

Gynecologic Care of the Female-to-Male Transgender Man

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Transgender men are a vulnerable population whose health care needs have been difficult to identify because of limited research and an inability to identify the population. Limited evidence suggests that transgender men are at increased risk of having polycystic ovarian syndrome, contracting HIV, experiencing violence, and committing suicide. This qualitative study, conducted through face-to-face interviews of a convenient sample, was a three-part interview containing a demographic and health questionnaire, the Norbeck Social Support Questionnaire, as well as the Health Care Relationship Trust Scale. Audio recordings and written notes were reviewed and common themes were identified via content analysis. Six self-identified transgender men between the ages of 19 and 45 years were enrolled in the study. Participants were at varying degrees of social and medical transition. Four major themes were identified: 1) receiving gynecologic care was perceived to be important; 2) breasts caused the most gender identity conflict; 3) transgender men struggle with revealing their gender identity to health care providers; and 4) the male/female boxes on health intake forms, as well as pronoun usage by medical staff, were barriers to receiving health care. This gynecologic health care needs assessment of transgender men begins to characterize the barriers transgender men face when seeking health care. *J Midwifery Womens Health* 2008;53:331–337 © 2008 by the American College of Nurse-Midwives.

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INTRODUCTION

Transgender individuals are routinely marginalized in society and health care. Multiple studies have shown that transgender individuals have an increased risk of committing suicide, contracting HIV, experiencing violence, and lacking access to health care.^{1–10} The social struggle to conform to a gender binary (that of male or female), and the psychological struggle to gender identify increases their risk of suicide.^{1,9,11} Many members of the transgender community are forced to turn to prostitution for income and to use drugs to escape social stigmatization; therefore, they increase their risk of contracting HIV.^{1,7,9,12} Needle sharing to administer counter-sex hormones, which are often bought through an illegal drug market, also increases transgender individuals' risk of exposure to HIV.¹² A confounding factor, exacerbating transgender individuals' risk of suicide and HIV exposure, is their increased risk of experiencing physical, sexual, and emotional violence.^{1,9,11} Because of discrimination in society, and specifically within the workplace, transgender individuals are often unemployed and without health insurance, which limits their access to health care.^{1,5,6,9} Finally, because of a lack of sensitive and competent primary health care providers, most transgender individuals only seek health care during emergencies.^{6,13} These emergencies are often exacerbations of routine primary care issues that go unrecognized and untreated because of fear of marginalization by health care providers.⁶ Because transgender individuals are

vulnerable to society's prejudices and violence, their need for easily accessible and empathetic primary care is significant. This study was designed to inform the health care literature regarding the gynecologic needs of the transgender male community. This article provides midwives and women's health care nurse practitioners with tangible ways of becoming increasingly sensitive to the transgender community's specific vulnerabilities and to inform the literature, using patient's own words, about their health care experiences and struggles.

BACKGROUND

Statistical data regarding the number of transgender individuals in any given area at any given time is nearly impossible to find, though estimates have been made based on the number of individuals who have received sex reassignment surgery, been diagnosed with gender identity dysphoria, or legally applied for a sex change on their permanent records.^{11,14–16} The United States is particularly lacking in its census of transgenderism. The international estimates of the prevalence of transgender individuals are 1 in 11,900 for transgender women (male-to-female) and 1 in 30,400 for transgender men (female-to-male).⁶

Transgender individuals are often included in the lesbian, gay, and bisexual (LGB) community because they are viewed as sexual and gender variants within society; however, LGB issues are most often concerned with one person's sexual relationship to another individual, while transgender issues focus on one individual's gender identity. The transgender community has barriers to health care that are unique from LGB individuals, but

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they are rarely separated in the literature on this subject.^{3,4,17,18} The transgender community should also be divided into two subcategories: transgender men and transgender women.^{19,20}

Minimal research has been done on the specific health care needs of the transgender male population. Phalloplasty and metoidioplasty, two different procedures used to create phalluses, lack safety, efficacy, and long-term health outcomes research and evidence.^{17,14,15,21} Other medical aspects of a transgender man's transition include taking testosterone, breast binding, hysterectomy, oophorectomy, and a bilateral mastectomy.^{16,22} The World Professional Association for Transgender Health (WPATH) is an international organization that creates the transition treatment guidelines, though other treatment guidelines can also be found within the United States (Appendix A).

