

**NON-BINARY AND TRANSMASCULINE REPRODUCTION: STORIES OF
CONCEPTION, PREGNANCY, AND BIRTH**

by

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Abstract

The question that guided this inquiry was: how do non-binary and transmasculine people narrate their stories of conception, pregnancy, and birth? A qualitative, narrative approach was determined to be most appropriate for answering this question. Five non-binary individuals volunteered to participate in this study. Data were collected using largely unstructured, in-depth, tape-recorded interviews. Analysis of the verbatim transcripts and tape recordings yielded a chronological, cohesive narrative for each participant. Four participants reviewed their narrative and confirmed that their story was accurately represented. The individual narratives were then woven into one collective narrative and common themes across the participants' stories were identified. Before conception, most participants considered how to balance their medical and social transitions with their reproductive goals. Conception was relatively easy and straightforward for the four participants who used their partner's sperm. The gendered nature of, and language surrounding, pregnancy greatly impacted participant's reproductive experiences, leading to gender dysphoria, feelings of isolation and loneliness, and difficulties finding maternity clothes. Participants desired gender affirming care and reported mostly positive experiences with their health care providers. Their gender identity influenced their experiences of parenthood, as well as the decisions they made regarding the disclosure of their gender identity to others, their gender presentation, chestfeeding, and parental designations. The heteronormative, cisnormative scripts that surround pregnancy shaped the reproductive narratives of those who participated in this research. The findings reinforce the importance of inclusive, gender affirming health care and social support services.

Lay Summary

Similar to much of the population, trans people – individuals whose gender identity varies from the sex that they were assigned at birth - often seek parenthood. Little is known about the reproductive experiences of non-binary and transmasculine individuals. This study investigated the conception, pregnancy, and birth stories of five non-binary and transmasculine individuals. All participants were interviewed by the researcher. A unique narrative was written for each participant. Each participant reviewed their narrative to ensure that their story was accurately captured. These five narratives were then woven into one common narrative. The themes of this common narrative highlighted how participant's gender identity influenced each stage of their reproductive journey. The findings of this study reinforce the importance of inclusive, gender affirming health care and social support services.

Preface

This thesis is the original, independent work of the author, Olivia Fischer. A version of the fifth chapter has been submitted to an academic journal for consideration for publication. Olivia Fischer collected all data, conducted all analyses, and wrote the manuscript. Dr. Judith Daniluk provided guidance and feedback throughout the design, analysis, and writing of this research project. Based on Chapter 4, Olivia Fischer has also written a book chapter for the book titled, *Reproduction and Parenting Beyond the Binary*, edited by Kori Doty and A.J. Lowik. This chapter is meant to act as a knowledge translation tool and give back to non-binary communities. Olivia Fischer is listed as the sole author on both publications. This research was conducted with the approval of the University of British Columbia (UBC) Office of Research Ethics (ORS), Behavioural Research Ethics Board (BREB). The number of the certificate obtained for this research is: H18-03653.

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Glossary

Androgynous: a gender expression that combines both masculine and feminine characteristics

Chestfeeding: a gender-neutral term for breastfeeding

Cisgender: refers to those whose gender identity corresponds with the sex they were assigned at birth (Qmunity, 2019)

Cisnormativity: refers to the social roles and social structures that reinforce the idea that cisgenderism is the presumed norm and is superior to other gender identities (Qmunity, 2019)

Deadnaming: using an individual's birth name (the deadname) to refer to them instead of using their chosen name (Qmunity, 2019)

Gender Binary: the social system that views gender as two distinct, opposite, and static categories (male and female) (Qmunity, 2019)

Gender Dysphoria: the emotional distress caused by the conflict between one's gender identity and the sex they were assigned at birth (Qmunity, 2019)

Gender Identity: one's internal and psychological sense of oneself as a man, woman, both, in between, neither, or another understanding of gender (Qmunity, 2019)

Heteronormativity: refers to the social roles and social structures that reinforce the idea that heterosexuality is the presumed norm and is superior to other sexual orientations (Oswald, Blume, & Marks, 2005)

Hormone Therapy: also known as cross-sex hormone therapy, hormone therapy refers to taking hormonal medications (testosterone, estrogen, etc.) to more closely align one's secondary sex characteristics with one's gender identity

Misgendering: referring to someone with the incorrect pronouns. For example, using she/her pronouns to refer to a man who uses he/him pronouns (Qmunity, 2019)

Non-Binary: a term that generally refers to individuals who do not prescribe to the gender binary.

This can include (but is not limited to): a) identifying between or outside of the gender identities of woman and man; b) experiencing being a man or woman at independent times; or c) not experiencing having a gender identity (Matsuno & Budge, 2017)

Pansexual: An individual who is attracted to and may form relationships with any or all genders (Qmunity, 2019)

Queer: an inclusive term that refers to a range of sexual orientations and gender identities.

Increasingly, this term is being used to refer to the LGBT2SQ+ community (Qmunity, 2019)

Sex Assigned at Birth: The determination of an infant's sex at birth. Often done by a doctor, nurse, or midwife by examining the infant's external genitals (Qmunity, 2019)

Trans Man: transgender individuals who identify as men and were assigned female at birth (Qmunity, 2019)

Transgender: refers to those whose gender identity does not correspond with the sex they were assigned at birth (Qmunity, 2019)

Transmasculine: refers to those who identify with a gender identity that is masculine of center and is different from the sex they were assigned at birth (Qmunity, 2019)

Transphobia: the fear and hatred or, and discrimination against, trans people (Qmunity, 2019)

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Dedication

This thesis is dedicated to all members and activists of the trans community.

Chapter 1: Introduction

1.1 Research Problem

Trans is an umbrella term referring to anyone whose gender identity does not align with their sex assigned at birth, and captures the identities of gender non-conforming, non-binary, genderqueer, gender-variant, and gender-diverse individuals. Coming out as trans is a unique process and can entail medical transitions and changes to one's name, body, and gender expression (Downing, 2013). Non-binary is a term that generally refers to individuals who do not prescribe to the gender binary. This can include (but is not limited to): a) identifying between or outside of the gender identities of woman and man; b) experiencing being a man or woman at independent times; or c) not experiencing having a gender identity (Matsuno & Budge, 2017). Transmasculine refers to those who identify with a gender identity that is masculine of center and is different from the sex they were assigned at birth (Qmunity, 2019). The intention behind the terms "non-binary" and "transmasculine" are to capture all identities that fall under their umbrellas and encompass all stages of both medical and social gender transitions. Non-binary and transmasculine people who have retained and utilized their reproductive function are the focus of this study. Of note, many of the following reported studies are rooted in the gender binary system and have limited their research population to trans men. This identity falls underneath the transmasculine umbrella but specifically refers to those who were assigned female at birth and identify as male. There is limited research focused on non-binary individuals, as to be further discussed in upcoming sections.

Similar to much of the population, trans people often seek parenthood. Findings from multiple surveys suggest that 25-50% of trans individuals become parents (Stotzer, Herman, & Hasenbush, 2014). Many, if not most, NBTM people retain their reproductive organs and their

capacity to have children, and the majority of these individuals are of reproductive age when they transition (Obedin-Maliver & Makadon, 2016; T'Sojen, Caenegem, & Wierckx, 2013). These NBTM individuals might choose to engage their bodies in conception, pregnancy, and birth to create their families. In a survey of 50 trans men, Wierckx et al.'s (2012) found that 54% expressed a desire to have children and six percent (three participants) had previously given birth to their child. Despite this desire and capacity for parenthood among many trans men, being a relatively new and understudied phenomenon, little is known about the reproductive experiences of NBTM people.

Both Canada and British Columbia are working towards increasing the safety and acceptance for gender non-conforming individuals and their families. Bill C-16 was introduced to protect individuals from discrimination and hate propaganda as a consequence of their gender identity (Canadian Human Rights Act, 2016). A critical step towards solidifying equal rights for trans and gender diverse people in Canada, this recent legislation speaks to the increasing acceptance and visibility of trans individuals and the importance of knowing more about this population. In conjunction with this, the changes made to BC family law in 2011 expanded the definition of family and offered legal protections for those who have non-traditional family configurations (Family Law Act, 2011). These recent legal changes and shifts in attitudes towards the trans community are creating more openness for NBTM people to create their families through gestational pregnancy than ever before (Tornello & Bos, 2017). In addition, the Canadian Fertility and Andrology Society recently made a formal commitment to serving the needs of trans and gender-diverse people who are seeking reproductive health and fertility services, signifying the increasing prominence, importance, and relevance of this topic. This

growing interest in, and focus on, NBTM reproduction underscores an increased need for research in this area.

1.1.1 Gender Transition and Reproductive Function

Many, although not all, NBTM individuals elect to transition to bring their internal and external experiences of their gender into alignment. Transitioning is a process rather than a single event and can mean transitioning socially, medically, or both (Deutsch, 2014). What gender transition looks like or means is unique to each individual. It may mean moving from one gender category to another (for example, female to male), or it may mean transitioning away from the gender binary altogether to a non-binary identity. Social transitioning may include changing one's name, clothes, mannerisms, appearance, and/or pronouns (Reynolds & Goldstein, 2014). Medical transitioning may include using hormone therapy, and/or having surgical procedures to one's chest and/or reproductive organs (Deutsch, 2014). In the case of transmasculine individuals, hormone therapy likely means taking testosterone, resulting in changes to secondary sex characteristics such as increased muscle mass, fat redistribution, deepening of the voice, growth of facial and body hair, male-pattern baldness, and amenorrhea (cessation of menses) (Deutsch, 2014).

Little is known about the effect of taking testosterone in relation to conception, pregnancy, and birth (T'Sojen et al., 2013). It is recommended that NBTM individuals wishing to become pregnant stop taking testosterone in order to restore menses and fertility. However, some NBTM individuals become pregnant while taking testosterone, suggesting that in some cases menses and fertility can be maintained during testosterone use. Other NBTM people have irreversibly lost their reproductive function as a result of prolonged hormone use (T'Sojen et al., 2013). Given the above, in the current study it was important to attend to the extent in which

testosterone usage played a role in the reproduction decisions and experiences of NBTM participants.

1.1.2 Non-Binary and Transmasculine People's Experiences of Pregnancy

The limited available literature on this topic suggests that exclusion, isolation, and loneliness are predominant features of trans men's pregnancy experiences (Charter, Ussher, Perz, & Robinson, 2018; Ellis, Wojnar, & Pettinato, 2014; Light, Obedin-Maliver, Sevelius, & Kerns, 2014). Additionally, feelings of gender dysphoria are often heightened for NBTM people during pregnancy due to the heteronormative social norm that defines pregnant people as women (Obedin-Maliver & Makadon, 2016). Therefore, it is common for this population to struggle with both their internal and external identity during the reproductive process (Ellis et al., 2014). NBTM individuals are often challenged to grapple with feasible methods of parenthood, making decisions about disclosure of their trans identity, their sense of self, incongruence of pregnancy with their gender identity, and the fear of returning to being female-bodied after stopping hormone therapy (Ellis et al., 2014). Furthermore, they are often left without robust social support and frequently face transphobia and extensive discrimination (Grant et al., 2011). Such inequities are detrimental to the mental health of NBTM parents (Rotondi et al., 2011), potentially rendering them particularly vulnerable to postpartum depression (Charter et al. 2018; Hoffkling et al., 2014; Light et al., 2014). Given these vulnerabilities, it is critical that we understand more about the experiences of this population, in order to best support them in their reproductive decision making, and during their pregnancy and parenting journeys.

1.1.3 Health Care and Reproductive Services

Conception, birth, and pregnancy are increasingly medicalized in Western society, with approximately 95% of births in North America being based on the medical model of birth (Shaw, 2013). NBTM people who wish to biologically reproduce are also often forced into the health care system to have their children. However, medicine has not incorporated gender diversity into routine care and there remains a large gap between what is taught in medical schools and the needs of trans individuals (Obedin-Maliver & Makadon, 2016). Only 30% of 132 medical schools in Canada and USA cover issues related to gender transition and gender affirming surgery (Obedin-Maliver et al., 2011). Topics related to fertility and pregnancy in trans individuals are even less likely to be addressed in medical schools (James-Abra et al., 2015).

In light of the above, it is not surprising that a majority of NBTM individuals report negative experiences when accessing assisted reproduction services. James-Abra et al. (2015) conducted a qualitative study using semi-structured interviews with nine trans-identified participants who had accessed, or attempted to access reproductive services in Ontario, Canada. Participants in this study reported difficulties such as not being represented on clinical documentation, being misgendered and/or deadnamed (referring to a patient by their birth name instead of their chosen name) by staff and service providers, having to consistently combat heteronormative assumptions and, in extreme cases, being refused services. In addition, NBTM individuals frequently face discrimination and regularly encounter unknowledgeable staff when accessing reproductive services (Ellis et al., 2014).

Navigating spaces traditionally considered to be women-only, such as birthing wards and obstetric and gynecologic doctors' offices as a NBTM person frequently means that their bodies, identities, and kinship configurations are misrecognized and misunderstood (Epstein, 2018). This

reality often places NBTM individuals in a situation where they must defend, explain, and protect themselves, their lifestyles, and their reproductive choices. Given these challenges, many NBTM individuals express a desire to remain out of hospital settings when undergoing pregnancy and birth. In a mixed-methods study, Ellis and colleagues (2014) examined the experiences of conception, pregnancy, and birth of NBTM individuals. Of the eight people who participated in this study, 46% sought midwifery care, much higher than the US national average of 8.2% (Martin, Hamilton, Osterman, Curtin, & Matthews, 2015). This finding emphasises the discomfort and challenges that NBTM individuals face when accessing reproductive care in the health care system.

These disproportionate challenges faced by NBTM people when accessing health care and reproduction services can in part be attributed to heteronormative, cisnormative, transphobic societal attitudes. This backdrop of discrimination and the lack of equitable access to basic necessities such as health care signal an urgent need for rethinking how we view and serve trans people. This inquiry aimed to illuminate the reproductive experiences of NBTM people and contribute to this rethinking towards necessary changes in practice and policy.

1.1.4 Heteronormativity, Cisnormativity, and Transphobia

While many NBTM individuals have a desire to become parents, the limited available research suggests that they may not experience the same support and encouragement as their cisgender counterparts (Riggs, Power, & von Doussa, 2016). Cisgender refers to someone whose gender identity aligns with the sex assigned at their birth. NBTM individuals experience disproportionate challenges when undertaking pregnancy and have historically been viewed as unsuitable parents (Ellis et al., 2014; T'Sjoen, Van Caenegem, & Wierckx, 2013). Many

researchers have suggested that these difficulties and attitudes largely stem from heteronormativity and cisnormativity, the social structures that sees families as comprised of a heterosexual, cisgender man and woman couple and their heterosexual, cisgender offspring (Downing, 2013; Charter et al., 2018; Oswald, Blume, & Marks, 2005). Heteronormativity and cisnormativity lead to assumptions about the links between body parts, gametes, gender, sex, sexual orientation, and family configurations (Epstein, 2018). Therefore, a NBTM person who wishes to have a child via gestational pregnancy automatically destabilizes these traditional, heteronormative, cisnormative ideals.

The social backdrop of heteronormativity, cisnormativity, and transphobia inevitably color NBTM people's experiences of conception, pregnancy, and birth. As discussed in previous sections, these social systems contribute to, and perpetuate, their experiences of exclusion, isolation, loneliness, discrimination, and lack of resources (Charter et al., 2018). Therefore, having an understanding of heteronormativity, cisnormativity, and transphobia provides a useful lens to understand the challenges that NBTM individuals face when biologically creating their families. Furthermore, the reality and existence of this contextual backdrop further supports why learning about the reproductive decision making and experiences of this population is important.

1.2 Purpose of the Study

While there is a growing body of research around trans parenting (Stozer et al., 2014; Riggs, 2013; Walks, 2015), there is still little known about the experiences of NBTM people as they navigate conception, pregnancy, and birth. Due to the rapidly changing social climate and current state of reproductive technology, previous research in this area is now outdated (Ellis et al., 2014; Light et al., 2014; T'Sjoen et al., 2013). Additionally, past studies have been conducted

primarily using survey data (Charter et al., 2018; Ellis et al., 2014; Light et al., 2014; Riggs et al., 2016; Tornello & Bos, 2017; Wierckx et al., 2012). Addressing these gaps, this study was focused on NBTM people's experiences of conception, pregnancy, and birth, through the use of a bottom up, in-depth, qualitative methodology.

The objectives of this study were: 1) to understand how NBTM people narrate their stories of conception, pregnancy, and birth; and 2) to elevate the stories of this marginalized population. This second objective was meant to recognize that the voices of NBTM are often silenced, erased, or not considered. Birth is generally thought to be an experience that is only had by cisgender women. By gathering and sharing these reproductive stories, I provided a platform for NBTM people to share their birth stories and begin to combat this erasure. This inquiry was guided by the research question: **How do non-binary and transmasculine people narrate their stories of conception, pregnancy, and birth?**

To answer this research question, I used a narrative approach. This was the best suited method to address this question because it helps us understand the subjective and complex worlds of individuals and groups (Riessman, 2008). A qualitative method, narrative inquiry is an approach in which researchers collect descriptions of events and happenings and then configure them into sequential stories (Creswell, 2013). Within the field of psychology, narrative inquiry is particularly useful when studying a significant life event about which little is known, such as NBTM individuals' stories of conception, pregnancy, and birth (Crossley, 2011). Considering the lack of research in this area, using a narrative approach helped illuminate this important, yet understudied topic. Additionally, the previous work done on trans men's reproduction has rarely elevated the voices of participants as it has relied on survey data (Charter et al., 2018; Ellis et al.,

2014; Light et al., 2014). In an attempt to address this gap, I documented the personal reproduction stories of NBTM people who have gestationally carried their child(ren).

Given the heightened vulnerability and disproportionate challenges that NBTM individuals face during this critical life event, it is essential that service providers working in fertility and obstetrics are knowledgeable, equipped, and attuned to the needs of their trans clients. This group includes counsellors as they can play a central role in NBTM care during this exciting, but often uncertain time. Pyne, Bauer, and Bradley (2015) analyzed the survey data from 433 trans people living in Ontario on the stressors that impact trans parents. The findings from this study suggest that psychotherapy can be an important source of support for trans individuals while they build their family. Literature in counselling psychology has yet to look at the reproductive stories of NBTM people. Therefore, the findings of this study may be useful to mental health professionals working with trans parents and parents-to-be. Pyne et al. (2015) calls on mental health professionals to ensure that they are adequately trained, to advocate within their profession for equitable treatment, and to assist trans parents in accessing psychosocial support and family planning services. Responding to this call, my aim with this study was to increase the available knowledge for mental health professionals to better support this population.

In conducting this study, I have made the following contributions: 1) expanded on the limited existing research concerning NBTM reproduction; and 2) offered participants in this study the platform to share their stories. Ideally, the examination of the birth stories of these individuals may lead to an increase in trans-sensitive services, policies, and research, thereby mitigating some of the challenges that currently affect trans individuals disproportionately.

Chapter 2: Literature Review

2.1 Literature on Family Planning: Introduction

Within transgender studies, transgender reproduction is nearly invisible. Within reproduction studies, transgender reproduction is rarely broached; when it is raised, what is written primarily focuses on whether transgender people should even be offered fertility preservation technologies and assisted reproduction services (T'sjoen et al., 2013). The few available research studies on NBTM reproduction fall broadly into two categories: family planning (the desire to become parents, fertility preservation, and the experiences of accessing assisted reproduction services) and, the experiences of conception, pregnancy, and birth. First, I will present the available literature on family planning to provide context for the experiences that influence and foreshadow conception, pregnancy, and birth. The majority of work in transgender reproduction has been focused in this area. Second, I will present the limited research specifically examining NBTM experiences of conception, pregnancy, and birth. I have chosen this order to mirror the chronological events that NBTM people navigate in creating their families: the desire to have children; deciding how, and whether, to preserve their fertility; potentially pursuing assisted reproduction; conceiving an embryo; carrying a pregnancy; and birthing their child. Additionally, I believe this chronologically lends itself well to a narrative approach. In this chapter I provide a summary and critical review of the limited available literature on NBTM reproduction. Many of the studies reviewed in this chapter include the fertility experiences of both NBTM people (predominantly trans men) and transfeminine people (predominantly trans women). For the purposes of this review, I will mainly focus on the findings relevant to NBTM people.

2.1.1 Literature on Family Planning: A Desire to Become Parents

To specifically determine the reproductive wish in trans men, Wierckx and colleagues (2012) constructed and administered a survey to 50 trans men. This questionnaire addressed quality of life, sexual functioning, fertility wish, surgical results, psychological functioning, and medical history. All of these men had undergone gender affirming surgery between 1987 and 2009 at Ghent University Hospital in Belgium, a main research institution for transgender reproduction. A majority (54%) of these men expressed a desire to have children and 37.5% reported that they would have considered freezing their gametes if this technique had been available at the time of their surgery. These findings underscore the importance that NBTM people are counselled about their fertility options prior to initiating medical transition and that health professionals are knowledgeable about NBTM reproduction. The current inquiry increases the available knowledge to help educate service providers.

At the time of the survey, eleven participants (22%) already had children, three of these 11 men had previously given birth to their child, and the other eight reported that their female partner was inseminated with donor sperm (Wierckx et al., 2012). Of those who had given birth, two identified this experience as extremely problematic while one identified the experience as pleasant. This dichotomous experience of pregnancy and birth for NBTM people seems to be consistent across the literature (Ellis et al., 2014; Light et al., 2014). This finding will be further discussed in the following section on the literature on conception, pregnancy, and birth. Based on these findings, the authors concluded that it is important for healthcare providers to address family planning during all stages of the transition process. This was the first study ever conducted on trans men's reproductive wish and highlights that NBTM individuals' wish to have

children and that the experiences of pregnancy and birth are dichotomous across individuals. These findings highlight the need for further inquiry, as undertaken by the present study.

In a qualitative study, Tornello and Bos (2017) conducted an open-ended survey with 24 childless trans men and eight trans women (32 total) regarding their desire to become parents in the future. This study focused on the decision-making process of the participants and the challenges they faced when seeking parenthood. Being biologically related to their child was a common wish of respondents, with one participant stating, “I don’t like the idea of involving DNA from anyone other than myself or my partner” (Tornello and Bos, 2017, p. 117). Of the biological possibilities, 33.3% of the trans men wanted to become parents through sexual intercourse, 16.6% via surrogacy, and 25% using artificial insemination. The remainder of the trans men (25%) sought adoption or foster care to create their families. A limitation of this study is that they did not include partnership configurations (e.g. partnered with a cisgender male, transgender woman, etc.) when reporting the gender and preferred family formation technique of participants. This is an important inclusion because partnership configurations dictate which conception methods are feasible (through sexual intercourse, use of donor sperm, etc.).

