

## **Distribution Agreement**

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Abigail Parks Dunlap

11/3/2020

**Justice and Becoming: Reproductive Healthcare and Kinship Among Mothers of the Transgender Experience**

By  
Abigail Parks Dunlap  
(She/Her & They/Them)

Master of Arts  
Bioethics

---

Dr. John Banja  
Advisor

---

Dr. John Blevins  
Committee Member

---

Dr. Sydney Spangler  
Committee Member

Accepted

---

Lisa A. Tedesco, Ph.D.  
Dean of the James T. Laney School of Graduate Studies

---

Date

**Justice and Becoming: Reproductive Healthcare and Kinship Among Mothers of the Transgender Experience**

By

Abigail Parks Dunlap  
(She/Her & They/Them)

B.A. Smith College, 2013

Advisor: John Banja, Ph.D.

An abstract of the thesis submitted to the Faculty at the James T. Laney School of Graduate Studies at Emory University in partial fulfillment of the requirements for the degree of Master of Arts in Bioethics  
2020

**Abstract**

**Justice and Becoming: Reproductive Healthcare and Kinship Among Mothers of the Transgender Experience**

By

Parks Dunlap  
(She/Her & They/Them)

Author Note:

This research was funded by the Center for Reproductive Health Research in the Southeast, Rollins School of Public Health

**Abstract**

The narratives shared by the mothers interviewed in these three case studies are a testament to the resilience of sexual and gender minorities in the face of barriers to social and health equity. Structural inequities contribute to social determinants of health and build and reinforce barriers to family growth and creation. In this pilot qualitative study, mothers of the transgender experience shared their stories of how transphobia and sexism intersect with racism and ableism, contracting the capacity for mothers navigating their truths and prioritizing the safety of their children. Participants' descriptions of interactions with medical providers are striking examples of being left behind and neglected. The absence of justice and diminished respect for autonomy, beneficence, and nonmaleficence, provide evidence of large cracks in bioethical foundations. Yet, there is a narrative of immense joy and resilience woven throughout all these cases of demanding caretaking responsibilities and personal transitions. These stories are ones of becoming family and self. I conclude with recommendations for further research and bioethical critique of access to medical care for trans populations, as well as resource redistribution and increased education and training for medical providers.

**Justice and Becoming: Reproductive Healthcare and Kinship Among Mothers of the  
Transgender Experience**

By

Abigail Parks Dunlap  
(She/Her & They/Them)

B.A. Smith College, 2013

Advisor: John Banja, Ph.D.

A thesis submitted to the Faculty at the James T. Laney School of Graduate Studies at Emory  
University in partial fulfillment of the requirements for the degree of Master of Arts in Bioethics

2020

### **Acknowledgements**

I continue to be humbled by the power of seemingly small, intimate moments of bravery, expertise, & advocacy that move the needle. In these interviews, spiritual guidance is credited with healing, growth, and creation. Thank you, God, Goddess, Spirit, and Community, for showing up in the small moments and making them giant.

Most of all, this thesis belongs to Nina, Joyce, and Devin for sharing their stories with me- Kevin, Kingston, and Gili are blessed to have you as mothers. Additionally, I am thankful to my kin and to queer elders and community for fighting for our roses and inspiring this work and my scholarship. I am thankful to my committee and colleagues for their support and shared investment in advocating for health equity.

### **Reflexive Statement**

My investment in the health of sexual and gender minority (SGM) women's populations is both personal and professional. Rejecting objectivity as the goal of this research (and of any qualitative research), my insider status as gender non-conforming dyke is a particular positioning that must be accounted for. To account for this, I remain mindful of how my own bias and siloed sub-communities under the SGM umbrella may disconnect my experiences from those of research participants. An example of this is not experiencing transphobia myself, while having intimate knowledge of gender-based microaggressions. This is also a strength of my praxis, as I aim for participants to have an affirming experience rooted in community support, which I am tangentially.

Setting out to conduct this study, I had no concept of how large this undertaking would be. While applying for grant funding I was focused on defending women of the trans experience's (MTE) place in reproductive health research. Through the support of RISE, and

## Justice and Becoming

with the trust of my participants, I have been blessed with incredibly rich, complex, and vulnerable experiences. The subject of motherhood is gigantic. One which I may only attempt to pay tribute to.

I have wealth, access, power, and privilege in my social positions as a white graduate student, yet I have learned that to leverage my means within academia requires support and allyship from others. I am unsure where to go for that full support, and without it, how can I be in a position to provide reciprocity to the MTE included in this research? For example, how can I work towards supplying authorship to someone when I still depend on faculty support? It will take many more months (years) of work to fully share the findings of only a handful of interviews. It would be a missed opportunity if I were to end the analysis of these interviews with this thesis work.

This research was conducted during the time of COVID-19, which limited in-person interviews, ended on site recruitment, and was a generally more disruptive atmosphere than experienced pre- April 2020. For further context, some of these interviews were conducted during the June protests for Black lives. The timing of this research rested at the intersections of both pandemics, racism and COVID-19, which influenced methodology and results.

**Table of Contents**

Acknowledgements .....10

    Reflexive Statement.....10

Abstract.....13

Introduction .....14

Background and Significance.....21

Purpose Statement .....24

Theoretical Models.....26

Methodology.....29

Findings .....37

    “The Lines Are So Blurred”, Nina’s Story .....38

    “Not Be A Footnote in His Headline”, Joyce’s Story .....48

    “If I was to have a gifted see-er”, Devin’s Story .....59

*Becoming* .....71

    Reproductive Health & Medical Services .....79

Discussion.....84

Conclusion .....113

References .....117

**Appendix** .....122



**Abstract**

The narratives shared by the mothers interviewed in these three case studies are a testament to the resilience of sexual and gender minorities in the face of barriers to social and health equity. Structural inequities contribute to social determinants of health and build and reinforce barriers to family growth and creation. In this pilot qualitative study, mothers of the transgender experience shared their stories of how transphobia and sexism intersect with racism and ableism, contracting the capacity for mothers navigating their truths and prioritizing the safety of their children. Participants' descriptions of interactions with medical providers are striking examples of being left behind and neglected. The absence of justice and diminished respect for autonomy, beneficence, and nonmaleficence, provide evidence of large cracks in bioethical foundations. Yet, there is a narrative of immense joy and resilience woven throughout all these cases of demanding caretaking responsibilities and personal transitions. These stories are ones of becoming family and self. I conclude with recommendations for further research and bioethical critique of access to medical care for trans populations, as well as resource redistribution and increased education and training for medical providers.

*Keywords:* Transgender, Women, Motherhood, Reproductive Health, Principlism

## Introduction

### Structure of this Paper

This paper serves as the master's thesis for the completion of the bioethics portion of a dual master's degree program in Public Health and Bioethics. As a result of the cross-disciplinary nature of my graduate work, this thesis is a combination of an empirical public health research study and bioethics critique of foundational principles of medical ethics. Combining a series of case studies on mothers of the transgender experience (MTE), the first section of this paper will contain an introduction, background and significance, and methods. From there, the interviews will be presented as individual case studies, with emergent themes. A concluding discussion section on bioethical principles and practice will present circumstance, considerations, and limitations of Beauchamp and Childress's Principlism. The Conclusion will suggest next steps to advocate for mothers of the trans experience.

Throughout the background and significance section of this paper, and in part of the methods section, I will use the term "women" to describe the population and participants involved in this study. As participants who are transgender and mothers, and do not identify as women were deemed eligible for this research, I opened up recruitment to all MTE. To leave gender nonconforming, gender queer, and nonbinary mothers out of this study would ignore the intention of this research: to document the lives of sexual and gender minority (SGM) individuals and fill a large gap in literature on MTE. I chose to include mothers of trans experience of all genders in this research sample. Prior to enrollment, participants were informed of the study parameters and how it they had expanded to include all MTE. Potential participants were then asked to self-select if they were aligned enough with womanhood to feel personally comfortable being interviewed and included in the sample. This was at the participant's

discretion. To more accurately represent my entire sample, the term “mothers of the trans experience” (MTE), will be used in place of transgender women when possible.

### **Source Considerations**

Literature for this review was retrieved from mixed sources including text, online journals and databases, and personal narrative. Sources were identified using the keywords motherhood, transgender, trans, transgender women, women, sexual and gender minority, gender identity, sexual behaviors, reproductive health, and family planning. Literature recovered using the terms motherhood, women, gender identity, sexual behaviors, reproductive health, or sexual and gender minority needed to be thinned out, as there was little mention of transgender women or mothers of trans experience in the majority of articles outside of the definition of the LGBT acronym. Citing references that use more binary or dated language will make it impossible to use MTE at all times, and the language used in these interviews is diverse and varies between participants. This appears to be an inevitable limitation of the analysis below.

There was a wide disparity in available literature when searched by the subjects of transgender women, transgender reproductive, and women reproductive. PubMed yielded 2,048 results for “transgender women” published from 1997 – 2020; a similar timeline yielded 456 results for “transgender reproductive”, while the search for “women reproductive” yielded 306, 122 results from as far back as 1876. This reflects a historical pattern of gaps in literature pertaining to sexual health and risk of SGM populations, especially among transgender women and reproductive healthcare. This research aims to fill some of those gaps.

Frameworks used to identify women, motherhood, and reproductive health are limited by a cissexist understanding of gender, as transgender women, gender non-conforming, or gender

## Justice and Becoming

queer women's presence in literature was scarce. Literature was limited to studies conducted in predominately urban settings in the United States, there are no clinical interventions available regarding transgender women and reproductive health care. If there is a gap in research, there is a gap in knowledge and understanding of a large population's health. This research aims to contribute to the subject of healthcare and family building in SGM populations, to fill some of these gaps.

### **Language Considerations**

There is agreement across the bioethicist and linguistic community that terminology has a unique influence to affirm and shape reality ("Queer Terminology," 2016). One challenge of language is that it shifts with context; user, environment, time, and a myriad of other possible variables. Language is a powerful tool. Its use can shape interpretation of history and uplift marginalized experiences, documenting them to defend reality of those in lesser positions of power. Terminology is also deeply personal, as it is chosen to reflect one's self and experiences. But for those who are marginalized, the personal becomes political when language is used to document the stories that echo gaps in literature and in resource access. Language may, "empower consumers of history, claim or reclaim a past on one's own terms, or accurately represent an often marginalized history. ("Queer Terminology," 2016).

An example of the limitations and influence of language can be found in something as simplistic as pronouns. English uses the binary pronouns of "he" and "she", and when it is unclear the gender of the individual, "he or she" is used. This binary language snares gender nonconforming, trans, or queer individuals into choosing limited (and incorrect) options to describe themselves. The commonly used alternative to the pronoun binary, is to have

## Justice and Becoming

dehumanizing pronouns such as “it” used, thus implying that a person who is trans, gender nonconforming, or queer is less than human or nonhuman (King, 2016). This is what the English language tells us about trans people, that they are less than human, nonhuman, an “other” among individuals. Limited language to describe an entire population is a barrier to communicating about, and with, SGM. This then limits training documents for medical providers, educators, researchers, and limits the representation of SGM individuals in media. The binary of the English language erases trans people, and language is everywhere. It is a very loud silence.

One of the most fundamental elements of healthcare is communication between patient and provider. When the common language for SGM patients is dehumanizing or inaccurate to their gender, a barrier to respect for autonomy may be present, or at least reflected in language (ten Have & Gordijn, 2010). Responding to this binary limitation, SGM research has shown that members of the SGM spectrum are constantly innovating to self-identify, creating new language to describe their lives as a members of a minority population (King, 2016). SGM individuals have created new language or resurfaced old meanings, such as the pronoun “zir” and the singular “they/them”. (King, 2016; “Queer Terminology,” 2016). This shifting language prompts glossaries to describe sexual and gender minority populations and give disclaimers of languages constant development. Shifting language challenges consumers of SGM media and literature try not to think of terminology meanings as definitions, but rather linguistics practices. Language is always in transition.

To complicate things further, the fields of public health and ethics have their own specific dialect, semantics, and popular acronyms. To shift between two siloed academic disciplines and community is a form of code switching, which I will be mindful of as I write. The following glossary pulls from multiple fields of academic disciplines and is intended to guide the reader

through this thesis without asking them to code switch with me. However, this is not an exhaustive list.

---

*Term & Acronym Glossary*

\*Directly referenced from the Human Rights Campaign, 2020. (Campaign, n.d.)

**Cisgender\*** | A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.

**Family Building** | An adaptation of “Family Planning”, meant to include the various ways that families are created, and how they grow and shift. Pregnancy, adoption, chosen family, and all ways that family members are introduced to each other may be considered under the umbrella term “family planning”.

**Gender identity\*** | One’s innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

**Gender transition\*** | The process by which some people strive to more closely align their internal knowledge of gender with its outward appearance. Some people socially transition, whereby they might begin dressing, using names and pronouns and/or be socially recognized as another gender. Others undergo physical transitions in which they modify their bodies through medical interventions.

**Intersectionality** | A theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of

## Justice and Becoming

individual experience to reflect interlocking systems of privilege and oppression (i.e., racism, sexism, heterosexism, classism) at the macro social- structural level. (Bowleg, 2012)

**Mothers of the Transgender Experience (MTE)** | An adaptation of the common terminology “women of the transgender experience” and “men of the transgender experience” will be used throughout this paper to more accurately name the diverse representation of gender among transgender mothers in this study.

**Queer\*** | A term people often use to express fluid gender identities and sexual orientations. Often used interchangeably with Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ).

**Sex assigned at birth\*** | The sex (male or female) given to a child at birth, most often based on the child's external anatomy. This is also referred to as "assigned sex at birth."

**Sexual and Gender Minorities (SGM)** | will be used throughout this paper and is aligned as a synonym with queer.

**Transgender\*** | An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

---

### A Reflexive Note on Gender

I present this note on gender to give the reader an opportunity to consider gender as something that is constructed, performed, and enacted, and is not synonymous with biological sex. While attending Smith College, an older classmate named Sam summarized gender during a ride in the art department elevator. Sam said, to a group of younger students, “sex is your bits,

## Justice and Becoming

gender is everything else” and then made a sweeping motion with one of their arms to reference their own body and gender presentation. Sam was teaching an elevator of young undergraduates the definition of gender, and in turn Sam was presenting and performing their own curated butch gender, showcasing “everything else” to the captive group.

I share this memory as it was formative for my own studies of gender, both personal and professional. Sam’s use of their lived experience to educate with their elevator performance was the moment when Judith Butler’s work on gender performativity jumped off the pages of my theory syllabus and into my lived reality. Sam’s gender was made real by their enactment of it, an unapologetic signaling to the world that they were their own affirming force.