Review of the databases CINAHL, PubMed, Cochrane Library, PsycINFO, and SCOPUS for articles relating to transgender men's health published within the last 50 years revealed a paucity of information. Only a few recent case reports, an anecdotal story, and a few endocrinology studies performed more than 20 years ago were found. The case reports included three traditionally female diseases reported in transgender men. Hage et al.²³ and Driák and Samudovský²⁴ published cases of ovarian cancer in transgender men, and Burcombe et al.²⁵ published a case of breast cancer after bilateral mastectomy in a transgender man. Shaffer¹³ recounts an emergency room visit of a transgender man in which "despite the chief complaint of pelvic pain, no pelvic examination was performed in the emergency department . . . two days later he returned to the nurse practitioner who examined him and found blisters caused by a primary herpes outbreak."

In the 1980s and 1990s, studies looked for an endocrine explanation for female sexed individual's male gender identity by studying their sex hormone levels before receiving hormone treatment. Three studies found that the majority of transgender men had abnormally high endogenous testosterone levels and multiple characteristics of polycystic ovarian syndrome (PCOS) or other hyperandrogenic disorders.²⁶⁻²⁸ Futterweit et al.²⁷ conducted a retrospective study of 40 transgender men and found that 30 of the 40 participants had increased plasma levels of gonadal hormones characteristic of PCOS when compared to a control group of adult

females that were also studied in the early follicular phase of the menstrual cycle. Bosinski et al.²⁶ compared 12 transgender men with 15 sex and gender congruent women and compared their hormonal reactions to a 250-mcg dose of adrenocorticotrophic hormone stimulation. They found that clinical signs and symptoms of hyperandrogenic disorders were more prevalent in transgender men but that the difference from the control group was not great enough to explain the genesis of gender disorders.²⁶ Finally, Balen et al.²⁹ reported that 50% of their sample of 16 transgender men had signs and symptoms of PCOS and that 15 of the subjects had ultrasound evidence of polycystic ovaries. None of the studies discovered the genesis of transgender male identity and therefore have not been continued. These studies also provide only limited information about the health care needs and risks of the transgender male population.

Therefore, as health care providers, we have only anecdotal evidence that transgender men have unique health care needs and that they are routinely marginalized. We do not know how many individuals are affected, the extent of their physical transitions, what specific health care issues they need to have addressed, nor how to provide culturally competent care. What we must understand from the limited data is that transgender men are not receiving appropriate primary care and are not receiving the standard gynecologic cancer screenings, such as clinical breast exams, mammograms, and Pap smears. This puts them potentially at increased and unnecessary health risks. Care of transgender men is an important issue for all health care providers. However, midwives and women's health nurse practitioners are the leading providers of gynecologic primary care for vulnerable populations and therefore are in the position to take the lead in providing culturally competent care to the underserved transgender men population.

METHODS

A convenience sample of six female-to-male transgender individuals was enrolled in this study. Purposive and networking sampling was used to recruit transgender participants in an attempt to diversify the sample. Inclusion criteria were individuals who self-identified as transgender and of the female sex, lived within driving distance of the researcher, and were over 18 years of age. Each participant was asked what their sex specific chromosomes were (XX, XY, or XXY) so as not to define sex based on genitalia. Exclusion criteria were individuals who did not speak English, were cognitively impaired to a degree that the person was unable to participate in an interview, were under 18 years of age, and who did not self-identify as being of the female sex.