An important finding of this study was that a majority of the trans men surveyed sought biological relatedness to their future offspring while 75% of the trans women reported a preference to adopt or become a foster parent. The authors did not posit an explanation for this difference between trans men and trans women. Given that a majority of trans men desire biological relatedness to their future offspring, the current inquiry aimed to gain more understanding as to what influences this decision-making process and the experiences of this population pursuing this biological path.

The main barriers that influenced participant's decisions on how they wanted to become parents included physical limitations such as infertility, financial restrictions, and lack of legal protections (Tornello & Bos, 2017). Some of the trans men in this study reported that the option to gestationally have children was not possible for them because pregnancy and birth would disrupt their gender transition or contradict their gender identity. This finding is exemplified by the quotation, "I'm interested in the possibility of having a child genetically related to me, but I have no interest in being pregnant" (Tornello & Bos, 2017, p.118). This finding demonstrates a gap in our understanding as to why some NBTM people decide to overlook this barrier and pursue gestational pregnancy and others do not. The current inquiry aimed to elucidate the process of arriving at this important decision.

2.1.2 Literature on Family Planning: Fertility Preservation

Gender affirming procedures such as hormone use, and surgery adversely affect the reproductive potential of transgender people (Mattawanon, Spencer, Schirmer, & Tangpricha, 2018). Therefore, some transgender people elect to undergo procedures to preserve their fertility before medically and/or surgically transitioning. Health organizations such as the World Professional Association of Transgender Health, and the Ethics Committee of the American Society for Reproductive Medicine recommend that all trans people be counselled on their fertility options prior to initiating medical transition (Coleman et al., 2012). It is not known if the provision of this information actually takes place, as current research illustrates that many NBTM individuals lack the information and support to control their reproductive health (Jones, Reiter, & Greenblatt, 2016; Mitu, 2016). The present inquiry aimed to increase this knowledge provision by increasing the available knowledge available to service providers.

For NBTM individuals, there are three commonly accepted ways to preserve fertility: oocyte cryopreservation, embryo cryopreservation, and ovarian tissue cryopreservation (T'sjoen et al., 2013; De Roo, Tilleman, T'Sjoen & De Sutter, 2016; Jones et al., 2016; Mitu, 2016; Mattawanon et al., 2018). Oocyte cryopreservation requires controlled ovarian hyperstimulation followed by ultrasound-guided egg retrieval under anesthesia (Mattawanon et al., 2018). Oocyte cryopreservation offers trans men the option to preserve their fertility without needing to commit to a particular donor or partner (Mattawanon et al., 2018). Embryo cryopreservation requires fertilization of the NBTM person's oocytes with donor or partner sperm prior to cryopreservation. This option negates their future options to fertilize the eggs with another person's sperm. These two methods are presently considered the best options for fertility preservation in adult NBTM individuals.

Another method that does not require a partner is ovarian tissue cryopreservation. This experimental method involves the surgical excision of sections of ovarian cortex, which are then cryopreserved in liquid nitrogen (De Roo et al., 2016). A benefit of this technique is that it can be conducted prior to puberty and performed at the same time as gender affirming surgery without ovarian hyperstimulation. However, this is an experimental method and while there have been a few reported births from this technique, there is presently no long-term data available on the live birth rates in trans men (Mattawanon et al., 2018).

Oocyte cryopreservation, embryo cryopreservation, and ovarian tissue cryopreservation allow for the preserved tissue to be replanted in the patient. Preserved oocytes and embryos can also be implanted in their intimate partner or in a surrogate (Mattawanon et al., 2018). More commonly these procedures are undergone by those who wish to have an oophorectomy and

hysterectomy, although not exclusively. Being familiar with these methods provides important context to the field of NBTM family planning.

All three of these procedures require complex decision-making, financial resources, and may cause pain and distress (T'sjoen et al., 2013). Similar to medical and surgical gender affirming transitions, these are only accessible to those in the upper financial echelons of society as these procedures are often not covered by health plans. Factors such as the sex of their partner, age, socioeconomic status, as well as if and how a person has medically transitioned, all influence the availability of fertility preservation options (T'sjoen et al., 2013). In addition, there are many ethical and legal complications that are associated with these procedures. However, these important considerations are beyond the scope of this paper.

2.1.3 Literature on Family Planning: Assisted Reproduction

Generally, trans people access assisted reproduction treatments (ART) for two reasons. The first is when undergoing fertility preservation procedures such as oocyte cryopreservation, embryo cryopreservation, and ovarian tissue cryopreservation prior to fully transitioning. The second is when they are at an active stage of attempting to have children (James-Abra et al., 2015). While there has been a growing body of literature on gay, bisexual, and lesbian people's experiences accessing ART, relatively little attention has been paid to trans people's experiences with ART (James-Abra et al., 2015).

A notable exception is a qualitative study conducted by James-Abra et al. (2015) using semi-structured interviews with nine trans-identified participants (six were transmasculine), who had used, or attempted to access, assisted reproductive services in Ontario, Canada. These interviews were part of a larger project, titled *Creating Our Families*, which included lesbian, gay, bisexual, and trans people. Of the 66 participants, nine identified as trans. The interviews

with these nine trans participants were analyzed separately from the interviews with lesbian, gay, and bisexual people. The primary finding was that participants experienced extensive barriers and challenges when accessing assisted reproduction services. Two couples reported a positive experience with ART service providers, feeling that the clinic was trans friendly and that gender-neutral terminology was used. The other seven participants reported predominantly negative experiences due to providers' cisnormative and heteronormative assumptions, combined with problems with clinical documentation. In one case, a trans man was repeatedly refused services outright on the premise of his gender identity. When faced with instances of heteronormativity, cisnormativity, and transphobia, self-advocacy and avoiding confrontation with service providers were the main strategies used by these participants. This study is limited due to the small sample size, considering the broad range of experiences represented. In addition, the fact that it was conducted as part of a larger study that was not specifically focused on transgender reproduction is a limitation of the study design. The experiences of gay, lesbian, and bisexual people are often quite different than those of transgender people and are too often combined in research (Worthen, 2013). Sexual orientation and gender identity are separate constructs and, therefore, should be investigated individually (Worthen, 2013). Despite these limitations, this article is the first of its kind and provides a useful snapshot into the experiences of trans people accessing ART. The present inquiry limited recruitment only to NBTM individuals and was informed by the finding that the majority of transgender people have negative experiences when accessing ART.

Epstein (2018) conceptualizes the predominantly negative experiences of trans people accessing ART, as reported by James-Abra et al. (2015), by critiquing the heteronormative, cisnormative models of assisted reproduction. Epstein (2018) argues that ARTs were established

to assist cisgender, heterosexual, predominantly white, and financially well-resourced couples experiencing infertility to achieve their nuclear families. Those who are outside of these normative identities, particularly queer and trans bodies, are seen as deviant. Epstein (2018) argues that reproductive technologies disrupt normative reproduction and open up the possibility to procreate “unnaturally” and therefore, destabilize kinship. This disruption positions queer and trans bodies as sites for discrimination, as cisgender, heterosexual individuals attempt to protect their kinship by bolstering conventional masculinities and femininities within fertility clinics.

Based on an examination of three narratives of queer and trans people navigating ART from the *Creating Our Families* project (the same data used by James-Abra et al. (2015)), Epstein (2018) identified a common theme of misrecognition. According to Epstein, a trans man's maleness becomes unrecognizable and unseen because he is pregnant, resulting in constant misgendering and the assumption that he became pregnant through normative heterosexual intercourse, erasing both his gender identity and sexual orientation. This experience leads him to experience increased gender dysphoria and to feel a sense of violation. Theoretical in nature, this critical paper identifies some important sociological forces that operate behind the scenes of NBTM reproduction and begins to offer the foundations of a framework to assist practitioners, and others, conceptualize and work more effectively with queer and trans people. This conceptualization informed the current inquiry by situating heteronormativity, cisnormativity, and transphobia as sources of difficulty for NBTM individuals pursuing assisted reproduction.

2.1.4 Literature on Family Planning: Conclusion

In summary, the research focused on NBTM people's desire to have children, fertility preservation, and assisted reproduction experiences has some important findings. As is the case with many cisgender people, NBTM individuals wish to become parents and many are of reproductive age at the time of their transition (T'Sojen et al., 2013). Their options for biologically creating their families depend on the sex of their partners, their socioeconomic status, and what procedures they have elected to undergo as part of their gender transition (Wierckx et al., 2012). For those NBTM individuals wishing to preserve their fertility, there are three commonly accepted procedures: oocyte cryopreservation, embryo cryopreservation, and ovarian tissue cryopreservation. These each come with their own risks, benefits, and considerations. Accessing assisted reproductive services is rife with experiences of exclusion and discrimination (James-Abra et al., 2015). As Epstein (2018) suggests, these negative experiences may largely be due to heteronormativity, cisnormativity, and transphobia.

The empirical studies presented in this section primarily rely on quantitative, survey data. While central to understanding the reproductive outcomes and demographics of transgender individuals, they rarely position trans people as the experts of their own experience. Within this area, there is a need for a more in-depth, bottom-up, understanding of transgender fertility preservation. Additionally, none of the authors acknowledge their own gender identity or their social position (Epstein, 2018; De Roo et al., 2016; James-Abra et al., 2015; Mattawanon et al., 2018; T'Sojen et al., 2013; Wierckx et al., 2012). Given the problematic and voyeuristic history of transgender research, it is critical that researchers position their gender identity within their work (Vincent, 2018). A common limitation that spans across all of the studies discussed in this review is that the experiences of non-binary individuals have been overlooked. Furthermore, in

the literature to date, the participants and researchers are predominantly white, wealthy, and living in urban centers. The perspectives of those who belong to marginalized ethnic and socioeconomic groups are largely absent within the existing literature. As will be discussed in the following chapter, I made every effort to recruit those who are diverse in ethnicity, socioeconomic status, and rural and urban location for this inquiry and explicitly focused on non-binary individuals. In addition, I have included a reflexivity section in the following chapter that positions myself within this research.

2.2 Literature on Conception, Pregnancy, and Birth

While there is a growing body of research on trans parenting (Riggs, 2013; Stozer et al., 2014; Walks, 2015), there is still little known about the experiences of NBTM people as they navigate conception, pregnancy, and birth. Few studies have been published specifically focusing on the conception, pregnancy, and birth experiences of NBTM individuals. Four of the presented studies are based on original research (Charter et al. 2018; Ellis et al., 2014; Hoffkling, Obedin-Maliver, & Sevelius, 2017; Light et al., 2014) and one is a commentary that aims to educate and assist clinicians who care for trans men experiencing pregnancy (Obedin-Maliver & Makadon, 2016). A summary and critical review of these articles follows.

Light et al. (2014) conducted a comprehensive mixed-methods study to investigate the experiences of transgender men who became pregnant after transitioning. Using a web-based survey for the quantitative component, the authors inquired about demographics, hormone use, fertility, pregnancy experience, and birth outcomes. Of the 41 previously pregnant trans men who completed the survey, 61% had used testosterone prior to their pregnancy, 46% had a double mastectomy (top surgery), 5% had an oophorectomy, 5% had a hysterectomy, and 2%

had a phalloplasty. Unfortunately, it is not known whether respondents underwent these procedures before or after pregnancy. That limitation aside, the vast majority of participants conceived their child using their own and their partner's gametes; 88% of participants' oocytes came from their own ovaries and 75% of sperm came from their partners (cisgender men, transgender women, etc.). For the remaining participants, 10% participants used their partner's oocyte, 2% used an anonymous donor's oocyte, 10% used a known sperm donor, and 15% used an anonymous sperm donor. The median age of conception was 28, and 66% of the pregnancies were planned. The majority of participants (63%) had only experienced one pregnancy, with 37% having had two or more pregnancies. Pregnancy, delivery, and birth outcomes did not differ according to prior testosterone use. Most of the transgender men became pregnant within four months of trying. Fifteen percent of participants had a preconception medical consultation, and 7% used fertility drugs to become pregnant. It is interesting to note that none of the participants in this study used fertility preservation methods. The above findings provide important demographic context to NBTM conception, pregnancy, and birth and informed the current inquiry by offering comparative, informative data.

The following four open-ended questions were asked for the qualitative component of the survey: Is there anything you would like medical providers to know about transgender men and pregnancy? What was the experience of being pregnant like for you? What was the experience of giving birth like for you? What was the postpartum experience like for you? The themes that emerged from the responses to these questions included the effect of pregnancy on concepts of family structures, isolation, gender dysphoria and pregnancy, postpartum depression, and interactions with health care providers. Pregnancy was often seen as a necessary step towards building a family and participants used words such as "dad" and "carrier" to affirm their gender

identity and parenting role. Feelings of loneliness and isolation were common as participants felt that they were the only NBTM person to have undergone pregnancy, feeling invisible in their experience due to the lack of resources and support available. This theme is consistent across the literature (Charter et al., 2018; Ellis et al., 2014; Hoffkling et al., 2017). As previously mentioned, experiences of pregnancy and gender dysphoria seem to go in one of two directions. For some, pregnancy allows trans men to connect more with their bodies and lessens their experiences of gender dysphoria. For others, pregnancy increases their gender dysphoria and is a time of great distress, potentially resulting in post-partum depression (Light et al., 2014). The experience of gender dysphoria during pregnancy was attended to in the present study.

Finally, participants reported a wide arrange of responses to the question regarding their experiences with health care professionals. When practitioners used gender affirming language, participants reported positive experiences. In other instances, participants reported negative experiences such as improper pronoun use, rude treatment, and in one extreme case, a participant reported that, “Child Protection Services was alerted to the fact a ‘tranny’ had a baby” (Light et al., 2014, p. 1124). This example once again highlights the harmful and discriminatory treatment that some transgender people face during their reproduction journey and the need for sensitive health care provision.

By using a mixed-methods approach, this comprehensive and foundational study provides an overview of the relevant demographic, conception methods, and birth outcomes. In addition, asking participants about their experience provides insight into the complexity of their experiences and highlights postpartum depression as an area for future inquiry. This study was limited in that it was based on an online survey. Therefore, it did not allow for follow-up clarification with participants and did not capture the responses of those with low literacy or

other barriers. The present study instead relied on qualitative data, capturing the responses of those who were unable to fill out online surveys, and allowed for follow-up clarification if needed.

In a qualitative examination of the experiences of conception, pregnancy, and birth, Ellis and colleagues (2014) interviewed eight transmasculine people in addition to administering an online demographic survey. As with most clinical studies of transgender people to date, the sample size was small. In terms of how pregnancy was achieved, five participants became pregnant through sexual intercourse, two using home insemination, two via clinic insemination, one used fertility medications, and one underwent IVF. Using a grounded theory methodology, the authors identified loneliness as an overarching theme that permeated participant's experiences, social interactions, and emotional responses during every stage of achieving biological parenthood. This finding is consistent with the results of Light et al.'s (2014) and Hoffkling et al.'s (2017) studies. Ellis et al. (2014) suggest that these feelings of loneliness stem from pregnant NBTM people being acutely aware that they are transgressing societal expectations that male and gender variant people will not use their bodies to have children. This suggestion once again highlights the power of the social backdrop of heteronormativity, cisnormativity, and transphobia in shaping the pregnancy experiences of NBTM parents.

The participants in the study by Ellis et al. (2014) reported that their emotional responses throughout the process ranged from joy to intense distress, with the highest levels of distress occurring during the preconception period. The emotional complexity of the experience of transmasculine pregnancy was highlighted by one participant's comment, "I was my own surrogate" (Ellis et al., 2014, p. 65). Another common theme was the process of navigating identity, both internally and externally. Participants reported struggling internally when they

were considering the most feasible way to become a parent, wrestling with their sense of self, and with making decisions about disclosure. Similar to the findings of Wierckz et al. (2012) and Light et al. (2014), participants reported a disparate range of pregnancy experiences. For a few participants, pregnancy was primarily positive as they experienced a sense of embodiment and connection with the developing fetus. However, others reported experiencing disembodiment and a lack of connection with the developing fetus. Externally, participants struggled with social interactions and trying to best protect themselves and their future child when deciding whether or not to disclose their gender identity. The authors concluded that the stages leading up to gestational parenthood for NBTM individuals are consistent with heterosexual and lesbian parenthood, but with unique features of continually navigating identity and feelings of persistent loneliness. Given these additional qualities, it was important to attend to the extent which loneliness and navigating identity played a role in achieving biological parenthood for NBTM individuals in the current inquiry.

Also using a grounded theory methodology, Hoffkling et al. (2017) conducted interviews with 10 transgender men who had given birth while identifying as male. One of the central findings of this study was that participants reported a wide variety of experiences in regard to pregnancy, identity, gamete source, social support, and degree of outness. Some participants accidentally got pregnant, while others had a strong desire to build their family. All participants in this study used their own oocytes but used a variety of sperm sources. Social support ranged from robust to tenuous. Once again, the experience of isolation was a predominant theme that arose from the interview data. Participants engaged in a variety of strategies in regard to outness such as choosing to pass as a cisgender woman, hiding their pregnancy and appearing as a cisgender man, or being out and visible as a NBTM pregnant person. Each of these strategies

offered distinctive benefits and drawbacks. Being perceived as a pregnant cisgender woman, participant's experiences of pregnancy were affirmed, and they were not exposed to discrimination and violence. However, this made their trans and masculine identities invisible, increasing their experience of gender dysphoria. Being seen as a cisgender male erased their identities of being pregnant and trans but also protected them against transphobia. Finally, being out and visible was affirming for all the identities held by the participants but resulted in more exposure to transphobia and violence.

A unique finding that surfaced from this study was the prioritization and sequencing of transition versus reproduction (Hoffkling et al., 2017). There was a tension reported by some participants between pursuing their reproductive goals and their transition goals, primarily when navigating testosterone use. The authors concluded that it is important to recognize the diverse experience of NBTM individuals and subsequently provided recommendations for service providers. Similar to Obedin-Maliver and Makadon (2016), they suggested service providers use gender affirming language, explain why they are asking sensitive questions to their patients, and have resources available that are not women-specific. Calling for future research, the authors stressed a focus on understanding how NBTM people who have given birth are navigating their social relationships with their communities and with their children. This topic emerged in the reproduction narratives of the NBTM people in the current inquiry.

More recently, Charter et al. (2018) conducted a very similar study to Ellis et al. (2014). Using online survey data and in-person interviews, the authors of this mixed-method study asked 25 trans men (aged 25-46) living in Australia about their experiences and constructions of pregnancy and parenthood. This study took place as part of a larger parenting study on transgender individuals (N=66). The data from those who had experienced gestational pregnancy

were used for their article. Unlike Light et al.,’s (2014) study, 18 of the 25 participants were partnered to cisgender women and therefore, used donor sperm to conceive their child. This difference showcases the large range of methods that NBTM people may undertake when seeking biological parenthood.

Participants reported that parenthood was initially alienating but that transitioning to their correct gender assisted them in the negotiation and construction of their parenting identity (Charter et al., 2018). This finding demonstrates the importance of providing gender affirming care throughout the perinatal process and minimizing gender dysphoria. Pregnancy was positioned as problematic but a “functional sacrifice” (Charter et al., 2018, p. 69). Negotiating with their masculinity, participants reported that their experiences of gender dysphoria increased due to withdrawal from testosterone, leading to re-feminization of features, and a growing fecund body. In addition, inhabiting a pregnant body and changes to their chest were reported as particularly concerning. Consistent with the findings of Epstein (2018) and James-Abra et al. (2015), experiences related to assisted reproductive services were mainly negative, discriminatory, and isolating. Overall, health care was reported to be generally not supportive and many participants experienced significant challenges when interacting with health care providers. This study elucidates the experience of gender dysphoria during pregnancy and highlights the necessity for gender affirming care. These findings were important to consider during the conduction of the present study.

Obedin-Maliver and Makadon (2016) provide a brief commentary to assist clinicians on how to care for NBTM people, primarily drawing on the same literature presented in this paper (Ellis et al., 2014; Light et al., 2014; Wierckx et al., 2012). Obedin-Maliver and Makadon (2016) conclude that preconception counselling should include a discussion of testosterone use during

conception and pregnancy as well as anticipating an increase in experiences of gender dysphoria during and after pregnancy. In addition, they suggest that all health care providers need to be versed in appropriate language, and options for chestfeeding. They emphasize the importance of gender affirming policies. According to Obedin-Maliver and Makadon (2016), a positive perinatal experience begins the instant a NBTM individual presents for care and is dependent on a comprehensive affirmation of gender diversity at the onset and throughout their care. These considerations provide a useful starting point to increase trans-competent services by informing health professionals who work with this population.

2.2.1 Literature on Conception, Pregnancy, and Birth: Conclusion

In summary, the limited existing literature on conception, pregnancy, and birth in NBTM individuals identifies some common and important experiences and challenges. Feelings of loneliness were reported by all participants in these studies, as they often felt that they were alone in navigating this experience. This sense was compounded by the lack of resources and support for this population and the social climate of heteronormativity, cisnormativity, and transphobia. Pregnancy reportedly led to a dichotomous experience of either feeling more connected to their body, or to an increase in gender dysphoria. In addition, NBTM individuals in these studies appeared to struggle with their identity both internally and externally and chose a variety of strategies in terms of their degree of outness. Participants across studies chose to conceive their children through a variety of methods, with none reporting the use of fertility preservation technologies. The small size of this population, the relatively recent and budding social acceptance of trans parenthood, combined with the fact that many of the fertility

technologies and gender affirming surgeries have only recently become available may explain the lack of literature in this area.

While the current study builds upon these foundational studies, it also differs in some important ways. First, none of the above studies utilized narrative inquiry as their method. By using a narrative approach, the current study contributes to this area of research because this method has the ability to uncover new and unforeseen realities and allow for a deeper understanding of NBTM reproduction. Second, many of these studies (Ellis et al., 2014; Hoffkling et al., 2017; Light et al., 2014) were examined in the American context. This study was focused on the Canadian context. Third, given the rapidly evolving nature of this field, with changes to the social climate and reproductive technology, these studies have become quickly outdated. The present inquiry aimed to capture the experiences of those NBTM who have experienced birth in the previous five years. Fourth, the experiences and identities of non-binary people were not focused on in the above studies. Despite the fact that about one third of individuals who identify as transgender identify as non-binary, and that non-binary people face additional challenges than the wider transgender population as a result of living in a society that is structured around binary gender identities, there remains little research focused on the reproductive desires and experiences of these individuals (Matsuno & Budge, 2017). The current inquiry captured the experiences of this population. Finally, many of the studies analyzed data from existing data sets that were gathered to answer broader research questions. This study was specifically designed to examine the reproductive stories of NBTM and generated unique and specific data to accomplish this goal.

Once again, a limitation of the above studies is that a majority of the participants were white, wealthy, well-educated, and financially well-resourced. A gap that remains in the

literature is on the experiences of transgender men who chose to never conceive, those who wished to conceive but were not able to, and those who conceived but whose pregnancies ended in miscarriage, abortion, or stillbirth (Hoffkling et al., 2017). Finally, literature focused on the transition to parenthood for transgender people is absent from the field. These are important areas for future inquiry.

