sensitive to how challenging it may be for black transgender women to build and maintain trust and rapport with their providers. As such, it is critical that providers work to build such trust to ameliorate the unmet health needs of many black TW bear.

Resilience

Despite the barriers and challenges black TW face due to misogynoir, they also display particular kinds of resilience due to their unique social locations [77]. Resilience describes as "a dynamic process encompassing positive adaptation within the context of significant adversity" [78]. Whereas early research conceptualized resilience as consisting of individual characteristics or traits [79], more recent scholarship understands resilience as being derived from a constellation of factors at the individual, family, and community levels [80]. Furthermore, the ability to adapt to stress and adversity also is related to resource levels, indicating that resilience can be shaped by access to different dimensions of social, human, economic, and political capital [81].

Key to theories of resilience for black TW is the role of their social networks [11], which often operate as families of choice for black TW [82]. As stated in the context of sex work, contact with other members of their community can serve to connect black TW with vital social and economic opportunities. Furthermore, connection with other black TW offers opportunities for gender affirmation and support [12]. However, black TW do not exist within networks of only similar individuals. They also are connected to families and communities, which may or may not be supportive. In this situation, black TW may demonstrate resilience through their use of specific strategies to protect themselves from potential rejection or violence, such as the strategic disclosure of their gender identity or removing themselves from social networks wherein their identities are not affirmed [12, 17].

Healthcare providers and organizations can play a key role in supporting the resilience of black TW. Within the research literature on resilience, healthcare providers are often seen as supporting resilience by providing gender-affirming and trauma-informed care and facilitating access to resources (i.e., referral to social or behavioral health services) [83]. When healthcare providers demonstrate competence in transgender healthcare, trans women indicated feeling a greater degree of trust in the care they could be provided, which increased their commitment to remaining in care. The impact of culturally sensitive healthcare providers is not just additive though. In Bowling et al.'s study [83], transgender women indicated that they were better able to activate their existing coping skills when they engaged with a provider who seemed to have an understanding of their cultural context.

Dedicated community organizations outside of the medical space—namely House Ball communities—also grant black TW opportunities for community engagement and social support [84, 85]. The House Ball community is a collective of sexual and gender minority individuals who create chosen family relationships and compete in dance and performance competitions within that community [86]. A number of studies have found that the House Ball Community provides black TW with opportunities for health education, building community with others who understand their experiences, and access to financial/instrumental support [84, 87••]. For transgender youth, the process of recognizing their movement towards adulthood as they renegotiate their racial and gender identity together gives them a source of resilience [88]. Resilience reveals the double-edged sword of social networks, media representation, and gender literacy, as each becomes both a source of support and a potential site of gender-based harassment and violence [89].

However, regardless of how black TW manage to stay strong in the face of trauma and violence or adapt to situations equally capable of producing great harm or social affirmation, it is important to remember that their coping mechanisms are a direct response to structural and systemic forms of marginalization such as racist policing, socioeconomic discrimination, and legal otherization that require focused policy reforms [89]. Paradigmatic shifts in social structures, like changes pursued under the Trump administration, presented new sources of minority stress that require both interpersonal intervention and structural resolve [90]. Furthermore, these dynamics highlight the need for trauma surgeons to develop structural competencies that are attuned to the unique impacts of transmisogynoir within the lives of black TW and how changing social and legal contexts may operate within different geographic and political spheres.

Implications

Black TW face the compounded violence and trauma due to their triply marginalized identity (i.e., transmisogynoir). As they navigate medical institutions, a precarious and imbalanced economy, the carceral state, and their interpersonal and communal relationships, their status as black, women, and trans inflect one another. However, this identity is constructed in relation to the violence, trauma, and marginalization inherent to discriminatory social structures, steeping their own identities within violence. When providing care to black TW, it is essential to recognize the embodied, psychological forms of trauma that are deeply linked to their experiences with institutions infrequently designed to support their

needs [91]. Successful interventions and researchers looking to develop interventions have focused on gender affirmation [92], accessible, destigmatized, and culturally-sensitive language [40], and greater involvement with the community, curating services and resources to community needs [93].

