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## The transgender parent: Experiences and constructions of pregnancy and parenthood for transgender men in Australia

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### ABSTRACT

**Background:** Transgender (trans) men are commonly born with the reproductive anatomy that allows them to become pregnant and give birth and many wish to do so. However, little is known about Australian trans men's experiences of desiring parenthood and gestational pregnancy.

**Aims:** The present study aims to address this gap in the literature through addressing the following research questions: how do Australian trans men construct and experience their desire for parenthood? And, how do Australian trans men construct and experience gestational pregnancy?

**Methods:** This study aimed to explore these experiences, through a mixed-methods research design using online survey data and one-on-one interviews, with 25 trans men, aged 25–46 years old, who had experienced a gestational pregnancy. Data were analyzed using thematic analysis.

**Results:** For our participants, parenthood was initially described as alienating and complex, however transitioning enabled participants to negotiate and construct their own parenting identity. Pregnancy was positioned as a problematic but “functional sacrifice,” however formal assisted fertility experiences were rife with exclusion. At the same time dysphoria associated with withdrawing from testosterone and the growing fecund body were significantly troubling. Changes to the chest were of particular concern for participants. Exclusion, isolation, and loneliness were the predominant features of trans men's experiences of gestational pregnancies. Healthcare systems are not generally supportive of trans bodies and identities and trans men encounter significant issues when interacting with healthcare providers. As such, the results reinforce the importance of inclusive and specialized health services to support trans men through pregnancy.

### KEYWORDS

Fertility; pregnancy; parenthood; transgender men

### Introduction

A transgender man is a person who identifies as male, but whose sex may have been designated female at birth. As such, transgender (trans) men are commonly born with the reproductive anatomy that allows them to become pregnant and give birth (Obedin-Maliver & Makadon, 2016). With recent cultural shifts in community and legal attitudes around the trans community, the openness of trans men desiring parenthood and becoming parents through gestational pregnancy may be more a reality now than ever before (Tornello & Bos, 2017). Whilst there is growing body of research around trans parenting (Riggs, 2013; Walks, 2015) there is still little known about the experiences of Australian trans men negotiating parenthood and gestational pregnancy, the focus of this article.

Many trans men elect to transition to bring their internal and external experiences of gender into

alignment (Burnes & Chen, 2012). Transitioning is a process, rather than a single event, and can take a variety of forms. A trans man may transition physically by using hormonal or surgical treatments; they may change their appearance, their name, and their gender pronoun to transition socially; and they may pursue recognition of their gender identity legally and formally (Biblarz & Stacey, 2010; Pyne, 2012; Weiner & Zinner, 2015). However, it is important to note that not all trans men pursue a transition. This may be because they are not medically or financially able to, because they do not have the support of those around them, or because they choose to express themselves in a different way (Pyne, 2012).

Many trans men wish to be parents (Haines, Ajayi, & Boyd, 2014; Riggs, 2014; Riggs, Power, & von Doussa, 2016). However, hormonal and surgical transitioning can impact significantly on their ability to

biologically reproduce (Light, Obedin-Maliver, Sevelius, & Kerns, 2014). For example, as testosterone therapy leads to anovulation and amenorrhea, fertility is adversely affected (Amato, 2016; Light et al., 2014; Wierckx et al., 2012). This effect can be reversed if testosterone use ceases; one study found that 80% of trans men who stopped testosterone therapy resumed menstruation within 6 months (Light et al., 2014). Whilst the impact of long-term or continued testosterone use on ovarian functioning is not fully known, trans men have successfully conceived and carried a pregnancy after suspending testosterone therapy (Ellis, Wojnar, & Pettinato, 2015; Mitu, 2016; Obedin-Maliver & Makadon, 2016). For trans men who have undergone a surgical transition, such as hysterectomy, metoidioplasty, or phalloplasty, gestational pregnancy will no longer be a viable option (Amato, 2016; Obedin-Maliver & Makadon, 2016). Trans people may access-assisted reproductive technologies to save their gametes or reproductive tissue, or if they need assistance in conceiving their children (James-Abra et al., 2015). In general, reproductive options for trans men include cryopreserving embryos, oocytes, and ovarian tissue, which can be carried out on its own or during a hysterectomy (De Sutter, 2009; James-Abra et al., 2015; Jones, Reiter, & Greenblatt, 2016). It has been argued that it is vital trans men are informed of the impact of hormonal and surgical treatments on their ability to reproduce, pretransition, in order to make decisions regarding the preservation of their fertility (De Sutter, 2009; Light et al., 2014; Wierckx et al., 2012). Health organizations, such as The World Professional Association for Transgender Health (2011), and the Ethics Committee of the American Society for Reproductive Medicine (2015) have recommended that healthcare providers (HCPs) counsel their trans patients about their fertility preservation options before commencing transition. However, it is not known if, or how routinely this information provision actually takes place, as current research illustrates that many trans men lack the information and requisite support to control their reproductive health (Jones et al., 2016; Mitu, 2016; Veale, Watson, Adjei, & Saewyc, 2016) with some researchers concluding that trans men, and the broader trans community, are “invisible” within health research (Merryfeather & Bruce, 2014).