2.3 Literature Review: Conclusion

In this chapter, I have reviewed the existing literature on transgender reproduction including family planning (the desire to become parents, fertility preservation options, and the experiences of accessing assisted reproduction services), as well as the experiences of conception, pregnancy, and birth. Based on these studies, it is clear that many NBTM people desire and seek parenthood and there are a variety of options for fertility preservation and conception. Both common and different experiences of NBTM people emerge from the literature when they are navigating assisted reproduction services, conceiving an embryo, carrying a pregnancy, and birthing a child. This wide range of experiences signals a need for more research and increased understanding in this area. As vital as the above findings are to understanding the context of NBTM reproduction, it is evident that there remains a limited understanding of NBTM conception, pregnancy, and birth. A widespread limitation across the literature on transgender reproduction is the lack of representation of non-binary people. The previously presented findings demonstrate a gap in the literature about the birth stories of this population and highlight the need for an in-depth understanding that positions the voices of these individuals at the forefront of the research, as was examined in this study.

Chapter 3: Method

3.1 Research Design: Narrative Inquiry

Employing the qualitative, inductive research method of narrative inquiry, I sought to answer the research question: **How do non-binary and transmasculine people narrate their stories of conception, pregnancy, and birth?** Adopting a social constructionist approach, I adopted the ontological stance that there are many explanations, interpretations, and realities. Epistemologically, I did not assume objectivity but instead privileged subjectivity and positionality (Riessman, 2002). A qualitative method was selected for this inquiry because it was best suited to the research question. There is a lack of both qualitative and quantitative research in this area, ergo the need for a bottom up, qualitative approach.

Narrative inquiry differs from other qualitative research methods because it relies on lengthy accounts that are preserved and treated analytically as holistic units, rather than fragmented into thematic categories (Riessman, 2008). Maintaining the whole of the story was particularly important for the accomplishment of the second objective of this study, to elevate the voices of this marginalized population. This practice of preservation honored individual agency and intention and allowed this research to include many voices and subjectivities (Riessman, 2008). It permitted participants to tell their stories in their own words, capturing each individual's rich and unique account. Given the problematic history of voyeurism and objectification in transgender research, to be elaborated on in a subsequent section, this quality of narrative inquiry was particularly appropriate to address this research question.

The telling of birth stories is a common and important social practice. These birth stories are predominantly told by cisgender, heterosexual women, often neglecting and erasing the voices and reproductive experiences of NBTM individuals. Narrative inquiry is a particularly

powerful methodology as it allows a focusing in on the voices of marginalized people and making these experiences visible (Riessman, 2008). My belief is that the heteronormative, cisnormative context within which NBTM people conceive, carry, and birth their child(ren), is invariably intertwined with their lived experience, and cannot be disentangled from the stories they tell. Therefore, a narrative approach was particularly well suited to this inquiry because it centered the individual in the context, spaces, and societies in which they inhabit and prompts the reader to think beyond the surface of a text (Riessman, 2008). Drawing heavily on Riessman (2008), I have elevated the voices of the participants in this study and conveyed what their stories of conception, pregnancy, and birth are in the context of a heteronormative, cisnormative society.

For the purposes of this inquiry, narrative was defined as the telling of personal stories related to conception, pregnancy, and birth, that participants perceived to be important (Riessman, 2008). Storytelling is a major way people make sense of their experiences, construct their identities, and create and communicate meaning (Chase, 2003). Therefore, narrative served as a powerful way to understand NBTM reproduction. Riessman (2008) outlines some questions addressed by narrative inquiry: How is the story constructed? Why is the order of events configured in the way that it is? What cultural resources does the story draw upon? What does the story accomplish? Are there gaps and inconsistencies? These questions guided my analysis and allowed for a nuanced and deep understanding of the experiences of NBTM individuals as they moved along their reproductive journeys.

3.2 Participants and Recruitment

Inclusion criteria encompassed identifying as other than cisgender, having biologically conceived, carried, and birthed a child, and that their youngest child was between six months and

five years old. This final criterion was to allow parents some time to adjust to having a newborn and to reflect on, and integrate, their experiences (six months) while not having so much time transpire that they were no longer able to accurately recount their experiences (five years). Participants were not excluded if they had more than one child. Given the narrative method applied to this study, it was also necessary for participants to be fluent in English and able to describe their stories in a way that I was able to understand. It was also important that participants were able to read and comprehend the consent form and able to attend interview times in the Greater Vancouver area, or participate over Zoom. Participants were excluded if they had experienced a stillbirth. These experiences were outside of the scope of the research question as many people experience profound and prolonged grief after stillbirth (Mills et al., 2014).

Recruitment of participants began immediately after approval was granted by the Behavioural Research Ethics Board at the University of British Columbia and took place between January 2019 and February 2019. Participants were purposefully sampled with the aim of studying stories that were both data rich and relevant to the research question (Patton, 2002). Primarily, I relied on criterion-based sampling because participants must have met the inclusion criteria listed above to participate. Employing convenience and snowball sampling, participants were recruited through social media groups, queer and trans resource centers, and through community contacts. These contacts largely stemmed from my work at the Ending Violence Association where I co-facilitate and coordinate community workshops on healthy relationships for queer and trans individuals. I made efforts to obtain a diverse sample in terms of ethnicity, social economic status, education attainment, ability, age, sexual orientation, gender identity, and other demographic variables. For example, I specifically reached out to groups that served

people of colour and those who live in rural settings. However, these attempts were not successful.

Characteristic of both in-depth, qualitative research, and transgender research, this study had a small sample (Braun & Clarke, 2013; Ellis et al., 2014). Five NBTM individuals who had a child between six months and five years ago were recruited. As recommended by Josselson and Lieblich (2003), five is the minimum requirement for interview-based projects. I believe that my positionality within the queer and trans community allowed me greater access to the reproductive experiences of NBTM people and provided a more comfortable environment for participants when discussing this intimate topic.

Data saturation was not the goal of this inquiry. Saturation refers to instances when additional data fails to produce novel information (Morse, 1995). This concept is based in post-positivist paradigms and was developed for grounded theory methodology (Braun & Clarke, 2013). Given that I was operating from a social-constructionist epistemological stance, assuming that every person's story was unique, and used a narrative approach, data saturation was not relevant to my inquiry.

3.3 Data Collection

Interested participants contacted me via email and through the research page I created on Facebook. Once they contacted me, I conducted an initial phone screening interview to determine their eligibility to participate in the study, answered any questions they had, and provided more information about study procedures (see Appendix A). If they were still willing to participate after this initial process, I provided them with a consent form prior to the data collection interview. This form detailed the purpose of the study, listed any potential risks and benefits, and the procedures that were taken to ensure confidentiality (see Appendix B). Any

questions or concerns that potential participants had were addressed prior to beginning the data collection interviews. The use of the data and anonymity of participants was discussed with each participant. Participants were informed of their ongoing right to withdraw from the study.

Consistent with narrative inquiry, data were collected through one, in-depth, largely unstructured interview with each participant. This style of interviewing allowed for a flexible and in-depth understanding of how the participants constructed their stories of conception, pregnancy, and birth (Riessman, 2008). These interviews were approximately one to one and a half hours (60- 90 minutes) in length. One interview was conducted in person at the participant's house and the remaining four interviews took place over Zoom. Every effort was made to conduct these interviews in person, but the majority of interviews were conducted via Zoom due to participant's geographic location or personal circumstance. Zoom calls are encrypted, and therefore, the online platform offered a secure method to conduct the interviews.

Unstructured interviews are in line with narrative inquiry as the goal of narrative interviewing is to generate detailed accounts rather than to merely answer questions (Riessman, 2008). In unstructured interviews, participants are more likely to discuss sensitive material, participants have more control and agency, and the depth of data is increased (Corbin & Morse, 2003). This interviewing style has a more "facilitative" flavor and allows for a conversation to take place between participants and the researcher who are all actively constructing narrative and meaning together (Riessman, 2008). It was essential to not let my agenda direct the interview but rather to have allowed each participant to share their story in their own way. Given that this topic was intimate in nature, interviewing was guided by Hermanowicz's (2002) 25 strategies for conducting excellent interviews on sensitive topics to ensure that data were rich and detailed. Hermanowicz (2002) stresses that the most essential objective of great interviewing is to expose

intimacies, thoughts, and personal perspectives. To achieve this, Hermanowicz (2002) provides a framework on how to converse, listen, find out what is important to participants, probe, remain quiet, persist, maintain ideal timing, word questions clearly, balance topics, preserve the integrity of the participant, show respect, rehearse, start off on a strong note, and end on a positive note. This framework aided me when conducting the interviews.

Each interview was carried out by myself, a 26-year old queer, non-binary, white, childless, single, Canadian person who has six years of experience working on qualitative research projects. At the start of each data collection interview, I reviewed the consent form with participants and answered any additional questions they had. We then each signed the consent form, and both retained copies of the form. Once the consent form was signed, I turned on the audio-recording equipment. I then read the general orienting statement to give additional context to the study and begin to establish rapport (see Appendix C). Language sensitivity was key to establishing rapport with participants. As a member of the queer community, and as someone who works alongside queer and trans individuals, I had already received a vast amount of training on appropriate language. I did not assume participant's pronouns, their parental identity, their partner's identity, or what terms they use to refer to the donor, birther, etc. I only respectfully asked questions about identity if it was relevant to what they had already told me.

I began each interview with the open-ended question: "what is your story of conception, pregnancy, and birth?" Consistent with narrative inquiry, it was important to allow participants to tell their story relatively uninterrupted. Therefore, I allowed them to take the lead and tell their stories as they wished. I had a list of open-ended questions to prompt participants, if needed, to help deepen the telling of their story and seek clarification when appropriate, responding with prompts such as "can you tell me more about that experience?" (see Appendix C). These

questions were developed to allow respondents to be able to construct their answers in ways that they found meaningful (Riessman, 2008).

Once participants felt that they had adequately conveyed their stories, and the interview was drawing to a close, I discussed upcoming steps with them. Before closing the interview, I asked them their preferred mode of contact (email, phone, etc.), how they would like to receive the completed narrative (email, courier), and their preferred mode for the validation interview (in-person, phone call, Zoom).

I informed participants that they could expect to receive their narrative once I had completed the data analysis, for their review and input. They received their completed narrative approximately nine months after the data collection interview, in October 2019. All participants were invited to add, change, clarify, or remove any element of the story. Four out of five participants responded and participated in the validation interview. These validation interviews took approximately five to thirty minutes and were recorded. These interviews were meant to act as a form of member checking, to increase the rigor and trustworthiness of this study, and to ensure that I was not distorting participants' voices with my own. The feedback received during these interviews, which was minimal, was integrated into the four participant's final narratives.

Participation in this study took approximately three hours (180 minutes). How much or how little time spent was largely up to each participant. The interview portion of this study (data collection and validation interview) required approximately two hours (120 minutes) of the participants' time. The narrative review portion of this study did not take more than one hour (60 minutes). Participants were remunerated \$50 each for their participation in this study, paid at the beginning of their involvement, and theirs to keep even if they decided at any point to withdraw

from the study. This remuneration was referenced on the recruitment ad, (Appendix D) recruitment poster (Appendix E), and on the study's designated Facebook page.

Every effort was made to ensure confidentiality. All documents were in a locked cabinet and all electronic files were password protected and encrypted. All files will be destroyed after five years. All data are being stored on a password protected, encrypted USB stick on the University of British Columbia's campus in the ECPS department. Online platforms are increasingly being used to conduct research interviews as it allows for increased accessibility for participants (Deakin & Wakefield, 2014). Zoom was selected as the medium to conduct interviews when participants were unable to attend in-person interviews. All participants were reminded that the interview was being recorded and were able to see that the interview was being recorded on the Zoom online platform. Participants named specific agencies, community health organizations and/or individuals that had been part of their reproductive lives. This information was anonymized in transcripts and in any written or electronic notes or reports that are resulting from this study. Furthermore, participants were asked to choose a pseudonym that aligned with their gender identity but still maintained anonymity. This name was used in place of their actual name in the presentation of narratives and all written materials.

Given that this is a sensitive topic, I was aware that asking participants questions about their reproductive experience may bring up some unresolved conflicts. Accordingly, I aimed to conduct each interview in a manner that minimized any harm or distress to participants. At no point during the interviews did a participant become upset. I referred participants to the list of counselling resources I compiled should they have felt a need to seek additional support, as required by UBC ethics (see Appendix F).

Another ethical consideration of this study was childcare. Conveniently, all participants were able to arrange for someone to take care of their child(ren) during the interview. If it was requested, I was prepared to arrange childcare during the interview and use funds from my SSHRC funding to cover the cost.

Throughout the study, I kept a reflexive journal and reflected on how my social location and pre-understandings impacted the research process. I contributed to this journal after each interview and during the course of writing. In these journal entries, I noted my motivations for conducting this research and any interpersonal dynamics between myself and participants. I reviewed these entries throughout the process, particularly when transcribing and analyzing the data.

3.4 Data Analysis

There are multiple ways of conceptualizing narrative inquiry. Riessman (2008) has distinguished between three types of narrative analysis: thematic analysis, structural analysis, and performative analysis. Thematic narrative analysis emphasizes the content of the story and differs from the other types of analysis by not focusing on how the story is communicated. This analysis is most frequently used by novice researchers because it is the most intuitive (Riessman, 2008). Structural analysis is also concerned with content but is primarily focused on narrative form and how the story is structured. Performative analysis combines both thematic and structural analysis but adds an element of how dialogue is produced and performed and requires a close reading of context. The purpose of the research determines which analysis is most appropriate. Thematic analysis is used when the purpose is to explore the content of the story. Given my aim to explore the reproductive stories of NBTM people, I thematically analyzed the conception, pregnancy, and birth narratives of the NBTM individuals in this study.

The interviews were transcribed verbatim according to the procedures outlined by Braun and Clarke (2013) and guided by Riessman (2008). I included pauses in speech, laughter, and “ums” and “uhs” in the transcriptions of the interviews. How I conducted the transcription process invariably shaped how I interpreted the data and understood participants’ stories (Riessman, 2008). Once I completed each transcript, I re-listened to the audio and checked the document to ensure that I had not missed data and had accurately transcribed the interview. Individual’s narratives were constructed after all data collection interviews were transcribed. Once the narratives had all been written and validated by four participants, I analyzed them all as a whole and constructed the common narrative.

In approaching the data analysis, I first immersed myself in the data by reading each transcript multiple times and became familiar with each participant’s story. I wrote down first impressions and made memos of significant sections. Working with a single interview at a time, I isolated and ordered relevant episodes into a chronological account (Riessman, 2008). Adhering to an inductive method, I then identified important concepts or themes that emerged from the transcripts, looked for narrative tone, and identified striking images (Crossley, 2011). Narrative tone was evident from both the content of the story and the manner in which it was told. For example, the tone of a story was predominantly optimistic or pessimistic, emphasizing either the positive or negative aspects of the participant’s experience (Crossley, 2011). Looking for striking images meant paying attention to how participants used images, symbols, and metaphors to convey their stories. This process allowed me to construct a coherent story for each person. Each of these narrative accounts borrowed heavily from interview material and participants were quoted directly throughout (Riessman, 2008). This process aimed to preserve

and not fracture the narratives of each of these individuals by interpreting their cases as a whole (Riessman, 1993).

After completing the individual narrative accounts and having them validated by four participants, I constructed the common narrative. This relied on Lieblich, Tuval-Mashiach, and Zilber's (1998) categorical-content approach. First, I read each validated narrative multiple times, noting similarities and differences across stories, and compiled sections of text relevant to the research question from each story to create new subtext. Second, examining context, interactions, and connections to analyze the stories, I identified, named, and defined the content categories. The number of context categories chosen (10) aimed to maintain the depth of the stories but not be overly detailed (Lieblich et al., 1998). Third, I sorted the subtext collected from the first step into these defined categories. This process allowed for various storylines to be clustered into broader narrative types. Fourth, using the sorted, defined categorial text, I constructed a common story and drew conclusions. Throughout this common narrative, I inserted salient quotations from each individual's story to portray relevant findings and discussed how these stories of NBTM reproduction relate and differ from one another. This process was not able to account for all of the unique details in each participant's story. Rather, it provided an overarching picture of NBTM reproduction, and allowed for the elevation of voices of these participants, putting their experiences in conversation with one another.

3.5 Data Presentation

For the purposes of my master's degree, I am completing my thesis in a manuscript-based format and have submitted a version of my final chapter to an academic journal. The structure of this manuscript follows the guidelines for submission outlined by the journal and borrows from the first four chapters of this thesis. The data from this study are presented in the form of a

broader, common narrative that spans the five stories, and is categorized into narrative types and themes chronologically under the headings: conception, pregnancy, birth, and parenthood.

3.6 Strengths and Limitations

One of the main strengths of this study is that I employed member checking and validated the narratives I created with four out of the five participants. This process allowed participants to reflect after their initial data collection interview and gave them the opportunity to add anything that they missed. In addition, it increased the likelihood that I presented their story in their words and minimized my voice as a researcher. This co-creation helped provide a strong analysis, discussion of their stories, and a congruent common narrative. I gave participants up to a month to review their narrative and select a time to conduct their validation interview. Unfortunately, after multiple contact attempts, one participant (Finley) never responded to the invitation to participate in the validation interview. Therefore, I am not able to maintain the same confidence that the narrative I constructed for them accurately captures their reproductive story as I am for the other four participants. However, their narrative did not differ significantly from the other narratives – lending strength to the accuracy of the common narrative. While member reflection is a strength, it is also a limitation to this study as only four out of five participants elected to participate.

Another limitation of this study is that given my limited resources, the sample I recruited was relatively small and homogeneous in terms of ethnicity (white), socioeconomic status (upper middle class), and location (urban). I attempted to recruit a diverse sample but was restricted in this respect due to the small nature of this population. As discussed in the upcoming reflexivity section, I am an outsider to this population. Therefore, I have a limited ability to understand what it is like to be a parent, and how being a parent intersects with trans identity. Overcoming this

gap required me to do a significant amount of reading, keep an open mind, and ensure that I asked questions in a respectful manner.

3.7 Trustworthiness and Rigour

Reflexivity and member reflection were the main strategies used to enhance the trustworthiness and rigour of this study (Berger, 2015). Creswell (2014) emphasizes the importance of maintaining descriptive and reflective field notes throughout the entire research process. As I undertook each stage of this project, I kept a reflexive journal and reflected on how my social location, pre-understandings, and previous experiences impacted the research process. This journal documented my assumptions, thoughts, preliminary connections to the literature, important moments, and personal reflections (Creswell, 2014). I contributed to this journal at each stage of the process beginning as I wrote my research proposal, before and after each interview, during transcription and analysis, and finally, during the writing of my final manuscript. I used the material from these entries to maintain my awareness of my positionality as a researcher and an outsider to this population.

Member checking is an extensively used method of ensuring rigor within qualitative research, popularized by Lincoln and Guba (1985). Also known as participant validation, member checking involved having participants review the narrative I constructed and confirm the accuracy of my retelling of their story (Smith & McGannon, 2017). This process contributed to the trustworthiness of the study by having respondents validate the credibility of the data and helped correct the imposition of subjective bias from the researcher. Social constructionism recognizes that knowledge is co-constructed between participant and researcher, therefore member checking allowed for understandings to be shared and reviewed, establishing a co-constructed understanding of reality (Smith & McGannon, 2017). Participants reviewed my

narrative representation and not the transcripts, as suggested by Creswell (2014). This allowed participants to approve of the integration of the data and ensure that it was an accurate reflection of their experiences (see Appendix G). I took each participant's feedback into account when finalizing their narrative. Allowing participants to reflect on their narrative was not meant to verify the results or find the "truth;" rather it was to generate additional insights and prevent my interpretation from overshadowing their experiences (Smith & McGannon, 2017). Given the historical concerns of transgender research mentioned later, member reflection was particularly important to ensure that I was in fact giving participants a voice in the reporting of the findings, rather than speaking for them.

Reflexivity is increasingly being recognized as a crucial strategy to enhance the rigor, ethics, and trustworthiness of qualitative research (Berger, 2015). Given the importance of acknowledging the researcher's position and how it may affect the research process and outcome, I included a reflexivity section in the following paragraphs. As a queer, non-binary person who is childless, I am an outsider to the group I studied. This positionality has been identified as particularly important when studying marginalized and disadvantaged populations (Berger, 2015). Some advantages of being an outsider researcher included the automatic positioning of the respondent as the expert and the researcher as ignorant. As someone who is unfamiliar with the experience of becoming pregnant as a NBTM person, I approached this topic with a fresh viewpoint and posed questions that led to innovative directions (Berger, 2015).

Contrastingly, some disadvantages that came with being an outsider included being unable to fully comprehend what it is like to be NBTM parent. In line with this, the research question I conceptualized may not have been relevant to participant's experience and the language I used may have lacked sensitivity (Berger, 2015). To mitigate these potential

challenges, I consulted a NBTM parent before undertaking this study to ensure that it is a useful area of inquiry. Initially, I had intended to focus on trans family's transition to parenthood but upon discussing this with them, they confirmed my hunch that this area is less relevant to the daily lives of trans parents and that I would be better off focusing on conception, pregnancy, and birth. This conversation was the catalyst to shifting my focus to my current area of inquiry. What has drawn me to this topic is the desire to act as an ally to the trans population. Recognizing that their voices and experiences are largely absent from the existing literature, I wished to respectfully gather their stories and increase the available knowledge and awareness in this field.

3.8 Presuppositions

As part of the reflexivity process, it was important to articulate my presuppositions and expectations. After reflecting on my knowledge, beliefs, biases, and assumptions of NBTM conception, pregnancy, and birth, I formulated the following presuppositions that invariably influenced my undertaking of this research. First, I thought that the experience of conception, pregnancy, and birth for NBTM individuals would be heavily laden with challenges due to the realities of living within a heteronormative, cisnormative, transphobic society, such as facing implicit and explicit discrimination. However, despite these challenges, I believed that conceiving, carrying, and giving birth to a child would also be a magical experience for many participants, similar to the reproductive experiences of many cisgender women. Second, I hypothesized that NBTM people's experience of gender dysphoria would be heightened during pregnancy and birth. I thought that the constructed gender prescriptions of our society that define pregnant people as women would likely lead to increased incongruity for NBTM people between their gender identity and their body as they moved through trimesters. I thought that this experience would likely be compounded by ceasing testosterone use, resulting in feminization.

Third, it was my belief, particularly after consulting the literature, that conception would be a time of high distress and challenge for many individuals. I thought that the following factors would contribute to the difficulties of this period: making the decision to undertake pregnancy, the lack of empirical knowledge on testosterone and pregnancy, and the potential need for a sperm donor and associated stresses. Finally, from the NBTM parents I have known and spoken to, I anticipated that participants would have experienced not being seen as the parent of their child by others. Perceived as a male, the possibility that they carried their child would often not be considered, resulting in their experience of pregnancy, birth, and parenthood becoming invisible. I anticipated that the above experiences would appear in the reproduction narratives of the NBTM individuals I interviewed.

