Family Creation Options for Transgender and Gender Nonconforming People

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Family creation can be an important part of transsexual, transgender, or gender nonconforming (TGNC) people’s lives. The implications for fully informed consent leading to gender confirming medical interventions are significant as some interventions will impact an individual’s ability to procreate. In some cases, adolescents who initiate puberty suppression may be foreclosing on their ability to provide genetic material to create a family. TGNC people are making decisions to create families in increasing numbers. This article addresses options that are relevant to TGNC people with a range of gender identities and expressions to assist TGNC people to make informed choices about the important life domain of family creation. This article focuses primarily upon reproductive options, including assistive reproductive technologies (ART) for family creation in addition to options of fostering or adopting and chestfeeding for TGNC people. The article also addresses working with TGNC clients who are unable to access family creation options. This article does not address how to parent TGNC children.

Keywords: family creation, parenting, fertility, reproduction, gender transition

Family creation, or the process of becoming a parent, can be a natural part of a transsexual, transgender, or gender nonconforming (TGNC) person’s life (American Psychological Association [APA], 2015). Historically, it was assumed that transwomen would forgo the ability to “father” a child, that transmen would forgo the ability to “mother” a child, and that “true transsexuals” (the only TGNC people who were considered legitimate candidates to access gender affirmation services) would be uninterested in doing so. In some contexts, sterilization has been a requirement for transition (De Sutter, Kira, Verschoor, & Hotimsky, 2002). However, many TGNC people who transition are interested in one day becoming a parent (De Sutter et al., 2002; Schoen & Arnold, 2010).

Family creation can be an amazing process of discovery and can deepen intimacy in relationships. For some people, the process may also be confusing, disruptive, and overwhelming. TGNC people face unique biological and social considerations that can be a challenge to navigate, especially when current decisions about puberty suppression, hormone therapy, and affirmative surgeries can impact future family creation options in permanent ways. Some TGNC people are unaware of their family creation options and may prematurely foreclose their hopes or desires to create a family. Although TGNC family creation role models and information are increasing, it is critical for TGNC people to have easy access to accurate, empowering information that can guide their thinking and inform their choices in family creation.

Societal Expectations of Family Creation

Societal expectations of family creation can affect TGNC people and cisgender people alike, embedding assumptions about how families should be created and what constellations of adults and children make up a “real” family. Heteronormative expectations might include the presence of a mother and father (Cohler & Galatzer-Levy, 2000). Exploration and deconstruction of these norms and expectations may support TGNC people in making personally fulfilling family creation choices. When socially prescribed scripts for family creation do not fit, this can open up the possibility of creative approaches to family creation, which are a better fit for the people involved (APA, 2015). Mainstream society has low tolerance for unique family creation narratives, although some racial and ethnic groups are more likely to embrace and enact family structures outside of a traditional nuclear family. For example, African American families may create intergenerational parenting relationships more frequently, with grandparents being primary caregivers to grandchildren (Gibson, 2005; Szinovac, 1998; Wakschlag, Chase-Lansdale, & Brooks-Gunn, 1996). Other cultures identify a variety of family constellations as normative, with intergenerational family units and families made up of children and parents who may not be directly genetically related.
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perception of adoption or other family creation alternatives as a fallback if genetically related offspring are not possible. Because the legal system can privilege genetic connection to children, some TGNC people are interested in family creation that includes such a connection in hopes that this will assure their ability to maintain recognition of their parental rights and bonds with their children (Minter & Wald, 2012; Murphy, 2010). On the other hand, TGNC people may assume that having children with a genetic relationship is not possible or find these family creation options less desirable. TGNC people may see fostering or adoption as a first choice in family creation (e.g., the idea of using their reproductive system exacerbates feelings of gender dysphoria).

Challenging Gender Dichotomy in Family Creation

In addition to deconstructing societal values about reproduction, it is also important to challenge the typical gender dichotomy in family creation. Community and professional sources describe family creation alternatives for trans women (male to female) and trans men (female to male; Polly & Polly, 2014); however, this focus collapses the diversity of the gender spectrum and can make genderqueer, gender nonconforming, and androgynous people invisible. The language of this article intentionally broadens the family creation dialogue to include a diverse representation of the gender spectrum. When offering support or information to TGNC people about family creation alternatives, the ultimate focus should be the empowerment of the client(s) making the choices. When considering family creation, an open exploration of all options is encouraged, while recognizing that many TGNC people will not have access to all options.