Accessing general healthcare can be significantly challenging for trans men, including outright

discrimination and refusal of treatment, as well as a lack of relevant clinical knowledge and cultural understanding amongst HCPs (Byron et al., 2016; Coleman et al., 2012; Grant et al., 2011; Scheim, Zong, Giblon, & Bauer, 2017). Multiple studies report that around half of the trans people surveyed forgo medical assistance when they need it, due to significant experiences of transphobia and discrimination (Coleman et al., 2012; Grant et al., 2011; Johnson, Mimiaga, & Bradford, 2008). In surveys from the United States and the United Kingdom, up to a third of trans patients report being turned away by HCPs, who have refused to treat them due to their trans status (Reisner, Perkovich, & Mimiaga, 2010; Roller, Sedlak, & Drauker, 2015). For those HCPs who do treat trans patients, many lack basic knowledge about trans people and their health needs. For example, in a US survey, 50% of transgender people reported having to teach a HCP about providing appropriate care (Grant et al., 2011).

This suggests that whilst many trans men desire to become a parent, they may not experience the same support and encouragement as their cisgender counterparts (Riggs et al., 2016).<sup>1</sup> Many researchers suggest that this stems from the heteronormative social model that excludes trans men and women from being seen as suitable parents (Downing, 2003; Oswald, Blume, & Marks, 2005; Riggs, 2014), wherein the only family structure of worth is comprised of a cisgender male and female heterosexual couple and their cisgender heterosexual offspring (Fish, 2008; Hudak & Giammattei, 2014; Mamo & Alston-Stepnitz, 2015; Nordqvist, 2012; Oswald et al., 2005). Thus, a trans man who wishes to become a parent through a gestational pregnancy is disruptive to heteronormative ideals (von Doussa, Power, & Riggs, 2015).

Research on pregnancy is also centered within a heteronormative framework (Karaian, 2013). The pregnant body is a powerful symbol and “performer” of gendered convention, and failure to conform to homogenous expressions of the pregnant body as female, can serve as a transgressive act (Butler, 1988, 2011; Levitt & Ippolito, 2014). A parent’s gender transition or gender nonconforming identity, or development of a parenting style that does not rely on gendered norms, can provoke a rethinking of what it means to perform “mothering” and “fathering” within the family context (Downing, 2003). Therefore, trans parents may be uniquely positioned to challenge hegemonic constructions of gender around the family, that

consider certain parenting behaviors as inherently “masculine” or “feminine” (Ryan, 2009).

To date, there is a need for research exploring Australian trans men’s desire for parenthood, and the ways in which they negotiate and construct gestational pregnancy. This research is needed in order to allow HCPs to offer an informed dialogue around fertility preservation, conception, and prenatal support, and to support trans men’s wellbeing during their pregnancy and into the postnatal period. A greater understanding may also help expand the inclusivity and visibility of trans people in reproductive and broader health literature. The present study aims to address this gap in the literature, through addressing the following research questions: how do Australian trans men construct and experience their desire for parenthood? And, how do Australian trans men construct and experience gestational pregnancy?

## Method

### Participants and recruitment

This study is part of a larger project titled “The Constructions and Experiences of Parenthood amongst Transgender Australians.” This larger study was open to any transgender person in Australia who was also a parent. A mixed-methods research design using online survey data and one-on-one interviews was used to explore the parenting experiences of 66 trans individuals. This article examines the experiences of a subset of that broader study population; 25 trans men who had experienced a gestational pregnancy. These participants were aged 24–46 years old ( $M$  35.6,  $SD$  6.66), and had gestational children ranging in age from 3 years to 12 years old. Twenty-four participants had one gestational pregnancy, and one participant had experienced two gestational pregnancies. The majority of participants also parented other children, whom they had not carried gestationally. Full demographic details are presented in Table 1.

Participants were recruited from within Australia, through the distribution of an information sheet to transgender support groups and community organizations as well as advertisements for the study posted on social media. After reading the information sheet outlining the research and participation details, participants were asked to complete an online survey collecting demographic information as well as open-ended questions related to their experiences of

**Table 1.** Sociodemographic characteristics of participants.

| Variable                                 | <i>n</i> | <i>M</i> ( <i>SD</i> ) |
|--|----------|------------------------|
| Age                                      | 25       | 35.6 (6.66)            |
|  | <i>n</i> | %                      |
| Sex assigned at birth                    |          |                        |
| Female                                   | 25       | 100.00                 |
| Sexual orientation <sup>a</sup>          | 23       |                        |
| Heterosexual                             | 7        | 30.43                  |
| Bisexual                                 | 4        | 17.39                  |
| Asexual                                  | 3        | 13.04                  |
| Queer                                    | 3        | 13.04                  |
| Asexual                                  | 3        | 13.04                  |
| Fluid                                    | 2        | 8.70                   |
| Not sure                                 | 2        | 8.70                   |
| Pansexual                                | 1        | 4.35                   |
| Cultural background <sup>a</sup>         | 23       |                        |
| Australian                               | 16       | 69.57                  |
| New Zealand                              | 3        | 13.04                  |
| British                                  | 2        | 8.70                   |
| Malay-Chinese                            | 1        | 4.35                   |
| German                                   | 1        | 4.35                   |
| Education                                | 25       | 100.00                 |
| Left school before completing            | —        | —                      |
| Finished high school                     | 3        | 12.00                  |
| Trade/certificate/diploma                | 3        | 12.00                  |
| University degree or higher              | 17       | 68.00                  |
| Other                                    | 2        | 8.00                   |
| Living full-time in preferred gender     | 25       | 100.00                 |
| Yes                                      | 23       | 92.00                  |
| No                                       | 2        | 8.00                   |
| Current relationship status <sup>a</sup> | 21       |                        |
| Partnered                                | 13       | 61.90                  |
| Divorced/Separated                       | 4        | 19.05                  |
| Other                                    | 4        | 19.05                  |