To say that gender is a performative act is to say that it does not need a material referent to be meaningful, is directed at others in an attempt to communicate, is not subject to falsification or verification, and is accomplished by “doing” something rather than “being” something. A woman, performatively speaking, is one who says she is- and who then does what woman means. This biologically sexed body guarantees nothing; it is necessarily there, a ground for the act of speaking, but it has no deterministic relationship to performative gender. (Stryker et al., 2006)

Theories of homosexuality have overwhelmingly drawn from essentialist gender beliefs. In these hegemonic archetypes of “real” men and women, gender and sexuality are woven together into descriptive typology and theories of SGM (Drescher, 2015; Stryker et al., 2006). Disrupting this essentialism, the mere existence of trans people disputes the cissexist binary of gender. In the 90’s, academic research caught up to SGM communities in acknowledging that



sex and gender are tied together through social construction, but are not synonymous (Stryker et al., 2006).

I hold that as the gender binary is dismantled and becomes more publicly known, academics are in a unique position to challenge it and advocate through inclusive research. My research on MTE work aims to challenge cissexism and uplift trans people through documentation of trans experience, while being mindful of the ease of gender sensationalism. To more accurately understand our own cissexist lens towards gender, and towards motherhood, it is necessary to hold that sexuality and gender are different subjects, biological sex guarantees nothing, gender is performative, and that one is who they say they are.

### **Background and Significance**

It has been estimated that SGM individuals make up 2.4 % of the United States population (reported 2013-2015), making the health of SGM populations a small yet significant chunk of national health (Lunn et al., 2017). There is substantial evidence that SGM populations experience greater health inequities in contrast to the heterosexual and/or cisgender population (Wood et al., 2016). SGM individuals report higher rates of health risk behaviors such as tobacco use, alcohol and other drug use, and self-harm. Additionally, literature has shown that SGM populations have higher rates of suicidality, discrimination, and violence in comparison to their heterosexual and/or cisgender peers (Alpert et al., 2017). Within the SGM population, Trans and gender non-conforming (TGNC) individuals experience discrimination at higher rates than cisgender SGM (Grant et al., 2011).

In 2011, The National Transgender Discrimination Survey (NTDS) contributed a groundbreaking full view of discrimination experiences of trans and gender non-conforming

## Justice and Becoming

(TGNC) individuals. The NTDS sample included a sample of 6,450 transgender and gender non-conforming study participants. Of the NTDS respondents, 38% reported being parents, compared to 68% of the general population. Several studies and surveys, including the NTDS, have identified parenthood as a sought after and an affirming experience of trans individuals (de-Castro-Peraza et al., 2019; Grant et al., 2011; Liu et al., 2019). Being a TGNC parent was strongly related to the age of transition. TGNC individuals who transitioned later in life reported higher rates of parenthood. This may be because gender affirming (transition) care such as hormone replacement therapy (HRT) and surgical procedures have historically resulted in limitations or loss of a trans individuals' reproductive capabilities (Liu et al., 2019; Schneider et al., 2019). Fertility and sperm counts may be restored upon reversal of hormone therapy, which often places trans people at a crossroads of receiving gender affirming care or reproduction (de-Castro-Peraza et al., 2019). For some, this is an extremely difficult choice between authentic self and family building by biological reproduction.

Available literature is in agreement that the biomedical field considers fertility preservation to be a part of best practice when working with individuals who may be hormonally transitioning. The World Professional Association of Transgender Health has identified that fertility counseling during gender affirming medical care is mandatory (Schneider et al., 2019). However, this best and mandatory practice is not the lived reality of many trans individuals. A survey among transgender adults shows that over half of male and female participants would like to have biologic children; and more than a third would have considered fertility planning if it had been offered and available to them. Additionally, experiences of regret were expressed by trans women participants in the survey (Liu et al., 2019). These findings are evidence that trans women are parents and want to be parents. This aligns with the findings of the NDTs.

## Justice and Becoming

Transgender women reported being parents at higher rates than transgender men, and transgender respondents reported higher rates of parenthood than GNC respondents (Grant et al., 2011). Rates of TGNC parenting were reported as lower than the general population. There is a hypothesized association between parenthood and gender transition, based on identified associations between access to gender affirming healthcare, gender transition, and parenting.

Social progress towards equality for SGM individuals has encouraged the field of reproductive health to expand its focus beyond cisgender women's health. SGM populations are an area of prioritized interest in reproductive health research, public health, and medical ethics (Liu et al., 2019). There are barriers to accessing reproductive healthcare regardless of gender, and trans populations may experience increased barriers to assisted reproductive healthcare (Liu et al., 2019). Examples of these barriers are social harassment, discrimination, rejection from family, social isolation, and inaccessible health care (Feigerlová et al., 2019). Psychosocial considerations when providing medical care to transgender populations are gender identity, risk and resiliency, and family and community dynamics (Wagner et al., 2019). Individualized care will encourage retention of transgender patients and has been shown to lead to better health outcomes (Wagner et al., 2019).

## **Gaps in Literature**

There is a gap in available literature on transgender reproductive health and parenting. Recently published literature reviews have identified that only 22 articles out of 2400 articles published on transgender health before 2014 focus on fertility or reproduction (Liu et al., 2019). The majority of articles on the subject focus on bioethical considerations for reproduction and alternative reproductive technologies (ART) such as sperm preservation and uterine transplants. There are very few clinical studies on transgender fertility or reproduction (Liu et al., 2019). Recently published reviews briefly address the social aspects of parenthood for transgender persons, but no qualitative work addressing social facets of parenthood or MTE was recovered. This thesis research will address the identified gaps in literature, contributing to knowledge of trans women's experiences of motherhood: reproductive care, barriers to motherhood, definitions of motherhood, family structure, and parenting practice. A better understanding of this conflict will support recommended best practice for holistic gender affirming reproductive care for trans individuals (de-Castro-Peraza et al., 2019).

## **Purpose Statement**

### **Research Question**

This study will direct attention towards motherhood and family planning services as they are experienced by MTE in a large metropolitan area in the Southeast. Research will be conducted to better understand how the MTE population in a Southeast metropolitan area experience motherhood and mothering roles in their kinship networks. Clinical resource seeking has been included in the sub questions of this study.

## Justice and Becoming

Selection of the research question, “How is motherhood embodied and enacted in the daily lives of trans women?” was informed by the reviewed literature on the reproductive health inequities of the SGM population, specifically among MTE. Researching how MTE perceive motherhood in relation to themselves will deepen understanding of the population’s motherhood experiences, family and kinship building methods, and access to reproductive health care. The findings of this and further research will improve resources for providers and patients to educate, advocate, and agitate for improved trans healthcare. From fleeting microaggressions to the harmful structural barriers created by intersecting transphobia, racism, ableism, ageism, and homophobia, this research is a tool for both personal and public health advocacy.

### **Goals of the Current Study**

The goal of this pilot qualitative study is to advance understanding of the reproductive health and wellbeing of MTE in a Southeast metropolitan area. It will focus on the reproductive and social experiences of motherhood, family structure, and reproductive care. Providing evidence of MTE perception of motherhood in relation to themselves will give researchers an opportunity to better understand the context of family planning in the lives of MTE and SGM. The intended audience of the findings are reproductive health researchers, medical providers, and members of the SGM community.

This research aims to answer the question, “how is motherhood embodied and enacted in the daily lives of trans women?” This research documents trans lives, and further affirms the inclusion of transgender populations in reproductive healthcare and research. The small sample size will not be representative of the overall MTE population of this large metropolitan area in

## Justice and Becoming

the Southeast. I endeavored to offer a qualitative description of complex, intersectional social and interpersonal factors that affect MTE's experiences of motherhood and related healthcare.

### **Specific Aims**

1. Explore the influence of gender identity on motherhood, reproductive healthcare, and family building.
2. Describe systems-level barriers and facilitators to motherhood and family building among trans women in a Southeast metropolitan area.
3. Explore the perceptions and experiences of reproductive healthcare and motherhood among trans women in a Southeast metropolitan area.
4. Provide a list of recommendations to improve and advocate for trans women's health, and to support trans parents.

### **Theoretical Models**

The following theoretical models will be used to analyze results and provide context for critique. Principlism is a highly influential theory for medical bioethics and will be used to situate the participant's experiences with medical providers and healthcare. The Social Ecological Model (SEM) is intended for use in public health interventions. As such, it can be a tool to tease apart the "levels" of social ecology contributing to barriers to care. The Minority Stress Model provides a more detailed theoretical model for teasing apart the individual level impacts of stress caused by injustice. Intersectionality is necessary to see the complex ecosystem of oppression that participants navigate as they do not lead single issue lives.

## **Principlism**

Beauchamp and Childress's Principlism has been credited as being the bedrock of biomedical ethics. This is a contentious claim in the field of bioethics, but literature agrees that Principlism is highly influential. The foundational importance of Principlism to medical ethics is why it was selected to analyze the findings of this research. With each edition, Principlism has been revised, and the four main principles have remained stable in wording but are in flux with changing social application (Dige, 2019).

1. Respect for Autonomy (a norm of respecting and supporting autonomous decisions)
2. Nonmaleficence (a norm of avoiding the causation of harm)
3. Beneficence (a group of norms pertaining to relieving, lessening, or preventing harm and providing benefits and balancing benefits against risks and costs)
4. Justice (a group of norms for fairly distributing benefits, risks, and costs)

(Beauchamp & Childress, 1983)

Principlism will be applied to the findings of this research with a lens towards reproductive ethics.

## **Social Ecological Model**

The social ecological model (SEM) a framework for prevention, will be used to interpret this analysis (Fig. 2). The SEM holds that public health interventions aimed at prevention should intervene on multiple social levels: the society, community, interpersonal, and individual levels (Jill F. Kilanowski PhD, 2017; *The Social-Ecological Model*, 2020). The CDCs SEM model “enables community-engaged partnerships to identify a comprehensive list of factors that

## Justice and Becoming

contribute to poor health and develop a broad approach to health problems that involves actions at many levels to produce and reinforce change (*The Social-Ecological Model*, 2020).

This model depicts how individual behaviors are influenced by outside structures and interactions. However, it does not depict how individuals can become resilient to that influence when it is negative. For the sake of this analysis, the levels of individual, social & sexual networks, and community will be considered as mechanisms for prevalent behaviors putting MTE health at risk.<sup>1</sup>

### **Minority Stress Model**

The Minority Stress Model (Figure 3), a development on the Social Ecological Model, can be interpreted to acknowledge that minorities are not solely passive victims in their oppression and experiences of disparity (Meyer, 2003). Crated with SGM in mind, the Minority Stress Model includes potential mediators such as coping and social support of the individual. Meyer's Minority Stress model was selected because it has advanced scientific theory to engage with the tension of interaction between the social and personal, and the personal and political.

Literature provides an example of this tension, as there is strong evidence that discrimination towards SGM populations create elevated stress levels, which can disrupt development and psychological function. This may hinder coping mechanisms, regulate emotions, and contribute to feelings of self-hate and isolation (Girouard et al., 2019). When paired with stigma of sexuality and HIV, minority stress may act as a large barrier to health (Hatzenbuehler & Pachankis, 2016). Although common in the general population, the minority stress model holds that social and structural inequity contributes to poorer mental health

---

<sup>1</sup> This may also be considered as MTE's children are concerned.



## Justice and Becoming

outcomes and experiences of trauma, aligning SGM populations with a higher likelihood of PTSD (Girouard et al., 2019).

### **Intersectionality**

Public health practice and the field of bioethics is limited by a crucial need to understand the various forces contributing to inequity. Although intersectionality is a crucial tool for equitable public health and biomedical practice, uptake of intersectionality in public health conceptual frameworks and interventions are low. Public health interventions are often, and overwhelmingly, geared to support a single issue, such as access to reproductive health care, but miss the mark as people navigate many issues, including oppression of and stigma towards SGM individuals (Ndumbe-Eyoh et al., 2016). Multitudes of issues, oppression, and minority stress have influenced the experiences and health of SGM, creating complicated crossovers (Bowleg, 2012). Black lesbian poet and visionary Audre Lorde is famously quoted as saying, “there is no thing as a single-issue struggle because we do not live single-issue lives” (Lorde, 1982).

## **Methodology**

### **Revisions to the Research Question**

The main research question I am investigating is, how is motherhood embodied and enacted in the daily lives of mothers of the trans experience? Motherhood was selected as the research subject to provide an open platform for MTE to share how motherhood is a part of their lives, identities, and communities. Consequently, the methodology included asking about motherhood specifically and placing questions about reproductive health care and family into subcategories. To address this, the three sub questions I used to craft the interview guide are:

## Justice and Becoming

- What are your experiences of motherhood?
- How have your medical providers asked about your family and discussed reproductive healthcare with you? and
- What reproductive health options or family building options have you considered?

These research questions were revised due to limited time and scope of the research study. The few edits made to the in-depth interview guide are, added follow up questions about medical providers, and the expanded the definition of family building.

## Study Design and Setting

Qualitative methods were used to answer the selected research question and sub questions. Data was collected through three, hour-long interviews, using audio recording. Participants were invited to ask questions about my research process and results. Participants were informed of the intimate nature of the interview questions and asked to take breaks or pass on questions as desired. Interview questions were selected to best address the aims of this research and answer the main interview question. The interview guide was crafted with the input from two community leaders, mothers of the trans experience (MTE) who are directors and managers for a large nonprofit clinic serving SGM and specifically trans individuals. The input from these community leaders was pursued to account for and check my own influence and priorities for this research.

The results of these conversations yielded an interview guide focused on motherhood, kinship, and interactions with medical providers. To ensure that the interview focused on the holistic lives of mothers, and not the trope of queer tragedy, no questions about trauma, medical diagnoses, gender transition, or mental health were included in the interview guide. My decision

## Justice and Becoming

to build the interview guide without questions about trauma was informed by Whittle's critique of the "academic project of narrative repetition, in which trans people have told their anguish" (Stryker et al., 2006). This decision was a critical part of my methodology to document the lives of mothers of the trans experience and reject this overwhelming singular narrative of trans suffering.

Interviews were completely voluntary, and participants were compensated \$50 for their time. No participant was asked to disclose their medical information as a part of their participation or eligibility. Participants were ensured of confidentiality, with the exception of legal reporting requirement due to my mandated reporter status, or by court order. Participation could be withdrawn by the participant at any time, without justification. Participants were informed that all data would be de-identified during analysis.

Setting of the research was in person at a nearby university. This location was chosen because of proximity to an all gender restroom and available free parking on weekends and evenings. After COVID-19 mandated physical distancing, research was moved from in-person interviews to remote phone interviews. The Emory Institutional Review Board (IRB) recommended that to conduct this behavioral research, that I use an oral consent script for all interviews, this transferred well as in-person interviews became remote. Nina's interview was conducted in person, while Joyce and Devin's interview were conducted over the phone.