Recruitment of transgender participants was done through self-referral (notified by e-mail listserv, advertisement, or flyer). Flyers were posted throughout com-

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Table 1. Vocabulary Used by the Transgender Community*

Word	Definition
Gender	Psychosocial construct that culture uses to identify male, female, neither, and both
Gender Queer	Used most often by youth to describe both their gender identity and sexual orientation; often has political connotations
Queer	The sexual orientation called “queer” is most often individually defined though in general usually means that their sexual attraction is blind to sex and/or gender. Queer in the gender variant community often means that the individual does not completely conform to either male or female genders
Sex	Physiological make-up of a person including genetics, hormones, morphologic, biochemical, and anatomic structures
Sex Reassignment Surgery	Also known as gender reassignment surgery, these are surgical procedures which modify the biologic body to align with the individual’s gender identity; some examples might be mastectomy, breast implants, metoidioplasty, vaginoplasty, or phalloplasty
Transgender	Umbrella term used to describe people with gender identities and expressions that are not traditionally associated with their biologic sex
Transition	Process through which transgender individuals move through in aligning their gender identity; particularly physical, legal, and psychological
Transgender Man	Biologic female who gender identifies as a male
Transgender Woman	Biologic male who gender identifies as a female
Transsexual	Individuals who believe that their physical bodies do not represent their true sex; transsexuals usually desire sex reassignment surgery, but may choose varying degrees of surgical transition

Adapted from Dean et al.¹⁷ and Lev.¹⁹

*These terms are fluid and their meaning evolves; therefore, this definition may not be universal though it is the most common.

munities in the New England region within reasonable travel distances from New Haven, Connecticut. Snowball sampling was used to broaden the diversity of the sample.

Participant involvement consisted of an interview with open- and closed-ended questions designed to elucidate the participant’s thoughts of, feelings about, and experience with general health care and specifically their gynecologic care. The interviews lasted approximately 1 and 1/2 hours. Interviews were done in a private area chosen by the participant. A few example interview locations were the researcher’s office, the participant’s home, local coffee shops, and conference rooms at collaborating health centers. Interviews at the Yale School of Nursing were carried out in either the researcher’s office or a shared research interview room. Multiple studies were being performed, so a person was not necessarily identified as transgender by coming to the school for an interview. Gender-neutral bathrooms were also available for subjects. Subjects interviewed at health centers or coffee shops were seen as customers to that facility and therefore were not necessarily identified as transgender for participating in the study. Questions were constructed using language consistent with the speech of the transgender community, as well as in language understandable to people not familiar with transgender culture. The language and questions asked in the interview were reviewed by two different members of the transgender community for cultural clarity. Examples of some of the interview questions can be found in Appendix B.

This study was approved by the Yale School of Nursing Institutional Review Board. Signed informed consent was obtained from transgender participants at the

scheduled time of the interview before beginning the interview. All forms could be signed by either their given or chosen name. The participant was specifically informed that they could withdraw from the study at any time or refrain from answering any questions. A Health Insurance Portability and Accountability Act (HIPAA) confidentiality form was also explained, read, and signed by the interviewee before the onset of the interview because of the exchange of health-related information. Signed copies of the consent form and the HIPAA form were given to the participant as well as filed in a secure locked cabinet. All participants were assigned a study ID number. The link between the participant’s personal identifying information and the study ID number were kept in a separate locked file cabinet in the researcher’s office. All interview notes, recordings, and transcripts only contained the participant’s study ID number. Participants were asked not to use names during the interview; if names were mentioned, they were referred to by a single letter in transcriptions. Addresses and other personal identifiers other than name were not collected. The only exception to this was if the subject agreed to be contacted in the future.

Using a phenomenologic framework, four specific themes were identified because of their significance to each interview as a whole. The first author conducted the data analysis and consulted with the secondary authors throughout the data collection process. Interviews were recorded and listened to by each author. Each interview was manually evaluated for themes about the participants’ health care experiences and concerns. Initially, the first author identified and recorded themes based on participant’s responses to similar questions. Subsequently, each interview was reevaluated by all of the

authors to assess the consistency of chosen themes. More commonly held or universal themes were identified as data collection proceeded. Analysis was conducted of descriptors, phrases, and sentences of each interview's content. Similar and differing themes between interviews were next identified. Interviews were listened to again to identify supporting or competing content for chosen themes. Descriptive statistics regarding demographic information was used to characterize the population sampled.