<sup>a</sup>Indicates missing data where  $n < 25$ .

transitioning, their family history, relationship history, experience of support, and any other information about their experiences of parenthood that they felt was important. At the end of the survey, participants indicated whether they would like to take part in a one-on-one interview to further discuss their experiences as a parent. Sixteen of the 25 trans men who had experienced a gestational pregnancy consented to being interviewed. Data used in this article are taken from the 25 survey and 16 interview responses. The University Human Research Ethics Committees granted ethical approval for this study, and all participants gave informed, individual consent.

### Measures and procedure

The survey items consisted of a series of closed- and open-ended questions collecting information related to four areas: demographic data, such as age, education, and sexual orientation; participants’ experiences of their gender identity, such as the term or terms they use to describe their gender identity, and steps they may have taken toward transitioning; parenting information, such as number and age of children, care

arrangements and relationship with coparents; and support systems. Additionally, participants were asked to share any other information about their experiences of parenthood that they felt were important.

One-on-one semistructured interviews were conducted, by telephone, to examine the subjective experiences of parenting, personal relationships, wellbeing, support systems, gender identity and transitioning within the family context. A semistructured interview style was utilized as the means of data collection, as this was best suited to exploring “perceptions and opinions of respondents regarding complex and sometimes sensitive issues” (Barriball & While, 1994, p. 330). Interviews opened with participants being asked, “think back to when you first had children, what was life like for you then?”. Participant responses from online survey items were used to inform and guide individual interviews, eliciting prompts about subsequent children, relationships, experiences growing up, their own parents and siblings, support networks, employment, and other experiences. Interviewees were reimbursed for their time with a modest-value supermarket gift card.

There were strengths and limitations to this study. One strength is, as this area is currently under researched, employing a qualitative method allows us to ask trans men directly about their desire for parenthood and experiences of pregnancy. It also allows them the space to inform those with an interest in reproductive and health research of what they require and where support is needed. Two limitations are that firstly, whilst the broader study, from which these data were taken, sought to include gender-diverse populations, it was primarily advertised through trans support groups and as a result, may have inadvertently not captured a wider variety of parents who do not identify specifically as trans but may identify in other gender diverse ways. Secondly, the data for this article come from a larger study looking at a variety of experiences around parenthood. As such, there may be gaps in our knowledge of the full range of participant experiences in relation to their pregnancies.

From a qualitative perspective, researcher reflexivity is vital for understanding how one’s own personal assumptions and experiences influence the way research is conducted. In keeping with the writing of Galupo (2017) we believe that our work is shaped by our own backgrounds and perspectives, and it is vital to acknowledge that these differences may impact on

our scholarship. The researchers conducting this study have diverse gender identities and sexualities. The first author, a cisgender researcher, conducted all interviews. As a cisgender researcher working with a gender-diverse population it is imperative that one understands one’s own impact and position within the research process. Some of our reflexive practices included a commitment to interrogating our use of language within the study, being led by each participant on their individual preferences for terminology, discussing and incorporating participant observations and suggestions as well as consulting with other researchers and colleagues in the trans community on the context of surveys and interviews.

### **Analysis**

Open-ended survey data and interview data were analyzed using thematic analysis. Thematic analysis is an analytical tool, which seeks to identify and describe meaningful patterns across data by searching for implicit and explicit themes related to the research question (Braun & Clarke, 2006). All interview data were transcribed verbatim and integrity-checked for errors in transcription. An initial thematic coding framework was then generated from the data. Examples of themes include “orientating toward fatherhood” and “chest distress.” Data were then coded using the NVivo software program. The initial coding framework was used to organize data, identifying commonalities, differences, and patterns. Coded data were repeatedly reread and themes refined in order to distil data whilst simultaneously searching for new patterns and relationships. Each theme was considered, not only in the context of the individual theme itself but also how it related to the overall story told within the data (Fielden, Sillence, & Little, 2011).

Three major themes were identified that addressed the research questions in this article, under which a number of subthemes clustered. These were: (1) Perspectives on parenting, which consisted of two subthemes: “Growing up female: The assumption of motherhood” and “Orientating toward fatherhood: Parenting on my own terms”; (2) Pursuing pregnancy, which consisted of three subthemes: “A functional sacrifice,” “The struggle: Living without T,” and “Accessing reproductive assistance”; and (3) The pregnant man, which consisted of three subthemes: “Inhabiting the pregnant body,” “Chest distress,” and “The

Isolation of Exclusion.” In the presentation of results, participant details are provided for longer quotes, including pseudonym and age.