3.9 Problematic History of Trans Research

Unfortunately, trans research has historically been pathologizing, voyeuristic, objectifying, and delegitimizing (Vincent, 2018). Given this troubled history, I believe that it was important to not only recognize the injustices that trans research has inflicted on the trans population, but to also explicitly outline how I would not reproduce these injustices. Using Vincent (2018)'s framework for how to conduct ethical trans research within social and psychological research, I endeavored to conduct ethically sound and respectful research. This step was particularly important given that when I first conceptualized this project, I did not yet identify as non-binary (I settled into this identity prior to participant recruitment). There has been criticism as to how trans lives have been primarily investigated and correspondingly constructed by cisgender people (Stone, 2006). However, it is possible for cisgender researchers to produce excellent trans research that has the potential to contribute to positive social change if they conduct it in an ethical and respectful manner (Vincent, 2018).

Vincent (2018) asserts the importance of knowing relevant transgender history, assuring transparency, using nuanced language, including intersectionality, and the necessity of respecting trans spaces. This framework informed all stages of my research process, particularly, recruitment, data collection, and analysis. I was alert for what pronouns participants used, and did not make any assumptions about their parental identity, their partners' identity, and what terms they used to refer to the donor, birther, etc. If I was unsure about something, I asked in a respectful manner. I was transparent about what has brought me to this research, that I identify as non-binary, and the fact that I am not a parent (see Appendix C).

Chapter 4: Narratives

4.1 Sam's Narrative

Sam is 33 years old, identifies as queer, non-binary, and white and works within the non-profit sector. They use they/them pronouns. They began considering co-parenting with a good friend of theirs, Riley, in 2012. At that time, Sam had recently broken up with their partner, but were certain that they wanted to become a parent. Sam and Riley began to discuss the possibility of having a child together as friends. Over the years, both of their romantic partnerships changed and who all the parents were going to be shifted. At the time of the baby's birth, there were four parents involved: Sam and Riley, the "lead parents," and their partners, the "vice parents." At the time of the interview, Sam and Riley's child was one year old.

4.1.1 Conception

In 2015, Sam started to try to get pregnant using Riley's brother's sperm. For Sam and Riley, it was really important to know the sperm donor. They wanted an uncle figure to be involved - "we're just lucky enough that we have uncles, literal uncles, that could be sperm donors." Sam and Riley were "interested in there being a connection so that [their] baby could know the person if they wanted to." Discussing family law in British Columbia, Sam explained:

It's automatic that the sperm donor isn't one of the legal parents, whereas in other countries and I think even in some of the other provinces, you have to do a bunch of legal paperwork to say like, this person isn't going to give any child support, doesn't have any rights to the kid, rights and responsibilities. Basically, if you're not having sex to get pregnant, the people who are emotionally conceiving of the kid are considered the parents.

For Sam, the conception process was “long and terrible”. Riley’s brother lived a two-hour flight away and this posed many logistical challenges. They tried shipping his sperm via mail as well as flying back and forth until 2017, when Sam got pregnant. They weren’t trying to get pregnant that entire time, but they tried about twelve times over those two years. When Sam began to try to conceive, their mindset was that they knew it was going to take some time but, as time went on, the process became increasingly challenging. “When I got my period, it felt harder and harder...those two weeks are pretty terrible of waiting and trying to not get your hopes up.”

Looking back at it now, Sam feels that they needed those two years before getting pregnant. During the time they were trying to conceive, Sam, Riley, and Riley’s partner all bought a place together. When they were first developing their parenting plan, they were renting and living in communal houses. Sam commented, “I don’t think we had any concept of how hard it is to have a newborn.” Sam also feels like they needed the time to meet their current partner and to fall in love with her. Sam’s partner lives by herself in a neighbouring city but is also involved in the parenting. “It’s easy to make sense of how long it took in retrospect but at the time, during those couple of years trying to conceive, it was very difficult.”

The conception process was also complicated by the fact that Sam was not telling anyone that they were trying to get pregnant but needed to take time away from work to fly the two-hours to inseminate. Riley’s brother would fly to Sam and Riley whenever he could. Sam mentioned that they had never actually met Riley’s brother before - “it got less awkward over time, but it was never not awkward.” As time went on, Sam became more relaxed about insemination. “At first, I would lie on my back with my legs in the air for like five hours, and do magic, to make this baby happen...and by the end I was like, “Whatever...sperm...””

To conceive, they were doing at-home inseminations. After a few unsuccessful attempts, they began to look into fertility clinics which Sam referred to as “a weird, terrible process for non-straight couples.” Commenting on how challenging it would have been to go through a clinic, Sam explained:

If you are using a known donor, the only place in Canada that you can donate is in Toronto, meaning that we would need to fly Riley’s brother to Toronto and quarantine his sperm for three months. If you’re a couple, having sex to get pregnant, and you’re not getting pregnant, they’ll just like do the insemination right there in the clinic...but because it’s risky, imaginary risky, to put sperm into someone else’s body when they’re not already having sex. Which is silly because I’d been putting sperm, this person’s sperm in my body already for two years.

Once they got a referral from a local clinic, they were put on a six to eight month waiting list.

4.1.2 Pregnancy

While they were on the waitlist, Sam got pregnant. Conceiving at home allowed them to “not have to deal with all of the questions, all of the assumptions, and all of the norms in the clinic. Not only me not being, not identifying as a woman, but our family being very unusual and weird, it’s just better to not deal with that.”

Sam was at work when they found out that they were pregnant. They woke up early in the morning on the day they were supposed to get their period and did the pregnancy test. It came out positive. They reported that they felt a lot of disbelief: “I feel like I probably looked at the stick, and looked at the instructions, like seven to eight times. Was I reading it right? Like this does say that I’m pregnant, right?” Sam noted that they were not invested in this particular test remembering that “that time I had actually convinced myself that I wasn’t pregnant, probably

just to ease the emotional process of it all.” The nature and location of their work prevented them from contacting Riley, their partners, or friends immediately. They took a picture of the test and sent it to the other parents as well as their best friend. At that time, Riley and her partner were on a month-long vacation. Sam remarked, “so I found out I was pregnant but didn’t actually see my co-parent to celebrate with her for a full month after that, which was also just weird timing.” Sam’s parents happened to be visiting their place of work so they told them as soon as they could.

During their first trimester, Sam felt tired and nauseous all of the time and struggled to keep it a secret from their co-workers. They would try and nap in the middle of the day and avoid the lunchroom because of the smells: “I was surprised that nobody said anything. I don’t think that anyone had any clue.” Two months into the pregnancy, they began to feel better and went on a vacation with their partner. During their vacation they felt the baby kick for the first time and remarked that they “felt great in [their] body.”

It was not obvious that they were pregnant until the third trimester and Sam doesn’t remember feeling weird in terms of people commenting on their body or making gendered comments about pregnancy. However, they recalled some instances at work when they had to navigate “weird gender stuff around being obviously pregnant.” Their boss and immediate coworkers were really good at respecting their non-binary identity and using they/them pronouns. However, the coworkers they did not work with directly would refer to them as a woman and talk about them becoming a mom. According to Sam the hardest part was picking their battles and having to figure out how to navigate these situations. In one instance, their boss announced to everyone, with Sam’s permission, that they were pregnant. Someone came up to them after and asked, “So are you having twins? I don’t get the “they” thing.” Sam answered,

“nope” and then walked away. The awkwardness was compounded by the fact that everyone wanted to know if the baby was a boy or a girl. At that stage, before the baby was born, they felt it was slightly easier to say, “we’re not finding out” and not get into conversations about the baby’s gender with people. People would then ask, “are you excited to find out?” Sam’s reaction was, “no, I don’t actually care what the shape of my baby’s genitals are; I’m excited to find out who they’re going to become as a human, unrelated to the genitals.” Overall, gender was not at the forefront of Sam’s pregnancy experience - “I didn’t feel dysphoric in my body, I felt dysphoric in the language used to talk about my body.”

For Sam, maternity clothes posed a challenge. Their mom did some maternity clothes shopping for them and the first time she went she said, “I went to this maternity store and I asked them if they had anything that wasn’t very feminine, and they rolled their eyes at me and I couldn’t believe it!” Sam was very appreciative of their mom’s efforts to find them neutral clothes that they felt comfortable wearing. They went into a maternity store once to find clothes and said, “that was one of the few times that I felt uncomfortable.” They remarked, “most actual maternity wear, that is designed for like having a big pregnant belly, is very feminine.” Mostly they were able to make things work that weren’t specifically pregnancy clothes. For example, for work, they would wear something that was open in the front such as a suit jacket over top of a slightly too large t-shirt.

Sam and Riley felt that the midwifery clinic they chose was very inclusive. Their midwife identified as non-binary and a specific part of their practice was working with gender diverse and queer families. Sam received gender affirming care and remarked, “It’s so easy, why do people think it’s hard?... I can’t imagine, I think the whole process would have been so different if I didn’t have access to that care.”

4.1.3 Birth

Sam went into labour a couple of days before their due date and described the scene of their water breaking “like a movie.” They were at their partner’s place, in the elevator, coming back with a bunch of groceries when they said, “I’m pretty sure my water just broke.” Knowing that labour could take a long time, they relaxed at Sam’s partner’s house and called Riley and her partner to let them know. Sam’s best friend drove Sam and their partner back to their house. They felt like “a lot of things were falling into place.” Five hours after their water broke, their contractions ramped up to the point that Sam “couldn’t really talk.” They laboured all through the night, which according to Sam was “very hard”. They threw up the entire time and felt very tired and weak. Riley, Riley’s partner, Sam’s partner, and their best friend were all present. Sam felt that having so many people around was a huge help because everyone could take turns getting some sleep.

Their plan was to birth at home for the same reasons they didn’t want to go to a clinic to get pregnant:

to not have to deal with questions about our family, to not have to deal with telling everyone about my gender, to not have to deal with all these people who don’t know us, and I don’t trust to be affirming of our family and my identity.

However, at around eight in the morning, their midwife said that they should go to the hospital. At that stage, Sam was prepared to do whatever their midwife said. Their midwife had a very “patient-centric” stance because they presented them with options and didn’t insert their opinion. This attitude led Sam to really trust the midwife and made it easier for them to go to the hospital. Sam felt that the worst part of their labour was the hour and a half between making the decision to go to the hospital and the epidural kicking in.

Through the night I had enough determination and knew that there was an outcome, the next phase of birth will come, and we'll get this baby out, it will happen. But when we decided that we were going to the hospital, to get an epidural, it felt like all of those contractions were pointless...I know that's not entirely true, but in my imagination, it was like these are now the pointless contractions, just waiting until I don't have to feel them anymore, I had to like sit in the car...which is very uncomfortable when pregnant and having contractions.

Once they got to the hospital, their midwife worked hard to minimize any potential difficulties regarding their gender and their family. The midwife went and talked to everyone before Sam got there about how they were going to talk about them and how to monitor their language. Anytime someone new came into the room, their midwife would stop them at the door, and give them "the spiel". Sam recalled feeling very heard and validated. There was one nurse who struggled with her gendered language and Sam's midwife pulled her aside and said, "I don't think this is working. I know you're trying but it's not good enough. Maybe we should switch out nurses." The nurse became upset and said, "I want to do it! I'm so sorry, I want to try. I will do it." It was brand new to her, but she could see that it was important to use inclusive language. At that moment, Sam recalled that they didn't care, they were "so tired and had much more important things to focus on".

Once the epidural kicked in, they got their energy back and things started to move quickly. A couple of hours later they began to push. After an hour of pushing, which Sam said felt relatively easeful because of the epidural, the baby was born at three in the afternoon. While it was weird for them to be numb and not actually feel the baby come out, Sam recalled that the epidural allowed them to be very present. Everyone started to cry but Sam did not, which

surprised them. Instead, Sam said the whole experience “felt surreal”. There was one point that they wished they were at home and not in the hospital when the nurse quickly washed the baby off and put them on their chest: “that part felt like it moved really fast.”

A friend brought them sushi and as Sam sipped their miso soup they thought, “this is the best.” They had to lie in bed until their legs regained feeling. It “felt like a little bit of a daze and everything was in a bit of a cloud, but in the peaceful, kind of nice way.” The epidural took longer than normal to wear off and it wasn’t until around midnight that they finally got home.

4.1.4 Parenthood

Sam stayed at home and didn’t go out much for the first few weeks following the birth of the baby, which they felt was necessary. Sam reflected on how one of the hardest things for them during that time was the physical separation from their baby. Having been joined to their baby for nine months made the first few days of separateness “really hard”. They did some “magic, ritual, and support” to feel grounded in the fact that they and the baby were “two separate people now.” At the same time, they still felt connected because of how dependent the baby was on them for food and care. Sam felt that their connection to the baby was special and unique from the other parents in the child’s life. There’s an “extra layer of attachment which makes sense, I mean because our bodies were attached but also because I’m the one who spends most of the time with them because I’m the one home, for the year.”

Sam recalled the first few months being a blur of not sleeping and being at home with the baby. They said that time felt “boring and monotonous” going from sleeping to feeding to diapers. Sam was intentional in staying present and enjoying the time with their baby but at the same time, they also felt “lonely and isolated” given that most of their community was in a

different city. Riley and her partner are gone for most of the day so it's mostly just Sam and the baby at home.

Sam really enjoys chest feeding their baby. They weren't sure how they were going to feel about it and really don't like having a larger chest, but they feel that it's given their chest meaning:

Why do I have these stupid things on my body that give me nothing? You know? What's the point? So, it's kind of nice...here's a nipple because there is function to it. Its relaxed my relationship with my body and with my chest.

According to Sam it took a couple of weeks to really feel like a parent. At first, it felt like a "magical haze", "very surreal", and then slowly, it became more real and dawned on them that this was permanent. They remember a friend coming over with two little kids and saying, "You guys! You're parents!" In that moment, three or four weeks after the baby was born, it really sunk in for Sam that they were a parent. Sam commented on the identity piece, "I guess I'm a parent now, but just like, how my day to day life function changed so drastically - it was a really big change of my life."

In some ways, as the baby turns one year old, they feel like the parenting is just beginning because of recently having to make decisions about how they are responding when the baby clearly wants something, and they have to say no, and then navigate their upset feelings. The parenting will increase as the baby gets older and they continue to develop a common parenting strategy amongst the four parents. Sam feels that they and Riley still need to have a lot more conversations and figure things out but overall, that it's really nice having four parents. Once Riley is finished her schooling and the baby is between two and four years old, the plan is for her to get pregnant using Sam's brother's sperm to expand their family.

4.2 Finley's Narrative

Finley is 31 years old, identifies as queer, non-binary, and white and works as a birth worker. They use they/them pronouns and have been married to their wife, a trans woman, for 16 years. They have three children together. At the time of the interview, their oldest child was six years old, their middle was four years old, and their youngest was one year old. They focused their reproduction story on the experience of conceiving, carrying, and birthing their youngest child because both Finley and their wife were “in the closet” when they had their first two children. It was during Finley’s third pregnancy that they discovered their non-binary identity. Their experience as a birth worker greatly influenced their third reproductive journey.

4.2.1 Conception

For Finley, compared to the conception of their first two children, the conception of their third child felt “very calculated and experimental in some ways.” Their wife was on hormone replacement therapy and testosterone blockers and she didn’t want to stop taking these entirely. She decided to lower her dose and hope that her fertility returned. They decided that they would try to conceive for three months before considering fertility treatments. Finley remarked that they “were probably just going to give up at that point.” This three-month timeline caused some stress for Finley, particularly knowing that their wife was scheduled for bottom surgery and that she would be permanently infertile after that day. The doctors didn’t think it would be possible for them to conceive with Finley’s wife’s sperm. “We were uncertain that it would happen.” They began to discuss the idea of using a sperm donor.

For Finley’s wife, the conception process was “very challenging” and “very dysphoric.” “It wasn’t a fun time trying to conceive this baby.” For Finley, they felt “okay” during the conception process, but they had to calculate everything, tracking their cycles intently and noting

the days that they should have sex. Because it felt so forced, they started using a soft cup - a silicone cup filled with semen that they put up against their cervix. During this third conception, both Finley and their wife were out as non-binary and trans. “It felt like we were having a queer conception, but it didn’t feel that way the first two times.” Overall, Finley described their third pregnancy as “very experimental” and that they were “paving their own way.”

4.2.2 Pregnancy

On their third month of trying, Finley became pregnant. Both Finley and their wife “were very thankful.” Shortly after becoming pregnant, Finley began to experience feelings of gender dysphoria. “I felt uncomfortable in my body, with my breasts and belly growing and not being able to hide it.” During their third pregnancy, they came out to themselves, immediate family, and care providers as non-binary. Finley explained that their wife had transitioned after their second child was born and that her experience provided Finley with the language and resources to better be able to understand their own feelings of gender dysphoria. Finley’s wife’s transition was quite public, and this led Finley to question if their feelings of gender dysphoria were as valid because she had “gone through such a drastic transition.”

I know I shouldn’t have felt that way, because my feelings of gender are valid even though she’s had more of a drastic transition I guess, I’m not on hormones, I haven’t had any surgeries, and I know that is not something that defines someone as being trans or not, I totally know that. But I didn’t want people to think, “I’m only doing this because she did.”

Finley noted that pregnancy is a common time for people to experience feelings of gender dysphoria, with their bodies changing and pregnancy being such a gendered experience in mainstream culture. For them, coming out felt like they were “becoming more of who [they] wanted to be...it just felt more right.” Part of their experience of gender dysphoria revolved

around finding clothes that they were comfortable wearing, “I would go into maternity stores looking for clothes and would come out with nothing because I hated everything.” They questioned if their feelings of gender dysphoria would persist after pregnancy, but they did. Commenting on their experience of gender dysphoria, Finley said that it was “mostly how other people portrayed me; I just really didn’t like it.”

When you’re visible as a pregnant person, you get a lot of gendered energy directed towards you...Everyone assumes that you’re a mother and that’s how you identify, and that you have a husband...the heteronormative, cisnormative stuff...it’s hard to have those conversations all the time...I can be pregnant myself and not view it as a female, mothering event...when it comes from other people it feels challenging.

Finley “did not enjoy being pregnant.” Their third pregnancy was “very physically difficult” and they felt “very nauseous, were in a lot of pain, and developed fibromyalgia.” While Finley was nursing their second child, they became pregnant with the third and developed nursing aversion: having negative feelings, often coupled with intrusive thoughts when the infant was feeding. They were vomiting all the time but continued to work throughout their pregnancy.

Even when Finley was 40 weeks pregnant, they were still working. In scrubs, they weren’t able to hide the fact that they were pregnant, which they “did not enjoy.” They also worked in a fertility clinic which added additional layers to being visibly pregnant when working with couples who were struggling with infertility. Finley was faced with peoples’ assumptions that it was easy for them to become pregnant even though it was a “very stressful” process for Finley and their wife. A fear for Finley was going into labour while they were working in the hospital:

Despite working in hospitals, I have a phobia of birthing in one...I didn’t want to be in that system when I went into labour...dealing with people who wouldn’t necessarily respect

our family, our pronouns, or wishes, or you know, especially in terms of having a medicalized experience.

Finley feels their profession as a birth worker is “very gendered” and is very committed to combating those gendered assumptions by providing gender affirming care to their clients.

I have sort of conditioned myself to not view pregnancy as an inherently gendered experience...I don’t gender people, I never call pregnant people women, I always call people pregnant people, I always respect people’s pronouns, not very many people are like that.

Finley and their wife had already decided that they weren’t going to gender their baby and were going to raise them with they/them pronouns. People would ask, “When are you due? What are you having?” These questions were “uncomfortable” and “hard to answer” because they did not want to be public about the fact that they weren’t gendering their baby. Finley’s response to these questions was often, “we don’t know.”

They picked a midwife who they knew was trans inclusive and identified as queer. Knowing that she’d be supportive of them, they were more comfortable birthing their child with her assistance. “I would have been very worried picking somebody, you know, randomly who may not be very competent.” Their primary midwife was very supportive around gender and used the correct pronouns and gender markers.

4.2.3 Birth

Thankfully, Finley went into labour while they were at home. Around noon, their water broke shortly after they arrived home from a 24-hour shift. Their contractions didn’t start until a few hours later. They had been considering having an unassisted birth and had made preparations to do so. They planned to make that decision based on how they “felt in the moment.” Knowing

that their favourite midwife was on call, they ended up calling their midwifery team “later than [they] should have but it was a good time for [them].” They didn’t end up needing the midwifery team but ultimately felt more comfortable with them there.

Finley “loves giving birth.” Their experience as a birth worker combined with this being their third birth, they “felt comfortable with how they wanted things to go.” They elected to have a home, water birth, similar to what they did the previous two times. They preferred that their “family be outside of the hospital system.” Their two older kids, wife, mom, friend, midwife, and a midwifery student were all present at their birth. It felt “like a big party...laughing, joking, playing music, I played video games...I really controlled the atmosphere of who would be there.” This led to a “really good experience...having the people around us who supported us was important.”

According to Finley, they were very sleep deprived but “felt in control.” Their birth worker knowledge allowed them to do most of the necessary clinical things themselves such as doing their own vaginal exams and checking the baby’s heart rate. Once things got going, the birth process moved pretty fast. They caught their own baby with the help of their midwife at 10:30 that night. Overall, they shared how their experience of birthing their third child was “lovely” and said they felt “very in control of things.” After the fact, it felt like they were “a very happy and complete family.”

4.2.4 Post Birth

Seven days after giving birth, Finley returned to work due to financial restrictions. They felt their workplace wasn’t very supportive, and it was hard to be amongst “hetero, rich, white new moms” and feel like they “didn’t fit in at all.” Their wife stayed at home with the kids and was pumping to supplement the milk supply. Finley’s wife induced lactation and witnessing her

nurse their baby was “amazing” for Finley. Finley experienced some “guilt” about returning to work so early because they had stayed at home for a year with their first child and six months with their second child.

This time, starting work when they were seven days old, I felt like I was sort of failing as a parent. But then I had to realize that I had these heteronormative assumptions still stuck in my head, that the person who gives birth is the one who needs to stay home with them...our baby is at home with their other parent. So, I had this sense that it had to be me until I sat back and realized, I’m not putting them in daycare as a seven-day old, they’re at home with their other parent. And that is okay, and in heteronormative families if you have a father go back to work after seven days, nobody thinks anything of it. But because I’m the birthing parent, there is this assumption that the mother stays home, and birthing parent equals mother who needs to stay home for a certain amount of time. So, it was harder on my own recovery but once I let go of some of that guilt and the heteronormative assumptions behind those things, I felt better about it.

Now that Finley is no longer pregnant, they feel like they are able to wear clothes that they are comfortable in and represent themselves more authentically. However, they can’t bind while nursing and noted that their dysphoria mostly comes from their breasts and that it’s “not their favourite thing to nurse.” Finley is grappling with full term nursing and letting the baby be done on their own, but also doesn’t know how long they want to continue. Finley plans to get top surgery in the long run but is still nursing their third child and is trying to “balance those things.” When the baby is 18 months, they think they will start binding and “see what happens from there.”