RESULTS

Six individuals whose biologic sex was female and whose gender identity was transgender man, man, gender queer, or a combination of these three options were included in the sample (Table 1). The age range of the participants was 19 through 45 years of age, with an average age of 25.6 years. All participants completed at least some, if not all, of a college education. Four of the participants racially identified as white, one identified as being both black and white, and another as a mixture of several ethnicities. Three of the interviewees identified their socioeconomic class as middle class and one each as upper middle, lower middle, and lower class. Three of the participants identified their sexual orientation to be queer, while one identified as being straight/heterosexual and two as gay/homosexual. All of the participants were asked their preferred gender pronoun and are referred to by that pronoun throughout the remainder of this paper. All but one individual asked to be referred to with male pronouns.

Four prominent themes regarding transgender men's health care experiences emerged from these interviews: 1) receiving annual gynecologic care was perceived to be important; 2) breasts caused the most gender identity conflict; 3) revealing their gender identity to health care providers was a struggle; and 4) the male/female boxes on health intake forms, as well as pronoun usage by medical staff, were barriers to health care.

Annual Exams

Receiving gynecologic care was perceived to be important despite the incongruence between the interviewee's gender identity and their physical bodies. All but one of the participants received gynecologic care at least once in their lifetime. It was universally mentioned that gynecologic care included a Pap smear. All participants identified a generalized dislike of receiving gynecologic care, but each expressed an interest in maintaining their physical health despite the emotional challenges to receiving care.

"That's my biology . . . I just say to myself before I go in, 'You know what they are going to call you, she, and they are going to call you, [name], and

that is okay because that is my body and that is my biology and I need to make sure I'm healthy so that is my priority in that moment."

This generalized dislike was not just feeling vulnerable because of exposure of personal body parts. Rather, gynecologic exams are often a unique time when extreme emotional conflict between self-perceptions and physical anatomy are heightened because of physical touch, much like victims of sexual abuse. The one individual who had not received gynecologic care stated that she had never felt comfortable enough with a provider to receive this type of care. While all but one participant received gynecologic care on a semi-regular basis (ranging from once per year to once every couple of years) their motivation, approach, and coping mechanisms with receiving the care differed.

Breasts

Breasts caused gender identity conflict, and the act of binding one's breasts was crucial to gender perceptions. Breasts were identified as female organs that could not easily be hidden beneath clothes in order to be perceived as male unless they were bound tightly to their torso. The breasts are a constant irritating reminder of the individuals' biologic sex. The act of binding one's breasts can be equated to any of those routine things individuals do when they prepare themselves for the day. Binding was one of the first physical aspects of transition.

"I've always been way more comfortable having a vagina than having breasts . . . [breasts] are kind of like . . . when you have people staying in your house, like roommates or whatever, and they are just like there, but they are not paying rent, like that is how I feel about my breasts."

Three of the six individuals interviewed explored the implications of binding their breasts. One individual, who had undergone bilateral mastectomy years ago, did not speak of the act of binding but addressed the implications of having scars on his chest. The remaining two individuals who did not bind, and have not had bilateral mastectomy, expressed gratitude for their inherent biologically flat chest shape, which was perceived as being gender-neutral. The five participants who had their breasts all expressed desire for bilateral mastectomy. Concern was expressed regarding the long-term health implications of binding, health care providers' perceptions of binding, and the struggle with their own identity perceptions regarding their breasts.

While only half of this study's participants bound their chests, it was evident that they all identified with their bound bodies rather than their unbound bodies. Yet, it was also evident that the participants had some reservations about binding: participants had some long-term health concerns regarding their bodies and the implica-

tions of binding. While these reservations did not restrict their daily practices, they clearly raise questions regarding physical health.

Revealing Identity

Transgender men struggled with revealing their gender identity to health care providers. Internal struggle regarding when it is medically necessary to disclose one's transgenderism was identified by all participants.

"I'm often worried . . . about my identity and people finding out because I don't live that way and then worried about 'Do they need to know this?' I don't know if they need to know, because it makes a difference."