## Reciprocity

I am so grateful for participants' trust in sharing their stories. When introducing the research to participants, I chose to share reflections about the personal and academic process of conducting this research, and brief personal insights into my own life and connection to SGM

## Justice and Becoming

community. Sharing snippets of my own story was a tool to build rapport with participants and to diminish power dynamics between researcher and participant. This reciprocity of information often looked like a participant asking me about my own identities, requesting to add me on social media (LinkedIn was offered), and asking about my own drive to conduct this research. I answered all questions honestly and removed my “academic” hat while doing so, aiming for the outcome that participants and I could speak more as community than researcher and participant. One participant did not have any questions, another wanted to know how queer I was essentially, and another wanted to hang out at community events sometime, which I informed them would be limited due to research ethics. This research will provide reciprocity through supporting the validity of MTE and build on limited data and information about MTE family planning (Feigerlová et al., 2019).

## Sampling and Recruitment

Participants were recruited using advertisements, which we posted through gatekeepers in the SGM community on social media platforms. Participant eligibility depended upon three requirements; that they identify as a woman of the transgender experience, be a mother (self-identified, not necessarily legal), live in the identified large Southeast metropolitan area, be eighteen or older, and be willing to be recorded during an in-person interview about their experiences as a mother. These methods were appropriate because they allowed for participants to approach me, which was an ethical consideration due to the stigma often associated with being an MTE, the intimacy of motherhood, and possible discomfort discussing reproductive healthcare.

## Justice and Becoming

I tapped into my limited network of queer people in a Southeast metropolitan area and allies, my friends and community were a great support to me. Originally, I posted a series of ads using Facebook's option for boosted posts. I spent about \$200 and had two participants respond to the post over two months. These were my first two interviews. I then asked my good friend to refer me to his connection to Wussymag, a queer culture magazine with a strong social media presence. Wussymag and I communicated about the study directly, and they offered a discounted advertising rate due to the community health nature of the study. I received a significantly increased number of interested potential participants. This advertising method is preferred as I was able to support queer culture with my money, and it was more effective than Facebook advertising. However, even with boosted posts and community advertising, I was unable to hit my recruitment goal of five participants. I suspect that this is due to my disconnect with the SGM population and community in a Southeast metropolitan area, specifically the trans community. COVID-19 also limited my recruitment options as it added the extra challenge of reaching people online when many in-person SGM social spaces were closed.

### **Data Collection**

The in-depth interview guide (Figure 1) was used to conduct qualitative data collection and was created to account for time restrictions, participant fatigue, and to answer the research questions. Beginning with a full consent protocol, participants were reminded of their autonomy to participate or not participate, reminded of the sensitive nature of this interview, and given information about how their identities would be protected. To ensure understanding of consent information provided, each participant was asked "What questions do you have?" which was framed as an open-ended question to prompt participants to ask questions and seek further

information. When participants said that all of their questions were answered, I then asked, “knowing this, would you like to participate in this research study today?”

The opening question, “Tell me the story of how you became a mother” was designed to encourage participants set the pace of the interview with self-reflection, recollection of a memory, and share something vulnerable but not medical in nature. This would help to establish rapport, as participants were then asked about their interactions with their children and community, and then the interview guide shifted towards questions about their family building and reproductive health care. The closing questions, “if you could do it all over again, how might you do things differently, what advice would you give to future mothers, and what did I not ask about that you would like to share,” were intended to prompt participants to be reflexive about their own care and experiences of mothering.

Data was collected using my personal iPhone recorder app, and then uploaded to Emory’s secure Box account. All data was documented in Microsoft Word, de-identified, and files were password protected to ensure confidentiality. Otter Ai transcription software was used to transcribe the interviews, with editing and quality checking done by hand in word.

### **Study Design**

This study was conducted in a large metropolitan area in the Southeast. This research has been conducted using a qualitative narrative case-study design, suitable for this research considering the exploration of the “bounded system” (case) of MTE’s experiences with motherhood and reproductive healthcare. The limited sample size and gaps in social behavioral literature on the subject meant that interviews would be strongest when paired with literature from multiple disciplines, including grey area literature and personal accounts. This design

## Justice and Becoming

offered the benefit of treating each interview as its own case, reporting on descriptions and themes unique to that interview as to not dilute analysis (Lewis, 2015).

Data was collected from February-June 2020. Audio recorded qualitative interviews were conducted in person and through the phone. Participants were purposely sampled from a Southeast metropolitan area. Results of research will be shared with participants and/or the target community through an online webinar of findings to be shared easily through social media and community centers. Participants seeking additional reciprocity and recognition for their labor may discuss authorship opportunities.

### **Analysis**

During preliminary analysis of the first interview, I made the decision to alter the interview guide. During the first interview, unprompted, Nina shared her advice for medical providers and mothers. This was such a rich part of the interview that I chose to include the question, “what advice do you have for medical providers?” and “what advice do you have for other mothers?” in the interview guide moving forward. This was the only edit made to the interview guide.

Analysis consisted of reviewing hard copies of the transcripts individually, circling themes and taking notes in the margins of potential codes. Each transcript was analyzed individually as a case study. Themes were then identified from abstracted patterns shared by all three case studies. Categories that encompass themes were then produced and included as findings. Although the reporting of categories as findings is not standard with case study methodology, it was included as to not miss an opportunity to recognize what could be key findings for future research. The intention of this research as a pilot study was kept in mind

## Justice and Becoming

during analysis, as well as my aim to deprioritize SGM suffering or hardship in my own analysis and interpretation of the interviews. Resulting findings included a meld of case studies, categories, and narrative critique of access to medical care.

### **Ethical Considerations Regarding Methods**

Interview questions were created with the intention of filling an identified gap in research, while accommodating for participant discomfort. Medical information was not requested as a part of eligibility or in the research questions, as all questions were behaviorally based. Research questions were limited, with gentle probes such as “tell me more about that” to make sure that participants could share information about their experiences at their own pace. This focus on participant comfort and autonomy was used to break down barriers to participant disclosure and yield greater data collection of vulnerable information.

To protect participant privacy, interviews were conducted in a closed interview room at a nearby university, on a weekend morning where it would be quiet. Phone interviews were conducted through the phone, in a closed private room. Additional ethical considerations of participant fatigue were addressed by offering and providing structured time for participants to take breaks during their interviews, and I checked in with participants throughout about how they were doing.

Measures were taken during data collection and management to protect participants. Data was protected and managed through de-identification and was stored in password protected files on a personal computer, which was only used and accessed by the researcher. This was to protect confidentiality of participants, which was an especially pertinent ethical consideration because of the stigma associated with being a sexual and gender minority woman, a transgender



## Justice and Becoming

person, an SGM mother, and women's sexuality and reproductive health overall. Additionally, all participants interviewed worked in human service capacities. Should information of their gender, sexual health, and interactions with the health field be compromised, it could impact their careers and livelihood.

## Findings

### Summary of Sample

This ethnography reviews three different case studies of MTE. The sample of MTE interviewed consisted of three participants, ages 23-36. Two of the three participants were white, and one black. Two of the three participants self-identified as women, while one of the participants identified as transgender and gender nonconforming. Each participant's interview was woven together with the common statement that no two trans people are alike. Each participant found unique language for their narratives of immense pride, loss, uncertainty, joy, and individual experiences.

### Individual Case Studies

Representing these narratives as three individual case studies meant that I needed to change my tone to accurately represent the interviews and data collected. I made the decision that the positionality of the researcher was inappropriate considering how I aimed to uplift the stories of MTE. Pulling method and writing style from Tourigny's piece, ' "Choosing" HIV/AIDS', I aim to showcase the complexity of these vulnerable narratives and lives of the mothers who entrusted me with their stories.

**“The Lines Are So Blurred”, Nina’s Story**

The lines are so blurred. I was like, yeah, I’ll say my boundaries have, I love them to death. I love my students. I mean, I call them my kids. They are my kids. I have several who call me mom now. I have kids who’ve graduated that stay in touch with me. One that I’m her other mother, and so I have a job to do with my students. And so, I keep that in mind. But the only thing that really, one thing that separates them from being my biological kids, I can't punish them the way, I can't take their phones for a week. (Nina)

*Summary*

Nina is a mother and woman of the trans experience who came out later in life, when her son was in high school. Nina had her son with her ex-wife, who birthed Kevin, and Nina later gained full custody of Kevin while he was in elementary school. As a mother and a teacher, Nina considers her students and her son to be her “kids”. Nina discusses including her kids as a part of negotiating her transition and coming out process, the importance or representation, and barriers to reproductive healthcare and family building options.

*Nina’s Story*

When Nina asked the question, “how did different people navigate being?” She found herself drawn to characters in novels with similar challenges of fitting in. She saw her own complex experiences as a survivor, trans woman, and mother in these stories. Literature, forums, and blogs were a lifeline for Nina, because “if someone wrote about it, I knew I wasn’t the only one”.

## Justice and Becoming

I didn't care if it was trans man or trans woman or anything I just wanted to know. How did different people navigate being? You know, I've always loved, people who are outside the mainstream. And I've read so many books of that. I mean, going all the way back to high school and *Catcher in the Rye*, *The Misfits*, but you know, these were more of like a specific group of people who just weren't fitting in, based on something that should be so simple and yet was infinitely complex to a society that refuses to see past binaries. (Nina)

Nina's story of motherhood is full of vulnerable magic moments, pockets of joy that made her eyes light up. I swear that she grew taller with pride when sharing her memories with me. Nina is a mother to her children: her son, Kevin, and her students at the high school where she teaches English. Seeking knowledge to better invest in the care of her community, she uses what resources others have shared with her to support her children. She kicked off our interview by stating, "I want everyone to have as easy a road as possible".

Nina did not have an easy road. Throughout her interview, Nina downplays her challenging experiences, punctuating them with candid descriptions and accounts. The themes of fear, representation, fierce advocacy, and existing in the blurred lines between binaries are woven throughout Nina's narrative. Depression and suicidality complicated, clouded, and nearly ended Nina's life on many occasions. Nina credits becoming a mother with giving her a reason to live.

I was a mess. And really, I did not think I would live and then kind of having a child saved my life. And it's a really shitty reason to have a kid, you know, maybe you're

## Justice and Becoming

gonna have a kid or kill myself, but it wasn't like that. It was just like I finally found a reason to live. (Nina)

After “things got rough” with Kevin’s birth mother and Nina’s first wife, Nina spent 8 months looking for her son, not knowing if he was still alive. Upon finding him, Nina was unexpectedly awarded full custody, and Kevin never asked about his birth mother again. Her second marriage “fell through, lots of problems” when Kevin was in 9<sup>th</sup> grade. At this time, Nina was not yet out as a woman of the trans experience, “Lots of problems” included her wife’s threat to out her to her employer using photographs of Nina wearing women’s clothes.

The only reason I was still with my ex for a while was she had threatened that if I didn't stay with her that she would send pictures to my employer, and I'm teacher, of me as a woman. So, I stayed with her two extra years out of absolute terror. I live in the south, you would get fired. It's just not a question. She knew that if any of this became public knowledge, I'm done for. I was someone who had a lot of problems and finally got myself together, kept a steady job was considered pretty damn good at it. And it all could just crumble. So, I submitted.<sup>2</sup> (Nina)

---

<sup>2</sup> Until recently, there was no protections federally for transgender workers, and GA remains an employ-at-will state, so there was plenty to heed in her partner’s threats. Transphobia, stigma, and lack of policy protections for trans workers put Nina in a position where her only option was, “submitting” to her ex to keep her employment and livelihood. The distinction of regional contribution to Nina’s fear of losing her job is notable, and geography was a theme throughout all the interviews.

## Justice and Becoming

Nina credits her parents and extended family as being a part of her son's resilience and strength during her divorces and transition, that love has always surrounded him. And while she was a rock and champion for her kids, Nina's parents "never, ever, wavered" in their support of her.

I mean, the kind of accusations that get thrown in your direction and getting probed and prodded by every possible investigation, I mean, it was tearing me apart. My parents said, we're in this together the whole time. And they were, they never, they never wavered. And then when I when I transitioned and everything my mom didn't bat an eye. Her main concern was the same as mine. How will this impact my son? We both are on the same page. (Nina)

Nina identifies gender performance and the timeline of her coming out process and the fluid roles of parenting complicating the term "mother" for her.

So I was, I was his father. And so, when you said talk about motherhood, you know, that's more of a recent development...I do believe that some of the roles we put on people it's all over the place. And really when you do more of the single parenting, you're more role fluid. You know it's like gender fluid but you're role fluid, you have to do both. You have to be nurturing and loving and all the things that people usually associate with mothers. And you have to be stern and, and fun, and things that you associate with fathers- it was really just, I was a parent. I couldn't really call myself a mother or father at that point. I was his parent. (Nina)

## Justice and Becoming

### *Seeing It Through*

Her tenacity towards caring for others is clear in negotiations as intimate as Nina's timing of and inclusion of Kevin in her transition.

I decided I was going to try and see it through. Scariest thing wasn't losing my job, it was losing the love of my son. (Nina)

Nina first tested the waters as she floated trans identity by Kevin without coming out just yet, but these hints did not catch on.

And the sad thing was months going up to it I would just give little hints. What do you think about, isn't that cool that Caitlyn Jenner came out? Everyone look! People are okay with it! Isn't that neat that we're advancing as a society? (imitates son's voice) "Yeah, that's cool". What would you do if I did something like that? (imitates son's voice) "I don't know". But it was like, (whooshing noise) over his head, he could not picture it at all. (Nina)

Upon coming out to Kevin, he was concerned and scared for her. Kevin understood the stigma his mother and family would face.

So, it really upset him, and he was scared for me. He was scared of what it meant, the impact it would have, and he just didn't know what to make of it. So, it was tough. It was tough for a good nine months. (Nina)

She included Kevin in negotiating her coming out process. She told him that she would wait, “until he got out of high school to start it if he needed that for me”. Collaboratively, she and Kevin negotiated when and how she would present as Nina.

I said (to Kevin) I know how hard high school can be. Last thing I ever want to do is hurt you or put you in a place that makes you uncomfortable. But yes, this is something I really need to do. At the same time, I can wait if I have to. And he said, no, you know, I'll be okay. (Nina)

Nina's adult allies and support network advised her that this was not a necessary negotiation, but it was a priority to her. She negotiated her performance of gender with her concerns about job security, her son's security, and her own needs. Although a crafted skill of Nina's, the stress of performing as a teacher, and then as a teacher who could not be her full authentic self with students and in her life was exhausting and destructive for Nina.

Being a teacher's playing pretend so much of the time. You can't come in and be like, “Oh, I'm so depressed Oh my God, my life sucks. So, let's talk about this an awful...” you know, you just can't do that. So, you have to put on a good performance and everything. And it's exhausting to have to, then, to them, I'd have to put on male Performance plus the teacher performance and then come home. And if we were going out somewhere put on another performance. And it was exhausting. It was killing me. I mean, there were days when I just, it's just destroying me.

Although still including Kevin in her coming out process, Nina decided that once she was out at her job with her students that she would not pretend to be anything other than her authentic self, regardless of Kevin's concerns or discomfort.