Finley loves being a parent but also said that it has been “isolating”. Finley and their wife are home schooling their kids and they spend time with other queer families. They’ve been very intentional in surrounding their kids with people who will be “uplifting.” Commenting on raising a child without gendered pronouns, Finley said:

It gets even worse because when you’re pregnant you can just say “oh we don’t know what we’re having.” When they have a baby in front of you, that’s where it gets more challenging to say, “oh we don’t know how they’re going to identify, we’re just going to see.”

Reflecting on their reproductive journey, they noted that “body parts, chromosomes, sperm, and eggs aren’t inherently gendered things...that’s our own imposition of them that makes them seem gendered. Our family is our family...it’s not defined by the genetic material we’ve used.” If Finley was to do anything differently, they said they would be more upfront with their pronouns with the people involved in their pregnancy care. Thinking about any advice they would give another non-binary person, they underscored that everyone has the right to define their own experience and to advocate for the things that are important for that person. They would recommend midwifery care and to talk to other non-binary and trans people who’ve had pregnancies to find out “what’s been awesome for them and what hasn’t worked...what kind of care providers they would recommend, because care providers are one of the most important things you can have.” In conclusion, they said: “we are a visibly queer family, so I wouldn’t say our experience is outside the norm of what you deal with every day as a visibly queer family.”

4.3 Alex's Narrative

Alex is 32 years old, identifies as queer/pansexual, non-binary/transmasculine, and white. He uses he/him pronouns and has two kids with his cisgender male partner. They met online and decided to become parents four years after they got married. He spends his time being a stay at home dad and working as a freelancer. At the time of the interview, Alex's oldest was three years old and his youngest was one year and eight months old. His reproductive narrative is about his experience conceiving, carrying, and birthing both of his children with a greater emphasis on the first time he underwent pregnancy.

4.3.1 Conception

Alex always knew he wanted to become a parent. When he started to consider transitioning, he began to "realize that he would have to do one or the other first." Alex attended a trans-specific conference and asked the medical professionals in attendance about how transitioning would affect his fertility. He was surprised to learn that no one could give him an answer:

At the time I didn't know whether I could do one before the other. Like, I didn't know if it was possible to transition and then have kids afterwards. I asked around and every doctor I talked to told me that I couldn't, that it would render me infertile and that it would be impossible to have kids after I started testosterone. This was heartbreaking to me because I didn't know how much longer I could delay transition without impacting my mental health. So, I continued looking online and discovered an entire community of transmasculine folks who had done exactly that, who had gone on testosterone and then gone off and still conceived children. I learned that there was actually no data on our population at all, as a fertility population, that doctors had been speaking mostly from ignorance and fear...The

cautions that it would render us infertile were not based on data, but based in them not wanting to advise on something they did not know about, so they would just advise against it.

Alex likened his experience of balancing his transition and reproductive goals to the career compromises people make when starting a family:

It feels like you can't do the two at the same time...you're kind of compromising one way or the other...like obviously I can't physically transition at the same time as I'm pregnant because, you know, that's medically contraindicated. But socially, it feels like that also, it doesn't just stand still, but it moves backwards, because a lot of that is about how other people see you. And the way other people see you when you're pregnant is as a woman... It's only ever really a circus if you start [trying to conceive] after you've begun transitioning because at that point it's like you're invalidating societies ideas about gender. If you do it before transitioning, well then that doesn't count... it kind of all the, all the really outdated ideas about what transition means, and what it means to change your gender in the eyes of society has a lot more to do with validating society's ideas about gender than it is about your own.

After Alex found an online community of transmasculine and non-binary people who had conceived children, he determined that anecdotally, his fertility was not “meaningfully different” from the general population after being on testosterone (T) so he “decided to go for it” and began testosterone.

The conception process for Alex and his partner was “surprisingly easy” both times. He was medically supervised by an endocrinologist who he said was “fantastic.” Alex went on T for about six months, with the goal of changing his voice. He said that this was the “minimal

physical change” he needed in order to maintain his mental health while pregnant. After six months, he stopped taking T. Within a month, his hormone levels “normalized,” and his menstrual cycle returned pretty quickly. After he was off T for three months, Alex and his partner stopped using contraception. They “didn’t really do anything in particular, just had intercourse on a fairly regular basis until conception happened.” After three months of trying, they were able to conceive their first child.

Five months after their first child was born, Alex accidentally got pregnant with his second child. He “kind of wanted two kids” but was planning on giving himself a break between the two. In fact, he had an IUD insertion scheduled the week after he discovered he was pregnant again. He was relying on the “iffy period” of “dampened fertility” while chestfeeding and therefore, he was not using contraception.

4.3.2 Pregnancy

A month or two into Alex’s first pregnancy, he and his partner had previously planned a vacation with some friends. They determined it would be their “final hurrah as childless people.” Some people they didn’t know were also in attendance and at one point he was talking with a group of them. He informed them that he’s “actually a guy” and asked them to use male pronouns. They then started to ask him very “invasive questions about [his] genitals, organs, and surgeries” including questions like, “how can you possibly be pregnant and be a guy?” Alex did his best to briefly answer these questions and go about his vacation but referred to this as a “demoralizing experience.”

Overall, Alex’s pregnancies were “routine.” At the beginning of his first pregnancy, he recalled having severe morning sickness and “feeling horrible.” He experienced a lot of joint pain and could never get comfortable when sleeping. He “projected outwards” and had to wear a

support belt, which he said was “uncomfortable” but also “helped a lot.” He worked during both of his pregnancies and took a leave of absence a couple of weeks each time before his due date.

Alex’s gender dysphoria during both of his pregnancies was “not as bad as [he] was expecting.” For him, his gender dysphoria was “not really any different than it was before [he] started testosterone.” It was “unpleasant but a normal type of unpleasant...this is my body, again, it still doesn’t feel like me but not really any less like me.” He said that the worst of his gender dysphoria was “more social in nature, not from what the shape my body was, but the way people treated me as a result of it...the way people talked about me.” He elaborated on the gendered assumptions that accompany pregnancy and his resulting feelings of “invalidation” and “isolation:”

I find that pregnancy is an incredibly gendered experience. Everything from the support groups and the online peer groups to the culture of it, the expectations, the apps that are designed for it, everything is incredibly gendered. It’s really alienating even when people aren’t trying to be...they just have these assumptions that pregnancy is an inherently female thing. Even my trans friends while I was pregnant would just slip up and gender me female...just because...it’s just such a deeply subconscious association for so many people. I never really felt comfortable...it’s really invalidating. It’s made me feel more isolated than I would feel otherwise. I’ve been reluctant to even try and reach out to connect with other parents or support groups or anything like that. I didn’t go to any classes while I was pregnant because I didn’t even want to face it. Unless the group was something that was explicitly for a queer population, I felt like it would be just too much work to try to advocate for myself and represent myself at the same time as I was trying to deal with all the other stuff that everyone else was.

Discussing the experience of finding clothes, he remarked that “it was terrible...everything is so gendered. I refused on principle to wear any of it.” Jokingly, he said that for a while he “looked like a clown going to the gym.” He wore oversized sweatpants and giant t-shirts. He bought one pair of maternity jeans that were “really cut for a more feminine look” but he “just wanted to be comfortable...and to see [his] legs again.”

4.3.3 Birth

Alex was at home in bed both times when his water broke. He felt most comfortable with doctors assisting in the birthing process, so both times he decided to deliver in a hospital. He recalled feeling that the hospital staff were “really nice” and “very eager to show how supportive they were, but none of them were really educated on the subject...a lot of them used it as an opportunity to educate themselves by turning it into a classroom experience. I should not have to be educating healthcare providers.” Alex said he usually feels “pretty comfortable talking to people” but that this part of his birthing experiences felt “demoralizing.”

I was in the position of knowing more than them about a subject...meaning that they were not wholly qualified to handle me as a patient. There’s the trans broken arm situation of course. Everything is assumed to be related to that just because they’ve never seen it before.

Expanding on his experience with health care providers during his children’s births he said:

As a transgender parent, I received very compassionate care from my providers, but it was clear that they were not accustomed to working with transgender patients. Most of them, they tried, they really wanted me to know that they supported me but they were not good about remembering pronouns, and when it came to nurses or support staff, they were in and out and they often weren’t informed and you know, we’d have to tell them all over again. I

tried to use male terms with my genitals, but it was an extremely awkward experience because they had to first figure out what I was talking about and then they had to pretend to not be weirded out by it.

At the beginning of Alex's labour with his first child, he was determined not to have any pain relief. He said this was a "silly contest" he was in with his mom. She had four children without any pain relief, and he thought "if she can do it, I can do it." He quickly realized this was a "pointless exercise" because she delivered her children in two hours and it took him 12-14 hours both times to deliver his children. He tied his idea about no pain relief to his gender identity: "I was internalizing ideas about what it means to have a stiff upper lip, pain and all that...I was trying to be masculine in that sense, but it was a silly thing to do." During his first birth, he opted for the epidural after six hours. During his second birth, he got the epidural immediately. He "delivered naturally" both times, mentioning that it was easier to deliver his second child. During his first birth, he had an episiotomy to assist in the delivery.

4.3.4 Parenthood

Alex felt that there was "a lot of pressure" to chest feed his children from both the general social consensus and from his family. In reference to his first child he said: "I did it even though I hated it. It was nice with the closeness, but it felt terrible, it was a very dysphoric experience, I ended up weening him off of that at about six to seven months. I honestly wish I had done it sooner. It was not a good experience for me." When his oldest turned four-months old, he went back to work and started pumping to keep up his supply. He stopped chest feeding when his first baby was seven-months old. Alex chestfed his second child until he was around six months old and then switched to formula and banked milk. "I was much more confident in

weaning the second time around, but I still ended up chestfeeding for the first few months because I knew I could handle it for about that long.”

Commenting on the experience of becoming a parent, Alex said that “it’s like having three full-time jobs.”

It’s harder than I expected which I’m pretty sure is a universal experience. It’s really, really hard to never have any time to yourself, to not really have a lot of sleep. It requires a lot more patience than I really understood, in part because you’re so drained that you kind of have to run on empty which is hard to do. I’m generally a very patient, relaxed person and I find it’s difficult even for me to really maintain that. But it’s absolutely worth it. I find that really putting in the effort to be a positive, nurturing parent, it really pays off. I love my kids a lot. The greatest gift of becoming a parent is knowing that two people exist who wouldn’t otherwise and they’re amazing little people and I get to help them be who they are.

One of the greatest challenges in becoming a parent for Alex was feeling “isolated.” He said that he “mostly goes in alone” and that both his, and his partner’s families, live far away. Alex’s family supports their grandkids, but they don’t support that Alex is transgender which has been “an awkward situation.” “They approve of the work I’m doing as a parent, but they don’t approve of me being a dad.” Another challenge for Alex has been “trying to continue moving forward in [his] transition and in [his] career at the same time...It’s kind of impossible to do all of these things at once so I’m trying to do my best, to you know, make things work.”

Thinking about the advice Alex would give to other transmasculine and non-binary parents, he said, “if they want to do it, they can...their bodies are capable of doing things that medical professionals don’t really realize they are capable of.” He emphasized the importance of

a support network because it's "really, really hard to do it by yourself." According to Alex, this network doesn't need to be traditional but can be friends, people in the community who are like you: "You can find support, but it might take more work than it does for most people. I think most people have an automatic support network built in because society has a roadmap for that, but we don't, really."

Reflecting on his reproductive journeys, he's learned how arbitrary the assignments are for the roles of parenthood and gender. "You get out of it what you put in, and gender doesn't have to factor into that." If Alex were to do anything differently, he would have taken testosterone longer before starting to try and conceive if he had known that "it wasn't such a big deal." "I would have invested more time in myself." Being further along in his transition would have allowed him to be "more comfortable" and "not get misgendered as much."

When his youngest child was about seven months old, Alex went back on testosterone. Even though he has been on it for over a year and is no longer pregnant, Alex is still getting "hyper-gendered remarks" from people by just being in the proximity of his children:

One of my pet peeves is that everyone refers to you as "mum" or "mom" as if it's your name. It irritates me because they're making assumptions for one about, you know, what you go by with your children and for another, they're trying to pigeonhole you in some way and kind of placate you. It feels very condescending almost; I don't like it.

Alex discussed his pronouns in relation to having two children. Previously, he tried using they/them pronouns but found it "hard to live like that even though [he] knew himself to be somewhere in the middle." He added:

It seemed impractical to do with two children. Our culture is even just now starting to acknowledge trans people, binary trans people, even that they exist and are maybe worth

respecting. Non-binary people, society doesn't really have a box for that, it's considered to be unserious and it's not respected generally. So, me being non-binary or somewhere in between male and female, I found it extremely challenging getting, even the people who supported me, to remember to use they pronouns.

Eventually, he moved to he/him pronouns because he was "exhausted" with having to ask people over and over again to remember. "You're also in a position of having to fight for that and I just don't have the energy for it...I just think that level of self-advocacy is extremely isolating and it's hard enough really." Reflecting back on his reproductive journeys, Alex remarked:

Before I had kids, I think it was very important to me to have kids that I conceived myself, and I didn't know in a visceral sort of way if I would feel the same about kids I had adopted. Interestingly now that I have kids of my own, I'm realizing that I could feel the same about kids that were not genetically mine. I think that the important thing is that you love them. And that little children are wonderful wherever their DNA comes from. So, if someone wants to conceive genetically, go for it, they can, there's nothing stopping you really, but, if that's not comfortable for you, you can still be a parent and they are no less your children."

4.4 Sol's Narrative

Sol is 44 years old, identifies as pansexual and non-binary, and spends their time as a stay at home parent to their two children. They use they/them pronouns, identify as multiracial and disabled, and are married to a cisgender man. At the time of the interview, Sol's oldest daughter was seven years old and their youngest daughter, who is trans, was five years old. Their reproductive story captures their experiences of conceiving, carrying, and birthing both of their daughters. They lived in the United States during both of their pregnancies and gave birth there. They have lived in Canada for the past two years.

4.4.1 Gender Dysphoria

When Sol was three and a half years old, they started to question their gender identity. In college, they used the word "androgynous" to describe themselves and began to research transgender topics. They learned about the possibility of surgery and decided that they didn't want to pursue medical intervention because, in Sol's words: "it would just lock me into the same problems on the other side of the spectrum."

Sol experiences gender dysphoria "every day." They expressed that getting their period is a "super dysphoric" experience for them and that binding is not possible because they are "large breasted." Discussing how they cope with gender dysphoria they said:

My main coping mechanism for dysphoria is to remember that I have all these wonderful nerve endings. I may not love having breasts, but they sure have a lot of nerve endings, and feel really good...I just try and focus on the pleasure I can have... and accept that like...and sometimes, I just need to be miserable about it.

4.4.2 Conception

Both of their children were conceived through sexual intercourse. The first time Sol got pregnant was a “surprise.” Sol quickly knew they were pregnant because they got “really ill.” When their oldest daughter was 22 months old, Sol became pregnant with their youngest. Sol and their partner “hoped for” their second daughter but did not explicitly plan the pregnancy. They were expecting conception to take a lot longer because Sol was still chestfeeding their oldest at the time.

4.4.3 Pregnancy

Both of Sol’s pregnancies were “extremely challenging.” They had hyperemesis both times and were vomiting constantly. They were so sick during both pregnancies that they had to have a permanent IV put in so that they could receive daily fluids. Their first pregnancy “was harder because everything was so new, and the nausea, and the vomiting, and the pain, dehydration causes a lot of pain, a lot of physical pain, and a lot of cognitive decline too.” During their second pregnancy, they were hospitalized five times and at one point they “ended up having a heart attack.” Towards the end of their second pregnancy, they were doing stress tests regularly to monitor the baby. Sol’s oldest was very active in the womb but their youngest “didn’t move very much at all because I was so sick, and she was so sick. So, I literally never knew if she was still alive or not.” Sol said that this was extremely “stressful.” Each day, Sol would receive three liters of fluid which was “particularly challenging” for them because they were caring for a toddler. In addition, there was a massive flood in the town where they were living, and their family had to leave their house. They were homeless and staying at friend’s houses. Sol recalled that time as being “terrible.” They found a place to move into but two days

before they got possession of the apartment, Sol became so sick that they had to induce the labour of their second child.

They commented that they were “consistently gendered female” throughout their pregnancies. They asked health care providers to “use they/them pronouns” but that “didn’t happen.” When they were pregnant with their first child, they grew their hair long, which they “loathed.”

I felt this intense pressure to, that she and I would both be safer the more feminine I was...the more I appear cisgender, female, the more we look like the traditional, hetero couple, the better we’ll be treated.

Sol mentioned that they “felt a little more secure” during their second pregnancy because they had already experienced pregnancy as a non-binary person. This security allowed them to feel “safe” to cut their hair off.

They had the same midwives during both of their pregnancies. During their second pregnancy, Sol tried to communicate that they felt something was wrong with the baby but one of the midwives on their team “dismissed” Sol’s concerns. Sol wondered what the midwife’s dismissal was related to and even questioned: “If I had kept the hair, would that have helped?” A prominent theme for Sol during both of their pregnancies was how to balance their gender identity, need for safety, and access to care, particularly in light of the health challenges with which they were faced:

I had complicated pregnancies, both of them were complicated, and therefore I felt a ton of pressure to present as female as possible so there wouldn’t be another barrier to care. I realized that if I was presenting as how I wanted to, as more masculine, that would become another argument in favour of I didn’t want the baby, that I was doing this to myself, I

didn't deserve good treatment... There was a lot of like, calculating, I'm asking for so much to keep my health okay, do I dare ask for correct pronouns, do I dare ask for them to stop referring to me as "mom." You know, is it worth fighting that battle if it means less care that's going to keep me and the baby alive. And I decided no, it wasn't."

These precautions were informed by an experience Sol had had earlier in life when they were in college. They were with a male partner at the time and they were perceived as a gay male couple by a few strangers. They were threatened with physical violence and Sol ended up lifting up their shirt to "get out of that without the two of us getting our asses kicked. Which, you know, was this weird form of heteroprivilege that I was tapping into." This experience put Sol in the mindset of "I'm never going to put these kids in danger just because they're with me."

When Sol started to show with their first child, their gender identity really "showed up" and this led to a "rough transition." They discussed how becoming a parent is a particularly "brutal" transition but that the added layer of their gender identity complicated their experience even further. Sol discussed how challenging their pregnancies were and how this related to their gender identity:

To me personally, it felt like, kind of confirmation in a way of like yeah, "I'm not so good at this female thing. This female embodiment thing is not working out so well for me."

And that hurt, some, because I had worked really hard to accept the body I have...and then to have it not work so well for [pregnancy]...so in a way it was very confirming of...yeah, no, whatever this thing that people call super feminine and femininity and femaleness and womanness is not something that makes a lot of sense to me.

Sol recounted how they "tried really hard not to think about" gender dysphoria during pregnancy and instead tried to focus on the "biological processes that [their] body can do... as opposed to

equating it with femininity or womanhood.” They framed their pregnancy as “this body is capable of having a pregnancy and delivering and stuff, and there are bodies that are incapable of pregnancy.”

The way that “people talk about [pregnancy], the way society talks about [pregnancy]” was “extremely tiring” for Sol “because everything around pregnancy and childbirth is so ridiculously gendered.” They commented on how people treated them differently during both of their pregnancies:

Instead of being perceived as androgynous, the whole world perceived me as woman, right? And perceived as a woman, it was a lot of people violating your boundaries, especially when you’re pregnant, like strangers coming up and touching your belly, strangers offering advice...It was harder, it was much harder in interaction with others because I always felt like I had to make a choice of like, “am I just going to nod along with the bullshit that happens, or am I going to push back this time?”...It’s totally exhausting and not everyone deserves an education from me.

In addition, they often felt so sick that they “did not have the energy” to have those conversations with other people. This led Sol to question themselves and their trans identity:

Are you really? Are you really trans? How can you say that? How can you say that when you’re walking through the world looking like a cisgender woman, not calling people out when they assume that you’re a cisgender woman, right?...It became a weapon against me. And I have that thing of certainly wondering if I’m trans enough. When you’re accessing as much cisprivilege and heteroprivilege that I access on a daily basis, I spend some time wondering.

It didn't help Sol that it was "impossible to find maternity clothes that weren't super feminized" and that more specialized maternity clothes were not an option because they were unaffordable.

I would go to the men's section and buy big sweatshirts...the best I could do were plain white t-shirts and like jeans, right? You know they're cut differently, and even more so when you're pregnant because that societal language around "now you're super feminine" right? It shows up in the clothes. The clothing is so hard.

4.4.4 Birth

Both of Sol's pregnancies were induced and they birthed both of their daughters vaginally. Sol was eight days past the due date during their first birth, so they did an ultrasound to learn that there was no amniotic fluid left. Sol was rushed to the hospital for an induction and laboured for 13 hours. According to Sol, their daughter "did not want to come out" and they were close to needing a C-section. Sol ended up getting an epidural, which they had hoped to avoid due to their dislike of anesthesia, after which they began to dilate. Sol recalled experiencing a lot of "fear" during their first birth:

You're in a very altered mental state, or at least I was in a very altered state during that whole process, there was a lot of fear for me, and fear for her, and not knowing if I was going to live, I wasn't so sure I'd be able to do the childbirth part, you know, and, I don't want to say going to fail the test but that's kind of how it felt, am I'm going to pass and live?

Sol also reported suddenly feeling "defensive" of their "vagina" immediately after their first birth:

It created this very fearful dynamic which had not previously existed. There was a lot of dislike dynamic before, but it was the first time that I was afraid of my body in that way. It felt really weird that I was like, “please stay together vagina, please be okay. No, no, no, no.” I don’t know how to explain what a weird mental space that was... I felt very defensive of a body part that previously I had just been like, “if I could trade that in easily, I would trade that in in a minute” For the first time in my life I was like, “no, no, no, no, be careful, please little vagina, be okay.” You know? I was like so worried for it.

They remarked that “gender wasn’t much of an issue [during birth]. There wasn’t enough of me processing for it to be, you know?” They also mentioned appreciating the fact that there was one nurse, who later became their friend, who identified as genderqueer. “She understood why I didn’t want to be coded as female so much, so I felt very comfortable around her.”

Just before their second birth, Sol was very concerned about the health of the baby. One midwife on their team listened to Sol’s concerns and sent them home with a urine test for preeclampsia. The results came back positive and once again, Sol was rushed to the hospital. They got an epidural immediately and induced labour. Sol was vomiting so much that they remember being covered with red dots from the broken blood vessels. Their labour was significantly shorter than the first time and their actual second birth was “remarkably smooth.” Sol was “less afraid” the second time because they were more confident that they would survive.

