Caring for Transgender and Gender-Nonconforming Patients in Pregnancy and Post-Partum

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Learning Objectives

By the end of this presentation, participants will be able to:

1. Describe terminology and concepts related to gender diversity in perinatal care.
2. Identify unique psychosocial/psychiatric stressors and risk factors experienced by transgender and gender non-conforming (TGNC) people during pregnancy and postpartum.
3. Apply gender-affirming principles to psychiatric assessment and treatment.
4. Address clinical considerations relevant to pregnancy, lactation, and gender-affirming care.

A note

- General LGBTQ+ health is under-researched and under-documented
- Existing research is limited due to heterogeneity in definitions of gender identity, inconsistent documentation/recording of LGBTQ+ identities, small sample sizes, unrepresentative sample populations, limited policy/funding restrictions

Key Terminology

- **Sex assigned at birth:** Biological classification assigned to a person at birth, based on anatomy and chromosomes.
  - AFAB= assigned female at birth
  - AMAB= assigned male at birth
- **Gender identity:** An individual's internal sense of being male, female, both, or neither
- **Cisgender:** Gender identity aligns with sex assigned at birth.
- **Transgender:** Gender identity differs from sex assigned at birth.
- **Nonbinary:** One's gender identity falls outside the traditional male/female binary → may identify as having no gender, multiple genders, or fluctuating gender
- **Gender non-conforming:** umbrella term for those whose expression/identity does not adhere to societal standards of one's assigned sex at birth
- **Gender dysphoria:** Psychological distress associated with incongruence between one's gender identity and sex assigned at birth

***Today's talk will be only focused on AFAB, all individuals of reproductive potential.**

While individuals across the LGBTQ+ spectrum can become pregnant, I will be focusing on TGNC individuals.

Background/Statistics

- Estimated **that ~17% of pregnant individuals identify as LGBTQ+** (JAMA 2023)
  - Accurate estimates vary due to limited data collection
  - In 2012, an estimated 3 million LGBTQ+ Americans reported having had a child, and 35% of LGBTQ+ individuals were raising a child younger than 18 years
- The PRIDE study: LGBTQ+ parents (n=2,122) (Hum Repro 2025)
  - 56% became parents through pregnancy from sexual activity
  - 14% through pregnancy without sexual activity (donor gametes, surrogacy)
  - 28% through non-pregnancy (adoption, fostering)
    - → Majority of LGBTQ+ parents became parents through their own pregnancies

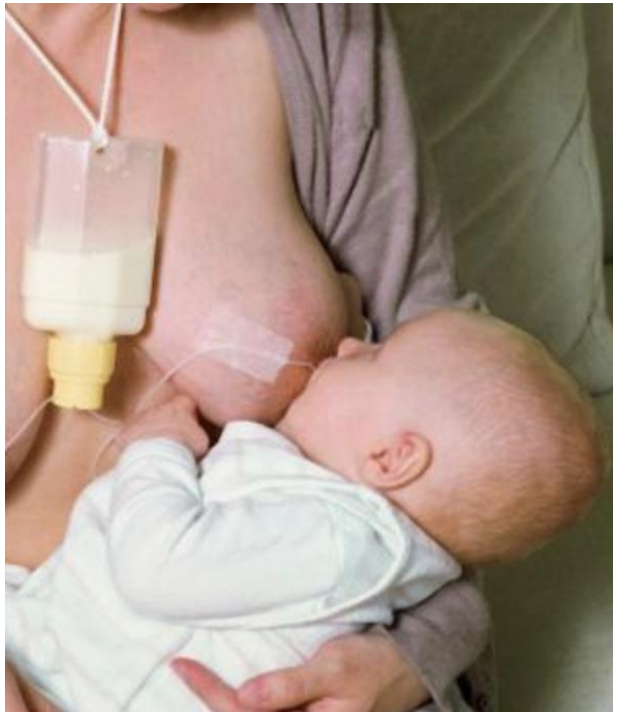
- Estimates on TGNC-specific pregnancy data is very limited; a small but **growing** percentage of pregnant people
  - 0.6% of adult population identifies as TGNC, this rises to 1.9% among younger adults
- Targeted health surveys of TGNC adults indicate 12% have experienced pregnancy at some point in their lives (Moseson 2021)

