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"I don't know if I'm a dad, I don't know if I'm a mom, I think I'm both": Gender identity, parenting desires, and pregnancy among transgender, nonbinary, and gender expansive adults

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ABSTRACT

Many transgender and gender expansive (trans*) people assigned female at birth retain the capacity for pregnancy and want to become parents, through pregnancy or otherwise. We explored the role of gender in parenting and pregnancy desires among gender minorities theoretically capable of pregnancy. We conducted in-depth, open-ended interviews with 12 trans* adults (18–35 years) from July–August 2023 in the US. Interviews focused on gender identity, parenting, and pregnancy decisions. We recorded, transcribed, and analyzed interviews using a combination of thematic and inductive methods. Two related themes emerged: (1) the relationship between gender identity development and parenting and pregnancy desires, and (2) how the gendered nature of pregnancy and obstetric care shaped feelings about pregnancy. Participants had complex feelings about parenting, and some realized they wanted to become a parent only after more fully understanding their gender. Others felt becoming a parent would help them better understand their gender identity. Participants were keenly aware of the gendered nature of parenting and pregnancy, and how their experiences and presentation conflicted with social and gender norms. Gender identity was salient in how participants experienced and made decisions about parenting and pregnancy. Healthcare providers should prioritize providing trans-competent reproductive and obstetric care to ensure trans* populations are supported in reaching their reproductive goals. Importantly, broader social and structural changes that allow for expansive gender identity expression in both pregnancy and parenthood are necessary to create safe and healthy environments for trans* people to make parenting and pregnancy decisions and pursue parenthood.

1. Introduction

Many trans and gender expansive people (trans*) assigned female at birth retain both the capacity for pregnancy (Brandt et al., 2019; Feigerlová et al., 2019; Light et al., 2014) and desire to become pregnant (Auer et al., 2018; Durcan et al., 2022; Morong et al., 2022; Tornello & Bos, 2017). Those who do not desire to carry a pregnancy may still desire children through adoption, fostering, or surrogacy. In several studies, more than half of trans* adults in the US reported that they were interested in becoming a parent (Light et al., 2018; Morong et al., 2022; Wierckx et al., 2012). Many trans* individuals do become pregnant. A national survey of US adults found that 12 % of trans* people assigned female at birth had experienced a pregnancy and 11% wanted to become pregnant in the future (Moseson et al., 2021). While many trans* people desire pregnancy and parenthood, qualitative research suggests that they face barriers to achieving this goal, including access to healthcare, financial constraints, and social-emotional support (Cottrill et al., 2022; Ellis et al., 2015; Riggs et al., 2021; Tornello & Bos, 2017).

While many trans* people want to become parents, they may have complex feelings about pregnancy and parenthood due to the potential incongruence between their gender identity and social and gender norms typically associated with pregnancy and parenting (Ellis et al., 2015; Hoffkling et al., 2017; MacLean, 2021). Complex feelings about the gendered nature of pregnancy and parenting, including gender dysphoria, may be intensified for those who are prescribed gender affirming hormone therapy (GAHT) and must discontinue use prior to

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becoming pregnant and during pregnancy (Cottrill et al., 2022; Light et al., 2014; Obedin-Maliver & Makadon, 2016). While some people may achieve pregnancy while taking testosterone – and, indeed, it should not be used as a method of contraception – current World Professional Association of Transgender Health (WPATH) standards of care suggest discontinuing testosterone when trying to become pregnant and during pregnancy (Bonnington et al., 2020; Coleman et al., 2022). These guidelines direct providers to advise patients on fertility preservation options prior to initiating GAHT, but there is limited guidance on how to preserve fertility (Coleman et al., 2022; Feigerlová et al., 2019). Indeed, many trans* people desire gamete preservation, a procedure that may be necessary to ensure that genetic parenthood is possible after initiating GAHT; uptake of gamete preservation is a clear indicator of a sustained interest in genetic parenthood even after medically transitioning (Auer et al., 2018; Coleman et al., 2022; Stolk et al., 2023; Wierckx et al., 2012). However, decisions surrounding fertility preservation are complicated by a lack of reliable research on the impact of exogenous testosterone on fertility, as well as significant financial and other access barriers to fertility preservation (Coleman et al., 2022; Feigerlová et al., 2019).