Issues to Consider Prior to Family Creation

Possible interest in having children is an important consideration before beginning hormone therapy or undergoing affirmative surgeries (De Roo, Tilleman, T’Sjoen, & De Sutter, 2016). Informed consent for hormone therapy or affirmative surgery requires that TGNC people receive information about the effects on fertility and the impact this may have on future family creation options (APA, 2015; De Sutter et al., 2002). People with sperm can donate and cryopreserve the sperm prior to beginning hormone therapy or undergoing an affirmative surgery that will impact the vas deferens or testes. This will assist in the retention of the healthiest, most robust sperm sample to be used at a future time. Cryopreservation of sperm for up to 5 years is estimated to cost $2,000 to $3,000 (Gorton & Grubb, 2014). People with eggs can have them surgically removed and cryopreserved prior to beginning hormone therapy or having an affirmative surgery that affects the ovaries. It is estimated that the cost for this process in between $5,000 to $15,000 for each ovulation cycle (Polly & Polly, 2014). As with preservation of sperm, this will allow for the capture of the youngest, healthiest eggs to be used at a future time. The technology for egg preservation is not as advanced as it is for sperm preservation (Gorton & Grubb, 2014).

Legal issues can be significant and can dramatically impact parenting rights and legal custody of children. These legal issues should be carefully considered prior to family creation. Legal decisions are strongly influenced by whose genetic material is used to create a fertilized egg, by the process used to acquire the egg and sperm, and by how the relationships between the people involved in the creation of the fertilized egg are framed or described (Minter & Wald, 2012). TGNC people are strongly encouraged to explore the legal implications of any family creation decisions and process, regardless of the level of trust that exists between partners or people contributing the egg, sperm, or uterus, to ensure that the process being used will create the foundation and legal protections that are needed or desired.

It is important to weigh the personal impact of family creation choices on a TGNC person’s quality of life, transition process, and relationships. Although a TGNC person may want to carry a pregnancy to term, careful consideration should include the impact of disrupting hormone therapy or a transition process because such interruption might significantly intensify gender dysphoria (Murphy, 2012). Carrying a pregnancy may have other psychological impacts, including depression and anxiety (Evans, Heron, Franco, Oke, & Goldberg, 2001; Huizink, Mulder, Robles de Medina, Visser, & Buitelaar, 2004). Weighing other pressing needs against family creation needs can be difficult. People who choose not to undergo ART may experience feelings of guilt and loss. People who wish to pursue ART but are unable to do so because of a physical contraindication, previous affirming therapy (e.g., hysterectomy or orchidectomy), or lack of financial resources may also experience feelings of grief and loss or struggle with a having a body that is not able to provide them the children they would love to raise.
Becoming Pregnant Without Involving Medical Intervention

Becoming pregnant, without involving medical intervention, requires knowledge of the process for fertilizing an egg in a uterus. This may be through vaginal intercourse or do-it-yourself insemination. If either person contributing the egg or the sperm is currently on hormone therapy, hormone therapy should be halted and the body should be permitted to reestablish previous hormone levels. Because hormones are stored in fat tissue, it can take some time for hormones from gender affirmative hormone therapy to flush out of the system. If pregnancy occurs while one or both people are taking hormone therapy, there is a higher chance of birth defects and preterm death (Howard Brown Health Center, 2013a, 2013b). Because of this, informed consent for gender affirmative hormone therapy should include information that while hormone therapy can make unintentional pregnancy less likely, it is not, in and of itself, adequate birth control for TGNC people who engage in sex acts that could result in fertilization. TGNC people who are experiencing an unintended pregnancy and who wish to seek an abortion may have challenges in accessing care.