### **Perspectives on becoming a parent**

#### **“Growing up female” — The assumption of motherhood**

In contemporary western society, the “successful” expression of womanhood is grounded in fecundity, with motherhood positioned as central to female identity, and described as a “motherhood mandate” (Clisby & Holdsworth, 2016; Lowe, 2016; Nash, 2012). The majority of participants in this study reported that the expectation of future motherhood was impressed upon them from an early age. As these participants were growing up questioning or feeling at odds with their female gender identity, this mandate was reported to be particularly troubling:

They always seemed to put it (motherhood) right at the forefront of my future, right from the get go. Be good girl, you grow up, have kids, be a mum. Everything else felt very...secondary to that... (For me) those were extremely troublesome ideas at the time. I just really shut off (Tony, 34)

Many participants echoed this account and reported that “when you’re growing up female” motherhood is positioned as “nonnegotiable” or “assumed” and that to diverge or question that narrative, as Stevie (46) notes, “makes you feel even less normal than you already do.” This “assumption of fecundity” was reported to be “deeply isolating” and, for many, exacerbated struggles with gender identity, as Regan (37) said, “I just felt so shut off...from the future. I couldn’t imagine that future version of myself (as a mother), or any version, and it made me feel quite alone and angry, actually.”

Many participant accounts detailed isolating messages from the people close to them, which reinforced this sense of isolation or “estrangement”:

When I was growing up, people always talked about becoming a mum, my family, their friends talked about it...You’d see women on TV being pregnant and having babies. I think I pretended to feel the same but truthfully I felt completely estranged by the idea...I could in no way picture myself doing the same. (Roy, 24)

Others described these early notions of becoming a parent, or specifically a mother, as “alien” or

“unimaginable,” as Stevie (46) said, the “idea of becoming, and being, a mother was completely foreign to me.” Tommy (27) shared this account from when he was 11 years old:

(An employee of my parents) reached out and, kind of, gently squeezed my (breast). It wasn’t sexual at all. She made this comment about how it would breastfeed a baby one day, like it was already marked out just for that...it made me feel so mixed up and horrible about my body.

Experiences of a schism between how one feels and how one is perceived are not uncommon in accounts of young trans people (McGuire, Doty, Catalpa, & Ola, 2016). However, what can make these experiences so acutely alienating is that they are often driven by those closest to us, thus depriving young trans people of a support system (Johnson & Amella, 2014; McConnell, Birkett, & Mustanski, 2016).

In the majority of accounts, participants drew on experiences across their childhood, adolescence, and into young adulthood, when they had little control over how their gender was constructed and categorized by those around them. At this time, they were particularly vulnerable to dominant cultural narratives that associated femininity with fecundity.

Many participants chose to deal with perceived “maternal pressures” when they were younger by actively resisting and rejecting the motherhood mandate, as Marco (27) states: “For a long time I think I overcompensated by being very anti-children and, sort of, belittling motherhood as weak.” Colin (46) said: “I was very much against becoming a mother, actually, before I came out...I thought at the time it was about keeping my independence.” Other participants described parenthood variously as “a feminist issue” and “a form of control” over parents, or specifically mothers, that they wanted to resist. When asked what about parenthood was initially unappealing to him, Stefan (41) gave the following account:

In retrospect, I think it was part of my dismissal of all things, sort of, feminine about myself and (motherhood) seemed a huge part of that female character...It just seemed easier to put it aside. I threw myself into work and tried to forget about it.

Over time, however, participants began to reconcile notions of parenthood with their burgeoning understanding of their gender identity and how they fit in their individual world.

### ***Orientating toward fatherhood — “Parenting on my own terms”***

Previous researchers have noted that when dominant narratives are exclusionary, people will seek meaning through the creation of alternative narratives, which are crucial in allowing them to make sense of their experiences (Dryden, Ussher, & Perz, 2014; McKenzie-Mohr & Lafrance, 2011). For many participants, the desire to become a parent was kindled when they came out as transgender, or started transitioning. This shift of identity from “potential mother” to “potential father” was a powerful experience, giving many “a way to imagine parenting” (Tommy, 27). As Tommy (27) says: “Once I came to terms with being trans, the idea of being a parent, and a father, began to really excite me.” Others had similar experiences of “beginning to orientate toward fatherhood” postcoming out, describing experiences such as “picturing myself as a father made it all seem suddenly very possible and exciting” (Stefan, 41) and “realising that I could negotiate parenting on my own terms, as a dad, was really liberating” (Regan, 37). Noel (36) shared this account:

It was right after I started on T (testosterone)...I just felt so well, I was finally living authentically and I could have a family. That, that part of my life didn't have to be, sort of, denied. I was always meant to be a father.

These accounts demonstrate the transformative power of coming out and transitioning, wherein participants renegotiated parenthood identities to bring them into alignment with their experiences of masculine gender. This shifting of identities facilitated the ability to challenge both personal and societal assumptions around their capabilities of parenthood. In keeping with Berkowitz' (2007) work on procreative consciousness, as trans men create and negotiate “new” narratives around parenthood and gain acknowledgment of their fatherhood identities, the potential for other trans men to imagine themselves as parents and fathers also grows significantly.