Pregnancy in Trans/GNC Individuals

- Hormone replacement therapy (HRT): medically necessary treatment for many TGNC individuals with gender dysphoria, many TGNC individuals do not experience gender dysphoria and do not desire HRT
- Pregnancy is possible after transitioning
    - Transitioning can consist of Hormone Replacement Therapy (HRT)/testosterone, or surgery, or both
- If pre-conception counseling: important for contraceptive counseling (HRT is not an effective form of contraception)
- Some have pursued fertility preservation options prior to transitioning
- **Trans individuals taking testosterone may safely achieve pregnancy after cessation of testosterone**
- 2013 survey of 41 trans men who became pregnant after transitioning (Ob and Gyn 2014)
    - 2/3 had already been on HRT testosterone prior to becoming pregnant, and 81% used their own oocytes
    - Many of these respondents became pregnant within 4 months after testosterone cessation
    - 32% of these pregnancies were unintended (important of pre-conception counseling around HRT and ability to conceive)

Pregnancy in Trans/GNC Individuals

- Lactation: Breastfeeding & Chestfeeding
  - ”Breastfeeding” and “nursing” can contribute to gender dysphoria in this population
- Chestfeeding- lactation capacity and feeding expectations
  - If had prior chest masculinization surgery or “top surgery”
    - If some breast tissue was retained, may still be able to produce breast milk or to directly feed from chest though may be difficult latch
    - Often removal of glandular tissue and nerve connections to nipple significantly reduces milk production
  - Supplemental Nursing System (SNS)
- Include support to chestfeed if an option, without pressure
  - 22 TGNC individuals on lactation experiences: + pressure to breastfeed from OB and other HCP, friends/family, higher anxiety and distress MacDonald 2016
  - Among 16 participants chose to chestfeed, 7 experienced significant gender dysphoria while chestfeeding (layered clothing, reframing in terms of utility, privacy)
- Anticipatory guidance re: postpartum chest health MacDonald 2016
  - Regardless of intention to chestfeed, should still recognize engorgement, plugged ducts, mastitis if some retained glandular tissue



General LGBTQ+ Mental Health

- LGBTQ+ individuals are 2.5x more likely to experience depression, anxiety, and substance use disorders
- Higher risk of lack of social support, discrimination within own families (Ross 2005)
- Less likely to have access to regular mental health care and regular medical care, less likely to be privately insured

- TGNC population: (Umbrella Review in JAMA Psychiatry 2025)
  - Higher rates of diagnosed psychiatric illness, alcohol and other substance use disorders
  - 50% with history of lifetime suicidal ideation (OR 3.5)
  - 29% with history of suicide attempt (OR 3.5)
  - 18% diagnosed with ED, 11% diagnosed with ASD
  - Disproportionately affected by violence and other forms of trauma (Lombardi 2002)
    - PTSD: OR of 2.5 compared to cisgender controls (JAMA Psychiatry 2025)