Look, once he said he was okay with it, then it was like, all right. You know, you're gonna see me dressed differently. You're gonna see me present differently. And he asked if when we were out together and in public, if I wouldn't do that. So, I didn't. He was fine with me at home. When we're out in public, I went in male mode. I said, as soon as I don't do it for work, I'm not doing it for you. I put my limit, like, as soon as, like if I can, if they still keep me hired after I tell them this, then you know, that's it. (Nina)

*"It's Amazing What a Book Can Do": The Power of Representation*

Knowing that there are others out there with similar struggles, identities, names, and experiences gave Nina possibility models<sup>3</sup> to reference as she came into her truth. Nina sought out whatever trans resources she could find, saying, "that was probably the most nonfiction I've read in my life". Sharing her resources was a part of the interview where she lit up, it was filled with confident name dropping, a who's who of transgender representation in the 90's.

It was Kate Bornstein. And it was Jennifer Boland. Then also porn actresses. I'm like, well, you're in the business, you know some of this stuff here, you've navigated these things and no one else, I don't know any frickin' one else. Okay, Bailey J. Thank you for

---

<sup>3</sup> {Citation}



## Justice and Becoming

showing that. Well, showed a lot but you know. She of all of them, she was the best.

(Nina)

She also noted the importance of trans representation regardless of how much she liked them.

There was a bit of a self-competitive introspection when she made this comparison.

Caitlyn Jenner was right around the same time, and I think it was the same year (the year Nina came out). Yeah, I mean that was another, this probably sounds awful, but I was like if that piece of shit can do it (laughter)... I'm like God dammit, I need to have enough guts to do it. I can think she's horrible, but just that statement and the fact that it entered the public conversation was so fucking important. (Nina)

In her role as an educator, Nina brings diverse representation into her classroom, sharing opportunities for students to see others like them, especially in literature. She “tries to give them books that they can't have in the library” and noted that it was risky as her administration would try to remove “like 90% of my books” if they knew the varied queer, Black and Brown, and international literature in her classroom. Nina notes the power of representation, knowing that her students feel seen when they see themselves in her library collection.

Two weeks ago, I had a non-binary student, non-binary African American. They, we were doing a poetry project for Black History Month. So, I introduced them to (author) Dennis Smith. And just, “oh my god, you found a non-binary African American writer”. And I'm like, yeah, and here's the book of queer, non-binary, queer as well as non-binary

## Justice and Becoming

Muslim people. And they're like, "Oh my god", you know? Just to see like, they felt seen. They felt embraced, and it's amazing what a book can do. (Nina)

Nina's work in a conservative school district gives her the opportunity to change minds about how students felt about trans and queer people.

Because for a lot of kids, I'm working in a very conservative area. And they hate people like me. Then they end up loving me, and they don't know what to make of themselves. That's one of the greatest accomplishments. (Nina)

As if she were narrating her own place in the cycle of possibility models, Nina describes her son's support network as if she were looking in a mirror of her own accomplishments.

I had to depend on well, especially with raising, you know, had to depend on my parents. Every parent kind of has to depend on Teachers and the school system and all those you don't really want to trust but you kind of have to, to contribute to it but -- but if I had to say who my biggest support system the whole time was my parents. (Nina)

## *No One Tells You*

I mean, when you talk about reproductive health, they tell you like, hey, before you start the hormones, do you want to store some of your stuff (i.e. sperm)? Before it all dies? Well, great. Ya know, and I'm like no, I'm old. No one tells you guess what? Believe it or not, if you take a lot of estrogen, you could end up going through what women, other

## Justice and Becoming

women do when they get older and they haven't had a child which is really wanting a baby again, and it's too late at that time. (Nina)

Nina was not presented with every option or with the information she needed to make a full, informed, decision about her reproductive health. This is similar to her medical care when accessing gender affirmation surgery and hormones. The phrase that was repeated again and again in her interview when discussing medical care is “no one tells you” as providers only presented Nina with missed opportunities and immense obstacles. When she explored her options for having another child, she ran into biomedical limitations, cost prohibitive care, and discriminatory adoption policies.

If she could do it over again, she would have another child either through preserving sperm or adoption, but those are not attainable options. Should she ever try to re-generate sperm she would need to halt HRT, and Nina could not put her “body on that rollercoaster” again. When Nina looked into adopting a student of hers who was at risk of deportation, the “LGBT friendly attorney was really willing to help me out. And she just told me point blank you don't stand a chance.”

I would either maybe save some of, just depending on how expensive that is. Or just plan on adoption, but that's the problem, you can't adopt if you're trans not in Georgia. Who the fuck will let me adopt? They don't even want to let gay and lesbian couples adopt. It's a shitstorm in the South. (Nina)

## Justice and Becoming

Without skipping a beat, Nina took her own frustration, loss, and hurt caused by the lack of family planning services and medicine available to her and considers the next generation of trans kids. Advocating for providers to be educated on the “full scope” of trans health care and family planning, Nina defends youth who are beginning to transition, insisting that there has got to be something (more) for children, and future parents.

Because there's so many barriers, and that they (providers) need to understand the full scope. Whether it's because, you know, especially with people, young folks transitioning at younger ages, and everything then what happens, you know? If I'm like, 14, I can know what I am you know, I can know my gender identity, I can know it younger. I'm not gonna know if I want frickin kids. Who the hell knows that? And so, I really don't know what the right answer is for that. But there's got to be something you know, maybe just explaining this is what's going to go away or this is. (Nina)

### **“Not Be A Footnote in His Headline”, Joyce’s Story**

#### *Summary*

Joyce was asked to be Kingston’s godmother during an unremarkable afternoon while visiting her hometown<sup>4</sup>. Her friend Ava, Kingston’s birth mother, chose Joyce and asked her to formally join their family. It is an honor and a large act of trust to be chosen to godparent, being trusted with a child’s faith is huge, and as Joyce shares with us, it is a full parenting role. Joyce

---

<sup>4</sup> In Christianity, at least one godparent is chosen by the birth family to act as proxy for the infant child who is being baptized. In the event that the child’s birth parents are unable to provide religious education and guidance to the child, Godparents are tasked to provide a child’s faith education. Regardless of birth parent’s ability to provide religious education to their child, Godparents are consistently tasked with keeping watch over the child’s journey in spiritual life and growth. Godparents are often selected by the birth parents because they themselves have strong faith (*Godparent | Definition, History, & Role*, n.d.).

## Justice and Becoming

mothers Kingston with a powerful nurturing and tender nature. She describes the experience of mothering him as humbling. She sees this tenderness as a way to protect Kingston from the violence of white supremacy and racism, protecting his sensitive nature and whole self. She came out as a woman in her late 20's and offers a generous yet stern critique of the way medical providers have limited her access to family planning. Joyce's becoming story of her authentic self and her motherhood are ones of advocacy, care, and trust.

### *Joyce's Story*

Time is a golden resource and guiding compass for Joyce. There is nothing she would have done differently if she could retroactively change her life, because everything brought her to the exact moment that she became a mother to her godson, Kingston. With a divine goddess and spiritual guidance, Joyce trusts that things happen for a reason, even when that timing seemed off. She connects her transition to this timeline of perfect time perfect place, even when delayed, her "next steps were ordered" by the Goddess.

I don't know if there's anything I would do differently because the way I see it, every decision I made led me to the point of being able to be his godmother. And I just learned everything, not to be super spiritual, but I believe, I call, I refer to my higher power as Goddess. Goddess has timing for everything, and sometimes you have to trust that timing. (Joyce)

Honored with the request to godmother Kingston, it was affirming that Ava saw Joyce as her authentic self. The contrasting public perception that trans women are not "real" is something

## Justice and Becoming

that is laced throughout the interview, as silences and lack of information, or lack of affirming experiences inform her

I think a lot of people see trans women as something less than real. And, and then on top of that, they typically see us as predatory so for her to look at me and see not only a real woman, but someone who could genuinely love and care and protect her son. It was just such a huge honor. (Joyce)

From the ways she described Kingston throughout the interview, I imagined him as a young researcher, and Joyce as his mentor, guide, and guardian. Joyce gushes about Kingston as a creative, curious, observant boy with “so much swag”.

Oh, so I might be biased, but my godson has so much swag. He is so, thanks to his mom of course because his mom is very fashionable too. He is just always, every time I see this boy, he is just dressed to kill and he's just smooth like he's five years old and already knows how to charm the ladies and he's so funny. (Joyce)

But then like I said, he's very insightful, he really remembers the things that he hears, that go on. So, he's very, I guess in tune with his environment. And that that brings me joy too, because as a kid, I'm glad that he is aware of what's going on around him. He's not oblivious. He's not dull minded. He's smart. And that makes me happy. I can see already, even though he's young, I can see that he's very creative. I can tell he's going to be,

## Justice and Becoming

whatever he does, there's going to be some kind of creative spark to it. I can already see that creativity and that imagination in him, and I enjoy that. (Joyce)

### *Make Time for Him*

Joyce spends as much time with Kingston as possible, seeing time as precious, and a necessary way to show care as his godmother. Geography is a barrier to spending as much time with him as she would like, but her intentions show how much she sees quality time as a love language, not just towards Kingston, but also towards his (birth) mother Ava.

If I were there, in reality, I would probably see him multiple times a week, and look after him because his mom has a very difficult work schedule and things of that nature. I would certainly be more involved in his life if I were closer. But I would say when I, the times that I have visited in my hometown, I always make time for him whenever I'm there. It doesn't matter if I'm there for two days or I'm there for two weeks. He's going to see me. (Joyce)

Spending time with Kingston is a way Joyce can care for him but do more than provide. Pointing to her own experiences as a child, Joyce understands and appreciates the hard work of providing, and is making sure to provide more than financial security to Kingston. Joyce is his protector, provider, and friend, and is mindful of how her own traumas could influence how she treats her godson. "Hurt people hurt people" and she aims to break any cycle of negativity or absence as a mother. She looks to her own parents for this lesson, reflecting on their parenting to craft her own mothering.

Oh, my goodness, one of the mistakes that, it wasn't my mother that made this mistake, it was my father, but it can still apply to the mother. My father always prided himself on being a provider. And he was a very good provider. My dad always had a job. He always made sure I was taken care of, and all of that, but he wasn't a friend, and he wasn't nice. Just so I don't know, I was always somewhat afraid of him because of his temper. And like I said, he could just be kind of mean. So, I would say, applying it to mothers, because mothers can be providers too. Don't just focus on being a provider for your child. Be a friend. Be someone they can talk to so that when they no longer need you to provide, you're still relevant. (Joyce)

You know, as they say, hurt people hurt people. But your child doesn't need to be a victim of your childhood trauma. And so, whatever you needed as a child, whether that was attention, whether it was more hugs, whether it was adventure, whatever it was, provide that for your child. Because they will thank you later. (Joyce)

Making space for Kingston to explore, feel, and share his creativity is another priority for Joyce. She listens, is present, and asks him questions. Joyce is constantly learning from Kingston and knows that he is also paying attention to her, remembering her guidance and care.

With Kingston I try to ask him questions when he does talk, and oh my goodness, he can talk. When he does talk, I really try to just listen. Because what I realized, and listening to him is, he's five years old now, kids pick up on a lot. They really are very intelligent,



## Justice and Becoming

more than what we give them credit for as adults. I try to be tender; I try to listen. And most of all, I try to spend time with him. Because one of the things that I think sometimes as parental figures, that we take for granted, is that children aren't going to care, they're not going to remember if we did certain things when they were young, but they will.

(Joyce)

## *Be Very Tender*

Tenderness is a strength that Joyce nurtures in herself, and in Kingston. Tenderness is a family trait, a powerful trait, and an intergenerational sign of resilience and keeping hold of one's power. Tenderness is akin to love, and something to respect and hold close. The mother figures Joyce admires give tenderness and love. Joyce shares that this is unique to mothers.

I think one of the one of the qualities I love most about the mother figures I respect is their nurturing and tender nature. I don't care where you look in this world, you are never going to find somebody that loves you like your mother. Never. And you can look high and low. It's just very unique. I think part of what makes it unique is the nurture and the tenderness that goes into it. (Joyce)

I think what I've learned from the mother figures I look up to, is how to be a forgiving kind of woman instead of being bitter, and how to be tender and kind. I think the thing that I love about so many mothers, is that there's a certain softness to them and people, but these days, they kind of see that as an insult, well, you know, why would you call a woman soft? Are you trying to call her weak or something? but what I have learned is

## Justice and Becoming

that people who are soft, mothers who are soft, that takes power, especially in the kind of world that we live in. It's such a harsh and cold place, and to be able to maintain a mother's heart which is soft and nurturing, that is a power that is unrivaled. And I admire it a lot. And I've tried to model myself. (Joyce)

Joyce takes her own power and tenderness, and transfers it to Kingston, helping him defend his own power as a Black boy who will grow to be a man. Here Joyce directly connects the threat of murder at the hands of police to her son, and marks tenderness and sensitivity as something to protect in Kingston. This example of how white supremacy influences policy, policing, and community to create and be a danger for Black boys. This statement about how society hardens Black men, takes something from them, from their tenderness to their life<sup>5</sup>.

Kingston is a very sensitive young man. And Kingston is an African American young man. The reason I'm saying that is because this society has a way of hardening young Black men. And making them have to be these really tough individuals, who almost completely lose touch with their emotional intelligence because they have to survive in a very harsh society. When you look around, even with what's happened very recently with George Floyd, who was viciously murdered by the police. It's just like they grow up in a world where there's not a lot of tenderness. So, with Kingston, I try to be very tender.

Because I realized, he's cute now, but one day, he's gonna grow up and be a young Black

---

<sup>5</sup> This is an important connection with the reproductive justice movement's work to abolish white supremacy, and sees the right to parent without fear of police as a part of reproductive justice

## Justice and Becoming

man. And I want to make sure that as a mother figure, that I give him the space he needs to be the man that he's going to be, but to be able to still remain sensitive. (Joyce)

### *Motherhood & Womanhood*

This entire interview is focused on motherhood; however, although womanhood was not the focus of the interview, defining womanhood was a key theme in Joyce's interview. Joyce discussed her coming out story and gender identity in a way that was as de-sensationalized as possible. She acknowledged it as I asked about it, and when it came to her relationship as a mother, she touched on how the world's transphobia and prejudice influence her experiences. She didn't know how to elaborate on the fact that she is a woman, and that her womanhood is connected to her motherhood the same as any woman's,

You know, I think for me at the end of the day, I just see myself as a woman, I do.