### ***Pursuing pregnancy***

Whilst becoming a parent does not always necessitate carrying a child and giving birth oneself, each of the trans men in our study made a deliberate and informed decision to pursue a pregnancy. However, in doing so, they had to engage in a complex negotiation with their masculine identity, the traditional

association of pregnancy with femininity, and the material reality of the medical and biological aspects of pregnancy posttransition.

### ***A functional sacrifice***

The participants in our study chose to pursue pregnancy for a variety of reasons. Some participants had cisgender female partners whose fertility was affected by medical issues, as Sam (32) describes:

(My partner's) endometriosis was really severe...when we started talking about a family I just knew it wasn't going to be possible for her (to get pregnant) so I decided that I'd do it. It wasn't an altogether happy decision but I knew it was the right one for us and I feel, actually, very grateful that I could do that for us.

For other participants, being able to have a child that was biologically related to them was positioned as important and valuable: “It just seemed like a huge privilege to be able to have a child that shared my DNA” (Justin, 30). Equally, Bill (31) commented:

We'd had some close friends who'd really struggled with not being genetically related to their kids... it really made an impression on me and (my partner)... so we decided we'd take turns having a baby.

Some participants reported that they wanted to have a child before transitioning “took them too far” whereas others expressed the desire to “get something positive out of a body that had always felt like a curse.” In these accounts, pregnancy was positioned as a “functional sacrifice,” which Epstein (2016) describes as “something to endure in service of a long-term pragmatic goal” (p. 751).

### ***Accessing reproductive assistance***

It has been well established that trans men face significant difficulties when accessing care and support for their reproductive health and wellbeing, and assisted fertility is no exception (Coleman et al., 2012; Pitts et al., 2009; Reisner et al., 2010). As 18 of the 25 participants in this study were partnered with cisgender women at the time of conceiving children, they would not be able to conceive their children without accessing some form of external support, such as pursuing formal or informal assisted fertility, including the acquisition and insemination of donor sperm, and, in some cases, in vitro fertilization.

For many participants, accessing sperm was the first step toward conceiving their child. This generally involved two options. Firstly, using a known donor, such as a friend or colleague and generally doing a “DIY” insemination in an informal setting such as a home. The alternative, using an unknown donor, which relies on accessing a fertility clinic and having insemination done at a facility by a medical professional.

The majority of participants in our study used informal channels to acquire and use sperm, as Colin (46) explains: “For us, using a (known donor) was so much easier cause we could just do everything at home...We were extremely lucky and it worked on the second go.” Mickie (33) explains further:

Once we decided to use a known donor... it was really just a matter of approaching them and discussing what we were proposing. It’s tricky because the legal side of it was a bit of grey area at the time and we really just had to keep it to ourselves and hope for the best, to be honest...We were really lucky that (the donor) was keen and shared our feelings about what his relationship would be with (our child).

These accounts were echoed by other participants, who found “the negotiation process much easier” with a known donor, and DIY insemination “much easier,” “more personal,” and “less confronting” than accessing formal facilities. As Trent (36) describes: “We did (the insemination) at home...and, you know, rather than being weird or impersonal it was actually all very special.”

However, experiences of assisted fertility were very different for those participants who chose to use formal fertility services. Many described it as a “nightmare process” that none were able to see through to completion.

We were rejected from multiple clinics due to “reasons unknown.” “We had a range of appointments and each time the discussion centered almost completely on my gender identity...everyone just seemed so uncomfortable seeing us.” (Justin, 30)

Other participants echoed this account, describing “embarrassing” and “awkward” appointments followed by “cancelling our follow-ups.” Trent (36) stated: “The doctor we saw was so awkward with us, kept misgendering me and repeatedly asked why my (cisgender) partner wasn’t the one to have the baby.” For these participants dealing with negative experiences with fertility service providers was “the first in

many pregnancy-related rejections and disappointments” (Noel, 36).

Whilst trans people are protected legally in Australia from discrimination by HCPs (New South Wales Government, 1977) these protections are not necessarily born out in their actual experiences. No participant in this study who attempted to access a fertility clinic was actually granted treatment. This type of rejection and discrimination is reported to be pervasive in the trans community, and has a very significant impact on mental health and wellbeing (Rood et al., 2016). As such, like many in the broader LGBTQI community, trans men turn to informal networks and methods, indicated in the above accounts of using known donors and at-home insemination, to assist them in achieving their goal to conceive.

### ***“The struggle” — Living without T***

For many of the trans men in our study, going on testosterone represented their first line of treatment postcoming out as trans, and was experienced as a significant validation of their masculine gender identity. However, the first step for many participants wanting to conceive, posttransition, was tapering off their dosage of testosterone. For many this was a significantly challenging experience, as Zak (29) states:

It was really gradual at first. Then I noticed my body started to change, like my fat started to kind of shift, redistribute, around my body...my hips started coming back...my empty boobs started to really ache and then I got my period. Even though I knew it was going to happen that was still a huge shock. I had a real moment then. Like, I questioned whether I could go through with everything.