It may take 2 to 6 months to reestablish biological readiness of the egg and sperm before insemination is attempted, and it may take multiple attempts before a successful fertilization occurs. Maximizing the chance of a pregnancy can require tracking temperature and ovulation, and mixing egg and sperm at carefully timed intervals to maximize chances of fertilization (Polly & Polly, 2014). After cessation of hormone therapy, people with eggs will begin menstruation and will release mature eggs. People with sperm may take 3 months after previous hormone levels are reached to build and produce mature sperm. The best chance for healthy sperm development occurs when temperature is well controlled; tucking testicles is discouraged to avoid overheating and negatively impacting sperm development. Gender affirmative hormone therapy is contraindicated while sperm are needed or, for someone carrying the pregnancy, throughout pregnancy and breastfeeding. Use of testosterone therapy for long periods of time may reduce the likelihood of ovulation when testosterone treatment is halted and estrogen levels in the body increase, although some TGNC people have given birth to healthy babies using this approach. Use of estrogen therapy and/or testosterone blockers for long periods of time is likely to reduce the body’s ability to create healthy, mature, high-count sperm. Recovery of the ability to produce healthy, high-count sperm when estrogen therapy is suspended is unknown and will vary across individuals (Coleman et al., 2012; Eyler, Pang, & Clark, 2014). If a different approach to pregnancy is preferred or needed, it will likely require participation of outside people and organizations, such as medical providers, ART specialists, or adoption agents, in what can be a very intimate process of family creation.

Locating Trans-Affirmative, Informed Medical Providers

Finding trans-affirmative and informed medical providers wherever possible is a significant assistance (Polly & Polly, 2014). Although some providers are supportive, not all are prepared to offer informed guidance about family creation, and some may exoticize or fetishize TGNC bodies and pregnancies. Locating experienced providers in rural or conservative areas may be more challenging. Most people rely on word of mouth, Internet reviews, and personal recommendations to identify providers in their area or in an area they can access regularly. Entering into a process that may involve significant interaction with the health care system can be challenging for TGNC people who may already have a difficult or strained relationship with health care and health care providers (Schilder et al., 1998). Family creation care may intensify this, given the focus on body parts that may not align with gender identity, sometimes rigid technical language for body parts, the lack of control people may experience, and assumptions about which partner will be taking which role (e.g., egg = mom, sperm = dad) in traditional medical settings. When involved in larger medical systems that may not be trans-affirmative, some people have utilized a doula or midwife who can act as an advocate or interpreter, assisting the medical setting to offer more trans-affirmative options and care for TGNC people. Similarly, some people have chosen home birth or birth at a birthing center rather than a hospital in order to minimize the number of providers whom they have not met who may be present during the birth.

ART for TGNC People

The goal of ART is to enhance fertility and the possibility of a viable pregnancy and a healthy birth. Difficulty in conceiving for TGNC people might be due to challenges in accessing reproductive material (such as sperm, eggs, or uterus). This may necessitate the involvement of a donor (for sperm or eggs) and/or a gestational surrogate. One option for TGNC people to have genetically related children is donation of sperm or eggs from a relative that could then be used in conjunction with genetic material from the TGNC person’s partner. Some TGNC people prefer that their children have a genetic link to the other parent and therefore choose not to use sperm or eggs from a donor. In a situation in which one parent is genetically related to the children and the other is not, the parent without the genetic link can struggle with societal messages that they are not “real” parents (Minter & Wald, 2012). Additionally, one or both partners may grieve the inability to conceive children sharing their genetic material.

TGNC people may also have infertility factors like those of cisgender people who have difficulty in reproducing without medical intervention (Eyler et al., 2014). People undergoing ART should be prepared for the intense physical and emotional toll the process can take. ART can have a dramatic impact on emotional functioning because of the cessation of hormone therapy, hormone readjustment, and intense fertility medications that can cause mood swings, depression, irritability, anger, tearfulness, and decision-making difficulty. For TGNC people, the impact of hormone changes and fertility medications is intensified by the presence of hormones and medications that are shifting the body away from a person’s identity. In addition, ART can cause a person to feel as though they have little control of the changes in their body. Given how hard some TGNC people have had to fight to maintain body integrity, this loss of control may be especially anxiety provoking. Finally, ART techniques are expensive, and although fertility treatments are sometimes, though not always, covered by insurance, the way that infertility is defined can result in denial of coverage for TGNC people (Eyler et al., 2014). For example, same-sex couples have had coverage denied for infertility treat-
ment “because their health insurance plan did not consider their condition of infertility to be a ‘disease’” (Eyler et al., 2014, p. 154). This expense may functionally preclude these options for people who do not have the financial resources to pursue them. With regard to telling children born through ART, current recommendations suggest telling children about their genetic heritage in age-appropriate ways as they are growing up (Ethics Committee of the American Society for Reproductive Medicine, 2004). TGNC parents sharing with children about their genetic heritage may also involve talking with children about their own gender history in age-appropriate ways as the children are growing up.