Trans* people who want to become pregnant face structural barriers as well. Trans* people are disproportionately underinsured and uninsured, and ten states have laws that allow healthcare organizations to deny services to LGBTQ + people on the basis of religious or moral beliefs (Grant, 2011; Movement Advancement Project, n.d.). Even in states where such discrimination is illegal, healthcare practices that specialize in fertility treatment are often unregulated and may not serve trans* people (Hoffkling et al., 2017; James-Abra et al., 2015). While fertility treatments are often not covered by insurance, when they are covered trans* people may be denied coverage if they do not meet the criteria for infertility based on their gender identity or relationship status (Kawwass et al., 2021). When trans* people *are* able to access healthcare services, they frequently receive subpar care and experience overt discrimination, including misgendering and deadnaming – a term commonly used in trans* communities to refer to a person using the trans* person's former/birth name (Grant, 2011; Moseson et al., 2020). Subpar care may be intensified in highly gendered contexts like fertility clinics and obstetrics units (Moseson et al., 2020; Stroumsa & Wu, 2018).

Drawing on the reproductive justice framework, all people, including those who are trans*, have the right to decide whether and when to have children (Moseson et al., 2020; SisterSong Women of Color Reproductive Health Collective and The Pro-Choice Public Education Project, 2007). The reproductive rights of trans* people are routinely violated, and those who choose to pursue pregnancy face multifaceted barriers to care at the social, institutional, and policy levels (Cottrill et al., 2022; Moseson et al., 2020; Vyas et al., 2021). Researchers have highlighted the exclusion of gender minority people in reproductive health research and the need for trans-competent best practices in reproductive health care, yet gaps remain in both research and clinical practice (Hahn et al., 2019; Moseson et al., 2020; Obedin-Maliver, 2015; Stroumsa & Wu, 2018). More research is needed to understand the interaction between structural, social, and individual factors that shape the context in which trans* people and families make decisions about and, importantly, experience pregnancy and parenthood. Such factors are likely different, and are experienced differently, from those that shape the context for cisgender sexual minority and heterosexual women. In this study, we examine the role of gender identity in parenting and pregnancy desires among a sample of trans* adults who may be capable of pregnancy.

2. Methods

2.1. Interview guide

We developed in-depth interview guides focused on understanding how LGBTQ + people made sense of fertility, family building, and parenting within their political, community, and family environments. Guides were structured around identity development and decision processes related to family building, including whether and how to become a parent. Questions focused on parenting desires, conditions and barriers to becoming a parent, and participants' experiences or anticipated experiences of pregnancy and parenting. Some specific topics included: defining family, considerations for family building (e.g., how they envisioned [future] parenthood or other parenting roles), feelings about pregnancy and reproductive technology, and support around decisions to pursue or not pursue parenthood in the context of their identities/identity development. Interview guides covered broad topics, allowing the participants to expand on their experiences. Not all topics applied to all participants and interviewers had the flexibility to probe depending on the participants' experiences. For example, participants who did not want to become pregnant were not asked how they envisioned the process of becoming pregnant.

2.2. Recruitment

Participants were recruited through paid Facebook ads and screened using a brief online survey to ensure they met the eligibility criteria. Eligibility criteria included 1) living in the U.S., 2) aged 18–35 years, 3) English speaking, 4) LGBTQ + -identified, and 5) currently had a uterus. This analysis is further limited to those who identified as trans*. We limited data collection to those with a uterus because of our focus on fertility and family building among people theoretically capable of pregnancy. We purposively selected eligible participants to ensure representation of different sexual and gender identities, with a particular focus on recruiting those who identified as trans*, as these groups are underrepresented in fertility research (Moseson et al., 2020). We interviewed 24 participants and draw from the 12 who identified as trans* for this analysis. Participants provided digital consent using Qualtrics and reaffirmed their consent at the beginning of the interview. Participants were compensated for their time with a $40 gift card. This study was approved by the Institutional Review Board at The Ohio State University.