Other participants echoed these sentiments, stating that “going off T was extremely stressful,” and that it “felt like my lifeline was being taken away.” Trent (36) stated: “It really triggered old feelings I had about myself, I kept flashing back to being 16 again, wondering what the hell was wrong with me.” Other participants described feeling distressed as a result of perceived changes such as “losing my muscle,” accompanied by “lack of energy,” “intense mood swings,” “feeling depressed,” and “flat.” These are common experiences when withdrawing from testosterone (Davis & Colton Meier, 2014), but are also “symptoms” associated with the “monstrous feminine” changes across the reproductive life cycle, and

signifiers of a fecund body out of control (Ussher, 2006). Some participants “fell pregnant straight away,” whilst others, such as Jonnie (28) took longer, having to live with dissonance at inhabiting a feminine body not feeling “normal”:

We didn't get pregnant for almost a year, so my body had reverted back to much of its former self. I still had a little fluff on the face but everything else was really soft and round. I hated it so much. I didn't always 'pass' anymore, which was really demoralising... Ultimately, getting pregnant was a huge relief because then I had a timeline to when I could get back to normal (laughs).

The decision to go off testosterone can be a physically and emotionally complicated one. As mental health-related quality of life, depression, and anxiety are significantly improved in trans men who receive testosterone, withdrawing from this medication could have significant implications for wellbeing (Davis & Colton Meier, 2014; Gómez-Gil et al., 2012; Newfield, Hart, Dibble, & Kohler, 2006). Additionally, the loss of the masculinizing effect of testosterone, combined with the visual presentation of a pregnancy, can have a deleterious impact on a trans man's ability to “pass.” This can be highly distressing (Light et al., 2014; Newfield et al., 2006) and for many can compound experiences of isolation.

## The pregnant man

### *Inhabiting the pregnant body*

For many participants, pregnancy-related physical changes brought with them an unexpected psychological and emotional toll. Bill (31) explains: “The happiness at getting that (positive result) was pretty quickly replaced with sense of real dread...the early hormones made me feel really sick and shaky and I think the enormity of what I was doing really started to sink in and I got scared.” For others, the pregnant body was experienced as “frightening,” “distressing,” and “extremely difficult to handle.” Tommy (27) noted “the changes (to my body) really disgusted me. It was a very stressful time.” Changes such as “weight gain,” “breast growth,” “breast tenderness” as well as looking both “more feminine” and “less masculine” were the most commonly cited causes for distress. For these participants, pregnancy was an overwhelming experience that compounded and complicated what Regan

termed the experience of a “complete dysphoria of the body”:

I felt completely in the wrong body, my flesh, the roundness and bulges, the way it felt and looked, really frightened me, so foreign, like the more pregnant I got the more alien my skin felt. It terrified me. It wasn't the female-ness of it, it was the intense changes, the physical changes. (Regan, 37)

Many participants reported dealing with these acute experiences of pregnancy-related dysphoria by “distancing,” “detaching,” and “disassociating” themselves from their pregnant bodies. As Wyn (42) says: “In order to cope, I had to detach...I ended up so detached from my (pregnant) body that I sometimes needed to be reminded that I was pregnant.” Tommy (27) echoed this account, stating that: “As (the pregnancy) kept progressing I got more and more anxious...detaching kind of helped me cope in the short-term...I gave myself permission to do whatever I needed to just get through.”

Detaching, as a coping strategy, is not uncommon when dealing with acute stressors and is viewed as an adaptive coping method (Elklit, 1996; Roger, Jarvis, & Najarian, 1993). Creating distance between oneself and the stressor can bring with it the cognitive space needed to cope and get through challenging experiences (Elklit, 1996).

### *Chest distress*

The visual presence of “breasts” is a key signifier of adult femininity (Goin & Goin, 1981; Spencer, 1996). Many trans men refer to this area of their body as their “chest,” whilst some refer to it as their “breasts,” or use the terms interchangeably depending on factors, such as, pre- or posttransition status (Davis & Colton Meier, 2014; MacDonald et al., 2016). As such, for the trans men in our study, changes to the chest were experienced as the most challenging pregnancy-related physical change. As Regan (37) describes: “it was really stressful feeling my breasts grow so much, it made me feel sick.” Stefan (41) concurs “they (chest) got huge and it was extremely stressful, I didn't like to look at them, or touch them.” Other participants stated that they “hated looking at” themselves due to chest changes. Strategies normally used to conceal the chest, such as binding (MacDonald et al., 2016) were not as effective during pregnancy, with many participants unable to bind at all. This was described as “a

real struggle,” “very difficult,” “challenging,” and “extremely uncomfortable.” As Jason (26) explains: “not being able to bind was a nightmare. My chest was getting so big it was totally impossible to cover...people started misgendering me, a lot, which hurt.” For many, being unable to bind led to the decision to completely isolate themselves, and “hide out,” due to “fear of being outed,” or experiencing “shame” or “self-consciousness.” As Noel (36) says:

(Towards the end of pregnancy) I just stopped leaving the house completely... I felt really unsafe and anxious when I was out and it just wasn't worth it, in the end...I couldn't bind and I felt so uncomfortable in my body. I hated being seen. I felt like everyone was staring.

For some, this period of isolation was not just confined to pregnancy but continued well into the postnatal period:

(My chest) was huge and leaky after I had (my child)... It was so horrible and totally stressed me out... I couldn't bind because it was way too painful... it was also right in the middle of summer and it was so hot. I couldn't cover up, I couldn't bind. I ended up just staying home for months, which sounds simple but it was super isolating (Sam, 32).