4.4.5 Post Birth and Parenthood

A week after their youngest daughter was born, Sol had to return to work due to the limitations and requirements of American health care and maternity coverage. “I was still bleeding from the delivery and I was back [to work] because I didn’t have disability insurance.” After their first daughter was born, their hyperemesis went away fairly quickly, but it took one

and a half years for their hyperemesis to stop after their youngest was born. Sol chestfed both of their children for an “extended period of time despite hating chest feeding...it’s not a lot of fun and it’s painful at first...it really controls your time.” Sol remarked on their experience of chestfeeding in relation to being around other parents:

A lot of the parenting areas I was in, there was a lot of talk about how super feminine [breastfeeding] was and how they were really, how these women, these cisgender women, were getting in touch with their feminine side, their nurturing side, and their this and their that, which was all language that was not resonating, at all, right? I really felt like, this is just a biological function my body can do. I don’t feel more feminine when I do it. I don’t mind feeling feminine, feeling feminine is fine, you know feeling masculine is fine, feeling how I normally feel, which is neither of those, is also fine.

Sol continued to discuss how some women would react to their use of the term “chestfeeding:”

The fights I’ve had about the term chest feeding, just that term... and the number of cisgender women who took that as an assault on their identity, just the fact that I preferred a different term...you go ahead and use breast feeding. If that’s what you’re doing, then that’s your word for it, that’s not what I’m doing today.

Their youngest daughter is trans and this has impacted Sol’s experience of parenting.

When their youngest daughter was around two years old, it became clear that she was trans. This motivated Sol and their husband to move to Canada a year later to increase her chance of safety.

“We wanted to be able to provide that bubble for her. I have never had that bubble.”

I just want her to get the best care that she needs, whatever that looks like...she’s five right now that looks like leaving her alone [in terms of medical transition]...let her just do herself, which is what we do, but when she gets older she’s going to have to decide what

she wants for her body. And I don't know what that will be. But she deserves the best care and she deserves that care not to be influenced by who I am.

As a parent, Sol has thoughtfully and strategically considered their gender presentation. Sol's children call them "mama," but Sol is encouraging them to use their name. When they moved to Canada, they grew out their hair to "make sure that as we were meeting new parents, I would look super feminine and make it an easier transition into meeting new parents." They mentioned that they "don't have much community" and that it has been a "hard thing" to find in their current city. However, Sol has found some community online with other parents of trans children.

Sol commented that their "vagina is not the same" after birth and that this change has impacted their "menstrual management." Getting their period is a "super dysphoric" experience for them and using a menstrual cup was the "best option management" for them because it allowed them to take a "really long break" from having to "deal with the blood." More recently they have had to return to using pads and "that's the only thing post-childbirth that's been very difficult." They discussed how they are parenting their daughters in relation to their period:

My kids are very curious, so they know about periods and it's been really interesting to try and convey a more neutral stance towards it because I don't want my baggage around it to bother them...maybe my cisgender daughter who has a vagina won't even care. But I don't want to set the expectation that periods are horrible...and my younger, who is trans, is so sad that she won't have a period, already at five. So, it's really hard, and I feel this intense pressure to not let my gender dysphoria, which gets really ugly with the period, to affect them. That's one of the hardest parts of parenting and being dysphoric, or struggling with my identity, is the responsibility to both experience my feelings, and honor those, and

shield them from it. The dynamic in our family of her being trans and me, it feels so heightened...making that space is a big part of navigating my own experience.

Discussing trans identity, Sol said, “there are lots of non-binary folks who don’t use trans, but I like the term, it’s something that resonates with me.” Sol’s daughter on the other hand:

rejects the word trans, she hates the word trans...she doesn’t find it empowering, does not like it and if you use it in her vicinity, she will correct you... she has decided for herself that that term doesn’t make sense for her because she’s just a girl, right?

When thinking about any advice that they would give another nonbinary person who is considering parenthood Sol said:

I would tell them to think very carefully about where they wanted to spend their energy because it is extremely difficult to get away from the gender and the pregnancy. It’s a highly gendered activity, as portrayed in our society, it’s super gendered, and because it’s so gendered, so many people assume that you want to participate in that gendering, and it comes at you from all over the place. It’s going to happen to yourself but it’s also going to happen in so many interactions. It’s going to happen when you are googling at 2:00 in the morning, trying to figure out what is going on with your body, or why your baby is crying, or whatever, it’s going to be gendered. It’s everywhere.

Sol also spoke about activism and the different forms this can take:

It’s okay to give yourself the breathing space you need, whether you’re pregnant or not, but even more so when your body is doing a very challenging thing. The easiest pregnancy in the world is still hard... you get to give yourself as much slack as you need to get through that in the best way that you can.

Sol experienced postpartum depression after both of their births but said it was significantly worse after their second daughter was born. For them, it took the form of them feeling very angry and suicidal. Sol reflected that they were “so concerned about being able to create that strong attachment and parenting that [they] kind of forgot to take care of [themselves]. Sol concluded by urging future nonbinary parents to be aware of the signs of postpartum depression:

Especially for folks who aren’t gender conforming, are trans or non-binary, or whatever category works best for them, it may take slightly different forms, and might get missed by your healthcare provider. As a non-binary person if you’re already having challenges accessing care and you’re anxious about accessing care, like I was, then having to get help for postpartum depression, it was huge, it was a huge barrier, it was super hard.

Sol was able to get help through their primary care provider and access psychotherapy.

4.5 Perri's Narrative

Perri is 34 years old, identifies as queer and non-binary, and works in the publishing business. They use they/them and she/her pronouns, identify as white, and have been married to a cisgender man for four years. At the time of the interview, Perri's child was 15 months old. They gave birth in central Canada and are bilingual. The concept of language was embedded in Perri's reproductive experience. For them, language "complicated things...it was one of the factors that led me to not disclose at all that I was non-binary."

4.5.1 Conception

Perri and their partner decided that it was "probably about that time" to have a child and decided to start "being lazy about things and see what happens." About three months after making that decision, Perri had an "inkling that [they] were pregnant" and that feeling was confirmed shortly after. Reflecting on the conception process, Perri stated:

I was assigned female at birth and have a cis male partner, so, the actual conception part, you know, when you talk about queer conception and adoption stories, I have a lot of privilege there, it was a relatively easy process for us.

Becoming pregnant was an "interesting" process for Perri because they had spent most of their life "avoiding pregnancy." They had "built up some anxiety about whether or not [they'd] be able to conceive, but it was fine." Perri had some medical issues in the past and also had some friends who had trouble conceiving. Both of these concerns contributed to their anxiety about their ability to conceive. Perri and their partner had decided that they were only planning on having one child, and said following the birth of their child, they are now "done with that part of it."

4.5.2 Pregnancy

Perri said that accessing care at the beginning was “super difficult.” It was “really hard to find a doctor” and to “get into the system.” Perri was accessing their pregnancy care in French, their second language, and feels “that complicated things:”

Language is evolving for non-binary people in English....I remember googling and trying to figure out what the language would even be in French and I couldn't figure it out, so I just decided to grin and bear it for the nine months I was pregnant. I just navigated the systems feeling moderately uncomfortable...there's all this language around gestational parents in English and French, it's all focused on the mother carrying the baby for nine months, blah, blah, blah. I had already started doing this simultaneous translation in my head to sub out the words that didn't work for me with words that did, so I just sort of continued to do that in real life, which was alienating, but it was the solution for that problem.

The first trimester was “interesting” for Perri. They gained weight immediately and started to shop for maternity clothes. When they walked into a maternity store, their first reaction was, “Oh Christ. What am I getting myself into?”

There were frills, there were flowers, it's hyper gendered...It's a bit more niche than normal clothes, so if you have some trouble purchasing normal clothes, which I do, then stepping into a zone that is even more niche is obviously going to have less options.

Overall, finding clothes to wear during pregnancy was “annoying” for Perri so they ended up “wearing sweatpants a lot.” At the back of the maternity store, on a “lonely rack” they found some dark stretch jeans. They would also go into thrift stores to buy larger clothes because they “didn't relish the idea of cramming [their] pregnant body into anything really.” They also bought

some overalls online and found them to be a “really good option that [they] highly recommend.” A trans friend of theirs suggested getting muscle shirts because the big arm and neck holes allow for easy nursing, which has also worked well for Perri.

Perri recalled feeling nauseous throughout their entire pregnancy, but particularly during the first trimester. They also developed a lot of food aversions. Perri’s second trimester “went along smoothly” and was “the chill trimester.” During their pregnancy, Perri mentioned that they did not experience gender dysphoria:

Actually, the experience of being pregnant, I didn’t experience dysphoria, like body stuff. My hips and thighs and breasts all got bigger, you know, I probably wouldn’t have chosen that, but I knew that it was coming...in terms of my experience from inside my body, it was fine...it was so weird how people read me...public stuff.

During their pregnancy, Perri felt their gender identity “was a benefit in some ways, and in others, it was somewhat detrimental.” They offered an example of when they were attending a parenting class. This was an experience in which their non-binary identity was somewhat detrimental. The instructor never asked how everyone identified and assumed that “she had a bunch of hetero couples in her class, so all of the language was about mothers and fathers.” At points, this “felt very alienating” for Perri.

It’s weird to be in a class where you’re learning about how you’re going to care for an infant, which is kind of terrifying, and also what to expect when you go into labor, and all these things that feel very intimate, you probably should be pretty present for, this class. It was hard at times to feel alienated, like, having to do that simultaneous translation in my head, made me feel distant at points when I probably should have been more present. Depending on the mood I was in sometimes it just annoyed me. It’s much more

complicated to get the care that I would need as a non-binary person. And not every sentence the instructor said had to be, “the gestational parent, blah, blah, blah.” But just to have some of the sentences be like that would have been nice.

In contrast, Perri also discussed the ways in which their gender identity benefited them:

When you are googling stuff, you come across a lot of like what are called “mommy boards” for information. From my perspective, on these boards, a lot of women felt extremely anxious about their bodies getting bigger, just things of that nature and also these traditionally gendered, heterosexual relationships. They’re really anxious about their bodies changing. And I’ve had to deal with a lot of different body things around body dysmorphia and weight loss, weight gain, not fitting a particular mold, not being the ideal body mold in society. So, to a certain extent, I got pregnant at 32 or 33, I can’t remember, and I had already been through all of that stuff and my belly was growing and I was like, “cool.” I knew my body was going to change and it didn’t bother me. I was at some points astonished that there was an entire human growing in there.

Perri discussed their long battle with food and weight in their adolescence and that through these experiences, they eventually came to the conclusion that they were “never going to be an ideal woman.” So, by the time that they were pregnant, they were “comfortable enough” with their body. “I had really comfortably come to terms with the fact that weighing myself against whatever societal ideals of what a female body is, that was a project I had abandoned long prior.”

Perri also mentioned that there was the “complicating factor” that they have a mental health diagnosis and they were unsure of how being pregnant would affect that. They’ve been “in a stable place for a long time” but wondered, and continue to wonder, if their diagnosis is a “medically important thing to raise to care providers” because they knew that their mental health

diagnosis can complicate pregnancy. They went to a new doctor and could not “get [themselves] to disclose...It’s a question of how weird you want to be to all these normal people... and how they’re going to respond to that too, and how it’s going to affect your care.” Reflecting further on the decision to not disclose their non-binary identity while receiving reproductive care, Perri said:

I guess this is kind of crappy to myself but, it felt like, the [mental health diagnosis] felt like it was something I had to share, that it wasn’t just me, like it’s just wasn’t going to impact just me necessarily, it could have a potential impact on my kid. Like, it could endanger both of us. But not disclosing that I’m non-binary, I just felt uncomfortable, so it wasn’t going to impact her life at all... You tread a bit of a fine line when you disclose a mental health diagnosis when you’re pregnant. Part of it is showing I’m stable, I have support, I’m financially stable. Like the idea of someone taking your kid away is sort of terrifying. So, if I’m like, “oh, I’m also weird in this other way” I just felt somewhat protective of it. And decided I would just deal with feeling uncomfortable.

Perri ended up having antenatal depression during their pregnancy and “got really anxious about death.” This “didn’t ever get really bad, but it was just, not fun.” These thoughts and feelings disappeared after Perri gave birth. Reflecting on their experience of being pregnant, Perri said:

I wanted to have a kid, so, it was sort of more a means to an end rather than like, I had always dreamed of being pregnant or something. But I’d always been curious about it, I didn’t mind being pregnant. If we wanted to have a second kid, I’d do it again, yeah, it wasn’t too bad.

4.5.3 Birth

Approximately ten days before Perri's due date, their baby was still in the breach position. They went to the hospital to do the "baby-flipping procedure" but the baby would turn transverse then stop. Perri had done a lot of research on breach births and was weighing the risks and benefits of a breach birth versus a C-section. Their doctor gave them the option of a "regular birth," but noted that a major risk "of the regular route, is that the baby can get stuck and lose oxygen." Perri and their partner knew they only wanted to have one child, so this made having a C-section more feasible "because having a C-section makes it harder to have a vaginal birth after a C-section." However, Perri was aware that a C-section carries more risks for the gestational parent. The doctor presented the options as a choice, which Perri "really appreciated." Overall, they felt that their pregnancy care was "really great" because their health care providers seemed very competent and non-judgemental. "It was the best health care I've received in my life." They ended up deciding to have a C-section and scheduled the date. "I guess again, I preferred to take the risk myself then have this like tiny human take on any of those risks."

Perri recalled that the actual C-section as "fine but moderately awful." Perri reacted negatively to the epidural and both their and their baby's heart rate and blood pressure dropped significantly. "Everything happened super fast." Typically, the OB sets up the gestational parent in the operating room and then scrub in the partner, or whoever the birthing person wants in the room. During Perri's C-section, none of that happened because it became "a medical emergency" after they got the epidural. The baby was out before Perri's partner had even entered the room. They overheard the OB saying that the baby was out in under four minutes. While Perri acknowledged that the actual C-section was "difficult," they also said that they "really appreciated" that someone on the anesthesiology team sat with them throughout the procedure

and told Perri “exactly what was going to be happening and what was happening.” So, while the C-section was “a little bit traumatic, care-wise, it was really great. They did everything they could have done, and we were all good, everyone was good in the end.”

After the baby was born, Perri’s partner saw her first. He brought her over and put her on Perri’s chest and then Perri started “bawling.” When asked if they were okay, Perri responded, “yes I’m fine, just very overwhelmed right now.” Shortly after, Perri had to go into one recovery room, and the baby had to go into another recovery room. Perri reflected that “it was weird to be alone for an hour or two.” One of the effects of the epidural was that Perri was unable to keep their eyes open so the “first night was really hard.” They were “physically incapable of staying awake” so while Perri was nursing the baby, their partner had to hold her onto Perri’s body. Despite the difficulties during and following the C-section, Perri spoke very positively about their birthing experience in the hospital:

I had really good care. I found the structure of the hospital comforting. You’re like safe there, the starchy sheets, I don’t know, people helping you with this tiny infant that we didn’t really know how to take care of yet. So, it was scary to leave the hospital and take a cab home, like the whole being on the street in a car felt terrifying.

4.5.4 Parenthood

In recalling life after they brought their daughter home, Perri reflected on the difficulties of getting enough sleep:

Parenting can be very challenging. The first few months were very unique. You know, we slept in shifts at points and it’s extremely challenging, but I like a challenge, I like when things are difficult, I don’t know...I had been basically an insomniac for the whole third trimester. So, this probably sounds ridiculous to other parents but, after I gave birth, it was

easier for me on the sleep front because there had been this internal thing that was messing with my sleep and afterwards, I was so tired from like nursing, and taking care of the kid, and recovering from the C-section, okay, maybe I woke up every few hours, or three hours or whatever, but I slept so deeply. Like my head hit the pillow and I was out.

A theme throughout Perri's reproductive experience was the challenges they faced as a result of inadequate language. "Having linguistic space for myself, that's been complicated all the way through and continues to be complicated." Perri continued to discuss their challenges with parental designations:

The language stuff was complicated, and I had conversations with my family about how I didn't want to be referred to as the baby's mom...I tried to find like other, parent options. My partner goes by "dad"...so baba is a common one but it means father in a couple different languages including the language of my best friend's parents, so I don't know, I didn't want to choose something that felt culturally appropriated to solve my gender problems, so I tried out a few other ones. None of them really felt like they worked. My family sort of pushed back in certain ways. So, yeah, so just parent and she'll call me by my name, which isn't ideal but it's fine.

For Perri, becoming a parent has been "really great and challenging." Perri's partner was finishing up his schooling at the time and Perri continued to work. Perri was looking for a job and ended up getting a job across the country when the baby was five months old. They all moved into Perri's partner's mom's house for eight months. Those eight months were "tough" for all of them because Perri's partner was home with the baby all day and Perri only got to see both of them for one to two hours a day. After those eight months, Perri and their family moved again and Perri returned to working remotely from home. Perri's partner is currently doing most

of the childcare while they are working. He says that “it’s nice to get to be home with the baby, but it’s hard to have to be home with the baby.” Continuing to speak about gender roles, Perri mentioned that some of their friends “lost part of themselves in motherhood” and Perri wondered:

...if there are aspects of queer parenthood that help that a little bit because my friends are in very traditionally, heterosexual set ups... there are a lot of women, it feels like, who are not getting help from their husbands, partners, and boyfriends...I am not experiencing those issues in my relationship at all. Our plan had been to share as much of those duties as we could, and that was what we did. And my partner is actually now doing a bulk of the childcare while I’m working...having a different division of labour and not having those cemented gender roles and having that be a little bit more of a negotiation, or a figuring out what works in your partnership.

Perri’s experience with nursing was “slightly weird” but they are “a very practical person.” They framed nursing as “this is just the way the baby gets fed...this is why I kept these, may as well get some use out of them.” Perri remembers thinking that if there is some reason that they wouldn’t be able to nurse their child, they would “be so pissed.” They discussed the difficulties they had when thinking about getting a breast reduction and balancing this procedure with potentially nursing in the future:

I have quite large breasts and have always felt incredibly uncomfortable with them and actually went for a breast reduction consultation in my early 20s and then, had a bad experience. I left that appointment knowing that I probably did want to have kids someday, and that having a breast reduction or top surgery can significantly reduce your ability to nurse a kid, so I decided to hold off.

Now that their daughter is older and they are no longer breast feeding, Perri is planning to get a breast reduction in a couple of years. They discussed their anxiety about beginning the process and how this relates to their gender identity and body image:

You also have to go through these other hoops, and I might not be able to get through those hoops, even though it is partially, it is like a gender thing, I don't want these anymore. I haven't ever wanted them. It was sort of interesting piecing apart those two things for me, too. Like, I felt very negative about my body, came to a place where I was more comfortable, but still want this one thing to change.

Thinking about advice they would give to another non-binary person considering biological parenthood; they stressed the importance of community:

Finding community for yourself so you can pose questions and not have to be doing simultaneous translation of the literature in your head...there are other people who have gone before us, so find some of those people who have written about their experiences.

They suggested trying to find people in real life, and if that is not possible, try and find people online, to join Facebook groups. They spoke of how finding people who have gone through a similar experience was "a little bit tough. I have queer friends but not a lot of queer friends who have given birth or have kids. But then I have friends who have kids but they're not queer."

In addition, they also suggested that "if you're in a position to, I would highly recommend finding medical care that is affirming." Perri also had the following advice:

Just do what you need to do. In a certain way, being pregnant is a very common experience, and in another way, there are parts of it that are not as common so whatever you need to do to have it feel more comfortable for you, just do that and just be

comfortable making a new trail for certain things if you need. Prepare yourself to gently correct a million people...you get married and have a kid, those are the two spike points in gently correcting people language and assumptions around family composition and your identity. So, maybe come up with a little script or something and get used to saying it. Yeah, it really depends on someone's personality because part of me would rather just suppress myself to not rock the boat in social situations. So yeah, if another person is like that, just practicing until it feels more comfortable.

In reflecting back on their reproductive and parenting experiences Perri said, "I did the best I could in my circumstances. I don't know if I would change anything."

4.6 Common Narrative

All five participants identify as non-binary and queer. One participant, Alex, identifies as both non-binary and transmasculine. Four participants identify as white and one identifies as multiracial. At the time of their interviews, participants had between one to three children who ranged in age from one to seven years old. Four out of five participants were married to their partner/co-parent. Four out of five of the participants had routine, uncomplicated pregnancies. Contrastingly, Sol experienced multiple health complications during both of their pregnancies. All participants with the exception of Finley ended up getting an epidural during their birth. Four out of five participants birthed their children “the old-fashioned way” while Perri opted to have a C-section due to complications related to their baby being in a breach position. Three out of five returned to work within a year of their youngest baby being born.

4.6.1 Conception

Overall, *conception was relatively easy and straightforward* for most participants due to the fact that four out of five of the parents conceived their children with their partner, using their partners’ sperm. Perri commented on the privilege they felt they had during their conception process:

I was assigned female at birth and have a cis male partner, so the actual conception part, you know, when you talk about queer conception and adoption stories, I have a lot of privilege there, it was a relatively easy process for us.

Sam and Perri however, had a more challenging time during conception, due to the availability and viability of the sperm they were using. Sam, Finley, and Perri intentionally conceived their children. Both Alex and Sol “hoped for” their children but were “surprised” when they actually became pregnant.

Prior to conception, participants *consciously considered how to physically and socially balance their transition and reproductive goals*. For Alex, this was primarily around testosterone use. He likened his experience of balancing his transition and reproductive goals to the career compromises people make when starting a family:

It feels like you can't do the two at the same time...you're kind of compromising one way or the other...like obviously I can't physically transition at the same time as I'm pregnant because, you know, that's medically contraindicated.

For Perri and Finley, the tension they felt between their reproductive and transition goals centered around top surgery and nursing their children. Finley mentioned that it's "not [their] favourite thing to nurse" and that they are trying to "balance" their wish to have top surgery and continue nursing their youngest. Similarly, Perri commented:

I have quite large breasts and have always felt incredibly uncomfortable with them and actually went for a breast reduction consultation in my early 20s and then had a bad experience. I left that appointment knowing that I probably did want to have kids someday, and that having a breast reduction or top surgery can significantly reduce your ability to nurse a kid, so I decided to hold off.

In addition to the considerations participants gave to balancing their medical transition and desire to have a family, there was also consideration paid to their social transition such as their gender presentation and when and if to disclose their gender identity. Alex's comments capture this challenge:

...socially, it feels like that also, it doesn't just stand still, but it moves backwards, because a lot of that is about how other people see you. And the way other people see you when you're pregnant is as a woman. It's only ever really a circus if you start [trying to

conceive] after you've begun transitioning because at that point it's like you're invalidating societies ideas about gender. If you do it before transitioning, well then that doesn't count. It's kind of all the, all the really outdated ideas about what transition means, and what it means to change your gender in the eyes of society has a lot more to do with validating society's ideas about gender than it is about your own.