2.3. Data collection

Interviews lasted approximately 1 h and were conducted on Zoom during July–August 2023. Interviews were conducted by two qualitatively trained interviewers. Demographic information like race and ethnicity, level of educational attainment, gender identity, and sexual orientation were collected in the eligibility survey, though participants were asked to describe their gender identity and sexual orientation in as many words as they would like at the start of the interview. In the eligibility survey, gender identity was asked separately from a subsequent question asking if the participant was trans* (yes/no). Participants could select as many gender identity and sexual orientation descriptors as they wanted. We include all gender and sexual identity terms used by the participant in identifying excerpts, from both the eligibility survey and the interview. Participants were assigned pseudonyms, and those who reported more than one pronoun will be referred to using both pronouns interchangeably.

2.4. Analysis

We concluded data collection when we reached theoretical saturation on key themes, which we monitored through regular meetings during data collection (Guest et al., 2020; Hennink et al., 2017). Interviews were recorded, transcribed verbatim, and coded in Dedoose (version 9.2.12), a qualitative management and analysis software, using a combination of thematic and inductive methods. Two team members carefully reviewed two different transcripts, noting emerging themes and topics as they arose. The team members then met to compare their findings and collaboratively developed a codebook with comprehensive

code definitions to ensure that codes would be applied uniformly. Each team member coded the remaining transcripts independently, meeting frequently to discuss any emerging themes not captured by the codebook and reconcile discrepancies in how codes were applied. This process allowed us to compare data across transcripts as well as across themes (codes) within each transcript.

3. Results

Participants ranged in age from 18 to 35 years (mean = 28.5; see Table 1). Over half identified with more than one gender (n = 7) and more than half identified as nonbinary (n = 8). Many participants also identified with more than one sexual orientation (n = 7) and three quarters identified as queer (n = 9). Half of participants (n = 6) said that they definitely wanted to be a parent, a fourth probably or definitely did *not* want to be a parent (n = 3), and the remainder were unsure (n = 2) or were already a parent (n = 1). Participants were predominantly white (not shown).

Two related themes emerged from the data: (1) the experience of gender identity development and dynamic parenting desires; and (2) how the gendered nature of pregnancy and obstetric care shaped people's feelings about pregnancy.

3.1. Gender identity development & dynamic parenting desires

Participants discussed how 'coming out' as transgender or developing a better understanding of their gender identity caused a shift in their desire to become a parent. Several discussed how their evolving understanding of their gender identity made them want to become a parent, while others felt that additional positive changes associated with their new or evolving understanding of their gender led to a growing interest in parenting. Social norms around gender and parenting were particularly salient and several participants found themselves excited to fulfill parental roles that aligned with their gender identity.

Sam reflected on how narrow societal views around gender and parenting, particularly norms around femininity and motherhood, influenced his own evolving desire to parent:

> "I feel like, as a trans* person specifically, the question of like […] do I want to be a parent, has always been a little bit of a complex one, just because I think, especially as a little girl you're like, oh, you know [you're] gonna be a mom someday[…] that's how you're socialized. And so, for a really long time, especially like before I really came into my gender identity as solidly as I am now, I was like, well, no, obviously I can't have kids, because I don't want to be a mom, and I never thought about it more than that. I was like, well, I don't want to be a mom, so I can never be a parent, and that was it." *-Sam, he/him (identities: lesbian, queer, asexual, nonbinary, trans*)*

Sam went on to describe how his understanding of his gender evolved and the direct impact of this process on his desire to parent. He noted that realizing he could be a dad rather than a mom made him excited about the possibility of parenting:

> "And then it kind of like kicked me from behind, and I was like, [I don't want to be a mom] because [I'm] not a woman […] that's just not the role that I see [my]self in […] And then […] I was like, wait a minute, I could be someone's *dad*!" – *Sam, he/him*

While some participants, like Sam, became more open to the idea of parenting through the realization that they could be a "dad" rather than a "mom," other participants envisioned themselves parenting in a more expansive way that transcended the gender binary. Jesse, who identified as nonbinary, two spirit, and a trans* man, spoke about his excitement surrounding the possibility of fulfilling the roles of both 'mom' and 'dad':

> "I want to be a mom. And I also want to be a dad. Like, I want to be able to grow and change with my child. I want to be the nurturing mother in the very beginning, and be the strong provider dad, and teach them whatever they want, whether that's music, or sports, or dancing, or art, or whatever. Like I want to be, I want to encompass all of those things, because that is me." – *Jesse, he/they (identities: queer, pansexual, nonbinary, two-spirit, trans*)*

Jesse, who was Indigenous and Hispanic, lamented the ubiquity of normative gender roles in family dynamics and envisioned a future free of these restrictive norms. He asked rhetorically, "*what would it be like if we didn't have […] all of these different [norms that] the man has to be the breadwinner [and] the woman has to stay home and take care of the kids?*" They also pointed out that Indigenous cultures had expansive understandings of gender and gender norms prior to colonization: "*There was a plethora of identity and community and that's what I really want is to be able to have that come full circle*." – *Jesse, he/they*.