This struggle existed during every medical encounter, regardless of the type of health care they were seeking. The decision to reveal their transgender identity was often based on what type of health care provider they are seeing, the type of relationship they have previously established with that health care provider, and their current emotional patience and tolerance for explaining themselves.

One of the most surprising factors influencing their decision was the perception of the health care provider's level of acceptance. Individuals who completely pass as men in society showed some internal conflict about their female biology being discovered by medical providers. Individuals who did not completely pass as men were always forced to reveal their gender queer identity because of their inability to gender conform to traditional male and female gender appearance stereotypes. Some of the participants chose to be perceived as a female-bodied individual without revealing their male gender identity when receiving health care services.

Beyond being discovered, transgender men struggled with how, when, and to what extent their original biology affected their general medical care. For example, one individual expressed uncertainty regarding whether or not the dosage of anesthesia for his shoulder surgery might be sex-based and therefore whether his life and safety during surgery were dependent on revealing his transgenderism. The decision to disclose also seemed to be dependent on the medical staff's role in the patient's care. Unlike other participants, who routinely struggle with when and when not to reveal their gender identity, one participant removed the uncertainty from the start and informed his health care providers of his male gender identity and his chosen male name. This helped to affirm himself when receiving gynecologic care. This participant said that *"when people don't respect my name and my pronouns, it can feel really frustrating, and that definitely doesn't make me feel very comfortable or welcome in a medical situation."*

Language and Filling Out Forms

"More options on the forms means there is room in people's minds."

One of the simplest, yet most challenging, aspects of receiving health care and revealing one's gender identity were the intake forms completed upon the initial visit. The male/female boxes on health care intake forms, as well as pronoun usage by health care providers, were barriers for transgender men when receiving health care. Deciding if the M and F boxes on the intake forms were referring to sex or gender caused conflict for all of the transgender men in this study. Checking the male or female box on a health care intake form implied certain aspects of one's physical body, biologic sex, as well as physical appearance and gender expression. All individuals interviewed had stories of the conflict between the box marked on intake forms and their appearance, name, anatomy, and identity.

All the participants suggested that intake forms should have more clarification questions rather than just the male and female boxes. One participant described that the difficulty of filling out the forms added to his sense of vulnerability while receiving health care.

DISCUSSION

Seeking and receiving health care can be challenging for many individuals, and the specific barriers to health care may be unique to that individual or applicable to an entire group. Gynecologic care can be an exceptionally challenging type of health care to receive because the focus is the sexual reproductive anatomy, which many individuals find particularly private. Transgender men specifically struggle with their reproductive anatomy, or biologic sex, because it does not match their gender identity. It is this struggle that this investigation sought to understand for transgender men. Specifically, what are the gynecologic health care needs? This study found that transgender men were receiving gynecologic care on a semi-regular basis. Someone with whom they had developed a cursory relationship was often providing the care. However, their motivations for receiving care were highly varied. Secondly, breasts, breast exams, and binding caused a high level of stress for transgender men, which added to the struggle and conflict about revealing their transgenderism to health care providers.

The transgender men in this study had a wide variety of coping mechanisms for receiving gynecologic care, and these coping mechanisms were often dependent on whether or not they revealed their gender identity and biologic sex incongruence. Finally, language was a significant barrier to receiving care. These interviewees struggled with whether to mark female because they had a vagina beneath their clothing and were of female sex or male because they appeared masculine when sitting in

the waiting room and gender-identified as male. Beyond the forms, pronoun and name usage by the health care provider and their staff appeared to be a second barrier. The authors hope the discovery of these four aspects of the gynecologic care of transgender men will aid health care providers in giving culturally competent care and therefore decrease the barriers transgender men face when seeking care for their bodies.