Although I am a woman of trans experience, at the end of the day I see myself as a woman. So, for me, I don't know that it influences too much. I feel like I'm just as motherly as I would be if I was a ciswoman. So yeah, I don't know how to elaborate on that part, but yeah. (Joyce)

Having a family is a big part of Joyce's life, goals, and priorities. She largely does not have a "village" of support, but she has love, and has a model of what she wants for her family based upon what she did not have:

## Justice and Becoming

A lot of times I've had to be my own support system. I am blessed to have a man in my life. He's very supportive of me. We have definitely had our trials within our relationship, but I'm blessed to have that. I think what it has done for me, though, is, I felt like in some ways, it's helped to make me a little bit better of a mother figure. Because I know what it's like to feel like you don't have anybody. I know what it's like to feel like your village is virtually nonexistent. So, you know for me now there's this deep desire to have a family, to have my, to have children in my life, to have a loving husband. I guess the lack of having a village has made me more family oriented. (Joyce)

Joyce also finds this tenderness and mothering presence in role models on social media. Tabitha Brown is one of these figures for Joyce, as she provides a mothering energy and presence in her life. Joyce was notably nervous to share this with me, but it's worth noting the way that media played a role in providing Joyce with a mothering role model.

Tabitha Brown, I don't know, just hearing her voice, sometimes she'll make these quick videos where she talks about loving yourself. Not getting caught up with what people think of you, but what you think of yours. Like, things you need to hear from a mother pretty much. I think when you're in a position like when I'm in, when you don't have a biological mother anymore, sometimes you look wherever you can to find those conversations that you wish you could have with your mother, or to find those words that you wish you could hear from your mother, even if that's from some random woman on social media, so yeah. (Joyce)

## Justice and Becoming

### *Start by Just Discussing It*

Throughout her entire interview, Joyce describes advocating for Kingston, advocating for Ava, advocating for herself, and for her kinship networks. Family is powerful, and a core part of Joyce's life. But those directing her medical care knew nothing about her family, because they never asked. Her hypothesis of why this is, is an assumed lack of provider knowledge about working with trans patients, and the assumption that she does not have a family because she is trans. This experience of provider incompetence should be considered alongside her earlier comment on how trans women are seen as "less than real".

You know, sadly, my medical providers have not asked very much about that. I don't know if they take for granted that I don't have one, or that there's just not a large focus on that. Or that maybe they are, I hate to sound harsh, but potentially incompetent when it comes to really caring for and interacting with trans patients such as myself. So that hasn't been something they'd really asked me a lot about to be honest... I go to doctor's appointments pretty regularly for bloodwork and those types of things, to make sure that my hormone levels and everything are good. And in all the visits I've had over the last two years they, I don't think they've ever once asked me about that or talked to me about that at all. (Joyce)

Healthcare for cisgender women almost always involves questions about one's family, pregnancy status, and partners. Joyce not having any providers ask her about her family is a huge gap in her healthcare provider's knowledge of her life, and gap in information that could support her medical care. She also takes on some of the stark silences of her providers and notes that she

## Justice and Becoming

is experiencing embarrassment because they have not asked about her family, and Joyce does not know why she is embarrassed.

Although her providers do not know it, Joyce is interested in having children of her own. Even if it had been offered and available, sperm preservation pre-surgery was not an option for Joyce, as “it created a huge sense of dysphoria to use that part of my body in any way, shape, or form. So, I don't know that I would ever have done that (sperm preservation) even if I didn't have surgery”. But Joyce has considered adoption and sees womb implantation<sup>6</sup> as the ideal solution to family building should and when it becomes available.

For myself, the only thing I've strongly considered actually is adoption. Because, well, I'm trying to think of how to put this delicately. I don't necessarily have the ability to produce children of my own. At the moment I'm post op. So, I'm not able to birth children at this point. And of course, the option of freezing sperm has, that ship sailed a long time ago. So, at this point, my only viable option that I can see for myself is adoption, until they're able to implant wombs. Once they can implant wombs, I'm good to go. (Joyce)

Joyce's recommendations made to improve interactions with medical providers were to have providers ask questions about all women's families, and not making assumptions. Providers should take the time to be educated themselves and to educate patients

---

<sup>6</sup> Uterine implantation is being studied as a viable option for women who have absolute infertility. Research in Sweden has resulted in five live births after uterine transplants on cisgender women. Research speculates that uterine implantation could be a possibility for women of the trans experience, born without a cervix, who want to become pregnant and give birth (Jones et al., 2019).

I would say they could really start by just discussing it. You know, that would be great. So, you know, discussing it with us as I just been taking for granted that we actually want families and can have family because I think sometimes, they're not aware of that. Or they look at us as something other than human, you know? But beyond that, I would say, letting us know what options are available to be able to have our own families on our own terms. If that means preserving sperm, if that means using a surrogate, whatever the options might be that we can have. Letting us know, because I think sometimes some of us may want to have a family and know what kind of health care is available for that, but options are not discussed with us such as in my case, you know, nobody's ever actually, a medical professional has never sat down with me and had any discussion about reproductive care and all that. (Joyce)

### **“If I was to have a gifted see-er”, Devin’s Story**

#### *Summary*

Devin was a teenage mother, who gave birth to their daughter Gili at 14. Devin is trans, a mother, and a non-binary crone. When deciding to participate in this interview, they stated that no one needed to know what their vagina had or had not done, and they self-identified as being eligible for this research. Devin shared an hour of immense vulnerability and fierce advocacy with me. Devin’s interview is a window into intersections of gender, disability, queerness, class, and ageism.

Devin’s daughter, Gili, is differently abled. Devin’s role as Gili’s mother is intrinsically tied to advocating for disability justice, and their community reflects their family. Circus

## Justice and Becoming

performers, artists, creators, queers and leather folk, and other advocates for people who are differently abled care for Devin and Gili and are protective kin.

### *Devin's Story*

I would see, as someone who's disabled, but you know, they also are called differently abled. It's like, she's probably has more perceptive about me than I am about me. You know? If I was to have a gifted see-er, it would be like, here's this person who sees so much but cannot say, really? (Devin)

There are notable cultural moments stolen from Devin and their daughter Gili, thieved by instances of interpersonal and structural violence against women, trans folks, and people living with disabilities. Birthdays, weddings, graduations, big breaks in one's career, cultural celebrations are just that-- critical to culture. Devin's story of motherhood was one where they protected this right to milestones, joy, and above all, Gili.

It is not fair of me to project survival onto Devin, but I will say that in their narrative of motherhood I saw an almost feral survival instinct when it came to themselves and their daughter. Devin describes Gili as being, "born into an emergency situation in more ways than one", and if Devin's mothering is reactive survival, they have found a way to balance that with creation and nothing less than magic. Their voice during the interview moved from flat and matter of fact, as if they were reading from a book, they had no interest in revisiting, to laughter and cadence that almost sparkled.

Gili was born at 7 months, after sexual assault robbed Devin of the milestone of a desired first sexual experience. Devin spoke about their rape in that flat tone, reporting more than



## Justice and Becoming

recalling. Their description was haunting. Devin described their body as permeable, an unwilling vessel or location that was tread upon and through. This description of their body is the antithesis of the lioness, Goddess, and crone Devin would describe later in our interview. As they began to provide a window into their life, Devin noted that they were still in the process of sorting out the trauma and abuse they have experienced, but this quote set the terms of our interview. Devin will not work out all those little pieces for themselves, but they sort through them ruthlessly for Gili.

I'm not sure I'm ever gonna work out all the little pieces of things that mean things, but that was how I came to be a mom and whoever this person was to me, in some other past life, they walked through my body in this one. (Devin)

Devin considers teenage moms to be one of the most hated things in the world, and at age 14 they already knew that there was a big difference between themselves and others. Devin identified that their transness, being a teenage mother, and then when Devin will never fit in, because of transness, being a teenage mother, and a survivor of sexual assault. This speaks to the isolation Devin experienced, especially at the beginning of their time as a mother.

Because I was a young mother, I have several intersections going on. I was a teen mom; I could say that. I feel like one of the most hated things in our culture is actually teenage motherhood. I felt very victimized by it, because I was a victim, and actually never told anyone for a decade. I couldn't talk about it, I couldn't even put it into those words, you know, use the R word. (Devin)

## Justice and Becoming

I would never fit in with anybody in any way because I'm trans right? So, there's that. Not fitting in and then, how many people actually have babies at my age or even close to my age? And then so your friend groups are really interesting. I feel like there's both things as a trans person, you don't get a lot of, what do you call it? milestones, rites of passage, celebration. You know, my daughter has been disabled since birth and she doesn't get those rites of passage and whatnot, and then and then there's this mismatch of just the whole age card. (Devin)

Devin saw their survival in Hollywood's portrayal of Brandon Teena. Because this was one of the few representations of trans and gay characters in 90's, the truth Devin took away from the film was one where they were raped because they were gay, and because "that was kind of the world we lived in". But what a way to find yourself represented in media, to see your two truths tethered, as if cursed.

I was 14, it was the early 90s. And there wasn't anything out in the world really, there was, I don't know when Boys Don't Cry came out, but it might have been around then, might have been after that. I remember that being something that was just kind of like, Yeah, everybody experiences this, you know? But at the same time, not so much you get raped because you're trans, you get raped because you're gay. People will subvert you because you're gay, will be violent because you're gay or whatever. That was kind of the world we lived in. (Devin)

*You can make your life join with theirs*

## Justice and Becoming

Like, why am I only thinking about the world instead of myself? You know, and I would say that like in itself is real motherhood stuff, or terrible boundaries stuff I don't know, prioritizing everyone else before yourself, not giving yourself the care that it needs them to consider it. Because you're so used to sacrificing for other people all the time. When you have a child, you look at what everybody else thinks about you and the child and you, you have to consider someone sort of before yourself, but then you realize, you know, you have to actually take care of yourself in order to take care of your child. And it's this long, ongoing balance war there. (Devin)

When Gili was born, she had disabilities that would require specialized medical care for the rest of her life. Devin was 14, experiencing homelessness, the impossible choice of asking the lesser of two abusive parents for support when they could not do it on their own. They spent months in hospitals. Paperwork became a part of Devin's definition of motherhood, and a litmus test of who could call themselves "mother".

I largely did motherhood alone. I never had a co parent. Somebody tried to co parent with me, and I was like, absolutely no fucking way. If you don't spend time in the hospital, and you don't spend six hours a week doing these horrible paperwork things, you don't get to call yourself mom. (Devin)

Navigating medical care, social services and programs, and the obstacle course set out by a society that does not prioritize people with disabilities, Devin is Gili's protector, and Gili is Devin's core. Devin's second priority is the queer community. In this way, Devin summarizes

## Justice and Becoming

how their priorities and self are channeled as a mother: It's Gili, and it's things that support Gili and Gili's family. A guardian, guide, and mother, Devin's crone energy is one of creation and teaching, preparing Gili and their kin for the threat of other's discomfort, fighting to curate milestones for those who might have them taken from them. This is a monstrous task.

My first mission is for my daughter, to make sure she has all the tools she needs. And then my second life mission is to create visibility for LGBTQIA and disabled people. So that basically, humans don't try to kill them, which is what is going on right now, as well and like Black Lives Matter. Humans tend to kill anything that's not like them. unless they've had those moments of touching and feeling that humanity. (Devin)

An example of these priorities in in Devin's immediate decision to assimilate after Gili was born. Going from a 90's skater punk gay to a "straight" "woman".

Ah, I would say the first decision I made immediately, my thought was I can't look how I look and be a mom. So, I assimilated as fast as I could... I just tried to be straight. I tried to look like a woman. And really is like the work I had to do is to you know, do that in order to keep my daughter safe. (Devin)

To defend and protect Gili and their community, Devin does everything they can to align their life with Gili's, and with other queer people. Devin notes that when other parents see them caring for their daughter, they say things like "I just don't know how you do it", and the answer is,

## Justice and Becoming

sacrifice and mindfulness, and falling back on community when needed. But Devin's true trick to doing it all is to join Gili and get to know Gili without assumptions.

And I'm like, yeah, no matter what, I'm giving up something somewhere. So, I try to align the two, you know? If you can align, if you can join your kids, where they are, you can get a lot done. And, you also have to give up any preconceived notion of what your kid is going to be, period. Just go ahead and give it up now. And then you won't have to do more work later. So, it's truly about, this person has nothing to do with you. They just came out of your body or came to your life somehow. And now you're going to join them and give them the best time that you can give them on a planet and, you know, funnel life skills into them as much as you can. So, if you can make your life join with theirs, you'll have a lot more energy left for yourself. But you're still never gonna use the bathroom with the door closed. Never. (Devin)

To fully be there for Gili, Devin experienced individual losses, their career and their love life were notable. Devin recounted giving up an unpaid internship with Alexander McQueen in London at the start of their career, and more recently, taking over a successful circus studio and production company in the Southeast.

I gave that up because I'm a parent, and I cannot resent anything about it because I have to make my choices. And they're all mine to make. But – (Devin)

## Justice and Becoming

Among that “but”, Devin gave up romantic relationships for years, assuming that they “would never have one that was normal, you know, because there was something wrong with me. And because I was like, I'm damaged goods”. This perspective has begun to shift for Devin, after years of challenges, Gili's medical needs and care began to level out, and a part of Devin describing success is that they start to give themselves permission to be intimate again.

And when things started to get medically a little better in our lives, and I hit this moment a few years ago of, we still don't have any money, but things are leveled off and I feel like a successful person. And you know what would happen if I play? (Devin)

Although play is a common term used in leather community for sex, scenes, and dating, Devin's use of this word is notable. For someone who puts so much work into creating and preserving joy, to have limited their “play” in the face of scarcity is a sign of the weight of Devin's care for Gili. Devin pushes through the “energy management” challenges of raising Gili largely alone as a single mother, community was also there for them, specifically other parents of children with disabilities.

I think all the disabled parents, they're like some of my daughter's best friends. We kind of support each other a little bit, where we get together every few months and we end up talking about, what's the little piece that we're scratching at right now? And how do we find solutions? (Devin)

## Justice and Becoming

Devin glowed about one woman in particular, who taught them some critical lessons about raising a child with disabilities, such as the balance of care in the face of scarce resources.

One is that quitting your job in order to take care of your kid, even if you're the only income, is okay. You know, you have kids that have medical needs. You're either going to work to hire somebody to do it, or you're going to do it, whichever one works. I've tried both. (Devin)

And when you can't be there, like in the case of a contentious PTA meeting that Devin could not attend Devin had to trust community to show up for them. When an article in a local print news source came out about Devin's more "adult" fashion designs, parents at their daughter's school were upset about it, and Devin's ex's ex, a fellow queer, came to their rescue,

So she stood up in the middle of the PTA, which I could not go to because I couldn't afford four hours of babysitting, and you can't have kids in the PTA, even though the school is right across the street, so that's like single mom realness right there. (Devin)

Devin is now dating her.

### *As a Trans Person, I Suddenly Have an Answer*

Strangers inquire about Devin's motherhood and family, and they ask with prejudiced assumptions disguised as pragmatism. Comments from the billing department, the receptionist, to medical personnel are likely to make some sort of microaggression. This gives the message

## Justice and Becoming

that the provider does not trust patients to be honest about their risks and sexual health. Devin's similarity in age to their daughter is a common topic of "conversation" but among those who do not provide their medical care.