Participants also spoke about their growing desire to parent in relation to positive changes associated with coming out and/or transitioning – whether socially, medically, or both. Aiden, who was married to a straight cisgender male partner before coming out as trans, described his feelings toward parenting and pregnancy at that time. Aiden said he was: "really just […] adamant, like I don't want kids, like why would I want to be a parent, like I am ill-equipped to raise a child." However, after coming out as trans, he started to consider the possibility of having kids, noting that he recently discussed his developing interest in having kids with his current partner. He went on to say that this was "definitely a very huge shift for me as a part of like unpacking stuff, and finally evaluating my life in a more, I guess, like holistic […] whole person way." He emphasized the positive mental, emotional, and physical changes associated with social and medical transition. Through coming out as trans, he became part of a queer community that expanded his understanding of what "family" can be. Attributing his growing desire to parent to his experience with a loving, supportive, and inclusive community, he felt the idea of parenting became "more of *an area that's full of possibility than one that's full of […] dread and […] terror*." – *Aiden, he/him (identities: gay, queer, man, nonbinary, demiboy, trans*)*

Similarly, Jesse emphasized the impact of the emotional and physical changes associated with medical transition on their desire to parent. He reported he had polycystic ovarian syndrome and that prior to starting

Table 1
Participant characteristics (N = 12).

	N
Age (mean (range))	28.5 (18–35)
Gender identity (check all that apply)	
Woman	3
Nonbinary	8
Genderqueer	4
Genderfluid	2
Two-Spirit	1
Agender	1
Demiboy	1
Man	4
More than one gender identity selected	*7*
Sexual orientation (check all that apply)	
Lesbian	4
Gay	3
Pansexual	4
Bisexual	3
Asexual	1
Queer	9
More than one sexual orientation selected	*7*
Desire to parent	
Definitely yes	6
Probably yes	0
Probably no	2
Definitely no	1
Not sure/still deciding	2
Already a parent	1

GAHT he struggled with heavy, irregular periods, fatigue, pain, and associated anxiety and depression. After being on testosterone therapy for several months, they "*realized testosterone regulated [their] period*" and felt they could probably become pregnant more easily now that his menstrual cycle had become regulated. Along with these positive physical changes, Jesse developed a romantic relationship with an intersex nonbinary trans* person and felt this experience directly impacted his desire to parent: "*As I started to have a relationship where we were both […] caring for each other and being supportive […] I was like […] maybe we could have a family."*

While many participants experienced a shift in their desire to become a parent as they better understood their gender, some also felt they would better understand their gender identity through the process of becoming a parent. Barnett, who became a parent prior to realizing he was trans*, described how having a child was a catalyst in understanding his gender and eventually coming out as trans*:

> "I began to find that the experience of becoming a parent kind of put into sharper relief the kind of societal expectations of gender on parenting and on families. I was profoundly aware of how pregnant people are assumed to be women, are assumed to be feminine women, and how so many parenting spaces are dominated by feminine, cisgender women. And I became very aware of how uncomfortable I was being pushed into that box by members of my extended family, by members of my faith community, by members of just the broader community. And I became very, very aware that something, something was amiss […] And so, I went through a series of trying on every kind of woman I could possibly be, and none of them felt comfortable, until I randomly decided to experiment with my gender in a more masculine way and had an *Aha!* The egg cracked, as it were." – *Barnett, he/him (identities: queer, man, trans*)*

Referencing a well-known phrase in the trans* community, in which realizing one's transgender identity is described as 'cracking the egg', Barnett discovered his trans* identity because of the incongruence he felt resulting from normative assumptions about who becomes pregnant.