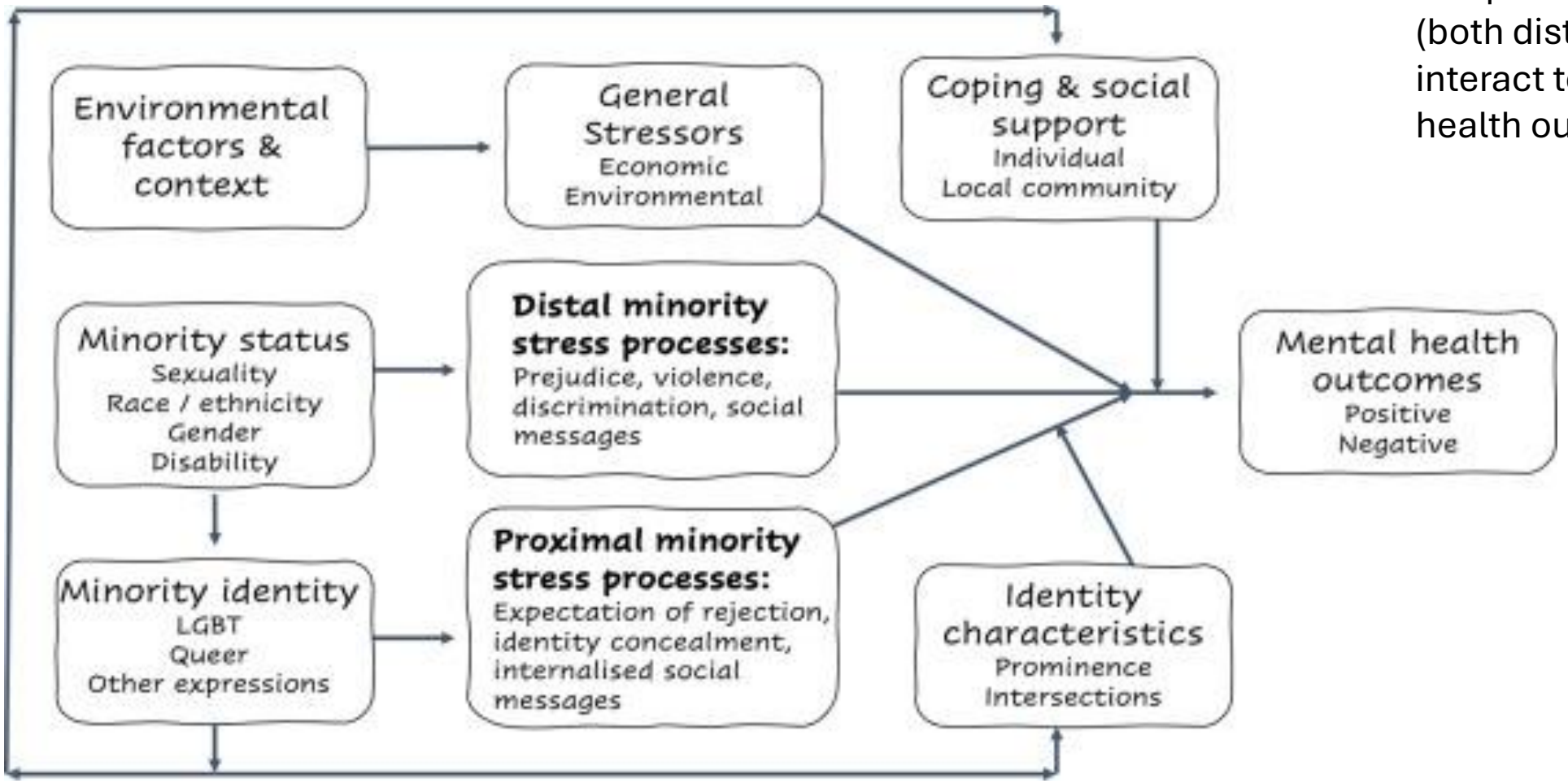
LGBTQ+ Perinatal Mental Health

- Data is limited, though most has focused on cisgendered lesbian women
  - More severe depressive symptoms and higher prevalence of PPD than heterosexual women (Lapping-Carr 2023)
  - More likely to experience negative mental health outcomes, 3x risk of frequent emotional distress during pregnancy
- Gender identity is not consistently recorded in perinatal data

Kirubarajan 2022: systematic review

1. 26 studies of 1199 LGBTQ+ childbearing participants
2. Key/recurring themes in **LGBTQ perinatal mental health:** heteronormativity, cisnormativity, isolation, exclusion from traditional pregnancy care, stigma, distress from gendered nature of pregnancy