I'm there like trying to get a medical thing done... It's going to happen more in the billing department, or something rather than the actual doctor where you're like, how much energy do I want to lose over somebody not knowing, and they're just doing billing? I don't want to have all those conversations all the time. (Devin)

Rude comments like "oh you started early" are anticipated. Unwanted and unnecessary pregnancy testing is a common experience of people with a uterus, and that standard protocol is yet another example of not trusting patients. Comments from providers like the one below shows the assumption that a patient is being dishonest about their risk and health status.

But I've had some things where when I only had sex with men, they'd still give you a pregnancy test. I'm sorry, when I had only had sex with women and not had sex with men for like eons, years. There was one time I was like, why do I have to pay for a pregnancy test for this? And they're like, well, it's routine. And I was like, but I'm gay. And they're like, we've been fooled before. We're generally, you just get these little tidbits of somebody saying something that they really shouldn't. (Devin)

During their interview, Devin offered a case study within a case study. I have included this meta-study because of the power of this narrative and the harm created when providers did



## Justice and Becoming

not trust MTE. The pain and medical harm began when Devin was a teenager and continued until they accessed medical care as a trans person. It's also notable that Devin credits Obamacare as the only reason they were able to access medical care for gender affirmation purposes, because they would never have spent the money on themselves and their transition when Gili could always use more care and resources. With how much Devin protects and prioritizes the wellbeing of others, the astounding neglect of their providers is especially harsh in contrast.

When I was 16 my mother had put me on birth control because she thought I was going to have sex. And, of course I didn't want, you know, I didn't consent to it anyway. And then the doctor changed it by half strength. Just for fun, just like, well, you might not take it at the same time every day, and just did that. I lactated for two years and then had breast pain for 16 years. And the moment that I started testosterone was the moment that my tits stopped hurting. If they had ever, I had tests done, I had, like all this other stuff, you know, for a long time. And then I would revisit it every now and then. And some years, it would be worse than others. Some years, I would wake up screaming at night, and didn't know it until somebody else told me. It's like, having a shoe box of pain on the front of your body. And so, as a woman, I would not get health care for that because I'm within the normal range in my hormonal levels and my prolactin levels. But as a trans person, suddenly I have an answer. I don't know what that means, but it just adds to my thought of like, women don't have health care, and nobody cares. I mean, if we can make tits bigger, and if we can make people have more babies and we can make women more desirable to the male gaze, then there's tons of money and funding and all of that. But

## Justice and Becoming

you'll see where men don't really have an interest. There's no funding and we don't care.  
(Devin)

The examples given at the end of this narrative are poignant when it comes to trans health care. Considering the differences in trans experience, motherhood, and diverse healthcare needs as no two trans people are alike, this perspective of what is prioritized by the US medical system leaves trans people out, leaves mothers out, leaves out anything that does not center the male gaze.

### **Major Categories in Interviews**

This research study aimed to answer the core research question, how is motherhood embodied and enacted in the daily lives of trans women? While exploring the influence of gender identity on motherhood and family building, the ethics of distributive justice and autonomy surfaced in each interview. These interviews had a consistent tone of advocacy, as each participant spoke to the importance of family, relationships, closeness, and self. Two major categories emerged from the interviews, becoming, and barriers to medical care.

For Joyce, Nina, and Devin, a large part of family building, and becoming oneself, involved interactions with healthcare providers. In medical and non-medical settings, Joyce, Nina, and Devin all used ethical considerations when caring for themselves, their children, and their communities. As each mother shared their stories of being a goddess, lioness, crone, a protector, healer, and educator, it struck me that they were all creating and becoming with their kin. However, all three participants had negative experiences with healthcare providers. I will

## Justice and Becoming

first share the individual theme of becoming, and then situate these experiences with providers using foundational principles in medical ethics.

### **Becoming**

Each interview began with a question on becoming with the prompt of, “tell me the story of how you became a mother”. Organically, almost intrinsically intersecting, participants ended up answering this question for almost the entirety of the interview, as these stories of struggle, becoming, suffering, resilience, and rebuilding were shared. I was unsure how to describe these layered narratives that intersected in these interviews and am mirroring participant’s language by including becoming one’s authentic self and becoming a mother as themes in this category.

It is a notable finding of this research that each mother interviewed mentioned their gender transition or queerness as a part of answering the first prompt about becoming a mother. The two are connected in the narratives of all mothers interviewed. Spiritual guidance and divine timing were secondary themes to these stories of becoming. Joyce’s becoming stories had a trusted sequence as “everything lined up”. Her self-reflection and frustration of not knowing sooner was healed by this faith in timing, and her role as a mother.

You have to trust that certain things happen for a reason. And they happened when they were supposed to happen. Because, I used to beat myself up over not transitioning to womanhood sooner. I would look at these girls that transitioned when they were 16, 18, 20 and I was 27 before I, the light bulb finally came on. And it was like, what the hell have I been doing all these years where I didn't recognize this part of myself sooner? But now that I look at it, everything lined up. And had I transitioned any sooner, any later, I

## Justice and Becoming

may have missed that divine moment in time when I was in that, when I was in Ava's living room, and she asked me to be his godmother. Yeah, I really feel like my steps were ordered. (Joyce)

For Devin, gender complicated their guiding force, and it took community to guide them to how energy and spiritual force can be present in their body as a mother. Goddess is tied to feminine, which is tied to creating life, but trans-ness does not mean male, or a disconnect with embodying the Goddess. Even their question, "does the world need a man now" is an example of them grappling with their own becoming of self, while being rooted in Goddess experience and energy.

I would say that the most feminine that I do feel is wrapped up in being someone who has created life. It took a lot for my friends to get me to use this term like Goddess, and to sort of wrap my head around how I could embody the goddess and, and then now it's just like, had a lot of gender identity stuff with, one, if I'm trans am I becoming a man? I look like a man, hey, let's just say does the world need a man now? Which is a very external thought, you know? (Devin)

I just heavily identify with being a lioness. I think like the chemical reaction of guarding your young is one of the most intense chemical reactions we have as humans. That has always been a really big part of my identity, because it started so young. (Devin)

## Justice and Becoming

Joyce tells her becoming and story of becoming with her transition and connected becoming a godmother to her transition, as the birth mother of Joyce's godson needed to see her as her authentic self to ask her to genuinely step into a mothering role in Kingston's life. Although she describes it as happening during a "casual" moment, it's clear how critical it is to be seen by her kin in this moment of family and new identity (motherhood). Ava's choice to ask Joyce to be Kingston's godmother was a part of seeing Joyce as her authentic self, and loving Joyce.

I just felt very honored that she would even ask me out of all the women to ask to be his godmother. That she would ask me and especially, I think as a trans woman, it's really validating. I can't I can't fully explain why, but well, maybe I can. I mean, I think a lot of people see trans women as something less than real. And then on top of that, they typically see us as predatory. So, for her to look at me and see not only a real woman, but someone who could genuinely love and care and protect her son, it was just such a huge honor. And so, I said yes within a few seconds. And, and that's how it happened, in her living room, just during a really casual conversation. (Joyce)

Nina did not become a mother "magically". It is clear that she critically considers gender as she moves from becoming a father, then parent, then mother.

I brought a woman back to A Southeast metropolitan area with me. She got pregnant, not magically I mean obviously I was a participant in it, but so we got married and had a kid ... So I was, I was his father. And so, when you said talk about motherhood, you know,

## Justice and Becoming

that's more of a recent development. ...I do believe that some of the roles we put on people it's all over the place. And really when you do more of the single parenting, you're more role fluid. You know it's like gender fluid but you're role fluid, you have to do both. You have to be nurturing and loving and all the things that people usually associate with mothers. And you have to be stern and, and fun, and things that you associate with fathers- it was really just, I was a parent. I couldn't really call myself a mother or father at that point. I was his parent. (Nina)

Both Nina and Devin considered their children in their transition timelines and having unique expectations of their children's understanding of their transness. Devin notes that Gili may have discouraging responses to their transition, which influenced Devin's decision to come out as trans when they did, and the fact that they have not come out as trans to Gili.

I think she would be angry if I have top surgery<sup>7</sup>. She'll be like, I don't like what you did to your body. Like, why'd you do that? You know? But other than that, I'm giving her a path. You get to call me anything you want. Yeah, for the rest. I don't really care. Like she calls me Bunny, and nobody else calls me Bunny, ya know?... I have no idea. She made a plaque with like my given name and then Bunny, you know? So, whatever, she earned it, she has me as a parent, dear God. (Devin)

---

<sup>7</sup> Top surgery is a subcutaneous mastectomy to remove breast tissue (Mayo Clinic, n.d.)

## Justice and Becoming

Its almost as if Gili has chosen a name for Devin that is fitting to their relationship and to Devin's gender. Devin may not be out to Gili as trans, but as a gifted see-er, Gili knows that there is something unique to the way Devin has shapeshifted to protect Gili.

Devin, Nina, and Joyce all reflected on their own families as other mothers they looked up to, learned from, admired. They shared immense pride, gratitude, critique, pragmatism, and creativity as they engaged with those who parented them. Joyce named how even something as intangible as loss and wanting for something that was not there was a guide for her to know how she would mother Kingston.

My village kind of started falling apart when I was 16. My Mother, she passed away from lung cancer when I was 16 years old, she was 38. We don't know how she got it. She never smoked, nothing like that. It's kind of a mystery how she even got lung cancer, but she passed away. I never really had a strong relationship with my father. You know, he did get remarried. So I have a stepmother. She's always been a pretty positive influence in my life. But my village, I would say, these days, my support system is very weak.

A lot of times I've had to be my own support system. I am blessed to have a man in my life. He's very supportive of me. We have definitely had our trials within our relationship, but I'm blessed to have that. I think what it has done for me, though, is, I felt like in some ways, it's helped to make me a little bit better of a mother figure. Because I know what it's like to feel like you don't have anybody. I know what it's like to feel like your village is virtually nonexistent. So, you know for me now there's this deep desire to

## Justice and Becoming

have a family, to have my, to have children in my life, to have a loving to have a loving husband. I guess the lack of having a village has made me more family oriented. (Joyce)

Devin, who shared that they are in limited contact with their mother and father, nominated another mother in the disability community as their possibility model.

This one mom is like a really incredible mom. She quit her landscaping thing and became a paralegal advocate for kids with special needs. And now I think she started another school and another church. And it's just, I don't even know, I don't even know how connected she is and how incredible like a resource she really is, you know, but she has figured out so many things with how to navigate and operate all of it. You know, you go you go through having to fight for free and appropriate education, which is never free or appropriate at the end of the day, and she did it she did it so well. You know, she really changed the world for other people. (Devin)

During the interview Devin downplayed their community at times, circling back to being a single mother and the struggle of navigating things alone. And, they shared admiration for this mother, other parents, and community that they trusted with their life- literally, on a trapeze. Devin describing this other mother as a community resource, present and great parent, and fierce advocate, is exactly the image of Devin I got from the hour I spent speaking with them. Devin's hero, a mother they look up to, is a lot like them.



## Justice and Becoming

Joyce finds the supportive mothering figure in her life in the social media personality, and actress Tabitha Brown. Although Joyce brushes this off as something “weird”, it is notable as she has found representation through alternative sources. This is not only resourceful; it is creative and insightful. What Nina did for trans representation, reaching out to alternative sources for affirmation, support, and care, Joyce is doing for representations of motherhood.

Just hearing her voice, sometimes she'll make these quick videos where she talks about loving yourself. Not getting caught up with what people think of you, but what you think of yours. Like, things you need to hear from a mother pretty much. I think when you're in a position like when I'm in, when you don't have a biological mother anymore, sometimes you look wherever you can to find those conversations that you wish you could have with your mother, or to find those words that you wish you could hear from your mother, even if that's from some random woman on social media, so yeah. (Joyce)

For Joyce, Devin, and Nina, becoming took whole kinship networks and their community seeing them and supporting them, their children most of all. And it became very clear when community resources were not supportive of them as mothers and did not see them. The way Devin describes not being known as Gili's parent during school pick up is a crude and pointed critique of what makes a mother, and part of it is knowing Gili.

Even in my daughter's school like just not being recognized as someone who is a parent, because I'm coming in as this queer dyke or, or whatever age I was, and rolling up in some affluent school with a pickup truck. Literally, one time I, we've gone to the school for five years, and the receptionist at the front was like, well, I can't let her out early because I don't know if you're her mom unless you have some proof. I was like, I

## Justice and Becoming

have stretch marks underneath my vagina, would you like to fucking see them right fucking now? Like Give me my kid we have to go. Oh, like you know, just immediate rage. I've dealt with this too much, that lioness saying comes out. And like, yeah, jaw on the floor, she picks up the phone.

Like, how are you gonna identify me as a mother? You know, like, how low my tits hang? What are you talking about? Nobody carries have a birth certificate. Yeah, we've been going to the school for five years. I knew the lady, she didn't know me. She had her eyes closed because I'm very visible. When you have like a kid that's got special needs, like how many of them are there in that school? You know? they should know all of them on a first name basis. (Devin)

Nina included Kevin in her transition from the beginning, but Kevin took his time calling Nina “mom”. When he did, Nina made sense of the comical moment of becoming “mom” by stating that she just didn’t know what it was going to take, but that she was happy she was no longer “Aunt Natalie”.

We went to the beach and this is the first time he called me something, because we're going through like, what am I going to call you? Aunt Natalie, I'm like what? You can call me by, like, I'm your aunt and that I was like, Okay, I mean, whatever makes you comfortable, you know, the thing is, I gotta let you find what works for you. So for a while, it was aunt Natalie. And then one day we were at the beach and we're in the store and he wanted my attention. He's like, (stuttering) uh da-uh-mo-MOM. and all of a sudden it was like --And I turn. He said, mom come here.

And it just came out, and he just kind of noticed that the world didn't crumble. You know? Everybody didn't go OH! No one was jumping no and no and Pat's not a mother. And then he was like, Okay. So that eased it up a little. But then one of his best friends came over. He hadn't introduced me to any of his friends as his mother yet. Finally met his friend, and we had a normal night, at least I thought it was normal and took her home. He got a text and just said, your mom is awesome. And he just, from that point on that was all he needed. To be okay with it, you don't know what it's gonna take. It might take outside affirmation; it might take a lot of negotiation. (Nina)

### **Reproductive Health & Medical Services**

#### *You Know What You're Doing, And Here You Go*

All the participants I interviewed had experiences with providers not taking them at their word, or not giving them all the information possible, or having them jump through hoops to access resources. This gatekeeping was a strong theme throughout the interviews. Nina faced a “women’s health center” that did not have resources for, nor were very friendly or helpful to trans women. She said that she had to look up most of the information about her transition on her own. Nina’s access to resources depended on her own research and perseverance, and investment from others, and a bit of luck. She spoke about her own access to resources as something she found herself or got lucky with.

Well, in order to get through any of this stuff, whether it's hormones or whatnot, you usually have to have sign off by doctors. So luckily, I had one for a long time. I've had a therapist for a long time. And so, I was able to talk with her about it. But there's no one.