The social, political, and health care implications of transgenderism are intricately complex yet deal with basic human needs. While it was the goal of this study to tease apart the general information in hopes of discovering finite ways to improve gynecologic care for transgender men, some basic principles of humanity were also reiterated. Transgender individuals have physical bodies that need health care. They also have evolving interpersonal struggles that, at times, may need the assistance of a counselor. While some of the health care needs of transgender individuals are unique, the majority of their needs are the typical primary care needs of all people. Transgender individuals get common colds, have their shoulders dislocate, and have diabetes, pneumonia, and hypertension. Treating transgender individuals with the basic principles of respect and a fundamental level of understanding opens the access gates of health care access and allows communication between health care providers and the transgender community.

IMPLICATIONS FOR CLINICAL PRACTICE

Through the stories of the transgender men who participated in this study, midwives and other women's health care providers can begin to understand the barriers to obtaining health care services faced by transgender men. The implications of the four major themes identified in these interviews directly affect how midwives and other women's health care providers approach the care of transgender men. Knowing that patients place value on receiving gynecologic care, midwives and other women's health care providers need to reciprocate this sense of importance by educating themselves on the cultural sensitivities of transgender care. Secondly, it is important that the cancer screening aspects of breast exams are emphasized and breasts become asexualized. Reiterating to patients that breast cancer is sex- and gender-blind and acknowledging that there is an absence of research on the long-term effects of testosterone on breast tissue may help encourage patients to obtain breast exams.

Revealing one's gender identity struggles to midwives and other women's health care providers may be no different than revealing other intimate personal issues. Developing a trusting, open, safe relationship over time is an important underlying aspect to receiving care for all persons.

Finally, the male/female boxes on health intake forms, as well as pronoun usage by medical staff, were identi-

fied barriers to health care. While the literature and the news tend to focus on larger health care barriers, such as lack of health insurance, it is equally important to acknowledge the smaller barriers like using the patient's chosen name. Barriers such as intake forms and name and pronoun usage are easily corrected, but they require the assistance of the entire practice, not just the health care provider. It is crucial to remember that a single health care provider is only as sensitive and competent as the rest of the practice.

With an enhanced understanding of these barriers, midwives and other women's health care providers can begin to make changes in their practice's intake forms, improve their sensitivity to gender and sexual variation, increase their sensitivity toward their patients' body perceptions, and create a welcoming environment for patient sharing. Midwives and other women's health care providers should also familiarize themselves with the language used within the transgender community (Table 1) and the resources available to aid them in their care (Appendix A).

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Appendix A. Resources for Transgender Patients

Callen Lorde Community Health Center
356 W 18th St
New York, NY 10011
Phone: (212) 271-7200
www.callen-lorde.org/index.html

Medical Therapy and Health Maintenance for Transgender Men: A Guide for Health Care Providers
Nick Gordon, MD, Jamie Buth, MD, and Dean Spade, Esq
www.nickgorton.org

Tom Waddell Health Center Transgender Protocol
50 Lech Walesa (Ivy) St
San Francisco, CA
Phone: (415) 355-7400 or (415) 554-2727

The World Professional Association for Transgender Health, Inc
Formerly known as the Harry Benjamin International Gender Dysphoria Association, Inc
Bean Robinson, PhD (Executive Director)
Standards of Care, 6th version
Phone: (612) 624-9397
www.wpath.org

Source: The Harry Benjamin International Gender Dysphoria Association Website,¹⁶ Gorton et al.,²² and Oriel.²⁸

Appendix B. Interview Questions Used in this Study

- Can you tell me a little about any barriers to health care you have experienced?
- For you, what is the most difficult part of seeking and receiving medical care?
- What are some of the reasons why you needed to see or why you saw a health care provider?
- Do you see a health care provider for preventive care (physical, gynecologic exam, or check-up)? (Yes/No)
- If no: Why do you not see a health care provider for preventive care?
- What is your goal for physical/medical transition (e.g., hormone therapy, phalloplasty, vaginoplasty, breast augmentation, or mastectomy)?
- What does gynecologic care entail for you (i.e., what happens when you are receiving gynecologic care)?
- Do you worry about gender-specific types of cancer (e.g., breast, ovarian, or prostate)? (Yes/No)
- If yes: What type(s) of cancer worry you?