While not yet a parent, Toni described their excitement about having a family, partially because they anticipated that it would help them better understand their own gender identity:

> "I think [my identity] is gonna […] make [parenting] way more exciting. It's going to be all new […] I think that one of the exciting parts is […] just not being defined by any of the traditional gender norms that exist. And it'll be really fun to explore who is going to end up stepping up in different areas, and possibly different times, and kind of see that ebb and flow between my partner and I […] And I think[…] the moment of stepping into the role [of parent] will help to define more of my identity. I don't know if I'm a dad, I don't know if I'm a mom, I think I'm both, you know, but it'll be really, really fun to see what comes out then." – *Toni, they/them (identities: queer, woman, nonbinary, genderqueer, gender fluid, trans*)*

Despite the various affirming and expansive ways participants envisioned fulfilling gendered parental roles, some participants were concerned about how their gender identity might negatively impact the experience of becoming a parent and parenting. Jamie, a queer, bisexual, pansexual, nonbinary woman who said they probably did not want children, spoke about the struggles queer people face trying to access family planning. They also described safety concerns surrounding how the uptick in anti-LGBTQ+ legislation might impact all trans* people, including those who wanted to become or were already parents. Jamie, like several other participants, cited potential discrimination as one of the reasons that they were unsure or did not want children. Others expressed similar concerns, although they still wanted to become a parent. For example, Flynn, a pansexual trans* man who said that he definitely wanted children, referenced growing transantagonism within the US. He said: *"I don't want my kids to be exposed to such harmful language, so I don't know if I would move to a different country, but that wouldn't fix the problem so […] it leads me to […] spiraling."* – *Flynn, he/him (identities: pansexual, man, trans*)*

3.2. The gendered nature of pregnancy and obstetric care

Along with parenting, participants often expressed complex feelings about pregnancy itself and the experience or anticipated experience of being pregnant as a trans* person. Some felt strongly that they did not want to be pregnant, which was separate from whether they wanted to be a parent. The gendered nature of pregnancy was particularly salient among participants and often posed a potential conflict between their gender identity and normative assumptions about who becomes pregnant. Participants described concerns about increased gender dysphoria associated with navigating traditionally "feminine" spaces, the possibility of being misgendered, and fear of stigma and discrimination.

Barnett, a participant who had been pregnant prior to coming out as trans*, shared his decision to not carry another pregnancy because of how feminine-coded the experience was, which conflicted with his gender identity:

> "I really wish that we had more expansive ideas around what parents look like that don't assume that you're straight or cisgender, because if, if I could be pregnant and like, be off HRT [hormone replacement therapy, i.e., GAHT] and go through the pregnancy and childbirth process without everything being so feminine coded all the stinking time and without my sexuality being assumed all the stinking time, I might be more open to doing it again, especially if there was good support for you know, 'oh, you're off HRT, so your life is a little bit more weird, and your body is a little bit more weird.' But those supports just aren't there." – *Barnett, he/him (identities: queer, man, trans*)*

Toni, who had not been pregnant before, echoed these concerns about pregnancy and gender dysphoria:

> "I think I want to carry [a pregnancy] at some point. But also, as a non-binary person, I deal with some gender dysphoria, so just questioning how that might make me feel. I think ultimately, I want to, I think I embrace my womanhood in that sense, I guess my anatomy in that sense. I think it's a really powerful thing to embrace. But that's a big question though still." – *Toni, they/them (identities: queer, woman, nonbinary, genderqueer, gender fluid, trans*)*

While Toni worried about dysphoria, they also felt that pregnancy was not inherently discordant with their identity, stating that they "embraced" their womanhood when it came to their body's ability to carry a pregnancy.

Most participants who were prescribed GAHT reported awareness of the standard practice of ceasing testosterone use prior to pregnancy, and several participants expressed concern with the lack of reliable evidence about how long prior to pregnancy testosterone should be stopped. Among those who had never been prescribed GAHT, Addison reported their provider told them they would not be able to get pregnant after starting testosterone. Several participants on GAHT discussed concerns around the impact of ceasing GAHT prior to and during pregnancy. Aiden, who was interested in parenting, felt there was too great a risk of increased gender dysphoria associated with stopping the use of testosterone for him to be interested in pregnancy:

> "… knowing what happens with my physical and mental health if I'm late […] doing [my testosterone] shot […] having to withhold for nine months to do the baby thing would just be hell for everybody. So I don't think that carrying my own child is gonna be a thing."