## Justice and Becoming

There's no one who understood it...medical community was not very insightful for me and even the people who gave me the hormones and everything they've worked with trans people before. (Nina)

Nina's note that even those with "experience" were not very insightful is critical, as no participant had glowing reviews for their providers when it came to working with trans individuals. All participants recommended further education for providers, that recommendation is supported by Nina's honest and disappointed review of her providers who were supposed to be familiar with trans patients.

Always the educator, Nina takes time to share protocols that removed some of these barriers to care. Transparency and trust between provider and patient are the reasons Nina loves her current provider. This provider advertises cost and that they see trans patients upfront so patients can come in prepared. This provider also uses an informed consent model of care, which is considered best practice when providing gender affirmation services.

They advertise it and they're very upfront, and they don't. I came in with the, I come in prepared. So, I come in with a doctor's thing and they're just like, Hey, you say you want it, you get it. You know, you don't have to twist our arm and convince us. And that's why I loved them. I loved them from the beginning. That's how it was. And it was just like, you know, informed consent. You know what you're doing, and here you go. You don't seem like you're doing this to blow up a building. You just want to be more, who you want to be. And I mean, that's honestly, what was so nice about it. (Nina)

## Justice and Becoming

### *“Treated as Individuals”*

The danger of a single narrative was discussed by every participant in this study. All the mothers interviewed cautioned that there was no “normal” or “typical” trans person, and that includes the medical care they will need. Nina noted that providers needed more than the education she would likely give to them when she became their patient. Devin pointed to gaps in research and medical knowledge regarding trans populations. And Joyce, directly and succinctly summed up all their critique and request for better representation and care.

Yeah, I mean as much as they're there to help me I'm, I'm something new to them and I don't consider myself like, yep, she's a typical trans or I mean there isn't such a thing. So, if they're gonna base everything off of me they're gonna be fucked. (Nina)

I think most of us just want to be treated as individuals, and not, this is what's normal for, you know? We do want to be measured against data that is normal for people like us, in our age range, and potentially our body type or whatever, the data is useful, but we want to hear that there is individual care that is being considered for our bodies. (Devin)

One trans person is not like any other trans person. (Joyce)

Because providers seem to be struggling to learn how to care for trans patients, self-advocacy is a tool that each participant used to interact with providers and to access the care they need. Devin defends their protective stance over their own wellness, and shares that they have low expectations because the training for providers is conducted in a patriarchal and transphobic

## Justice and Becoming

system. They also note the way that smaller things, such as documentation, play a role in the energy they bring to an appointment. Even with these low expectations and understanding that the issues are larger than a single provider, they are generous with their patience and kindness as they are misgendered.

These are my body parts and they're my current body parts, and I have to take care of them. It comes with an understanding from me that women period, any kind of woman, has zero healthcare. Trans people don't really have health care. And everybody is taught by men. So, that's where I'm starting, is not to expect too much...I have enough grapes to know like, I don't care. I don't it doesn't bother me what people call me. My license has not changed yet. My passport has not changed yet. There's only so much I can ask for. I don't need to be rude with any of them about it. (Devin)

### *“Just Start with Asking”*

But this solution to learning and connection is simple, human, and common- providers need to ask trans patients about their lives and about who they are. Joyce and Nina both experienced providers not asking about their families or about reproductive healthcare, and Devin was treated for things that they did not need to be.

Just start with asking people how they want to be addressed and what they want to talk about, and what is really going on for them and address those issues. (Devin)

## Justice and Becoming

No one asked me shit. Come on. No. I don't think-... I think they need to understand a lot of the issues and how important it is to convey it. I mean, like I said, I felt it was too late to really have a sound mind to make that decision. As long as like, Hey, we're going to do this and make it really affordable. (Nina)

(When asked how providers have asked her about her family) No. I'm so embarrassed. I don't know why I'm embarrassed answering these questions. But no, they have not. I don't think I've ever you know, because I go to doctor's appointments pretty regularly for bloodwork and those types of things, to make sure that my hormone levels and everything are good. And in all the visits I've had over the last two years they, I don't think they've ever once asked me about that or talked to me about that at all. (Joyce)

While discussing her very challenging and lacking experiences with gender affirmation medical care, I asked Nina the question, when does it get good? Her answer is that it doesn't, it is endless transition.

Shit...It's kind of like you want that to be the end. But it's not the end that you have to realize that we go through a metaphorical transition throughout our lives. We're constantly changing. We're constantly adapting we're becoming new beings but Kind of like, well, maybe this part's done, and it's not. And kind of might have had that thought like, well, at least that part will be behind. But it isn't, you still have things you have to deal with and, and that gets to you. And I think they, people could do a better job of

## Justice and Becoming

understanding...it's like, transitioning, go and transition and then start it all over again.  
And you know, that's what life is, is endless transition. (Nina)

### **Discussion**

The findings on reproductive and medical care services brought up themes of justice and autonomy, as Nina, Joyce, and Devin all shared the importance of being treated as individuals and experiencing inequalities due to transphobia and prejudice. Some of these discrepancies in justice and autonomy, such as not being informed of reproductive health care options, and participant's advocacy to discredit the single narrative of trans experience, prompted this discussion to focus back to the basics. I offer two founding publications that have contributed greatly to SGM's treatment by healthcare providers and the medical field. The American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM), and Beauchamp and Childress's Principles of Biomedical Ethics.

The DSM is an important medical text to situate the issues of autonomy and justice in the care of SGM. The DSM gives diagnoses to the dehumanization of SGM populations in clinical practice. Beauchamp and Childress's Principles of Biomedical Ethics, an ever developing and foundational framework of biomedical ethics, will be the focus of this discussion section. These works provide a roadmap of where SGM, and mothers like Joyce, Nina, and Devin, are further marginalized by systems set up to support medical care and healing.

### **Background and Significance of the DSM-5**

One of the outstanding sources of ethical debate over medical classification and treatment of SGM is the American Psychiatric Association's (APA) Diagnostic and Statistical Manual



(DSM). The DSM is critiqued and credited with providing highly influential organization to the medical stigmatization and pathologizing of SGM. The DSM is the primary resource for clinical mental health diagnoses in the United States. The history of the DSM's development gives context into how foundational the DSM was to national and international medical fields, practice, and research<sup>8</sup>. Now on its fifth edition, the DSM remains a cornerstone text of the mental health field, and a core diagnostic tool for healthcare providers, policy makers, and patient care.

In conversation with its significance, the DSM reclassifications of SGM offer a timeline of the pathology, immaturity, and normal deviance categorization of SGM. Pathology categorized SGM individuals as having a disease, a deviation from normal, defective, or morally corrupt. Immaturity used the lens that SGM behavior and self is something that can be outgrown, coached away, and is natural in youth but not in adulthood. Normal variation is the theory that SGM occur naturally, the born this way narrative is one of normal variation, where homosexuality can be defined as neutral (Drescher, 2015).

In 1952, the DSM-I included "homosexuality" as a "sociopathic personality disturbance" and in 1968, and then reclassified homosexuality as a "sexual deviation" (Drescher, 2015). The DSM-II took "homosexuality" and reclassified it as "Sexual Orientation Disturbance". In the case of gender, there was no mention of transgender or gender variance until the DSM-III, when in 1980 the diagnoses of "transsexualism" was added. In 1973, after much debate about what

---

<sup>8</sup> The APA's development of the DSM began pre-world war II in 1917, where the APA collaborated with medical associations and the federal government to begin to strategize about how to best collect and compare diagnostic data across multiple hospitals, known as ICD-6. This collaborative streamlining effort prioritized data collection on psychiatric illnesses. Post World War II the United States Army created a more detailed categorization system to better treat veterans, and, influenced by the Army's classifications process, the World Health Organization (WHO) developed the ICD-7. In 1952, the APA then published a variation of the ICD-7 that was to become the first edition of the DSM (*DSM History*, n.d.).

## Justice and Becoming

qualified as a mental disorder, the APA Board of Trustees voted to remove homosexuality from the DSM. They ruled that homosexuality did not qualify as a mental disorder because it did not fit the defining characteristics regularly causing distress, being associated with generalized impairment of social functioning. The DSM-III then reclassified “sexual disturbance” as “Ego Dystonic Homosexuality”, giving legitimacy and billing opportunities for conversion therapies (Drescher, 2015).

Although not removed from the DSM as homosexuality had been, in 1994, the updated DSM-IV replaced “transsexualism” with “gender identity disorder in adults and adolescents”. In 2005, the DSM-V replaced “gender identity disorder” with the diagnosis of “gender dysphoria”. The current version of the DSM, the DSM-V states directly that “gender nonconformity is not a mental disorder” (*TGNC Guide*, n.d.), This is a significant shift from 1980 as it diagnosed based upon gender related stress, and not on trans identity. These updates and removals of diagnoses pathologizing SGM shifted the conversation in the medical field from curative, to treatment, and now on the mental health needs of SGM individuals and populations (Drescher, 2015).

Although progress, the separation of SGM identities from mental health disorders is very recent, gender identity was only removed 15 years ago to date. Any medical provider who completed their training prior to 2005 would likely have been trained that gender identity was to be pathologized, or it was immaturity that would be outgrown. The DSM does not stand alone as a medical manual with a history of facilitating stigma towards SGM, but it is an excellent example of how SGM populations have been considered through the lens of healthcare: diseased, immature, and abnormal variation.

## **Background and Significance of Principlism**

## Justice and Becoming

Beauchamp and Childress's Principlist biomedical ethics (BPE) was selected as literature identifies it as a foundational bioethical framework that includes the principles justice and autonomy. Literature is in agreement that BPE is one of the most prominent and underived theory of biomedical ethics (Rauprich & Vollmann, 2011). Beauchamp and Childress are credited as critical contributions to founding the field of medical ethics.

The moral framework laid out in *Principles* has had an enormous impact on academics and practitioners across a wide variety of disciplines, ranging from bioethics, clinical ethics, and research ethics; to philosophy, theology, and public policy; to medicine, nursing, and social work; and more. Beauchamp and Childress's bioethical framework—usually referred to as “Principlism” or “the four principles approach”—is probably the most popular one in biomedical ethics today. (Shea, 2020)

Now on its 8<sup>th</sup> edition, Beauchamp and Childress's work has been consistently adapted to respond to criticism, and developments of the medical and bioethical field. Beauchamp and Childress's work has retained a respected presence in the field as it has been updated over the past 40 years. Like the DSM, these revised editions are considered a valuable documentation of how the field of bioethics and patient care has developed (Rauprich & Vollmann, 2011). In conversation with this comparison, it is of note that Beauchamp and Childress published the first edition in 1979, six years after homosexuality was removed from the DSM. This implies that BPE was created within the context of a new non-pathologizing understanding of homosexuality. However, trans individuals still considered diseased by the DSM until 2005, only a few years before the 6<sup>th</sup> edition of BPE was published in 2008.

## Justice and Becoming

BPE is comprised of four principles of biomedical ethics, with the theory that all ethical considerations in bioethics can be explained by one or more of these principles. The four principles that make up the Principlist foundation of biomedical ethics are:

1. Respect for Autonomy (a norm of respecting and supporting autonomous decisions)
2. Nonmaleficence (a norm of avoiding the causation of harm, lessening, or preventing harm)
3. Beneficence (a group of norms pertaining to relieving harm and providing benefits and balancing benefits against risks and costs)
4. Justice (a group of norms for fairly distributing benefits, risks, and costs)

(Beauchamp & Childress, 1983)

Principlism's detailed and complex framework has implications for biomedical issues, such as end of life care, consent, dying request, undue profit, etc. For the sake of this analysis, I will exclude subjects that are not included in Nina, Joyce, and Devin's interviews. With the narratives shared by these three mothers, I will take the opportunity to deconstruct and critique the limitations of BPE. By applying this bioethical framework, I aim to acknowledge possible cracks in the foundation of biomedical ethics, to encourage continued critique of the treatment of SGM populations and MTE by the healthcare field. I will use the most recent edition of Beauchamp and Childress's BPE to situate my discussion, as to keep critique current.

### **Respect for Autonomy**

## Justice and Becoming

According to Beauchamp and Childress, “to respect autonomous agents is to acknowledge their right to hold views, to make choices, and to take actions based on their personal values and beliefs. Such respect involves respectful *action*, not merely a respectful *attitude*.” (Beauchamp & Childress, 1983). Additionally, when framed as a negative and positive obligation, “autonomous actions should not be subjugated to controlling constraints by others, and, this principle requires both respectful treatment in disclosing information and actions that foster autonomous decision making (Beauchamp & Childress, 1983).

Competence is intrinsically tied to determining if a patient is an autonomous agent, and in multiple disciplines such as law and medicine, criteria for a competent person and an autonomous person are similar. “The law has traditionally presumed that a person who is incompetent to manage his or her estate is also incompetent to vote, make medical decisions, get married, and the like” (Beauchamp & Childress, 1983). Consider this alongside the only recently lifted legal restrictions on marriage, and the barriers that come with not having legal documents that match your name and photograph.

If a person is not competent and has inabilities to communicate, understand, give reason, understand risk, etc., they may be considered incompetent and unable to act as a fully autonomous agent in their medical decision making. The standards of competence often include measurement of mental or cognitive skills. Patients must be, “capable, psychologically or legally, of adequate decision making”. Beauchamp and Childress also note that, “in medical contexts, physicians usually consider a person competent if they can understand therapeutic or research procedure, deliberate regarding its major risks and benefits, and make a decision in light of this deliberation” (Beauchamp & Childress, 1983). Although legally, it may not be up to providers to deem someone incompetent; providers are still gatekeepers. Providers are in positions of power

## Justice and Becoming

over patients, and therefore the issue of competency is one that impacts patient and provider interaction.

“Physicians and other health professionals do not have the authority to declare patients incompetent as a matter of law, but, within limits, they often have the de facto power to override or constrain patients’ decisions about care.” (Beauchamp & Childress, 1983)

The position of power providers hold, and with a patient’s autonomy depending on one’s competency, the historical pathologizing of SGM populations must be considered in the context of determining SGM patient competency. Can a population considered diseased until 15 years ago have true equal footing as a competent autonomous being in a medical setting? In any setting?

### *Application of Findings, Autonomy*

There are multiple examples of respect for autonomy in the experiences shared by Joyce, Nina, and Devin, and suggestions of how providers may have perceived their competence. Beauchamp and Childress give examples of inabilities that help determine competency, and although we cannot know from Nina, Joyce, and Devin’s accounts what their providers were thinking, these mother’s experiences echo providers’ “inability to give risk/benefit related reasons” about medical practice. All three mothers interviewed offered critique and reflection on how they were in a position where they had to educate themselves and their providers about their health, specifically about their gender affirming healthcare.

## Justice and Becoming

I offer this quote from Beauchamp and Childress's section on the patient's understanding and autonomy as a script and tool to clarify the way PBE centers providers as experts, and the inverse option of patients as educators.