**ART for People With a Uterus, Eggs, and Ovaries**

For people with a uterus, eggs, and ovaries, testosterone therapy must be discontinued for the body to return to its hormonal and reproductive cycle (Light, Obedin-Maliver, Sevelius, & Kerns, 2014). Insemination with sperm through an alternative insemination (AI) process occurs and may take multiple attempts. The simplest AI process involves home insemination. Insemination by a medical provider can involve inserting sperm into the vagina or into the uterus. Gender-affirmative hormone therapy is contraindicated throughout egg maturation, pregnancy, and chestfeeding. There are multiple types of donors that can be used to provide sperm: (a) unknown donors (sperm is purchased from a facility), or (b) a known or “directed” donor. A known donor can be a partner or significant other, a family member, or friend. Although this article uses the term “donor” to mean an alternate source, caution is offered about using such terminology in legal documents, as this term has a very specific meaning and may minimize the parental rights of someone listed as a donor (Minter & Wald, 2012). If AI is not effective, additional female hormones and fertility medications may be prescribed and insemination will be attempted again. A TGNC person may also choose to take high doses of feminizing hormone and fertility medication to “induce increased ovulation” and surgically retrieve the eggs (De Sutter, 2009; Gorton & Grubb, 2014, p. 237).

The psychological ramifications of this treatment can be significant. Once retrieved, the eggs can be externally fertilized and implanted in a uterus, either in the person who produced the eggs or in another person. If the fertilized egg is implanted in the person’s partner, this is called “reciprocal” in vitro fertilization (Eyler et al., 2014). Alternately, a gestational surrogate could carry the pregnancy. Eggs can also be cryopreserved or frozen for use at a future time by the person, a partner, or a surrogate (De Roo et al., 2016; Wierckx, Van Caenegem, et al., 2012). Similarly, once the eggs are fertilized, embryos can be cryopreserved for use at a future time. Gorton and Grubb (2014) estimate that the removal, fertilization, and cryopreservation of eggs costs over $10,000, in addition to annual fees for continued preservation.

**ART for People With Sperm and Testes**

For people with sperm and testes, feminizing hormone therapy and testosterone blockers are discontinued and the body returns to its hormone levels (Wierckx, Stuyver, et al., 2012). If insemination is attempted using the sperm through an alternative insemination (AI) process, this may take multiple attempts. Hormone levels must be maintained until sperm are no longer needed. There are multiple types of donors that can provide eggs and a uterus: (a) unknown donors (frozen egg donor bank), or (b) a known or “directed” donor. A known donor can be a partner or significant other, a family member, a friend, or a hired gestational surrogate (Eyler et al., 2014). If AI is not effective alone, additional male hormones and fertility medications may be prescribed and insemination will be attempted again. If sperm count is low, if sperm do not have strong motility, or if sperm are less mature, intracytoplasmic sperm injection (ICSI) may be used. ICSI is a procedure in which a single sperm is injected directly into an egg (Van Steirteghem, Devroey, & Liebaers, 2002). When ICSI is used with a healthy, high-count sperm sample, the average fertilization rate is over 90%; this technique can increase the likelihood and the number of fertilized eggs that can be produced with sperm samples that are less mature or have lower mobility, which can occur after longer term feminizing hormone therapy (Eyler et al., 2014).

Some TGNC people who lack uteruses are interested in the potential future availability of uterine transplants to allow them to become gestational parents. This technology is currently in an experimental stage and may be years away from availability. Very recently, the first successful uterus transplant was completed and there was a subsequent successful birth (Brännström et al., 2015; Brännström, Wranning, & Alchek, 2010; Johannesson & Enskg, 2014).