Reese (he/him), a gay, trans* man who hoped to become pregnant in the next few years, was less concerned about dysphoria associated with pausing GAHT to become pregnant. He said, "*At this point, I think I'll be fine. If you had asked me that a couple of years ago I would have been like, never!.. [but] … I think it'll be fine at this point."* He felt he had been taking

testosterone long enough that the physiologic changes most important to him, like beard growth and voice deepening, would not reverse with pausing testosterone while trying to become and being pregnant. Instead, his primary concern surrounding dysphoria was associated with childbirth rather than pregnancy itself. This fear led Reese to decide a cesarean-section was the best option for him if he became pregnant, which would enable him to avoid vaginal or vulval tearing and the associated recovery.

Many participants were also concerned about how others would treat them as a pregnant person, particularly healthcare professionals, due to the incongruence between the gendered nature of obstetric care and their gender identities. Sam, who wanted to be a father but was undecided about whether he would carry a pregnancy, said: *"If I did try to give birth to a baby and I went to a hospital, everything would be like pink, feminine, women's care, like everything like that. I would feel like it was an actively hostile environment to me and my child, because I'm not a woman, and I'm in there being treated like I am."* These concerns were echoed by Max, a nonbinary participant who felt that medical care for trans* people was a "tricky situation":

> "I know, even for me, as like a nonbinary person, it's just like every time I go to a doctor's office […] I'm gonna have to misgender myself today. […] And even like that little step is […] an annoyance. […] It's not an annoyance, it's more than that. But even like those little things are like a lot. So I imagine that going for fertility treatment, or IVF or things like that is going to be even harder to find a trans* competent medical provider, you know someone who is gonna treat you and your whole identity […] in a caring, holistic way." – *Max, they/them (identities: bisexual, nonbinary, trans*)*

Morgan (they/them) – who identified as lesbian, queer, genderqueer, and nonbinary and planned to become pregnant within the next 5 years – had similar concerns surrounding access to equitable pregnancy care services. They spoke about the need for careful planning, which included locating a trans-competent doula and considering an extended birth stay in a larger city with more trans-friendly resources.

Barnett, who had already given birth, described how he and his partner were consistently gendered while receiving obstetric care during his pregnancy, as well as his discomfort with the emphasis on gender and gendered parenting roles. As the pregnant partner, he was routinely called "mom" and his nonbinary partner, assigned male at birth, was routinely called "dad" during medical appointments. He imagined a more inclusive and trans-competent future where providers refrained from assuming parental roles and medical forms avoided gendered terminology. While some participants had found trans* competent reproductive health care, many others had not, and this served as a barrier for those who were considering pursuing pregnancy.

Participants also expressed fears of experiencing stigma and discrimination from society in general. Addison, who wanted to become pregnant, described their fears surrounding pregnancy:

> "[I] anticipate that […] when I become pregnant […] I may choose to pass more often [… but] if I did more medical transition, I could see a lot of […] stigma and judgment from others because I see that when transmasc[uline] people are pregnant, people get so confused." – *Addison, they/them (identities: lesbian, gay, bisexual, queer, woman, nonbinary, genderqueer, gender fluid, trans*)*

Addison was aware of the possibility of "judgment and harassment," and they viewed "passing" as cisgender while pregnant as a protective mechanism to avoid potential stigma and discrimination. Reese, and other participants, echoed these concerns, unsure whether they would be accepted into traditionally "women's" spaces as pregnant fathers.

4. Discussion

We found that gender identity development influenced decisions about whether and how to become a parent, particularly the decision to become a parent through pregnancy. The process of coming out and transitioning led some participants to reconsider their previous decision not to become a parent. For others, the prospect of becoming a parent, and in some cases the experience of parenting, offered a unique opportunity to further explore their gender identity and become more aligned with their sense of self. Gendered norms around parenting roles and pregnancy were particularly salient among our participants, most of whom were overwhelmingly aware of the mom/dad dichotomy they had already faced as a parent or would face if they became a parent. At the same time, the idea of being a parent in a way that aligned with their gender identity – i.e., fulfilling the role of 'dad' rather than 'mom' – led to some experiencing gender euphoria, a feeling of joy, comfort, and ease resulting from perceived alignment between one's gender presentation and internal sense of gender identity. Others were excited about the idea of fulfilling both parental roles – i.e., 'mom' and 'dad' – and not being confined by prescribed gender roles in parenting.