Postbirth chestfeeding was also a significant issue for participants. For many, it was described as “trigger (ing) intense dysphoria” and was “deeply distressing.” As Bailey (25) says: “breastfeeding, for me, represented the absolute pinnacle of my dysphoria, unbelievably bad.” Support from partners was integral during this time, with many participants stating that it “saved” them: “I was so relieved when my partner supported me to not chestfeed, I really don't think I could've coped with that” (Clarence, 43).

Given their overwhelming association with fecundity and femininity, “breasts” are considered by some to be the physical attribute most in conflict with a male gender identity (Davis & Colton Meier, 2014; Spencer, 1996). As illustrated by participant accounts, changes to this area of the body can have far-reaching and significant implications for the wellbeing of pregnant trans men making this period of their lives much more difficult.

### ***The isolation of exclusion — “Am I the only one?”***

People who deviate from normative expectations of gender disrupt the societal assumption that gender

expression strictly adheres to one's assigned biological sex (Ryan, 2013). To diverge from this assumption can open oneself up to acute discrimination and social exclusion. It could be argued that the pregnant man transgresses these normative expectations of gender more than any other (Karaian, 2013). As such, for the men in our study, pregnancy brought with it much isolation and exclusion. As one participant stated, “For all the joy pregnancy should have brought, there were a huge amount of constraints put on me, and it was very, very isolating” (Jason, 26). Some participants expressed that they were “locked out of being able to really experience pregnancy,” or as Colin (46) explains:

I can't express how lonely it was to go through a whole pregnancy in hiding. I couldn't be 'out' as a pregnant person and it was really hard. Like, yes my friends and family knew but to the rest of the world I had to hide it to protect my own safety and my mental health from strangers. The loneliness was profound.

Others concurred that social exclusion stemming from “not confirming to what a pregnant person is supposed to look like” fueled isolation and loneliness:

I just felt so lonely, like “am I the only one?”. There was no one at the Drs or the clinic or in the pregnancy books or anywhere like me. I felt like a complete anomaly (Noel, 36).

Although there have been no studies on perinatal depression in trans men, experiences of isolation, and loneliness during pregnancy have been linked to perinatal depression in cisgender women (Bonari et al., 2004; Leung & Kaplan, 2009), and thus our participants could also be vulnerable to developing this condition. Within the context of this isolation and loneliness existed also the “lack of representation” of what a male pregnancy might look like. Zak (29) gave this account:

Not seeing yourself (represented) anywhere is so hard. I felt like I was really excluded from the whole thing (of pregnancy) and I didn't get any enjoyment from it. Reading the books, or looking on the internet for pregnancy advice was so depressing. It felt like it was just a constant barrage of information confirming how wrong I was.

These feelings were contextualized by others, commenting on the “complete lack of resources,” “invisibility of trans men” in pregnancy literature and the “complete lack of specialized support” for pregnant

trans men. Invisibility and marginalization due to gender identity is common in health research, and trans men, amongst others in the broader LGBTQI community, have been excluded from mainstream health-promotion research, policy, and practice (Mulé et al., 2009).

## Discussion

This article examined trans men's constructions and experiences of desire for parenthood and pregnancy. For the participants in our study, early experiences of pressure to become a parent through fulfilling the "motherhood mandate" were both confronting and alienating, leading to feelings of exclusion from dominant parenting narratives. Heteronormativity creates an expectation of motherhood for all those who are identified as "woman" (Obedin-Maliver & Makadon, 2016; Page & Peacock, 2013), with "woman" and "mother" being synonymous. The fecund body has thus "been socially gendered as unquestioningly feminine because of its association with female-bodied people" (Ryan, 2013, p. 119). In the majority of accounts of negotiating desire for parenthood, or of resisting the motherhood mandate, participants drew on experiences across their childhood, adolescence, and into young adulthood, when they had little control over how their gender was constructed and categorized by those around them. At this time, they were particularly vulnerable to dominant cultural narratives that associated femininity with fecundity. However, upon coming-out and commencing transition, participants were able to negotiate and construct their own parenting identity. These findings illustrate the significance that coming-out and transitioning can have in bringing a sense of congruence to trans men's lives (Fein, Salgado, Alvarez, & Estes, 2017), which in turn enables them to move forward within ways important to them, such as pursuing a pregnancy.

Trans men who make the decision to become parents must do so whilst navigating in a world designed to exclude. Healthcare systems are not generally supportive of trans bodies and identities (Conron, Scott, Stowell, & Landers, 2012; Pitts et al., 2009) and it is telling that none of the men in our study were treated at any fertility clinic that they attended, even though their right to treatment is, technically, protected in Australia (Anti-Discrimination Board of New South Wales, 2011; Easten, 2002; New South

Wales Government, 1977). The majority of the participants in our study thus relied on informal methods to conceive their children. However, this leaves them "locked out" of formalized treatments and support networks. Not everyone is comfortable with, or able to find, a known donor, nor to use at-home insemination successfully. The data from this study captured only the accounts of trans men who'd successfully had a gestational pregnancy. In our broader study, from which this data were taken, there were additional accounts from trans men who were not granted access to fertility services and who were then unsuccessful using informal means, causing a great sense of loss for these participants. Thus, our research illustrates that some trans men experiencing exclusion from pursuing gestational pregnancies through structural or potentially discriminatory. Every staff member of these organizations, from those administrators on the front desk, to the nurses, pathologists and doctors who treat patients, need to be educated on how to negotiate an inclusive and supportive provision of their service to those in the community.

