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Perinatal mental health, sexual violence and gender affirmation in a transmasculine twin pregnancy in the context of homelessness: a case-based short communication from Brazil

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Abstract

This case-based article describes trauma-informed and gender-affirming perinatal mental health care for a transgender man with a twin pregnancy after sexual violence in Brazil. The patient experienced homelessness or institutional shelter, psychological distress, substance-use vulnerability and high-risk obstetric complications, including threatened preterm labour, infection, gestational diabetes assessment, selective fetal growth restriction and suspected early twin-to-twin transfusion syndrome. Longitudinal care integrated maternity services, psychiatry, endocrinology, nutrition, social work, psychosocial care, alcohol and other drug services and institutional shelter. The case shows that clinical safety in complex transmasculine pregnancy depends not only on obstetric surveillance, but also on recognition of gender identity, fatherhood, bodily autonomy and the cumulative effects of social vulnerability. Gender-affirming language, trauma-informed consent, psychiatric follow-up and social protection supported trust, engagement and continuity before and after birth. The report highlights a replicable logic of care for community and public mental health settings: reference teams, intersectoral coordination and postnatal continuity can reduce fragmentation when pregnancy occurs at the intersection of sexual violence, housing instability and structural transphobia.

Introduction

Pregnancy in transgender men remains insufficiently represented in perinatal and mental health literature, especially in cases involving twin gestation. Existing evidence shows that transgender and gender-diverse people may experience misgendering, limited clinical familiarity among professionals, fear of discrimination and fragmented reproductive care (Light et al., 2014; Hoffkling et al., 2017; Besse et al., 2020; MacDonald et al., 2021).

These barriers may have even deeper consequences when pregnancy occurs after sexual violence and is accompanied by homelessness, psychological distress and vulnerability related to substance use. In such contexts, perinatal care must extend beyond a biomedical response by incorporating safety, listening, autonomy, gender affirmation and psychosocial coordination (Hahn et al., 2019; American College of Obstetricians and Gynecologists, 2021b).

Sexual violence is a public-health and human-rights problem with consequences for mental health, bodily autonomy and continuity of care. In Brazil, notification and survey data indicate that violence against LGBT and LGB+ populations remains substantial and underreported (Pinto et al., 2020; Vasconcelos et al., 2023). For a pregnant transgender man, trauma exposure may be intensified by cisnormative maternity routines, female-coded institutional language, repeated intimate examinations and lack of recognition of fatherhood. This short communication presents a de-identified Brazilian case in which high-risk obstetric care, psychiatric assessment, trauma-informed communication and social protection were integrated.

Case presentation

The case concerns an adult transgender man in his third decade of life who was socially recognised as male. He was referred to high-risk antenatal care at a tertiary maternity hospital in north-eastern Brazil after a second-trimester ultrasound identified a twin pregnancy. Name initials, medical record numbers, images, screenshots, photographs and regionally identifiable journalistic material were ethically excluded because indirect identification was considered a material risk.

The patient reported living in homelessness or, at some points, in institutional shelter. He reported limited schooling, informal work, previous sexual violence and multiple overlapping social vulnerabilities. He had not previously used gender-affirming hormone therapy. He stated that the current pregnancy resulted from sexual violence, while clearly expressing his wish to continue the pregnancy and care for the babies.

Initial assessment identified urinary symptoms, dyspepsia, vomiting, sleep disturbance and a pruritic breast/chest lesion, which was clinically treated. Laboratory screening detected syphilis, treated with benzathine penicillin, followed by a subsequent decline in serological titre. Urinary/genital testing also indicated Trichomonas vaginalis infection. Care required coordination among obstetrics, fetal medicine, psychiatry, endocrinology, nutrition, social work and the psychosocial care network, including referral to a specialised alcohol and other drug service.

During pregnancy, the patient was admitted with abdominal pain, vaginal bleeding and threatened preterm labour. During admission, he reported a recent relapse involving cocaine and alcohol, while maintaining motivation for abstinence and a strong therapeutic bond with the maternity team. Psychiatric assessment identified anxiety and psychological distress, without psychotic, manic or hypomanic symptoms. An antidepressant and a low-dose antipsychotic were prescribed, with regular follow-up and advice to return whenever needed, even without a prior appointment.