Some participants also experienced tension between socially transitioning and the safety and connectedness of their family. Reflecting on this tension, Sol spoke of the energy they dedicated to considering their gender presentation once they became a parent: "the more I appear cisgender, female, the more we look like the traditional, hetero couple, the better we'll be treated." They also mentioned that they grew out their hair to "make sure that as we were meeting new parents, I would look super feminine and make it an easier transition into meeting new parents." For Finley, this experience took the form of being very deliberate in their selection of friends and community.

4.6.2 Pregnancy

Prior to engaging their bodies in pregnancy, four participants were aware of their gender identity. However, it wasn't until their third pregnancy that Finley discovered their non-binary identity. All five participants discussed *how the gendered nature of being pregnant impacted their experiences*. Two participants linked the gendering of pregnancy to their experiences of loneliness and isolation. This experience was captured by Alex:

I find that pregnancy is an incredibly gendered experience. Everything from the support groups and the online causal peer groups to the culture of it, the expectations, the apps that are designed for it, everything is incredibly gendered. It's really alienating even when people aren't trying to be...they just have these assumptions that pregnancy is an

inherently female thing. Even my trans friends while I was pregnant would just slip up and gender me female...just because...it's just such a deeply subconscious association for so many people. I never really felt comfortable...it's really invalidating. It's made me feel more isolated than I would feel otherwise. I've been reluctant to even try and reach out to connect with other parents or support groups or anything like that. I didn't go to any classes while I was pregnant because I didn't even want to face it. Unless the group was something that was explicitly for a queer population, I felt like it would be just too much work to try to advocate for myself and represent myself at the same time as I was trying to deal with all the other stuff that everyone else was. You're also in a position of having to fight for that and I just don't have the energy for it...I just think that level of self-advocacy is extremely isolating and it's hard enough really.

Similarly, Finley stated that:

When you're visible as a pregnant person, you get a lot of gendered energy directed towards you. Everyone assumes that you're a mother and that's how you identify, and that you have a husband...the heteronormative, cishnormative stuff...it's hard to have those conversations all the time.

The experience of gender dysphoria was varied amongst the five participants. Sol and Finley felt dysphoric while pregnant, while Alex and Perri felt "uncomfortable" at points but gender dysphoria was not at the forefront of their experience. Contrastingly, Sam enjoyed being pregnant. While this was a mixed experience amongst participants, a common thread between participant's stories was *how the language used by others led to feelings of gender dysphoria*. Even though Sam liked being pregnant, they commented: "I didn't feel dysphoric in my body, I felt dysphoric in the language used to talk about my body." For Alex, their gender dysphoria was

“more social in nature, not from what the shape my body was, but the way people treated me as a result of it...the way people talked about me.” Commenting on their experience of gender dysphoria, Finley said that it was “mostly how other people portrayed me; I just really didn’t like it. I can be pregnant myself and not view it as a female, mothering event but when it comes from other people it feels challenging.” Sol mentioned how “extremely tiring” it was to deal with the way that “people talk about [pregnancy], the way society talks about [pregnancy]...because everything around pregnancy and childbirth is so ridiculously gendered.” Relatedly, Perri said:

Actually, the experience of being pregnant, I didn’t experience dysphoria, like body stuff. My hips and thighs and breasts all got bigger, you know, I probably wouldn’t have chosen that, but I knew that it was coming. In terms of my experience from inside my body, it was fine but it was so weird how people read me...public stuff.

Another area related to the gendering of pregnancy that all participants commented on was *the challenges of finding appropriate, non-feminine maternity clothes*. Given the gendered nature of pregnancy, many participants found that looking for clothes that fit their pregnant body while also being gender affirming was “alienating.” Sol said that it was “impossible to find maternity clothes that weren’t super feminized.” Finley would “go into maternity stores looking for clothes and would come out with nothing because [they] hated everything”. Sam said, “most actual maternity wear, that is designed for like having a big pregnant belly, is very feminine.” At times, some participants were able to find and settle for simple, dark pants in maternity stores although these were still femininely cut. However, most participants had to find creative solutions to this problem such as wearing a suit-jacket over a too-large t-shirt, maternity overalls, sweatpants, muscle shirts to assist with nursing, and affordable men’s clothes.

4.6.3 Birth

Four out of five participants gave birth in Canada, while Sol gave birth in the United States. Finley, Sam, and Sol opted for midwifery care during their pregnancies. This choice was often informed by their gender identity and *the desire for gender affirming care*. Finley, a birth worker, shared:

Despite working in hospitals, I have a phobia of birthing in one...I didn't want to be in that system when I went into labour...dealing with people who wouldn't necessarily respect our family, our pronouns, or wishes, or you know, especially in terms of having a medicalized experience.

Sam originally planned to have a home birth so they would “not have to deal with questions about my family, to not have to deal with telling everyone about my gender, to not have to deal with all these people who don't know us, and I don't trust to be affirming of our family and identity.” Both Finley and Sam were very intentional about who they chose as their midwives, ensuring that they were going to receive gender affirming care. Sol, who gave birth in the U.S., had a less positive experience with their midwives than Finley and Sam. Their care was less gender affirming and they felt “dismissed” at points during their pregnancy.

Participants had *mostly positive experiences with their health care providers during their births*. Four participants chose to disclose their non-binary identity to their health care providers. However, for Sol and Alex, who chose to birth in a hospital, disclosing their identity did not result in health care providers respecting their pronouns. Sol explicitly asked their health care providers to “use they/them pronouns” but said that “didn't happen.” Alex commented on the efforts and challenges of health care staff to treat him compassionately in regard to his gender identity:

As a transgender parent, I received very compassionate care from my providers, but it was clear that they were not accustomed to working with transgender patients. Most of them, they tried, they really wanted me to know that they supported me but they were not good about remembering pronouns, and when it came to nurses or support staff, they were in and out and they often weren't informed and you know, we'd have to tell them all over again. I tried to use male terms with my genitals, but it was an extremely awkward experience because they had to first figure out what I was talking about and then they had to pretend to not be weirded out by it.

Perri, who chose not to disclose their identity to their health care providers, said:

I had really good care. I found the structure of the hospital comforting. You're like safe there, the starchy sheets, I don't know, people helping you with this tiny infant that we didn't really know how to take care of yet. So, it was scary to leave the hospital and take a cab home, like the whole being on the street in a car felt terrifying.

Sam, who had a gender affirming midwife, noted, "I can't imagine, I think the whole process would have been so different if I didn't have access to that care."

4.6.4 Parenthood

One theme that was prominent throughout the five participant's narratives was *how their gender identity influenced their experience of being a parent*. This theme took different forms for each participant. For some participants, this meant *navigating their parenting identity outside of the bounds of heteronormative, cisnormative scripts*. In Finley's words:

This time, starting work when they were seven days old, I felt like I was sort of failing as a parent. But then I had to realize that I had these heteronormative assumptions still stuck in my head, that the person who gives birth is the one who needs to stay home with

them...our baby is at home with their other parent. So, I had this sense that it had to be me until I sat back and realized, I'm not putting them in daycare as a seven-day old, they're at home with their other parent. And that is okay, and in heteronormative families if you have a father go back to work after seven days, nobody thinks anything of it. But because I'm the birthing parent, there is this assumption that the mother stays home, and birthing parent equals mother who needs to stay home for a certain amount of time. So, it was harder on my own recovery but once I let go of some of that guilt and the heteronormative assumptions behind those things, I felt better about it.

Similar to Finley, Perri's experience with their gender and parenting identities also took the shape of seeing possibilities outside of the heteronormative, cisnormative doctrine. For them, queer parenthood opened up new parenting and partnership opportunities and allowed for more equal, non-traditional divisions of labour. In addition, when considering disclosing pieces of their identity, they made *decisions that prioritized the well-being of their child*:

I wasn't disclosing [my non-binary identity]. It didn't feel...I guess this is kind of crappy to myself but, it felt like, the [mental health diagnosis] felt like it was something I had to share, that it wasn't just me, like it's just wasn't going to impact just me necessarily, it could have potential impact on my kid...like it could endanger both of us. But not disclosing that I'm non-binary, I just felt uncomfortable, so it wasn't going to impact her life at all.

Sol also made strategic decisions about their gender presentation such as the length of their hair to increase their chances of receiving quality care, ensure the safety of their children, and to increase the likelihood that they would be able to connect with other families. The fact that Sol's

youngest daughter is also trans has influenced their experience of being a parent. Sol spoke about how they are challenged to manage their gender dysphoria around their kids:

I feel this intense pressure to not let my gender dysphoria, which gets really ugly with the period, to affect them. That's one of the hardest parts of parenting and being dysphoric, or struggling with my identity, is the responsibility to both experience my feelings, and honor those, and shield them from it. The dynamic in our family of her being trans and me, it feels so heightened...making that space is a big part of navigating my own experience.

Both Sam and Perri made the decision with their co-parents to use they/them pronouns for their child. They both commented on the challenges of having to continually navigate, explain, and defend this decision to other parents and people. Finley recalled that when they were pregnant, and people asked them if they were having a "boy or a girl" they could just say "oh we don't know what we're having." But after they had their youngest baby, it became more challenging for them to say, "oh we don't know how they're going to identify; we're just going to see." Sam had a similar experience and commented on how this led them to exercise caution when accessing parenting groups. They mentioned that they often feel nervous about whether other parents will be accepting of both their, and their child's, pronouns.

Most participants commented on the *lack of options regarding non-binary parental designations*. Most parents were encouraging their children to use their first names as parental designations. For example, Perri stated:

The language stuff was complicated, and I had conversations with my family about how I didn't want to be referred to as the baby's mom. I tried to find like other, parent options. My partner goes by "dad"...so baba is a common one but it means father in a couple of different languages including the language of my best friend's parents, so I don't know, I

didn't want to choose something that felt culturally appropriated to solve my gender problems, so I tried out a few other ones. None of them really felt like they worked. My family sort of pushed back in certain ways. So, yeah, so just parent and she'll call me by my name, which isn't ideal but it's fine.

Conflicting feelings related to the experience of chestfeeding was another theme that emerged from the narratives as all five participants chose to nurse their children. Sol, Alex, and Finley did not enjoy nursing and found it to be a dysphoric experience to varying degrees. Contrastingly, Sam found that nursing their child "relaxed [their] relationship with [their] body and [their] chest" because it gave "functionality" to their body. Perri also discussed functionality in relation to nursing. They found it to be a "slightly weird" experience but framed nursing as "this is just the way the baby gets fed...this is why I kept these. I may as well get some use out of them."

Despite these challenges, all five participants reflected on how *they feel very positive about being a parent*. Finley loves being a parent but also said that it has been "isolating." For Sam, becoming a parent changed their day-to-day life "drastically." Throughout Sol's narrative, it is clear that they really value their daughters and have made choices that prioritize their kids' well-being. Becoming a parent for Perri had been "really great and challenging." Finally, for Alex, while it can be "hard" to be a parent at times:

...it's absolutely worth it. I find that really putting in the effort to be a positive, nurturing parent, it really pays off. I love my kids a lot. The greatest gift of becoming a parent is knowing that two people exist who wouldn't otherwise and they're amazing little people and I get to help them be who they are.

Chapter 5: Manuscript

Non-binary reproduction: Stories of conception, pregnancy and birth

5.1 Introduction

Non-binary is a term that generally refers to individuals who do not prescribe to the gender binary. This can include (but is not limited to): a) identifying between or outside of the gender identities of woman and man; b) experiencing being a man or woman at independent times; or c) not experiencing having a gender identity (Matsuno & Budge, 2017). Similar to much of the population, non-binary people often seek parenthood. Like many, if not most, trans men, non-binary people retain their reproductive organs and their capacity to have children (Obedin-Maliver & Makadon, 2016; Tornello & Bos, 2017; T'Sjoen et al., 2013). Of the available reproductive options, these individuals might choose to conceive, carry, and birth their children to create their families (Wierckx et al., 2012). While there is growing societal acceptance of the trans community and an increasing body of literature regarding trans fertility and pregnancy, the experiences and identities of non-binary individuals are largely not represented (Charter et al., 2018; Light et al., 2014). Despite the fact that about one third of individuals who identify as transgender identify as non-binary, and that non-binary people face additional challenges than the wider transgender population as a result of living in a society that is structured around binary gender identities, there remains little research focused on the reproductive desires and experiences of these individuals (Matsuno & Budge, 2017). The limited available literature on transgender pregnancy is rooted in the gender binary system and is primarily focused on trans men (Charter et al., 2018; Ellis et al., 2014; Hoffkling et al., 2017; Light et al., 2014; MacDonald et al., 2016). Additionally, past studies on transgender pregnancy have been conducted using primarily survey data (Charter et al., 2018; Ellis et al., 2014; Light et

al., 2014; Riggs et al., 2016; Tornello & Bos, 2017; Wierckx et al., 2012). Addressing these gaps, this study is focused on non-binary people's experiences of conception, pregnancy, and birth, through the use of a bottom up, in-depth, qualitative methodology.

The limited existing literature suggests that isolation and loneliness are predominant features of trans men's experiences with pregnancy (Charter et al., 2018; Ellis et al., 2014; Light et al., 2014). It is common for this population to grapple with feasible methods of parenthood, to struggle with decisions about disclosure of their trans identity, and to contend with the possible incongruence of pregnancy with their gender identity (Charter et al., 2018; Ellis et al., 2014; Walks, 2015). Furthermore, they are often left without robust social support and frequently face transphobia and extensive discrimination (Grant et al., 2011; Pyne, 2012; Pyne, Bauer, & Bradley, 2015). It is important to understand more about the experiences of non-binary individuals and the extent to which their reproductive and parenting experiences are similar to, and different from, trans men to best support this population during their reproductive and parenting journeys. To begin to better understand the reproductive experiences of non-binary individuals, the following question guided this research study: ***How do non-binary and transmasculine people narrate their stories of conception, pregnancy, and birth?***

5.2 Methods

5.2.1 Theoretical Framework

A qualitative, inductive narrative approach was used to answer the research question because it relies on lengthy accounts that are preserved and treated analytically as holistic units, rather than fragmented into thematic categories (Riessman, 2008). This preservation honors individual agency and intention and permits participants to tell their stories in their own words, capturing each individual's rich and unique account (Riessman, 2008). Given the problematic

history of voyeurism and objectification in transgender research, maintaining the content and integrity of each participant's story was particularly important to begin to give voice to the experiences of members of this marginalized population (Vincent, 2018).

5.2.2 Participants and Recruitment

After University ethical approval was obtained, participants were purposefully sampled. Recruitment materials were circulated to community contacts and posted on relevant social media platforms. Inclusion criteria included: identifying as other than cisgender; having biologically conceived, carried, and birthed a child; having a child between the age of six months and five years old; and being fluent in English. Participants were excluded if they had experienced previous reproductive losses (e.g. stillbirth). Eligibility was determined during a phone screening interview. Five eligible participants elected to participate.

5.2.3 Interviews and Procedures

Data were collected during one, in-depth, unstructured interview. Participants were emailed the consent form one week prior to their interview. The consent form was reviewed and signed at the outset of their interview. Each participant was then asked, "what is your story of conception, pregnancy, and birth?" At the end of each interview, basic/relevant demographic information was collected, including their pronouns and chosen pseudonym. Four data collection interviews were conducted over the encrypted video conferencing software, Zoom, and one interview was conducted in person. The author, a white, childless, non-binary, queer person, conducted all of the interviews. The interviews lasted between 60 and 90 minutes. Participants were compensated \$50 CAN as a token of appreciation.

5.2.4 Analysis

All interviews were recorded and transcribed verbatim by the author (Braun & Clarke, 2013). To protect participants' identities, pseudonyms were used in the transcripts and narratives, and potentially identifying details were removed. The author reflected on their social location and preunderstandings throughout all stages of the study to ensure, to the extent possible, that these did not impact the data collection or construction of the narratives. Each transcript was read individually two to three times, significant sections were identified, and a chronological, cohesive narrative was written by the researcher for each participant. These narratives relied heavily on interview material and participants' actual words. After all of the individual narratives were written, participants were sent their story and invited to participate in a member checking interview to ensure that their story was accurately captured. Four out of five participants were able to be reached to provide feedback on their narrative. All five narratives were then thematically analyzed and woven into one common narrative that included the themes and experiences shared by the participants in their reproductive journeys (Lieblich, Tuval-Mashiach, & Zilber, 1998). The common story and themes are presented chronologically under the headings: conception, pregnancy, birth, and parenthood.

5.3 Findings

For a summary of the common themes, please refer to Table 1.

Table 1 Common Themes

<i>Conception</i>	Consideration of how to balance reproductive and transition goals
	Relatively easy and straightforward
<i>Pregnancy</i>	Gendered nature of pregnancy
	Maternity clothes

<i>Birth</i>	Gender dysphoria and language
	Desire for gender affirming care
<i>Parenthood</i>	Positive experiences with health care providers
	Gender identity and parenthood
	Chestfeeding
	Parental designations

5.3.1 Demographics

All five participants self-identified as non-binary and queer. One participant identified his gender identity as both non-binary and transmasculine. Four participants identified as white and one as multiracial. At the time of their interviews, participants had between one and three children who ranged in age from one to seven years old. Their ages ranged from 31-44. Four out of five participants were married to their partner/co-parent (three were married to a cisgender man and one was married to a trans woman). One participant decided to co-parent with a good friend. Only one participant had elected to undergo hormone therapy prior to conception and continued hormone therapy after ceasing chestfeeding. Three participants sought midwifery care during their pregnancy and two participants were cared for by doctors during their pregnancy. All participants lived in urban areas at the time of the interview.

5.3.2 Conception

Prior to conception, participants *consciously considered how to balance their medical and social transitions with their reproductive goals*. One participant likened this experience to the career compromises people make when starting a family, and reflected on how societal expectations impacted the consideration of balancing transition and reproductive goals:

It feels like you can't do the two at the same time... you're kind of compromising one way or the other... like obviously I can't physically transition at the same time as I'm pregnant because that's medically contraindicated. Socially, it doesn't just stand still, but it moves backwards, because a lot of that is about how other people see you when you're pregnant... as a woman. It's only ever really a circus if you start [trying to conceive] after you've begun transitioning because at that point it's like you're invalidating societies ideas about gender. If you do it before transitioning, well then that doesn't count. It's kind of all the really outdated ideas about what transition means, and what it means to change your gender in the eyes of society has a lot more to do with validating society's ideas about gender than it is about your own.

For other participants, the tension they felt between their reproductive and transition goals centered around sequencing top surgery and nursing their children: "Knowing that I probably did want to have kids someday, and that having a breast reduction or top surgery can significantly reduce your ability to nurse a kid... I decided to hold off."

Overall, *conception was relatively easy and straightforward* for most participants. All participants desired to become parents prior to becoming pregnant. Four out of five of the parents conceived their children with their partner, using their partners' sperm and their own oocytes. One participant used their own oocytes and their co-parent's brothers' sperm to conceive their child.

5.3.3 Pregnancy

A central theme in all five narratives was *how the gendered nature of being pregnant impacted their experiences*. Some linked the gendered ideas surrounding pregnancy with their experiences of loneliness and isolation:

I find that pregnancy is an incredibly gendered experience. Everything from the support groups and the online causal peer groups to the culture of it, the expectations, the apps that are designed for it, everything is incredibly gendered. It's really alienating... they just have these assumptions that pregnancy is an inherently female thing. Even my trans friends while I was pregnant would slip up and gender me female... just because... it's just such a deeply subconscious association for so many people... it's really invalidating. It's made me feel more isolated than I would feel otherwise... you're in a position of having to fight for that and I just don't have the energy for it... that level of self-advocacy is extremely isolating and it's hard enough really.

Another area all the participants reported related to the gendering of pregnancy was *the challenges of finding appropriate, non-feminine maternity clothes*. Given the gendered nature of pregnancy, they found that looking for clothes that fit their pregnant body while also being gender affirming was difficult and very alienating: "It was impossible to find maternity clothes that weren't super feminized." Most participants had to find creative solutions to this problem such as wearing a suit-jacket over a too-large t-shirt, maternity overalls, sweatpants, and muscle shirts to assist with nursing.

The experience of gender dysphoria was varied amongst the five participants. Some felt dysphoric while pregnant, others felt uncomfortable at points, but gender dysphoria was not at the forefront of their experience. Contrastingly, one participant enjoyed being pregnant. While this was a mixed experience amongst participants, a common thread among participants' stories was *how the language used by others led to feelings of gender dysphoria*. In the words of one participant: "I didn't feel dysphoric in my body, I felt dysphoric in the language used to talk about my body." This experience included people referring to them as "mom," being asked

invasive questions about their gender and bodies, being misgendered, and facing people's assumptions about their partnership and parenting configurations.

5.3.4 Birth

Unsurprisingly, all *participants desired gender affirming care*. Access to care depended on participants' geographical location and financial resources. One participant, a birth worker, shared:

Despite working in hospitals, I have a phobia of birthing in one...I didn't want to be in that system when I went into labour...dealing with people who wouldn't necessarily respect our family, our pronouns, or wishes, or you know, especially in terms of having a medicalized experience.

Another participant explicitly sought midwifery care from a gender affirming midwife so they would: "not have to deal with questions about my family, to not have to deal with telling everyone about my gender, to not have to deal with all these people who don't know us, and I don't trust to be affirming of our family and identity."

Some participants made conscious choices about their gender presentation when accessing reproductive health care to increase their chances of receiving compassionate care: "The more I appear cisgender, female, the more we look like the traditional, hetero couple, the better we'll be treated." Those who did not have access to gender affirming care regularly encountered unknowledgeable health care providers. This experience often left these individuals feeling "demoralized" and was reflected by one participant during their birth:

They were very eager to show how supportive they were, but none of them were really educated on the subject... a lot of them used it as an opportunity to educate themselves by turning it into a classroom experience. I should not have to be educating healthcare

providers... I was in the position of knowing more than them about a subject...meaning that they were not wholly qualified to handle me as a patient.

Despite some challenges, overall participants reported having *mostly positive experiences with their health care providers during their births*. Four participants chose to disclose their gender identity to their health care providers; however, this did not always result in health care providers using and respecting their pronouns. One participant commented on how the health care staff treated him in regard to his gender identity:

As a transgender parent, I received very compassionate care from my providers, but it was clear that they were not accustomed to working with transgender patients. Most of them, they tried, they really wanted me to know that they supported me but they were not good about remembering pronouns, and when it came to nurses or support staff, they were in and out and they often weren't informed and you know, we'd have to tell them all over again. I tried to use male terms with my genitals, but it was an extremely awkward experience because they had to first figure out what I was talking about and then they had to pretend to not be weirded out by it.

