# Trans men and nonbinary people asked to stop testosterone therapy during pregnancy. But evidence for this is murky

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Diane Rodríguez and her husband, Zack Elias, are a trans couple in Ecuador. Credit: Chichicko/Wikimedia Commons, CC BY-SA

When I talk about our research team's work on pregnancy in transgender people, people often recall Thomas Beatie, a pregnant man who appeared on "Oprah" and in People magazine in 2008. The media focus on Beatie and his pregnancy provoked public fascination that tended to overshadow the everyday lived realities of being pregnant as a trans

person.

Transgender people, as opposed to cisgender people, have a gender identity that is different from the gender they were assigned at birth. Some may go on hormone therapy to help align their body with their gender identity. Like most trans men, Beatie went off testosterone during his pregnancy because it was medically advised as standard practice. But testosterone therapy is often essential to the mental and physical health of many trans men as well as some nonbinary people whose genders don't fit within the categories of man or woman. What is the experience of pausing treatment like for them? Why do medical guidelines recommend going off testosterone?

As a sociologist who studies sex, gender and sexuality, and trans experiences of family, health and well-being, these questions piqued my interest. I work with an international team of researchers on a project about trans men and nonbinary people's experiences of pregnancy. We interviewed 70 trans and nonbinary people who were either currently or intending to become pregnant, as well as 22 health care providers specializing in working with these communities, across seven countries.

## Testosterone therapy

While testosterone is widely considered a "male hormone," all people produce testosterone. Physicians consider a wide range of testosterone levels to be "normal."

Many transgender and nonbinary people take testosterone as part of their mental and physical health care. Testosterone therapy often results in a more masculine appearance through facial hair and muscle growth, fat redistribution and lowered vocal pitch.

In addition to physical changes, many of our study participants spoke of

positive mental health improvements while on testosterone therapy, including feeling calmer, balanced and more fully themselves—sometimes for the first times in their lives. This is a common finding across research on hormone therapy and trans and nonbinary people.

While there's no universal dosing protocol for trans or nonbinary people undergoing testosterone therapy, the Endocrine Society's treatment guidelines recommend supplementing testosterone until blood ranges fall within those for cisgender men. By basing clinical standards on cisgender men, these guidelines can reproduce sex and gender binaries that may not fit with actual desires of many trans and nonbinary people. Some resist this prescriptive medical model by microdosing testosterone, with or without health care provider support.

**Testosterone and pregnancy**

When my team and I analyzed our research interviews, we learned that the health care providers in our study typically told their trans patients to stop testosterone therapy either six months before trying to get pregnant or immediately upon becoming aware of pregnancy. They also advised continuing to withhold testosterone therapy until either after birth or stopping chestfeeding (nursing their babies). This could mean a pause in testosterone therapy for up to two years.

Why do doctors tell trans and nonbinary patients to stop testosterone therapy during pregnancy?

The health care providers we interviewed expressed concerns about patients continuing testosterone while pregnant or chestfeeding. When we asked them what risks they were most concerned about, they often noted that there is either not enough or inconclusive research on using supplemental testosterone during pregnancy. Despite this, nearly all of

the providers we interviewed routinely advised patients to pause testosterone therapy without reservation.

Some providers compared continuing testosterone therapy during pregnancy to illicit drug use during pregnancy, perceiving it as a future risk to the child. Others suggested that testosterone use during pregnancy is selfish because it prioritizes the parent's own health and well-being in the present over the potential health and well-being of their child in the future. Some providers even suggested that trans and nonbinary patients shouldn't have children if they are unwilling or unable to pause testosterone therapy during pregnancy.

In contrast, the trans men and nonbinary people we interviewed described grappling with difficult and weighty decisions around pausing testosterone during pregnancy. These decisions often involved choosing between their own mental health and well-being against the potential health and well-being of their child. As one participant described their experience going off testosterone during pregnancy: "My lows were miserable, depressed, to the point of suicidal. … I knew that going back on testosterone would help. I didn't really know whether [my doctor] would be happy to re-prescribe me testosterone … and there was a fear there that it would be withheld from me … that they were going to say, "Well, sorry, you came off it, you're not getting it back.'"

## PCOS and producing 'normal' children

Despite it being fairly standard medical advice, there remains relatively scant empirical evidence guiding the practice of pausing testosterone therapy for trans men and nonbinary people during pregnancy and chestfeeding. There is also currently no published work on microdosing testosterone during pregnancy.

Instead, much of the medical literature on the potential developmental

effects of "excess androgen" exposure in the womb focuses on pregnant people with polycystic ovary syndrome who have testosterone levels that generally fall between those for cisgender women and men. These studies center on the likelihood of the baby later developing intersex conditions, or having biological traits that do not fit binary definitions of male or female characteristics; later self-identification as lesbian or trans ; metabolic and cardiovascular dysfunction, such as obesity; and neuropsychiatric disorders, such as autism and attention-deficit disorder. Most of these concerns have involved children categorized as female at birth.

People with polycystic ovary syndrome, however, are not routinely placed on testosterone blockers during pregnancy or discouraged from feeding their infants milk they produce.

In my review of our interviews and the medical literature, I became increasingly concerned that this focus on producing "normal" children fails to attend to both natural human diversity in cognitive processing, bodies and identities, and the mental health of trans and nonbinary parents. It may also echo eugenicist policies that attempt to eliminate human characteristics and communities that society deems inferior or bad. But people from these communities have done a great deal of work over the past several decades to ensure they are granted equal rights and protections.

Paradoxically, the desire to protect offspring from testosterone exposure during pregnancy and chestfeeding may become a method to prevent the reproduction of some of the very same characteristics held by trans and nonbinary parents themselves. As one participant noted: "There's a bunch of research around androgen exposure in utero and intersex conditions. … I did have complex feelings around working hard to not have an intersex child. … As someone who is a gender 'other,' to work hard to not create a different body that is a gender 'other' feels weird. It

feels hypocritical."

## Moving beyond one-size-fits-all

While concerns about "androgen excess" during pregnancy for trans men and nonbinary people parallel those for people with polycystic ovary syndrome, doctors treat these cases differently. This discrepancy in clinical approach indicates that there may be other pathways forward that don't require stopping testosterone therapy completely.

I believe that careful attention to the physical and mental health and well-being of trans and nonbinary people before, during and after pregnancy is long overdue in medicine. Instead of approaching testosterone therapy during pregnancy as a binary yes/no question or a one-size-fits-all standard, investigating how various dosages of testosterone may affect all stages of pregnancy and chestfeeding could lead to better outcomes for both trans parents and their children.



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