For many trans men, hormone therapy is experienced as essential to combating gender dysphoria and bringing one's gender into alignment (Nelson, 2016). The results from our study indicate that ceasing hormone therapy during the preconception period can trigger distressing dysphoric episodes and, as evidenced in the above accounts, can set a troubling pattern for the subsequent pregnancy. Pregnancy-related dysphoria was a huge issue for participants and one that is currently an unknown quantity for many HCPs (MacDonald et al., 2016; Obedin-Maliver & Makadon, 2016; Veale et al., 2016). The preconception, prenatal and perinatal periods pose many challenges for trans men, and they must navigate these experiences without, what is for many, a key treatment, testosterone. As such, HCPs and trans men alike need to develop a better understanding of how to manage gender dysphoria when hormonal therapies are not an option during the pre- and perinatal periods.

The "breasts" project has many cues associated with femininity and for pregnant trans men the growing pregnant chest is experienced as extremely troubling. The majority of the trans men in our study had not undergone subcutaneous mastectomy, or top surgery, and still retained their original chest tissue during their pregnancies. As such, their growing chest triggered intense dysphoria. This had a number of

implications, such as poor parental mental health, but also impacted on whether participants chest fed their babies. Whilst one study found trans men are comfortable chest feeding (MacDonald et al., 2016), the majority of men in our study found it too confronting and either chose not to, or only chest fed for a matter of weeks. The decision of how to feed one's baby is a very personal one for all new parents, but for trans men this choice must be balanced between the well-established health benefits of chest feeding and the challenges that such a practice might sustain (Obedin-Maliver & Makadon, 2016). Specialized resources need to be developed to support trans men in relation to pregnancy-related chest changes and lactation specialists and community nurses need to be trained in supporting trans men and their babies in the postnatal period.

Ellis et al. (2015) wrote, of their study into the conception, pregnancy and birth experiences of gender variant parents: "Loneliness was the overarching theme that permeated all participants' experiences, social interactions, and emotional responses through every stage of achieving gestational parenthood" (p. 63). This statement could be made from our own findings as experiences of profound isolation and loneliness overarched our own participants' accounts. A large body of research illustrates the connection between these experiences and an increased risk for postnatal depression, which could have serious implications for parental health and the health of their babies, both in the immediate postnatal period and into the future (Bonari et al., 2004; Wisner, 2009). Additionally, as baseline depression, self-harm, and suicide rates are higher amongst trans individuals than the broader population, particular attention to postnatal depression is certainly warranted (Obedin-Maliver & Makadon, 2016). However, there is currently negligible research on trans men's experiences of peri- and postnatal depression. To fully explore this area and aid in the development of resources that are more trans inclusive, more research is warranted.

This research demonstrates that trans men are having babies and are doing so without the formal support and resources that they not only need but have a right to. This leaves many feeling isolated, excluded, and vulnerable during a time when support is most required. Whilst there may be specialized HCPs who are knowledgeable about trans men's reproductive and obstetric health, it is unlikely that there are

enough to support this population. Additionally, given the prevalence of discrimination experienced by trans people within the healthcare system (Grant et al., 2011; Mulé et al., 2009; Scheim et al., 2017) work needs to be done by HCPs and others in the community to make reproductive health more inclusive of trans bodies and identities. Education of HCPs in regards to transgender issues and reproductive health is also necessary in order to counteract the lack of knowledge in this area and to stem the discrimination that prevails. Further, the current study illuminated an area of research that requires urgent attention, and that is the experiences of transgender men when accessing assisted fertility services. Future enquiries must also include trans men who have not been able to conceive, which may be associated with access to services, in order to provide a more inclusive picture of trans men's experiences of their fertility and pregnancy. Additionally, it may provide further insight into ways in which the provision of fertility services and information can be improved for trans men, and the broader trans community, who remain largely underrepresented in reproductive health research.

For the pregnant trans man, the materiality of the pregnant body is at odds with their identities as men and the subject position "father." Whilst transitioning can bring one's gender and embodied experience into alignment, the requirements of pursuing pregnancy serve to disrupt this alignment at a vulnerable time for any prospective parent. It is telling, perhaps that most of the participants in our study are yet to pursue a second pregnancy. This research also troubles static notions of "fatherhood" and "motherhood," suggesting that subject positions can be negotiated by individuals, even if this is at odds with their embodied experience, or how their body is viewed by others. The findings of this study are important insofar as they provide insight into how trans men experience and construct gestational parenthood and pregnancy. We hope that the body of research into trans men's experiences of pregnancy and parenthood can continue to be explored, and that appropriate services and resources for this population can be developed and delivered.

#### **Declaration of conflict of interest/ethical approval**

Full ethics approval was received for the data collected via the Western Sydney University Human Research Ethics Committee and have been performed in accordance with the ethical

standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

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## Note

1. The term cisgender refers to a person who identifies with the gender they were assigned at birth (Levitt & Ippolito, 2014).

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