Among participants who wanted to be a parent, some were open to the idea of becoming a parent through pregnancy, and others wanted to become pregnant, but still had concerns about how they would be treated. Participants were aware that in healthcare settings they would be assumed to be both a woman and a 'mom' if they became pregnant. Some participants imagined an alternate reality where gender was more fluid and pregnancy less feminized where they may be more comfortable becoming pregnant. Even among those who would need to pause GAHT, many felt that gender-affirming resources within and outside of healthcare settings could minimize gender dysphoria before, during, and after pregnancy. Other participants felt that they could manage gender dysphoria resulting from physiologic changes associated with pregnancy as long as they were not misgendered, stigmatized, or otherwise discriminated against throughout their pregnancy. The desire for a more expansive view of gender, parenting, and pregnancy was widespread amongst participants and this desire has been reported by other scholars (Cottrill et al., 2022; Kirubarajan et al., 2021; MacLean, 2021).

Our findings are in alignment with previous research that trans* people with the capacity for pregnancy often desire parenthood and pregnancy (Cottrill et al., 2022; Light et al., 2014, 2018; Moseson et al., 2021; Tornello & Bos, 2017). While there has been limited research on the role of gender identity development in parenting and fertility desires, a qualitative study of trans* parents comparing experiences of those who became parents before and after transition had findings similar to ours, concluding there are "lifelong, dynamic, and bidirectional influences between parental and trans* trajectories" (Petit et al., 2018). Parenting plans are often interwoven with thoughts about transition and are heavily impacted by gendered norms (Tasker & Gato, 2020). Trans* people use a variety of tactics to resist and reconfigure gendered parenting and pregnancy norms and normative cultural scripts (Pfeffer et al., 2023; Riggs et al., 2021; Von Doussa et al., 2015). Our study adds to this research by exploring the role of gender identity in shaping desires and decision-making processes surrounding both parenting and fertility.

Importantly, our findings illuminate an incongruence between how sex and gender are theorized in the biomedical context and how sex and gender are experienced by trans* people, including our participants. Sex and gender have traditionally been understood as binary, immutable categories, that are inherently linked – such that "female" sex is associated with femininity, womanhood, and pregnancy, and "male" sex is associated with masculinity and manhood. In contrast, our findings more closely align with trans* theory, which severs the presumed link between sex and gender, and emphasizes how the embodied experience of sex and gender are integrated with one's identity and sense of self through lived experience (Bettray, 2020; Nagoshi et al., 2023). By focusing on embodiment, trans* theory illuminates the deep internal sense of one's gender identity that many trans* people experience without drawing on gender essentialist narratives that treat sex and gender as binary and unchanging. All the participants in our study mentioned negative experiences with the restrictive nature of gender

normative views about parenting and pregnancy. While some participants were excited about the possibility of fulfilling gender-aligned parental roles, this did not necessarily correlate with a desire for pregnancy. In fact, some trans* people who looked forward to being a 'dad' were worried about being gendered female while pregnant. We found that prescriptive gender norms surrounding pregnancy, as well as parenting, led some participants to be reticent to become parents, even if they were otherwise interested in parenthood. Shifts in cultural and medical discourse around sex, gender, and the relationship between the two, may help support trans* people in fulfilling their parenting desires by de-emphasizing prescriptive gender norms in both pregnancy and parenting.

Fear of discrimination was ubiquitous. Participants felt they were at a heightened risk of discrimination because they did not fit into gendered norms around who can be a "mom" or a "dad," and who becomes pregnant. Many feared being discriminated against in all aspects of life but anticipated experiencing more discrimination in the gendered contexts of parenting and pregnancy. These fears were based on previous experiences as well as a general awareness that many healthcare providers, particularly those in obstetric care, are not trained in trans-competence. These fears are both common and well-founded (James et al., 2016; Wingo et al., 2018). Fear of discrimination is a barrier to equitable reproductive healthcare access among trans* individuals (Cottrill et al., 2022; MacLean, 2021; Poteat et al., 2013). Lack of trans-competent providers and perinatal care environments contributes to delays in care and further marginalization of trans* adults interested in childbearing (MacLean, 2021).

