Chapter 52

Trans Parenting

DAMIEN W. RIGGS, SALLY HINES, RUTH PEARCE, CARLA A. PFEFFER, AND FRANCIS RAY WHITE

Introduction

The normative assumption that assigned sex determines gender is fundamental to the experience of trans people. For trans people, this normative assumption is shown to be incorrect, yet its persistence shapes not only how trans people experience the world but also how it is used by others as legitimating discrimination directed towards trans people. In a now extensive body of work, Gavriel Ansara and colleagues (Ansara; Ansara and Hegarty; Riggs, Ansara and Treharne) have theorized how the normative assumption that assigned sex determines gender constitutes a form of cisgenderism—defined as the ideology that delegitimizes people's own understandings of their bodies and genders. Other forms of cisgenderism include the pathologization of trans people's lives, the silencing of conversations about gender diversity, misgendering (i.e., using incorrect pronouns or names), and the assumption that there are only two genders. Regarding this final form of cisgenderism, in the present chapter, the term "trans" is used to encompass both people with a binary gender (i.e., trans men or women), and people with a nonbinary gender (i.e., genderfluid or agender people).

Regarding parenting, cisgenderism shapes perceptions of who can be or should be a parent. Historically, reproductive bodies were solely presumed to be cisgender (i.e., not transgender) women's bodies and all such women were assumed to want to be able to reproduce and would be able to reproduce. Marginalized by these presumptions are, for example, transgender men and/or nonbinary people assigned female at birth who may be gestational parents. Furthermore, the presumption that all women are cisgender and capable of reproduction not only marginalizes cisgender women who are unable to, or who do not want to, bare children but also marginalizes trans women and nonbinary people assigned male at birth who may already be mothers or

parents or who may wish to become mothers or parents in the future. Although assisted reproductive technologies at present go a long way to meeting the reproductive needs of transgender men and/or nonbinary people assigned female at birth, lagging behind are technologies to facilitate reproduction for trans women and nonbinary people assigned male at birth (though recent developments in uterine transplants offer hope for a different future).

This chapter explores some of the broad contours of trans parenting, covering areas such as barriers to parenting for trans people, decision making about parenting, conception, pregnancy and birth, and parent-child relationships. Each section uses Ansara and colleague's (Ansara; Ansara and Hegarty; Riggs, Ansara, and Treharne) cisgenderism framework to highlight key challenges faced by trans parents, although attention is also paid to the agency enacted by, and the positive parenting experiences of, trans people. Additional theoretical concepts are introduced throughout to provide additional depth to the exploration of the topic of trans parenting.

Barriers to Parenting for Trans People

Historically, and still in some countries in Europe and Asia, trans people are subjected to forced sterilization as part of gender transition (Transgender Europe). This constitutes a significant barrier to people seeking to later become a parent to a genetically related child. Even in countries where sterilization is not mandatory, other barriers exist to future genetic parenthood. These include the lack of information provided by healthcare providers about reproductive options, the costs associated with assisted reproductive technologies, and a lack of legal protection for trans parents (Tornello and Bos).

Beyond genetic parenthood, trans people may become parents through foster care or adoption. Yet research suggests that trans people are more likely than cisgender people to fear discrimination from adoption and foster care agencies (Goldberg et al.). Discrimination may take the form of prurient questions about a person's gender history, misgendering, a lack of understanding of the specific needs and experiences of trans people, and general disapproval of trans people as parent (Goldberg et al.). Adoption in particular can also be prohibitively expensive for some trans people, thus presenting a significant barrier.

In terms of conceiving of oneself as a gestational parent, trans people may struggle with reconciling social norms about pregnant bodies and their own views about their bodies (Ellis, Wojnar, and Pettinato). Whereas some trans people may be entirely comfortable with undertaking a pregnancy, some may have concerns about how other people will view their pregnant body. Other trans people, while open to the idea of undertaking a pregnancy, may experience considerable gender dysphoria in relation to what it means to be pregnant (especially given the normative assumption that pregnancy bodies

are always female bodies), constituting an additional barrier to gestational parenthood (Kirczenow MacDonald et al.).

Decision Making about Parenthood

Despite the potential barriers that trans people face to foster or adoptive parenthood, it is nonetheless the case that trans people are more likely than cisgender people to be open to adoption or fostering. Moreover, trans people are more likely to be open to fostering or adopting children with physical or mental disabilities (Goldberg et al.). Trans people are also more likely to be open to adopting sibling groups, to adopting transracially, and to adopting LGBTQ young people (Goldberg et al.). For some trans people, despite the potential associated costs (e.g., regarding the home study and agency fees), adoption or foster care may be seen as an appealing option because they are seen as addressing certain issues, such as overpopulation, and because they offer the opportunity to provide a family to children who are unable to live with their birth family (Brown).