Fetal surveillance suggested a monochorionic diamniotic twin pregnancy, with amniotic-fluid discordance, suspected selective fetal growth restriction and findings compatible with an early stage of twin-to-twin transfusion syndrome. Expectant management with serial surveillance was adopted. The patient was also assessed for gestational diabetes mellitus and risk of preterm birth associated with a short cervix, and he received antenatal corticosteroids.

In the third trimester, he presented with vaginal fluid loss and pelvic pain. Preterm labour and ruptured membranes were diagnosed. Ultrasound showed both fetuses in breech presentation, with selective growth restriction. Caesarean birth was performed without relevant surgical complications. The neonates required surveillance, and the patient’s puerperium was physiological. He wished to breastfeed/chestfeed and reported milk production, although formula supplementation was required. At follow-up, he remained engaged with the multidisciplinary team and lived in institutional shelter while caring for the babies with social support.

At follow-up, the patient described pregnancy and fatherhood as a turning point. Before pregnancy, he had experienced homelessness, substance-use vulnerability, interpersonal violence and severe social

instability. During antenatal and postnatal care, caring for the babies strengthened his motivation to maintain abstinence, remain connected to health services and rebuild daily life around fatherhood. Recognition as a father, rather than cisnormative maternity language, supported therapeutic alliance, engagement with obstetric and psychiatric follow-up and connection with social-protection services. His wish to breastfeed/chestfeed, with formula supplementation when needed, was addressed within a plan that respected bodily autonomy, parental identity and infant wellbeing. This patient-centred approach is consistent with gender-affirming and collaborative perinatal care recommendations (American College of Obstetricians and Gynecologists, 2021a; Hahn et al., 2019).

Discussion and Conclusions

This case is relevant to perinatal mental health because risk was not confined to twin pregnancy, preterm birth, gestational diabetes, infection or fetal-growth concerns. Pregnancy occurred in the context of sexual violence, housing vulnerability, structural transphobia, psychological distress and alcohol and other drug use. The favourable outcome should therefore be interpreted as the result of longitudinal care, recognition of the patient's male identity, multidisciplinary coordination and social protection, rather than as spontaneous resolution of a complex obstetric case.

Table 1 summarises the de-identified clinical and social timeline, highlighting how obstetric, psychiatric and social-protection actions were coordinated across the course of care.

Table 1
De-identified clinical and social timeline

Phase of care	De-identified clinical and social information	Care actions	Outcome or interpretive point
Referral and start of high-risk antenatal care	Adult transgender man in his third decade of life, socially recognised as male, referred after a second-trimester ultrasound identified a twin pregnancy. The history included sexual violence, recent homelessness or institutional shelter and multiple overlapping vulnerabilities.	Referral to high-risk antenatal care; de-identification strategy adopted; longitudinal multidisciplinary planning initiated.	The patient clearly expressed his wish to continue the pregnancy and care for the babies.
Initial clinical and laboratory assessment	Urinary symptoms, dyspepsia, vomiting, sleep disturbance and a pruritic breast/chest lesion. Screening detected syphilis and Trichomonas vaginalis infection.	Clinical treatment of symptoms; syphilis treated with benzathine penicillin; coordination among obstetrics, fetal medicine, psychiatry, endocrinology, nutrition, social work and psychosocial care services.	The case required integrated obstetric, mental-health and social-protection responses, rather than isolated biomedical management.
Admission during pregnancy	Admission with abdominal pain, vaginal bleeding and threatened preterm labour. The patient reported recent relapse involving cocaine and alcohol and psychological distress, while maintaining motivation for abstinence and contact with the maternity team.	Psychiatric assessment; antidepressant and low-dose antipsychotic; maintenance of the link with maternity services and the psychosocial network; continuous communication with social work, institutional shelter and alcohol and other drug services.	The care bond was maintained despite acute social and mental-health vulnerability; the case demonstrates the importance of integrated pathways to avoid care fragmentation.
Fetal and endocrine surveillance	Monochorionic diamniotic twin pregnancy with amniotic-fluid discordance, suspected selective fetal growth restriction and findings compatible with an early stage of twin-to-twin transfusion	Expectant management with serial surveillance; endocrinological assessment; antenatal corticosteroids because of risk of preterm birth.	Specialised surveillance connected fetal risk, metabolic risk and prevention of preterm birth.