While guidelines exist for providing trans-competent gynecologic care, further research is needed to develop best practices for trans-competent obstetric care and to determine the impact of testosterone therapy on fertility and pregnancy (Coleman et al., 2022; Feigerlová et al., 2019; Hahn et al., 2019; Pfeffer et al., 2023; Tishelman et al., 2019). Many of our participants made specific suggestions to improve pregnancy care, such as avoiding gendered language; not assuming pronouns, parental roles, or who is capable of pregnancy; and training all relevant personnel in trans-competent care. Such suggestions are similar to those described in previous research (Feigerlová et al., 2019; Hahn et al., 2019; Kirubarajan et al., 2021; Obedin-Maliver & Makadon, 2016).

Trans-competent obstetric care is further complicated by a lack of reliable research on the impact of prior testosterone use on future fertility and of concurrent testosterone use on fetal development (Feigerlová et al., 2019; Hahn et al., 2019; Pfeffer et al., 2023; Rodriguez-Wallberg et al., 2023). Concern about the uncertainty of the impact of testosterone use prior to or during pregnancy, and the potential for future infertility, was widespread among our participants who were prescribed GAHT. While these concerns are in line with WPATH recommendations to stop testosterone use prior to pregnancy, a national survey of trans* people assigned female or intersex at birth found no difference in birth outcomes according to prior testosterone use (Moseson et al., 2021). Indeed, Pfeffer et al. have highlighted the dearth of scientific evidence supporting the notion that testosterone use during pregnancy is teratogenic. They point out that cisgender women with conditions associated with higher-than-average androgen levels, like polycystic ovarian syndrome (PCOS), are not put on testosterone blockers prior to pregnancy. Moreover, they argue that provider concerns about the impact of testosterone on the fetus may be more influenced by cisgenderism than the strength of the evidence (Pfeffer et al., 2023). Regardless, it is clear that prior testosterone use does not necessarily prevent a future successful pregnancy (Light et al., 2014; Moseson et al., 2021; Pfeffer et al., 2023; Rodriguez-Wallberg et al., 2023), but many of our participants did not know that. Clinical guidelines and policy shifts that reflect this uncertainty, as well as more widespread communication to healthcare providers and trans* people, may help both healthcare providers and trans* people understand their reproductive options better. Further research in this area is critical to facilitate informed reproductive decision-making among trans* people taking testosterone or considering GAHT and enable healthcare professionals to provide trans-competent reproductive and obstetric care.

4.1. Limitations

People with trans* identities who are considering parenting and pregnancy have many other characteristics that come with relative privilege or disadvantage. Our sample was majority white, and we were unable to collect data about socioeconomic status. These are important limitations to our research findings. Research exploring how people with a range of intersectional identities experience and think about parenting and pregnancy would enrichen our understanding, particularly with regard to people who experience racial discrimination and poverty. We are limited in our ability to delve into these questions with our data given the study's small sample size and the lack of racial diversity in the sample.

5. Conclusion

Many trans*, nonbinary, and gender expansive adults want to become parents, and some desire to do so through pregnancy. Gender identity, parenting desires, and feelings about pregnancy were deeply intertwined among our participants. It is imperative that healthcare providers and organizations prioritize the provision of trans-competent care before, during, and after pregnancy to help ensure that trans* people are supported in reaching their reproductive goals. Further, broader social and structural changes that allow for expansive gender identity expression in both pregnancy and parenthood are necessary to achieve reproductive justice and create safe and healthy environments for trans* people who want to become parents.

CRediT authorship contribution statement

Kaleb Masterson: Writing – original draft, Methodology, Investigation, Formal analysis. **Alison H. Norris:** Writing – review & editing, Conceptualization. **Marta Bornstein:** Writing – review & editing, Project administration, Methodology, Investigation, Funding acquisition, Data curation, Conceptualization.

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Declaration of competing interest

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

Glossary

Gender refers to the socially constructed characteristics of women, men, and gender expansive people, including the norms, behaviors, and roles associated with women, men, and gender expansive people.

Gender identity refers to a person's deeply felt and internal gendered sense of self, which may or may not align with normative expectations of their sex assigned at birth.

Trans* is an inclusive, umbrella term used to refer to transgender,

nonbinary, and gender expansive people – in other words, anyone who does not consistently identify with the gender traditionally associated with their sex assigned at birth.

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