Given the paucity of education surrounding the transgender experience, let alone the black TW experience, there are opportunities for medical schools, residency, and fellowship programs to integrate segments on transgender health into their curriculums, which are overseen by the American College of Graduate Medical Education (ACGME). At the medical school level, prior to entering clinical rotations, curricula involving the clinical experience of transgender persons can be readily woven into existing educational programs. For example, at the University of Washington School of Medicine, medical students have the opportunity to enroll in an LGBTQ pathway which exposes them to the diverse lived experiences of sexual and gender minorities [94•]. The simple integration of asking all patients about their preferred pronouns has the potential to create a more hospitable environment for transgender and gender-nonconforming patients [95]. This practice is a small acknowledgment that we cannot determine gender identity on sight alone and that our perceived notions of a person's gender may not be in line with their own identity. Given that the focus of clinical competency in medical school is based upon data gathering and obtaining patients' histories, this is a feasible, low-cost way for medical schools to train providers who can practice gender-inclusive and affirmative care [96].

Medical students often have the opportunity to practice their skills on standardized patients (SP), actors, who help to facilitate a clinical scenario. Scenarios featuring standardized black transgender patients have the potential to improve structural competencies in addressing the needs of transgender patients. For example, a study conducted at the University of Illinois College of Medicine in Chicago, IL found that SP training increased medical student's self-reported knowledge and skills to provide effective medical care to transgender patients [97]. A subsequent study with a sample of pre-clerkship medical students also found increased comfort in using patient pronouns and with taking a history of a transgender patient [98]. Furthermore, the integration of education that directly identifies racial stigma as a barrier to care among patients can be eye-opening to medical students and increase their attention to this barrier as they move into medical practice [99]. Focusing on patient-centered as opposed to problem-centered medicine has the effect of humanizing patients presenting with chief complaints, as opposed to viewing patients as their chief complaint [100]. To recognize the impacts of transmisogynoir on patients' lives and move toward a more structurally competent practice, a move toward a more patient-centered approach is necessary.

Similarly, residency and fellowship programs present a practical landscape for engaging with transgender patients, and curricula can be adapted to introduce concepts regarding broad transgender care needs not limited to pronouns, e.g., challenges with respect to physical exams [101••]. While residents and fellows do not have the same extensive curricular engagement with standardized patients and patient engagement curriculums, they have the benefit of experiential learning. Faculty may need to become more competent in transgender health in order to facilitate further learning for residents as fellows since many do not have experience with transgender health [102]. Attending physicians, residents, and fellows may benefit from specific rotations focusing on transgender health and familiarity with guidelines published by the World Professional Association for Transgender Health [103] and the University of California San Francisco Center for Excellence for Transgender Health [104]. These foundational resources may represent the starting point for transgender health curriculum integration into residency and fellowship training programs, but mandating segments on transgender health by the ACGME would ensure that each trainee is exposed to core competencies allowing them to effectively treat transgender patients [105]. Furthermore, physicians completing continuing medical education (CME) in all specialties should be required to earn credits in transgender health in order to ensure that those no longer in a training environment have the breadth of knowledge for competent, equitable, and affirming care of transgender patients. It may take partnering with the transgender community both inside and outside of the medical establishment to make these changes salient [106].

Conclusion

Physicians commit to a life of continued education, and transgender health is an important element of providing patient-centered care. Trauma surgeons play a unique role in the provision of care to black transgender women who are at the intersections of race, racism, racialized, and sexualized violence. The potential for all physicians, but trauma surgeons in particular, to become agents of change in the medical educational landscape is crucial, and in some cases, lifesaving in the care of black transgender women. The opportunity for trauma surgeons to become leaders in the field of educating faculty, medical students, and trainees in the care of black transgender women has great potential for contributions to both the literature and clinical experience of women who live at the nexus of black and transgender.

Declarations

Conflict of Interest The authors declare no competing interests.

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