Source: Prepared by the authors based on de-identified clinical records.

Phase of care	De-identified clinical and social information	Care actions	Outcome or interpretive point
	syndrome. Gestational diabetes mellitus and risk of preterm birth related to a short cervix were also assessed.		
Birth, puerperium and follow-up	Third-trimester presentation with vaginal fluid loss and pelvic pain. Preterm labour and ruptured membranes were diagnosed; both fetuses were breech, with selective growth restriction.	Caesarean birth; neonatal surveillance; puerperal follow-up; support for breastfeeding/chestfeeding with formula supplementation when needed.	Physiological puerperium; maintenance of multidisciplinary follow-up, institutional shelter and social support while caring for the babies.

Source: Prepared by the authors based on de-identified clinical records.

The first implication is that gender affirmation can function as a safety intervention. Correct use of name and pronouns, recognition of fatherhood, privacy during examinations, avoidance of unnecessary exposure and respectful communication may reduce retraumatisation and strengthen engagement (American College of Obstetricians and Gynecologists, 2021a; Chisolm-Straker et al., 2017; Coleman et al., 2022; Hahn et al., 2019). Terminology is not cosmetic: “maternal-fetal dyad” may not fit a pregnant transgender man who claims fatherhood; patient, pregnant father or pregnant person should be guided by the person’s preference and by clinical precision.

The second implication concerns psychiatric and psychosocial care. Psychiatric assessment supported safe psychotropic management, risk assessment, referral to psychotherapy and a trauma-informed plan responsive to gender identity and social determinants of health. Transgender and gender-diverse people may experience distress related to cumulative violence, stigma, discrimination, social insecurity, previous non-affirming care and fear of childbirth (Coleman et al., 2022; Malmquist et al., 2019). Integrating psychiatric care with gender-affirming services can strengthen continuity and reduce fragmentation in complex perinatal situations.

The third implication concerns intersectoral coordination. A purely biomedical response would have been insufficient. An individualised multidisciplinary plan connected obstetric surveillance, fetal medicine, mental-health care, endocrinology, nutrition, social work, institutional shelter and alcohol and other drug services. The case offers a replicable logic of care: institutional gender literacy, use of social name and pronouns, recognition of fatherhood, trauma-informed consent, a reference team, safety planning after sexual violence, postnatal continuity and anticipation of documentation barriers that may affect recognition of parenthood and continuity of care.

This report has limitations. It is a single case, with no capacity to estimate prevalence, causality or comparative risk. Some information derives from clinical records and may reflect documentation gaps. Because the case was rare and socially visible, anonymity was maximised, limiting chronological and sociodemographic detail. Even so, the case supports a practical conclusion: high-complexity transmasculine pregnancies require institutional pathways that combine obstetric safety, perinatal mental-health support, gender affirmation, trauma-informed care and social protection.

Declarations

Ethics approval

This de-identified case report was approved by an institutional research ethics committee in Brazil. Full identifying ethics information is provided in the submission system and in the separate title page/declarations file, in accordance with double-anonymous review requirements.

Consent to publish

Written informed consent for publication of this de-identified case report was obtained from the patient. The signed consent form is retained by the authors and can be provided to the journal if requested.

Clinical trial number

Not applicable.

Competing interests

The authors have no competing interests to declare that are relevant to the content of this article.

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Author Contribution

LASM contributed to the interpretation of findings and critical revision of the manuscript. WAFN conceived the study, developed the theoretical framework, conducted the analysis, and wrote the first draft of the manuscript. JOC contributed as advisor, supporting the conceptual development, methodological refinement, interpretation of findings, and critical revision of the manuscript. All authors reviewed and approved the final version of the manuscript.

Data availability

No public dataset is available because this is a single de-identified clinical case report and public release of additional details could increase the risk of indirect identification.

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