For some trans people desiring to become parents, pregnancy may be considered a default option due to both associated costs with other options and the relative ease of undertaking a pregnancy in comparison to other options, such as surrogacy or adoption (Riggs et al., "Negotiating Conception"). This may be particularly the case if a pregnancy is undertaken through private arrangements (i.e., through intercourse with a partner or through the use of known donor sperm). For trans people who become gestational parents before transitioning, pregnancy may be treated as a taken-for-granted part of the adult life course, reinforced by normative gender assumptions (Hines).

It is important to acknowledge that for some trans people, parenthood is not always chosen. Trans people may become pregnant as a result of sexual assault, or a pregnancy may be unintended (Moseson et al.). Furthermore, some trans people may also assume that hormone therapies suppress the ability to become pregnant, thus negatively impacting upon trans people's reproductive awareness and trajectories (Charlton et al.). Finally, for trans people who undertake a pregnancy, and as is true for all pregnant people, pregnancy loss can occur. For transmasculine or nonbinary people specifically, pregnancy loss can be fraught by cisgenderism on the part of healthcare professionals and family members (Riggs et al., "Experiences of Pregnancy Loss").

Journeys into Parenthood

Despite the growing visibility of trans people and gestational parenthood, only a small body of academic research (Charter et al; James-Abra et al; Light et al) and first-person accounts (Beatie; MacDonald; Ware) have investigated pathways to conception by trans people. Furthermore, to date, there has been little theorizing about how we might understand trans people's

conception-related experiences and negotiations. Damien Riggs and colleagues have used Carla Pfeffer's framework of normative resistance and inventive pragmatism to understand conception for trans people. The former refers to "strategies and actions for making life choices distinct from those considered most socially expected, celebrated, and sanctioned" and the latter to "strategies and actions that might be considered clever manipulations of an existing social structure in order to access social and material resources" (578). Riggs and colleagues found that the trans gestational parents they interviewed engaged in normative resistance by resisting the idea that conception only occurs through heterosexual intercourse and resisting the assumption that conception is always difficult for trans people. Participants engaged in inventive pragmatism by side-stepping reproductive clinic bureaucracy by finding a known donor and by treating conception by trans people as nonexceptional.

Following conception, transition to parenthood for trans people involves negotiating with cisgenderist stereotypes about parenthood (Fischer). Such stereotypes include the assumption that only women are gestational parents, that gestational parents must experience a particular normative relationship to their pregnant bodies, that all mothers are gestational parents, and more broadly, that all adults have an inherent desire to become parents (Riggs and Bartholomaeus). Some trans people actively resist these types of stereotypes, instead developing new language to describe their reproductive bodies or their roles as parents. Other trans people may adopt and/or rework existing cisgenderist stereotypes, using traditional language about reproduction in some instances and reworking it in other instances.

For trans people who undertake a pregnancy, disclosure about being pregnant is often a key concern regarding pregnancy. Some trans people may rely upon other people's assumptions about "fat male bodies" to hide a pregnancy (LaMarre et al.). Other trans gestational parents may choose to disclose their pregnancy to others so as to facilitate awareness and education. Decisions about disclosure are shaped by feelings of safety and the availability of support networks to help manage potentially negative responses. Disclosure is also a concern for some trans people regarding the informational needs of children (Veldorale-Griffin). Some trans people may choose to disclose to their children from an early age the details of their conception and birth and the gender histories of their parent(s). Other trans people may wait until their child enquires about their birth story.

As part of the transition to parenthood, some trans people experience high levels of support: from a partner, from family, from friends, and/or from support communities (Riggs, Power, and von Doussa). Other trans people, however, may experience additional rejection from family members, particularly when family members views trans parents negatively (Riggs, Power, and von Doussa). Trans people increasingly face media scrutiny in the context of parenthood (Pearce and White). Moral panics about transmasculine people and pregnancy or transfeminine people and uterine transplants, for

example, rely upon cisgenderist assumptions about reproduction and can negatively impact upon trans people's experiences of, and expectations about, the transition to parenthood. Media reporting can shape the decisions that trans people make about disclosing their gender history in the context of parenthood.

Chest feeding (for transmasculine people) and breast feeding (for transfeminine people) represent key areas where trans people negotiate the transition to parenthood. Trans women may choose to induce lactation if a partner is the gestational parent if they foster or adopt an infant or if they have a child through a surrogacy arrangement (Reisman and Goldstein). For transmasculine people, chest feeding can often represent a delicate balance between feelings of dysphoria and the sense that chest feeding gives purpose to the body (i.e., providing for a child). Dysphoria can relate to an individual's own sense of their body, or to the (potentially negative) views of other people about pregnant bodies (Kirczenow MacDonald et al.). Other trans people may choose to engage in milk sharing (i.e., a lactating person sharing their milk with another person for the purpose of feeding an infant), rather than feeding a child from their own body (MacDonald et al.).