5.3.5 Parenthood

Participants' gender identity influenced their experience of being a parent in various ways. For most, this meant defining their parenting identity outside of the bounds of the heteronormative, cisnormative scripts. Participants commented on how queer parenthood opened up new parenting and partnership opportunities and allowed for more equal, non-traditional divisions of labour in their families. One participant decided to step outside of traditional family configurations and co-parent with a good friend. Others returned to work while their co-parent remained at home with the child(ren). One participant discussed the guilt and internal conflict

they felt after returning to work when their baby was seven days old, based on their own internalized heteronormative assumptions:

I felt like I was sort of failing as a parent. But then I had to realize that I had these heteronormative assumptions still stuck in my head, that the person who gives birth is the one who needs to stay home with them... our baby is at home with their other parent. So, I had this sense that it had to be me until I sat back and realized, I'm not putting them in daycare as a seven-day old, they're at home with their other parent. And that is okay, and in heteronormative families if you have a father go back to work after seven days, nobody thinks anything of it. But because I'm the birthing parent, there is this assumption that the mother stays home, and birthing parent equals mother who needs to stay home for a certain amount of time. So, it was harder on my own recovery but once I let go of some of that guilt and the heteronormative assumptions behind those things, I felt better about it.

Each participant's gender identity also informed the decisions they made about disclosing their identity to others and their gender presentation, especially when it came to prioritizing the well-being of their children. The words of one participant capture this: "I felt this intense pressure to, that she and I would both be safer the more feminine I was."

The gender identity of participants' children also impacted their experiences of parenthood. Two participants chose to use they/them pronouns for their child and commented on the challenges they faced in having to continually navigate, explain, and defend this decision to other parents and people. This led them to exercise caution when accessing parenting groups and connecting with other families as they would often feel nervous about whether other parents would be accepting of both their, and their child's, pronouns. Another participant, who has a

trans daughter, found that navigating the dynamic of their family, and both their and their daughter's gender identity, influenced their parenting identity:

I feel this intense pressure to not let my gender dysphoria affect [my children]. That's one of the hardest parts of parenting and being dysphoric, or struggling with my identity, is the responsibility to both experience my feelings, and honor those, and shield them from it.

The dynamic in our family of her being trans and me, it feels so heightened... making that space is a big part of navigating my own experience.

Conflicting feelings related to the experience of chestfeeding was another theme that emerged from the narratives as all five participants chose to nurse their children. Three participants did not enjoy nursing and found it to be a dysphoric experience to varying degrees. Contrastingly, one participant found that nursing their child: "relaxed [their] relationship with [their] body and [their] chest because it now has a purpose." Most participants discussed nursing in terms of this functionality: "This is just the way the baby gets fed...this is why I kept these. I may as well get some use out of them."

Participants also had to contend with the *lack of options regarding non-binary parental designations*. In response, most encouraged their children to use their first names as parental designations:

The language stuff was complicated, and I had conversations with my family about how I didn't want to be referred to as the baby's mom. I tried to find like other, parent options... none of them really felt like they worked. So, yeah, so just parent and she'll call me by my name, which isn't ideal but it's fine.

5.4 Discussion

A thorough review of the literature suggests that this is the first study to explicitly focus on the conception, pregnancy, and birth experiences of non-binary individuals. The findings of this study demonstrate how heteronormativity and cisnormativity influence each stage of non-binary people's reproductive journeys. Previous scholars have analyzed how these social forces are embedded within reproductive health care and how they impact LGBTQ+ people's perinatal experiences (Charter et al., 2018; Epstein, 2018; James-Abra et al., 2015; Richardson, Price, & Campbell-yeo, 2019). The reality that these pervasive social forces negatively impact non-binary individual's reproductive experiences necessitates that we begin to disentangle gender from the acts of conception, pregnancy, and birth.

The findings of the current inquiry are largely consistent with a number of recent studies highlighting the unique features of trans men's pregnancy (Charter et al., 2018; Ellis et al., 2014; Hoffkling et al., 2017; Light et al., 2014; MacDonald et al., 2016; Obedin-Maliver & Makadon, 2016). In the present study, the pervasive gendering of pregnancy as a female-only activity contributed to participant's feelings of isolation and loneliness. This finding is consistent across the literature (Charter et al., 2018; Ellis et al., 2014; Light et al., 2014). Additionally, the experiences of participants in this study regarding the prioritization and sequencing of their transition and reproduction goals mirrors the experiences of participants in Hoffkling et al.'s (2017) study. Previous literature has emphasized the role of transition in trans men's reproductive experiences (Ellis et al., 2014; Light et al., 2014). Although the non-binary participants who took part in this inquiry commented on both social and medical transitions in relation to their reproductive experiences, this was not at the forefront of their narratives. Rather, they highlighted the complexity of living outside of, or between, the gender binary and the

nuances of how the heteronormative, cisnormative gendering of pregnancy influenced their experiences.

Similar to previous research, the experience of gender dysphoria was varied amongst participants (Charter et al., 2018; Ellis et al., 2014; MacDonald et al., 2016; Obedin-Maliver & Makadon, 2016). Mirroring what MacDonald et al. (2016) found, participants in this study made a distinction between their internal experience of gender dysphoria and gender dysphoria that resulted from the gendered language of others. This finding is particularly relevant to service providers. By using the correct pronouns and mirroring patient's language about their bodies, identities, and family configurations, service providers are well positioned to positively influence non-binary individuals' perinatal experiences and reduce their experiences of gender dysphoria.

The available literature indicates that health care providers are not well trained to work with trans individuals and the trans population is a medically underserved population (Giblon & Bauer, 2017; Richardson et al., 2019). In particular, those working in reproductive health care settings are often ill equipped to work with trans patients (Hoffkling et al., 2017; James-Abra et al., 2015; Light et al., 2014). Consistent with the reports of the participants in this study, a lack of knowledge combined with the heteronormative, cisnormative ideals within traditionally considered female-only spaces, erects barriers and creates challenges for non-binary individuals accessing reproductive care (Epstein, 2018). Service providers can limit these challenges by increasing the gender inclusivity of their services. By educating themselves on transgender-specific topics (rather than relying on their patients to educate them), explaining why sensitive questions are clinically relevant, acknowledging the long history of abuse trans people have faced within and beyond health care settings, and allowing patients to make choices about their reproductive care, service providers can provide gender affirming care (Hoffkling et al., 2017).

The experiences of participants in the current inquiry and their desire for gender affirming care reinforce these recommendations. (Giblon & Bauer, 2017)

While there are undeniable challenges that accompany non-binary pregnancy and parenthood, the findings of this study indicate that there are also advantages. The positionality of non-binary individuals outside of heteronormative, cisnormative scripts allows for increased possibilities to create their families in ways that do not rely on gendered norms (Downing, 2013; Haines, Ajayi, & Boyd, 2014; Hines, 2017; Oswald, Blume, & Marks, 2012; von Doussa, Power, & Riggs, 2015). As seen in this inquiry, some non-binary parents are constructing their families in ways that do not rely on romantic relationships, inventing unique divisions of labour, generating their own parenting identities, and not gendering their children to allow them greater freedom. Previous scholars have suggested that trans parents are uniquely positioned to challenge the hegemonic gendered ideas of ‘masculinity’ and ‘femininity’ that are tied to particular parenting practices (Downing, 2013; Haines et al., 2014; Ryan, 2009). Furthermore, trans individuals may build their families in ways that do not depend on biological ties if they have experienced discrimination by their families of origin (Downing, 2013; Maguen, Shipherd, Harris, & Welch, 2007).

5.4.1 Strengths and Limitations

The main strengths of this study are that it relies on a bottom up, in-depth, qualitative methodology, rather than survey data, and focuses on the non-binary population. A limitation of this study is that the sample is relatively small and homogeneous in terms of ethnicity (white), socioeconomic status (middle class), and location (urban). Efforts taken to recruit individuals who reflect greater diversity were unsuccessful. Future research is needed to explore the experiences of those individuals from diverse racial, socioeconomic, and rural backgrounds.

While member checking is a strength of this study, it is important to note that one participant was unable to be reached to confirm the accuracy of their individual narrative. However, their narrative did not differ significantly from the other narratives – lending strength to the accuracy of the common narrative.

5.5 Conclusion

The findings of this study underscore the need for significantly more research in the area of non-binary reproduction, in particular research that continues to explore the reproductive and fertility experiences and needs of non-binary individuals, their partners, and their children. Also, the consequences of transition (hormone therapy and surgical intervention) on reproductive outcomes (fertility, conception, pregnancy, and chestfeeding) need to be more fully evaluated. Finally, the findings of this inquiry revealed how parents' gender identity influenced their parenting experiences. This topic would also be a useful area for continued inquiry.

This article examined the reproduction narratives of non-binary parents. Participants shared their personal and nuanced birth stories and shed light on how the pervasive gendering of pregnancy permeated the reproductive experiences of these non-binary individuals. These narratives challenge the heteronormative, cisnormative status quo and highlight the need for increased gender affirming support, training for staff and service providers, and more research in this area.

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Appendices

Appendix A Phone Screening Interview

Thank you for calling. My name is Olivia Fischer and I am a Master of Arts student in the Counselling Psychology program at the University of British Columbia. This research is being conducted in partial fulfillment of the requirements for my Master's thesis, under the supervision of Dr. Judith Daniluk.

I am interested in learning more about transmasculine and non-binary people's experiences of conception, pregnancy, and birth. When I say transmasculine and non-binary, I am referring to anyone who identifies as something other than cisgender and was assigned female at birth. My intention is not to limit anyone's identity, if these terms do not feel right for you, please let me know what you would prefer. Before we begin, I would like to ask you a few questions to establish whether you meet the criteria for participation in this study. Then I will share more about the purpose and details of the study. You are welcome to ask questions at any point.

1. Do you identify as something other than cisgender and were you assigned female at birth?
2. Have you been pregnant and given birth to a healthy child?
3. Do you have a history of reproductive loss (stillbirth)?
4. How old is your youngest child?

If the person identifies as something other than cisgender (trans, non-binary, gender non-conforming, gender diverse, or another trans-umbrella identity) and was assigned female at birth, I will proceed to question 2. If the person answers "yes" to question 2, I will proceed to question 3. If the person answers "no" to question 3, I will proceed to question 4. If the person answers anything between 6 months and 5 years, I will proceed to the telephone screening. If the person identifies as cisgender, has not been pregnant, has a history of reproductive loss, or has given birth to their youngest child less than 6 months ago or more than 5 years ago, I will thank them for their interest and inform them that they are not eligible to participate in this study.

Now I will describe the purpose and procedures of this research, so you can determine whether you are interested in participating in this study. If you have any questions, please feel free to ask.

The purpose of this study is to explore the reproductive experiences of transmasculine and non-binary people. Given the changing social climate and advancing technology, more and more trans folks are choosing to engage their bodies in conception, pregnancy, and birth. However, there is limited available knowledge and resources in this area. My hope with this research is to elevate the voices of transmasculine and non-binary people and begin to counter the negative heteronormative, transphobic beliefs and messages that are prevalent within our culture. By hearing your story, I hope to provide others with the opportunity to hear and learn from your experiences and the experiences of the other participants, and help health care professionals, especially counsellors, work more compassionately and effectively with trans parents and families.

The study will involve two confidential audio-recorded interviews, which together, will total between two to three hours. During our initial interview, if we need more time and you are still willing to participate, we can schedule another follow-up interview. We can conduct these interviews at a mutually agreed upon time, in a private location of your choice or at an office on campus at UBC. Where are you geographically located? If we are unable to meet in person due to you being located outside of Vancouver or personal circumstances, a Skype video call (that will also be audio-recorded) can be arranged. During this interview, you will have the opportunity to speak freely about your experiences of conception, pregnancy, and birth. After I have transcribed your interview, I am going to write a synopsis of your story. I will send this story back to you for you to read. We would then speak a few weeks later – either in person, via Skype, or via a phone call – so you can share any further thoughts or reflections you have about the story I have written, to make sure the story accurately captures and reflects your reproductive experiences.

Your participation in this study is entirely voluntary and will be strictly confidential. You can choose not to answer any particular questions that I might ask during the interviews and you can withdraw your participation at any time, without consequence. You will be asked to select a pseudonym in place of your name, which will be used in any written or oral description of the participants and findings of the study, in order to protect your identity.

Do you have any questions?

Now that you have learned more about this study, are you still interested in participating?

If so: I will send you a copy of the consent form. After you receive the consent form you will have two weeks to decide if you would like to participate. If you are still interested in participating after that time, we can set up a time and place for our first interview. Would that work for you?

Before we say goodbye for today, I have a few questions about your contact information. I want to assure you that I will be keeping this information in a password protected and encrypted file and if you decide not to participate in the study, or after you participate in the study, it will be destroyed.

Name and Contact Information:

- 1) Phone number:
- 2) Email:
- 3) Preferred Time and Day for Contact:

Thank you.

Appendix B Participant Consent Form

Principal Investigator:

Dr. Judith Daniluk, Professor
Department of Educational and Counselling Psychology, and Special Education
University of British Columbia
Phone: XXX-XXX-XXXX email: XXX@XXXX.com

Co-Investigator:

Olivia Fischer, M.A. Student
Department of Educational and Counselling Psychology, and Special Education
University of British Columbia
Phone: XXX-XXX-XXXX email: XXX@XXXX.com

This study is being conducted as the thesis of a Master of Arts degree for Olivia Fischer, a graduate student in the Department of Educational and Counselling Psychology, and Special Education at the University of British Columbia. Dr. Judith Daniluk is a Professor of Counselling Psychology and is supervising this research.

After this research is completed, it will be submitted as a thesis to the Department of Educational and Counselling Psychology, and Special Education and will be made a public document. The results of this research may be presented at academic conferences or published in academic journals. Prior to publication, any identifying information will be removed or altered to protect your privacy and anonymity in any of these instances.

Study Purpose

You are being invited to take part in this research study to share your personal experience of conception, pregnancy, and birth. We are conducting this study to help us better understand the reproductive stories of transmasculine and non-binary people. The findings will help us better understand the needs of, and learn to better serve, this population.

Study Procedures:

The study will involve a commitment of approximately 3 to 4 hours of your time:

1. The co-investigator, Olivia Fischer, will meet with you for two individual interviews, during which you will have an opportunity to share your experiences of conception, pregnancy, and birth. The interviews will be scheduled at your convenience, and take place in person in a quiet, private, and mutually agreed upon location. The interview portion of this study will take between 2 to 3 hours of your time. The decision on how much of how little time spent is largely up to you as the participant. If we agree that an in-person interview is not possible, our interview will be conducted via video-chat. This confidential interview will be digitally audio-recorded, and your agreement to participate includes your consent to being audio-recorded. If needed, and you still wish to share more about your experiences, we can schedule a follow-up interview (maximum 1 hour). This is not a necessary component of participation in this study.

2. After transcription, analysis, and interpretation of the first confidential interview (and follow-up interview if applicable), the co-investigator, Olivia Fischer, will develop a narrative summary of your story. Some key themes, events, or processes may also be identified. After sending you a copy of your narrative for your review, through either e-mail or hard copy depending on your preference, she will meet with you in-person, via video-chat, or over the phone for the second interview to discuss the findings and ensure your narrative is an accurate reflection of your reproductive experiences.
3. Once all of the confidential interviews have been completed and narratives have been written, Olivia will develop a common narrative that spans the stories of all participants.

Study Results:

The results of this study will be reported in a graduate thesis and may also be published in journal articles, books, or presented at academic conferences. You may receive a copy of the results once completed by providing consent for us to send you the final narrative by mail or e-mail.

Potential Risks of the Study:

There are no foreseen risks associated with participation in this study. It is possible that you may feel some emotional discomfort when recalling and sharing personal or sensitive experiences. A list of counselling resources will be provided to you.

Potential Benefits of the Study:

It is possible that participation in this study will be positive for you, and that sharing your story will be rewarding and meaningful for you in helping others better understand transmasculine and non-binary people's experiences and stories of conception, pregnancy, and birth.

Confidentiality:

Your identity will be kept strictly confidential. Information that discloses your identity will not be released without your consent unless required by law. All information that is gathered in the initial interview will be digitally audio-recorded and transcribed. All digital files, including the audio recordings, transcriptions, and video-chat data if used, will be encrypted and password protected. You will be asked to choose a pseudonym that aligns with your gender identity. This pseudonym will be used in all written reports in order to protect your identity. All transcripts and consent forms will be stored in a locked filing cabinet in a private UBC facility. All digital files will be stored on the University of British Columbia's Workspace 2.0, a secure file storage and sharing service that aligns with national, provincial, and university-wide security requirements. You will not be identified by the use of your own name or initials and your identity will be kept strictly confidential in any publication resulting from this research. Direct quotes used in reporting the findings will not identify you or any of the participants. All digital recordings and transcripts will be destroyed five years after the research has been completed. Should you decide to withdraw from the study at any time, all files related to your participation, including audio recordings, documents, video-chat data if used, and the interview transcript, will be destroyed.

Compensation:

You will be paid \$50 for your participation in this study, paid at the beginning of your involvement, and yours to keep even if you decide at any point to withdraw from the study.

Contact for Information About the Study:

If you have any further questions or would like more information about the study, you may contact the co-investigator, Olivia Fischer, or principal investigator, Dr. Judith Daniluk. Our contact information is located at the top of this form.

Contact for Complaints or Concerns About the Study:

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Participant Consent:

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to withdraw from the study at any time without giving a reason and without any negative consequences.

Your signature below indicates that you consent to participate in this study and acknowledge receipt of a copy of this form for your own records.

Your signature indicates that you consent to having our interviews audio-recorded and transcribed.

 Participant signature

 Date

 Printed name of the participant signing above

 Researcher signature

 Date

 Printed name of researcher signing above

Appendix C Interview Guide

Orienting Statement:

Thank you for agreeing to participate in this study. As I previously mentioned, the purpose of this study is to learn more about transmasculine and non-binary people's experiences of conception, pregnancy, and birth. When I say transmasculine and non-binary, I am referring to anyone who identifies as something other than cisgender and was assigned female at birth. My intention is not to limit or circumscribe your identity, so if this term does not feel right for you, please let me know what you would prefer. Over the course of our time together today, I would like you to share with me your reproduction story. Given the problematic history of transgender research, one of my goals of this study is to elevate your voice, rather than my own. I come to this work as a cisgender, queer woman who is childless and hope to act as an ally to trans people through this research. With this in mind, I am not going to ask you a lot of questions. Rather, I will listen to your story and experiences. You are the expert here. I understand that this is a personal topic and I encourage you to only share what you are comfortable. I may ask you to expand on certain aspects of your experience or clarify elements of your story, but you are not obligated to answer any of my questions or share anything you feel uncomfortable with.

Please take a moment to reflect on your experiences of conception, pregnancy and birth. When you feel ready, please answer, "what is your story of conception, pregnancy, and birth?" Some people find it easier to talk about their experiences like a story with a beginning, middle and end. You may want to begin with the start of your journey towards parenthood. Please feel free to begin wherever you feel most comfortable.

Probing questions:

Can you tell me more about that experience?

How did you feel about that?

In what ways was that (realization, experience, change, insight, etc.) significant for you?

Can you clarify what you mean by _____?

Is there anything you would like to add regarding _____?

How do you think that experience/decision/moment impacted you at the time? Does it continue to impact you and if so, in what ways?

What are the notable moments for you during that time of your life?

How has your gender identity influenced that experience for you?

What has becoming a parent been like for you?

What were the greatest challenges for you in your journey to parenthood? What were/are the greatest gifts/joys?

If you could come up with a metaphor to describe your journey to parenthood, what would it be?

If you were speaking to a transmasculine person who was considering parenthood, what advice would you give them?

Reflecting back on your reproductive journey, what have you learned? What would you do differently?

Demographic Questions: (if not answered in data collection interview)

1. Current Age

2. Gender identity
3. Sexual orientation/identity
4. Ethnicity
5. Current city of residence
6. Education level
7. Occupation
8. Number of children
9. Relationship status/structure (e.g., partnered, single, polyamorous, monogamous)

What pseudonym would you like to use?



XXXXXXXXXXXX@XXXXX.XXX

Appendix E Recruitment Ad

- Do you identify as something other than cisgender? Were you assigned female at birth?
- Have you experienced a complete pregnancy? Did you give birth to your child more than 6 months ago? Is your youngest child between the age of 6 months and 5 years old?
- Are you willing to share your experience with a UBC researcher in a confidential interview?

This is a UBC research study being conducted by Olivia Fischer, a master's student in Counselling Psychology, under the supervision of Dr. Judith Daniluk. Its purpose is to understand what the stories of conception, pregnancy, and birth are for five non-binary and transmasculine individuals.

Participation in this study will take between 3-4 hours of your time. It will require two confidential interviews and the total interview component of this study will take between 2-3 hours. Participation in this study will also ask you to read and reflect on the reproductive story that Olivia will have written based on our interview(s) together, to make sure the story accurately captures and reflects your reproductive experiences (1 hour).

You will be paid \$50 for your participation in this study, paid at the beginning of your involvement, and yours to keep even if you decide at any point to withdraw from the study.

For more information or to participate in this study, please contact Olivia Fischer at:
XXX-XXX-XXXX or xxxx@xxxx.xx

Appendix F Counselling Resources

Catherine White Holman Centre - 604 442-4352

<http://www.cwhwc.com/>

Provides low-barrier wellness services to transgender and gender non-conforming people in a way that is respectful and celebratory of clients' identity and self-expression. Counselling services are offered free of charge twice a month.

Moving Forward Family Services - 778-321-3054

<https://movingforwardfamilyservices.com>

Pay-by-donation counselling for individuals and families. Offices in Surrey and South Vancouver. Graduate-level counsellors and counselling interns.

New Westminster UBC Counselling Centre - 604-525-6651

<http://ecps.educ.ubc.ca/clinical-instructional-resources/new-westminster-ubccounsellingcentre/>

Free counselling for the general public by counselling psychology graduate students, supervised by a registered psychologist.

Living Systems Counselling - 604-926-5496, ext. "0"

<http://www.livingsystems.ca/counselling/locations-fees-services#Counselling>

Individual, couple and family counselling using Bowen Family Systems Therapy. Lower cost counselling provided by supervised interns.

Family Services of Greater Vancouver, Counselling Program - 604-874-2938

www.fsgv.ca/find-the-support-you-need/counselling/

Counselling fees based on household income. Master's-level therapists. Program has a intake worker who can also refer to other counselling services or groups. Offices in Vancouver, Richmond, Burnaby, New Westminster, and Surrey.

Qmunity, Counselling - 604-684-5307 ext. 100

<https://qmunity.ca/get-support/counselling/>

Free counselling sessions (up to 12 sessions) for members of the queer, trans, and Two-Spirit communities.

Olive Fertility Centre, Counselling – 604-559-9950

<https://www.olivefertility.com/our-services/counselling>

A variety of counsellors and psychologists who specialize in fertility and infertility. Cost ranges for \$110 - \$185 per session.

24 Hour Crisis Line

Vancouver Crisis Line: 604-872-3311

Appendix G Validation Interview Guide

The purpose of this interview is to review the personal narrative I have written based on our interview together. Hopefully you were able to review the narrative I sent you. I have a few questions for you:

- Do you feel the narrative accurately captures your story of conception, pregnancy, and birth?
- Is there anything you feel I need to change, delete, or add to more accurately capture your story/experiences?
- Are there any other reflections that you would like to share with me?