Minority Stress Model

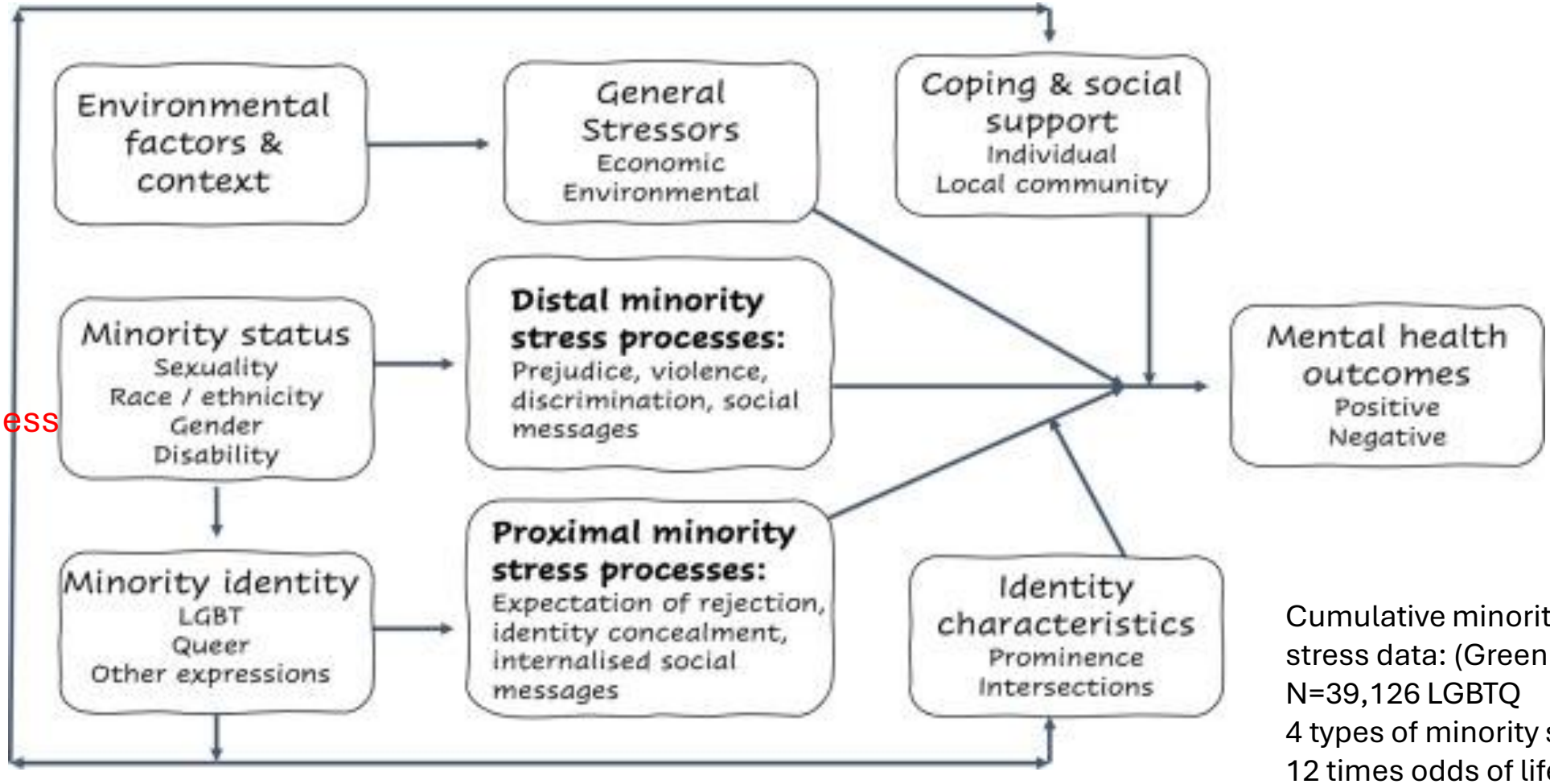


Unique/hostile stressors (both distal and proximal) interact to impact mental health outcomes

Minority Stress Model

Higher risk of decreased family support, social isolation

Higher rates of financial insecurity



Higher rates of:
Disability
Chronic medical illness

TGNC minoritized even in LGBTQ communities

Cumulative minority stress data: (Green 2022)
N=39,126 LGBTQ
4 types of minority stress:
12 times odds of lifetime suicide attempt

TGNC Perinatal Mental Health

- Increased risk for perinatal mental health conditions:
  - Depression
  - Anxiety
  - Suicidality
  - Trauma Exposure
- Concealment motivation: hiding one's orientation/identity associated with worse perinatal depression outcomes
- Limited social and familial support: increased risk for perinatal mood disorders (more common in families of TGNC patients)
- Role of discrimination and stigma in healthcare settings
- Clinical impact→ ultimately affects healthcare engagement and avoidance