**Family Creation Issues for TGNC Children and Adolescents**

Developmentally, family creation is not normally a prepubescent consideration. Given the availability of puberty suppression and hormone therapy for youth under 18, families, parents, and children are considering future life choices far in advance of the usual developmental timeline. Children and adolescents may not always understand the future impact of decisions about medical interventions (APA, 2015). Children should always be involved in discussions in a developmentally appropriate way about this aspect of their care. Parents may worry that youth will make impulsive choices and cut off family creation options that they will regret in future. Some of this caution is warranted given developmental stage, possible inability to fully understand adult choices, and the fact that some youths’ developmental trajectory will not include a TGNC identity in the future. Some caution may also stem from parents’ cultural values that place a high priority on reproduction with genetic material using body parts that do not align with a youth’s gender identity. Parents may struggle to retain their child’s options while also recognizing a youth’s immediate transition needs. It can be hard for parents to balance their hopes and expectations for the future (e.g., plans for how their children’s lives would unfold; being grandparents) while meeting their children’s current emotional and physical needs. At the same time, there is evidence that LGBT youth who are affirmed by their families are more likely to be interested in parenting themselves in the future (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Thus, as more and more families are affirming and supporting their TGNC children, it may also be that some of these youth will be interested in the possibility of becoming parents themselves some day. For TGNC youth who have experienced natal puberty and thus have mature reproductive systems, fertility preservation options are essentially the same as for TGNC adults.
If preserving this distant option is perceived as being in conflict with immediate needs for support in accessing gender-related care, youth may feel that they have forego the possibility of becoming parents with a genetic link to their children. An exploration with TGNC youth about their immediate goals, long-term life wishes, and potential options may help youth to feel more empowered to claim their identity. This may help them meet immediate needs and plan for a future in which as few options as possible are foreshadowed upon because of their gender identity. This should include a discussion of options that may be available later as well as decisions that need to be made and acted on more immediately. For example, gonads can be "stored" in the body until and unless surgical intervention to remove them is pursued, although this carries the risk of future infertility following gender affirmative hormone therapy (Eyler et al., 2014).

As discussed by Edwards-Leeper, Leibowitz, and Sanganjananavich (2016), puberty suppression is being increasingly used with adolescents. Puberty suppression (GnRH analogue) hails the development of secondary sex characteristics and the production of viable sperm and eggs, and can occur as early as Tanner Stage 2. This is a reversible medical procedure that does not affect long-term fertility; when exposed to testosterone or estrogen, puberty and the development of secondary sex characteristics will begin (Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). Puberty suppression can cost $1,500 to $2,500 per month and is rarely covered by insurance plans (Hembree et al., 2009). If puberty suppression is continued until hormone therapy is prescribed, youth may not develop viable sperm or eggs that could be used for family creation. Interrupting or delaying puberty suppression to allow a youth’s body to produce viable sperm or eggs would result in irreversible secondary sex characteristic development and biological maturation that could directly contradict the youth’s gender identity and that may require surgery to alter.

There are techniques for the cryopreservation of ovarian cortex and testicular tissue that have been developed with children undergoing cancer treatments that can be used with TGNC youth whose bodies will not develop mature sperm or eggs. One technique requires the surgical removal and cryopreservation of the ovaries and then surgical replacement of the ovaries; this technique has resulted in some births. Ovaries can also be surgically removed, cryopreserved and then stimulated outside of the body to produce viable eggs that could be used with other ART; this technique is still in development (Eyler et al., 2014).

Using cryopreserved testicular tissue to produce mature sperm is more complicated and less successful. Instead, collection of sperm from children for freezing prior to puberty suppression is the most viable option. Eyler and colleagues (2014) note that case reports document viable sperm collection from children as young as 11 years old. A sperm sample from someone so young may have a low sperm count or may contain sperm that are not mature enough to fertilize an egg. In those circumstances, ICSI could be used to maximize the chances of a fertilized egg. A technique called round spermatid injection injects precursors of mature sperm into an egg; this technique is still experimental but may provide options in the future (Eyler et al., 2014). As with all choices, the impact of sperm collection and surgery on children and adolescents should be carefully considered.