Whatever the decisions that trans people make about infant feeding, a significant barrier to decision making is a lack of awareness about potential options among healthcare providers, negative views among healthcare providers about trans people and infant feeding (and parenting more broadly), and a hesitancy to engage with trans people about infant feeding (MacDonald et al.). As a result, trans people who face challenges with infant feeding (such as problems with milk production, problems with latching, and mastitis, a common infection associated with breast or chest feeding) may have few options for formal support. As such, informal support networks run by trans people can be an important resource for trans people engaging in infant feeding (MacDonald et al.).

Parenting Practices and Children's Experiences

In terms of division of labour, Samantha Tornello's research on trans people who are parents suggests that they typically seek an egalitarian division in the context of couple relationships. Despite this, parents who make a lesser financial contribution, work fewer paid hours, and who are genetically related to their child(ren) are more likely to undertake a greater share of household and childcare labour. Tornello also found that undertaking a greater share of childcare was linked to higher levels of psychological distress, and undertaking a greater share of household labour was linked to lower levels of relationship satisfaction. Life satisfaction, however, was not related to division of childcare labour. Importantly, satisfaction and distress were further related to discrepancies between the division of labour that trans parents expect would occur after the arrival of a child and the actual division of labour that occurred. As such, although an egalitarian division of labour

was seen as ideal by trans parents, when this did not occur, it held the potential to negatively impact upon individual and couple wellbeing.

In terms of children's experiences, the limited research in this area suggests that children of trans parents report high quality relationships with their parents, that children report psychological adjustment on par with general population measures, and that children report average to high levels of self-esteem (Imrie et al.). These findings are notable given the context of cisgenderism in which trans parents and their children live. In other words, despite living with cisgenderism, children of trans parents appear to fare at least as well as their peers with cisgender parents.

Conclusions

Trans parents and their children face unique challenges as a result of living in the context of cisgenderism. This includes both explicit and purposive discrimination as well as unintentional discrimination that can serve to marginalize their experiences or exclude them from services. Ansara and colleague's (Ansara; Ansara and Hegarty; Riggs, Ansara and Treharne) cisgenderism framework thus provides an important lens through which to understand trans people's experiences of parenting. Additionally, Pfeffer's concepts of normative resistance and inventive pragmatism helps not only to focus on the agency enacted by trans parents but also to understand the positive experiences of parenting that trans people have. These include reworking normative gendered assumptions about gestational parenting specifically and parenting more broadly.

In terms of the future of the study of trans parenting, much of the research to date has focused on transmasculine people and nonbinary people assigned female at birth. More research is needed on the experiences of trans women and nonbinary people assigned male at birth. How trans women, for example, are recognized as mothers in cultural contexts where the category "mother" is often reserved for cisgender women who are gestational parents (i.e., rather than being appended with such terms as "adoptive mother" or "foster mother") requires ongoing attention.

Also needed is continued attention to the healthcare needs of trans parents. A slowly growing body of grey literature—such as the gender inclusion guide produced by Brighton and Sussex University hospitals in the United Kingdom or A.J. Lowik's trans inclusive abortion guide—provide clear information for healthcare professionals seeking to better support trans intending parents, parents, and those navigating decisions about reproduction. The academic literature has also begun to explore the specific health needs of transfeminine people (Ellis and Dalke) and to question what it means to reframe reproductive services as "women's services" given the growing number of transmasculine people using such services (Stroumsa and Wu).

The inclusion of trans parents in the context of maternal theory is vital, as trans people serve as a salient reminder that although gestation is still

primarily undertaken by women, it is not solely undertaken by women and, further, that not all women who are mothers are gestational parents. A focus on trans people can serve to expand our understanding of maternal theory by engaging with different questions, such as that raised by Andrea Doucet about "do men mother." And by conducting more research on trans men and reproduction in particular, more information can be uncovered about how such men negotiate a relationship to traditional discourses surrounding pregnant bodies, including in relation to conceptualizations of what constitutes the maternal (Riggs).

In conclusion, despite living with cisgenderism, trans parents and their children do well. This does not, however, negate the continued need to examine and challenge cisgenderism in all its forms so as to contribute to the wellbeing of all people and trans parents specifically. To imagine a world where cisgenderism does not exist is to imagine a world where trans parents and their children are supported to live the fullest lives possible.

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