Trans/GNC Perinatal Mental Health

- TGNC anticipation of poor perinatal care experiences
  - Shaped by **community** and individual previous experiences (transphobia and inexperience of healthcare providers)
- Loss of control: dysphoria, fear of poor care/discrimination → increased vulnerability/anticipatory fear of childbirth, hypervigilance, anxiety

- Shared (but greater) psychosocial risk factors with cis women for:
  - Perinatal mood and anxiety disorders (PMADs): history of diagnosed MH condition, history of trauma (family, healthcare providers), limited social support
  - Traumatic birth: past trauma, preexisting MH condition, poor care/perception and anticipation of poor care, **loss of choice and control during birth***

Czarnocka 2000, Greenfield 2016, O'Donovan 2014)

Special Considerations and Risks

Body image & gender dysphoria in birthing populations due to pregnancy-related bodily changes (Miller, Dupree, Monette 2024)

1. Discontinuing testosterone therapy
2. Chest changes/breast growth
3. Being socially "read" as pregnant, pregnancy bump
    1. Increased chances of being socially misperceived as a pregnant cis woman/misgendered
4. Birth event
    1. Previous detachment from reproductive organs/genitalia
    2. Concerns about having genitals exposed
5. Lactation in breast/chestfeeding (MacDonald 2016)
    1. If worsening sx of dysphoria with lactation, can discuss management of lactation suppression with cabergoline

"Less of a man", "not man enough",
"not pregnant enough", "not trans enough"
(Greenfield 2021)

Special Considerations/Risks

Mental Health and Perinatal loss in TGNC Populations

1. Higher rates of becoming pregnant via Assisted-reproductive technology (ART)
2. Increased effort/planning → perinatal loss associated with higher distress/grief
3. Perinatal loss → exacerbate gender dysphoria and detachment from bodies/shame related to bodies "not working as they felt it should"

HRT

- Advised to hold testosterone as soon as pregnancy is confirmed or when trying to conceive
- **When to resume postpartum?**
- If choose to chestfeed, limited concerns about testosterone passing into breast milk; however, because testosterone may suppress milk production, not recommended until chestfeeding is complete (ACOG Opinion 2021)
- **How does restarting testosterone affect post-partum mood?**
  - Testosterone as HRT --> reductions in gender dysphoria, perceived stress, anxiety, and depression (Lancet 2017)
  - 3-month RCT (n=64): (JAMA Network Open 2023)
    - Clinically significant decrease in depression (PHQ-9 mean difference -5.6)
    - Significant decrease in suicidality (SIDAS mean difference -6.5 points)
    - Resolution of SI in 52% of treatment group
  - Improved body image satisfaction, stronger amygdala-prefrontal cortex connectivity (PsychoNeuroEndo 2021)
  - 2-year prospective cohort study: improvements in positive affect, life satisfaction, depression (NEJM 2023)
- **Shared decision-making with: OB, Psychiatry, endocrinology, lactation**

Comprehensive MH Assessment

- Gender identity history
- Past transition history
  - HRT, surgeries
- Current hormone use
- Fertility history
- Pregnancy intentions
- Family structure
- Social supports
- Experiences of discrimination → **relationship with healthcare system**
  - **“What has made things better? What has made things worse?”**
- Trauma history
  - Clarify no need to disclose specifics, but can ask about hx of sexual trauma
- Psychiatric symptoms
  - Timeline, relationship to starting HRT in past
  - Emotional changes during early HRT should be distinguished from psychiatric decompensation (emotional reactivity with testosterone)
- Substance use

Psychiatric Medications

Overall psychiatric medication management remains consistent with recommendations for non-TGNC perinatal populations (even with use of testosterone).

Key considerations:

-Safety in pregnancy

-Safety in lactation/breastfeeding

-History/severity of illness and focus on relapse prevention

*Pharmacokinetic interactions are more clinically considered in trans-femme patients

-psychiatric meds and HRT estrogen (lamictal, anti-epileptic/mood stabilizers), spironolactone + lithium

-minimal pharmacokinetic impact from testosterone

__Shared decision-making__ with patient, discussing concerns, hesitations, mistrust in healthcare system. Meds only work if patients take them!