Eyler and colleagues (2014) specifically suggest that legal documents be in place to protect the autonomy of TGNC youth if their genetic material is stored. Because these youth are minors, the parents would be the official owners of the stored genetic material, and it is suggested that the documentation specify that ownership will transfer to the TGNC youth upon their reaching the age of majority, and the genetic material cannot be used until the TGNC youth has reached maturity.

### Adoption and Foster Parenting

Some TGNC people may choose adoption or foster parenting as a family creation option. Being TGNC is not a legal impediment to adoption or serving as a foster parent in the United States, but it may be challenging to identify an agency that does not discriminate on the basis of gender identity and/or gender expression. Some agencies explicitly seek TGNC adoptive or foster parent applicants (AFA, 2012). The decision of whether to disclose a TGNC identity when applying to be an adoptive or foster parent should be carefully considered. Given the intensive background check that may occur prior to placement of a child, it may be difficult to avoid discovery of this information and may prove even more difficult to explain the failure to disclose at an earlier stage of the process. Minter and Wald (2012) suggest that many lawyers favor early disclosure to avoid any potential challenges to the adoption process. Adoptions can be completed for an individual or single parent, a joint adoption by an unmarried couple, a second parent adoption, or a step-parent or domestic partner adoption (AFA, 2012). Current recommendations for parents who adopt infants are to tell them about their adoption history in age-appropriate ways as they are growing up (Brodzinsky, 2006; Brodzinsky, Smith, & Brodzinsky, 1998).

### Chestfeeding

Chestfeeding may be of interest to TGNC people whose parenting will begin with infants. This may include TGNC people of all gender identities, gestational and nongestational parents, and parents of adoptive children. Parents may be interested in chestfeeding their children for the many documented health benefits (Anderson, Johnstone, & Remley, 1999; Cunningham, Jelliffe, & Jelliffe, 1991; Evenhouse & Reilly, 2005) and/or because they value this aspect of the parenting relationship. For some TGNC people, chestfeeding is an option which is congruent with their gender identity and their identification with being a mother. Other TGNC parents may choose to chestfeed despite gendered assumptions about who chestfeeds, which may not fit their gender identity or family role (see Milk Junkies at [http://www.milkjunkies.net](http://www.milkjunkies.net)). Depending on the circumstances of how parenthood was achieved and what biology the TGNC parent has (including history of hormone therapy and/or chest or breast surgeries), pursuing chestfeeding maybe an endeavor that requires outside support. Regardless of these factors, parents who choose to chestfeed are mostly likely to succeed in general when they have a support system in place to facilitate their choice (U.S. Department of Health & Human Services, 2011).

### When Family Creation Options Are Unsuccessful or Unavailable

It can be intensely discouraging for a person to be unable to actualize personal hopes and dreams of becoming a parent. Many
ART procedures are very expensive, not covered by most insurance plans, and are unattainable by many middle and lower SES groups. Feelings of loss and grief may occur throughout the family creation process and may also sharply exist at each stage of the process that does not result in a viable pregnancy and healthy birth. This may include insemination without ART, attempts with ART, loss of embryos, miscarriages, neonatal loss or still births, failed adoptions, or a surrogate’s choice to keep the baby. TGNC people may have suffered through dysphoria, cessation of hormone therapy, the introduction of high levels of hormones incongruent with their gender identity, invasive procedures in systems, or with providers who were not trans-affirmative. As a result, TGNC people may feel betrayed by their bodies and may grieve the ability to create a family in the manner that matches their gender identity and true selves. In addition to personal loss, the process of family creation can take a toll on relationships. Sharing the loss or inability to create the family the couple or relationship constellation wanted may be too difficult to tolerate together or the relationship may have begun to evolve around family creation and may not be strong enough to survive without that focus. Loss and grief may be mixed with anger and resentment when a lack of financial resources has blocked a TGNC person from accessing procedures that could provide family creation options.

Conclusion

The advance in available family creation options for TGNC people compared with the past is enormous and there are additional promising options that are likely to be available in the future. Awareness of these options can be empowering to TGNC people. Whether and how they decide to become parents will be limited only by the availability of technologies to support the family creation process and TGNC people’s choices.

References


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