Trauma-Informed Care

A **strengths-based** service delivery approach grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for survivors, and that creates opportunities for survivors to rebuild **a sense of control and empowerment.** (ACOG 2021)

- Many TGNC individuals with hx of sexual trauma, medical trauma, gender-based harassment, family rejection
- Perinatal care may re-traumatize: pelvic exams, bodily exposure, loss of privacy, repeated misgendering

Awareness of a trauma-informed care model is of utmost importance in providing gender-affirming perinatal care to address the compounded effects of minority stress, prior healthcare trauma, and pregnancy-related gender dysphoria.

(1) safety, (2) trustworthiness and transparency, (3) peer support, (4) collaboration and mutuality, (5) empowerment, voice, and **choice**, and (6) cultural, historical, and gender considerations (Stokes 2024)

What is our role?

Language: can heal and empower our patients and improve health outcomes with words alone

- Pronouns, chosen name
- Gender neutral language- especially in perinatal health settings
  - “parent” and “parental” instead of “mother” and “maternal”
  - “Birthing individuals”
  - “Chestfeeding” if preferred to breastfeeding

-Gender is a “two-way street”, that involves declaring one’s gender to others, but also having one’s felt gender reflected back to them by others.

-Widely accepted in literature that using chosen name and identified pronouns reduces depressive symptoms, suicidal ideation, and suicidal behavior

- Large reductions in negative health outcomes (Pollitt 2019, Russell 2018)

-Increase language awareness and competence by practicing use of gender-neutral language outside of clinical settings.

“What words would you like me to use when talking about your pregnancy, body, and parenting role?”

When in doubt, **ask**!

Care providers can give clues early on in provider-patient relationship to demonstrate a flexible understanding of gender and roles in pregnancy/infant feeding/parenting.

Protective Factors/What is our role?

- Empower by identifying and fostering strengths: (Carter 2025)
  - Life-long self-advocacy and resilience → strong mutual aid networks and unique capacity to foster inclusive, supportive communities
  - “self—pride”, “community connection”, ”social support” as sources of power and strength
  - “collective strength” at intersection of race, ethnicity, and gender identity
  - Significantly higher levels of political engagement, local advocacy, organizing

Protective Factors/What is our role?

- Positive social interactions and meaningful relationships within healthcare settings
- **Timely access to needed interventions (screen and refer!)**
- Increased screening for perinatal psychiatric symptoms due to unique risks and vulnerabilities
- Loss of choice and control: ensuring full range of choices are **truly** available for pregnant TGNC individuals
- Language, communication, rapport-building
- Validate and explore patient's emotions around structural limitations
- **Work to build confidence in utility of these skills/language to improve perinatal health and MH outcomes**

Final Thoughts

- A useful question for clinicians:
- “What would change about my assessment, treatment, or clinic environment if I assumed that any patient I have is trans or GNC?” → The answer can lead to better care for everyone

- When in doubt, **ask!**
  - **patients**
  - **providers- endocrinologists, OBGYN, psychiatrists, lactation, pharmacists**

Resource List

https://postpartum.net/get-help/queer-parents/

Support Groups

PSI has over 50 specialized support groups to meet your needs, including our Queer and Trans Parent Support Group.

LGBTQ Support Groups

Peer Mentor Program

This program thoughtfully matches individuals recovering from Perinatal Mental Health Disorders with trained volunteers who have lived through and recovered from similar experiences, fostering a safe, supportive, and trusting peer-to-peer environment.

Learn More

Specialized Support Coordinators

PSI has volunteers with personal experience with experiencing a perinatal mental health conditions and the unique stressors with identifying as LGBTQIA+. These Specialized volunteers can provide LGBTQIA+ parents the opportunity to connect with someone who understands and share resources specific to this area.

Connect with a Coordinator

la leche league international .org

Information/Resources specifically for lactation/feeding support in TGNC parents

Find a Provider

Visit the PSI online directory to find qualified perinatal mental health professionals and groups in the United States and Canada.

Thank you for listening!

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