“Some patients have such limited knowledge bases that communication about alien or novel situations is exceedingly difficult, especially if physicians introduce new concepts and cognitive constructs. Studies indicate that these patients likely will have an impoverished and distorted understanding of scientific goals and procedures. But even in these difficult situations, enhanced understanding and adequate decision making are often possible. For instance, professionals may be able to communicate novel and specialized information to lay persons by drawing analogies between the information and more ordinary risks in both numeric and nonnumeric probabilities, while helping the patient or subject to assign meanings to the probabilities through comparison with more familiar risks and prior experiences” (Beauchamp & Childress, 1983)

Now, consider the roles reversed, with the patient as the educator, working to ensure the provider's understanding of their care and needs. This is a more accurate representation of how many individuals who are trans experience interactions with healthcare providers, as educators.

“Some providers have such limited knowledge bases that communication about alien or novel situations is exceedingly difficult, especially if patients introduce new concepts and cognitive constructs. Studies indicate that these providers likely will have an impoverished and distorted understanding of scientific goals and procedures. But even in

## Justice and Becoming

these difficult situations, enhanced understanding and adequate decision making are often possible. For instance, patients may be able to communicate novel and specialized information to lay persons by drawing analogies between the information and more ordinary risks in both numeric and nonnumeric probabilities, while helping the provider or subject to assign meanings to the probabilities through comparison with more familiar risks and prior experiences” (Edited excerpt from Beauchamp & Childress, 1983)

This demonstrates how Beauchamp and Childress give primacy to the provider in their analysis. The impact of this is that patients may not be seen as experts in their own experience. The healthcare field’s long history of pathologizing and stigmatizing SGM populations may influence providers care in such a way that even if their intention is to heal and care for an SGM individual, that they are replicating and inflicting further harm. Judith Butler offers a cautionary analysis of this occurrence in her essay, *Doing Justice to Someone*, looking at the David Reimer case and the provider’s will to create the unbothered cisgendered self through socializing an infant as a woman after a botched circumcision (Butler, 2001). This prioritization of provider and clinical “expertise” may disempower patients to receive care that fits their needs, and, put patients in a seat where field-opposing self-advocacy is a necessary tool to navigate medical care. In addition, it has necessitated SGM patients to be the educators, experts, and do their own research to self-guide their medical care.

The lack of guidelines from Nina’s provider put her in a position to self-educate, and during the late 90’s and early 2000’s, this meant that most of the resources for trans folks were other trans folks. Nina spent a lot of time on the internet reaching out to other trans women, trying to find out information that her provider had not.



Well, internet searches, like, “is this normal if I...I have not stopped crying in eight days straight. What the hell is going on?” Yep. You're going through this. Ah, Okay. Yeah, and then you find people on Facebook, and things like that.

Beauchamp and Childress note concern about providers fostering patient’s dependency on them, thus making patient dependency a staple of the shared decision-making process and creating a possible barrier to patients’ autonomous decision making. It is important that patients overcome their dependency so that they can gain control of their own medical care (Beauchamp & Childress, 1983). This is an interesting concern to pair with the immense amount of self-education and resource seeking Nina did during her transition. Nina praised informed consent models for HRT and gender affirming healthcare, and implied that the informed consent process is why she loves going to this particular healthcare provider. Nina’s providers may have reduced gatekeeping to HRT by trusting Nina’s independence, knowledge, and decision making. There was not concern about dependency, and Nina’s providers use of an informed consent model mitigated unequal power dynamics between patient and provider.

And that's why I loved them. I loved them from the beginning. That's how it was. And it was just like, you know, informed consent. You know what you're doing, and here you go. You don't seem like you're doing this to blow up a building. You just want to be more, who you want to be. And I mean, that's honestly, what was so nice about it. But they didn't, they didn't give you many guidelines or anything.

## Justice and Becoming

Nina's providers trusted Nina's competence in decision making and respected her autonomy, and this made her love them. Nina had full capacity to understand information, make a judgement in light of her values, and to intend a certain outcome, while communicating her wishes freely.

Beauchamp and Childress provide the guidance that align with the recommendation made by all three mothers interviewed: that no two trans people are alike, and that research and medical care needs to be tailored to the individual. Limited literature and research on transgender individuals and populations pose a challenge to providers tailoring care to trans patients. Sparse literature creates an over simplified narrative of trans experience and does providers and their patients a disservice as it constructs an incorrect normative trans experience. Beauchamp and Childress speak to the dangers of assumption about a patient based on their community and culture and encourage providers to ask questions and never assume.

Health professions should always inquire in general terms about their patients' wishes to receive information and to make decisions, and they should never assume that because a patient belongs to a particular community or culture, he or she affirms that community's worldview and values (Beauchamp & Childress, 1983).

While researchers and community advocates work to close the gaps in literature on SGM health, patients such as Joyce, Devin, and Nina are put in a position of being both educator, advocate, and patient. Often, family members take on this role. Devin notes how they are an educator and advocate for Gili in medical settings, and that is a part of their role as a mother.

In the case of a patient having diminished autonomy, it is common practice for their families to step in and handle their care and make decisions on their behalf. Joyce's healthcare

## Justice and Becoming

providers have never asked her about her family. This creates an immense barrier for Joyce's medical care and decision making should her capabilities be diminished. Additionally, they do not have her family history, as they have never inquired.

Although there were no instances of providers blatantly disrespecting autonomous decisions, there was neglect. In the case of a patient having diminished autonomy, it is common practice for their families to step in and handle their care and make decisions on their behalf. Joyce's healthcare providers have never asked her about her family. This creates an immense barrier for Joyce's medical care and decision making should her capabilities be diminished. Additionally, they do not have her family history, as they have never inquired. As stated by Beauchamp and Childress, the simple act of asking would have strengthened Joyce's healthcare. Not asking about her family may have been rooted in assumptions about MTE or may have been unintentional neglect to seek out information to support Joyce's care. Regardless of what prompted her provider's silence, the outcome was neglectful.

Nina's experience of having providers not share (or possibly know) the full extent of her medical care put her in a position to self-educate and educate her providers. If they knew it and didn't share it, but it was relevant to the care, this could in fact be a failure to respect autonomy by failing to provide relevant information, creating a lapse in the informed decision-making process. Nina's provider's failed to give her relevant information during her gender confirmation surgery. This was dangerous and contributed to her almost dying by suicide. Nina poses that her provider may have thought that because she participated in the informed consent model for HRT care, and as a result did not need additional information or support. It is worth mentioning that this was shared by Nina after my interview questions were complete, when I asked her if there was anything else, she would like to share with me.

I know you said you wouldn't ask me. So, I'm a volunteer. I did have the gender confirmation surgery, and what they don't prepare you for and that there's no one fucking around to help you with. Is the aftermath. It brought me closer to getting hospitalized than I've ever been. And it's not because I regretted it. That's what people always say is like, Oh, is it because you regret it? ...But hormones go fucking nuts. And I hit lows. And there were days where it wasn't just that I cried. It was I was wailing and sobbing for hours on end for a good month. Like there would be dates every day at that month. Just couldn't control the sobs and I didn't know what was happening to me. I didn't understand it. No one fucking tells you these things.

I went up for my six-month checkup and one of the first thing I did was buy a straight razor and a bunch of pills. Because I was like, if they can't fix this, I'm done. And then I was like, they can't fix this.

I knew it was going to be hard. I knew it would be physically exhausting. And I knew that they would tell you that you can suffer a little bit of depression afterwards. But no one no one told me it could be that dark, they felt like since I was under no delusions, like I did not, I did not think this was going to fix me. If I am depressed before a surgery, I'm going to be depressed after surgery. I didn't think that was going to change everything. Same with my transition. It wasn't about being happy. It was about being me.

...So, it wasn't the physical, but it was physical. It was all the different things going on with hormones. It was horrible and it's not about motherhood but man I could have used some fucking help. Psychological, something to help regulate that shit. It was miserable. I was going through puberty and menopause every five minutes (swooshing

## Justice and Becoming

sounds) so horrible. You like have the crying fits and hysterics of being a teenage girl.

And then at night you had the hot sweats and night flashes in you're like, (hits table with hand for exclamation) ...shit (Nina)

This is a failure of respect for persons, as people who are trans are persons and must be treated as such. This raises important questions about autonomy and the lack of autonomous representation of one's true self in contexts where the true self will not be accepted.

The DSM is an example of where the true self of SGM individuals, specifically individuals who are transgender, will not be accepted. In conversation with the DSM, pathology, immaturity, and normal variation are the identified typologies and theories used by health researchers to describe SGM as individuals and as a population (Drescher, 2015). These influencing typologies prompt me to question if the SGM individual's autonomy is related to psychiatric competency. Is the SGM patient, ill, immature, or a variation? If autonomy assumes cognitive functioning, and psychiatric diagnoses by their very definition presume some impact on mental functioning, a patient's SGM identity may predispose providers to treat SGM patients as not fully competent and autonomous persons.

### *Realness & Autonomy*

These interviews contained many accounts of not being seen as "real", not being represented in media and not having access to the same ability to parent as cisgender mothers. I argue that there is a connection between being seen as "real" and being competent and autonomous. Real describes something that has an "objective independent existence" and something that is "not artificial, fraudulent, or illusionary" (*Definition of REAL*, n.d.). Media with

## Justice and Becoming

strong trans representation, such as the television series *POSE*, uses the term *real* to describe a state of being respected and seen as one's true self, to have objective independent existence as a woman. Consider the exchange between two of *POSE*'s main characters, Blanca, a young woman of the trans experience, and Elektra, an established mother and woman of the trans experience.

*Blanca:* Can I be honest with you? I don't think I'll ever be as real as you. No one questions you or looks at you the way they do me. It's not that I give a fuck about what people think, but I do want to be seen and respected as a woman. That's who I see myself to be.

*Elektra:* You think I just woke up one day and poof I looked like this? No. It takes work, drive, sacrifice to be a woman. You have something rarer than beauty though. You have heart, and you're not afraid to lead with it. That quality will get you everything. Now, what is it you want, my child.

*Blanca:* I don't want to be cold again. And I don't want to be laughed at again. I want to be real.

In this quote from the series, Blanca shares her desire to be real so that she can be respected, will no longer be mocked, or experience homelessness. Elektra tells her that heart, work, and sacrifice are the pathways to *real* womanhood. Realness is describing an intentional performance of gender, one which can move through the world without being discriminated against on the basis of one's sex. It is incorrect and an oversimplification to akin realness to

## Justice and Becoming

being cisgender. Realness is described as something that does not depend on others except for the desire to be respected and seen as a woman, to not experience transphobic prejudice.

In these quotes from Joyce and Nina, they both acknowledge the experience of being seen as violent, predatory, and not trusted, because of their gender. They highlight the positive experiences of being seen as real and being trusted by providers and kin.

I think a lot of people see trans women as something less than real. And, and then on top of that, they typically see us as predatory so for her to look at me and see not only a real woman, but someone who could genuinely love and care and protect her son. It was just such a huge honor. (Joyce)

(The provider said re: HRT) You know what you're doing, and here you go. You don't seem like you're doing this to blow up a building. You just want to be more, who you want to be. (Nina)

In these quotes, Nina and Joyce are noting the importance of being seen as real, authentic, and good people. However, these are stand out moments for Nina and Joyce, and the interviews have many examples woven through them of Devin, Nina, and Joyce experiencing being “less than” others because they are MTE.

Dehumanization can be conceptualized as the denial of human qualities and rights to social groups or their members. When human traits are denied, individuals are represented as animalistic or lacking secondary human emotions (Broussard, 2020). Although not stated directly by Nina or Joyce, the surprise that they are not being treated as violent or predatory is

## Justice and Becoming

only a surprise because they are having regular experiences of dehumanization. Evidence of this is in the language Joyce and Devin use to describe how others view people who are trans.

So, you know, discussing it with us as I just been taking for granted that we actually want families and can have family because I think sometimes, they're not aware of that. Or they look at us as something other than human, you know? (Joyce)

My second life mission is to create visibility for LGBTQIA and disabled people. So that basically, humans don't try to kill them, which is what is going on right now, as well and like Black Lives Matter. Humans tend to kill anything that's not like them. unless they've had those moments of touching and feeling that humanity. (Devin)

In these quotes, Joyce, Nina, and Devin shared experiences of themselves and their community of trans and Black people being dehumanized, seen as predatory, inhuman, violent, or their murders normalized.

How does a patient, a person, and a population flourish in medical settings that respect autonomy when they are dehumanized? Principlism was intended to apply as a framework for human medical ethics. Even if there is great respect from providers, medical care does not exist in a vacuum. Dehumanization and pathologizing of SGM makes navigating medical care without barriers to autonomy impossible for MTE. When a patient is dehumanized, how can a framework meant for humans serve that patient population wholly? From a wider public health perspective, when a group of people are dehumanized so often that it is notable when they are treated with respect, there is something sinister rooting itself in our society. To respect autonomous agents is



## Justice and Becoming

to acknowledge their right to hold views, to make choices, and to take actions based on their personal values and beliefs. The dehumanization of people who are trans negatively influences their interaction with medical care, as BPE was not crafted to support patients whose humanity has been put into question by the field of medicine.

## Nonmaleficence and Beneficence

### Nonmaleficence

1. One ought not to inflict evil or harm

### Beneficence

1. One ought to prevent evil or harm
2. One ought to remove evil or harm
3. One ought to do or promote good

Each of the three principles of beneficence requires taking action by helping- preventing harm, removing harm, and promoting good- whereas nonmaleficence requires only intentionally refraining from actions that cause harm, “do not do X”.

Defining harm is necessary in order to consider these narratives using the principles of beneficence and nonmaleficence. According to Beauchamp and Childress, “wronging involves violating someone’s rights, but harming need not signify such a violation. People are harmed without being wronged and can be wronged without being harmed. Although a harmful act may

## Justice and Becoming

not be wrong, or unjustified, Beauchamp and Childress defend that, “acts of harming in general are prima face wrong”. This is because they “set back the interest of the persons affected”<sup>9</sup>.

This group of beneficence norms pertains to relieving, lessening, or preventing harm and providing benefits and balancing benefits against risks and costs. Beneficence requires “positive actions”, and the prevention and removal of harm. Beneficence seems to be akin to protecting another. Many of the hypothesized barriers for providers to provide truly nonmaleficent care can be held alongside provider’s (assumed) intention of beneficence towards their patients.

Beneficence includes the obligation to advocate for others, as it includes all actions intended to benefit others.

### *Application of Findings, Nonmaleficence and Beneficence*

While beneficence is present in the way Nina, Joyce, and Devin describe their own investment in their children, kin, and communities, there is no indication that their medical care included beneficence. It’s absent from their critique and experiences with providers. There are consequences to absent beneficence, and the consequences are found in the findings section on negative experiences with healthcare providers. Throughout these interviews, I saw beneficence mainly discussed outside of medical contexts. Nina and Devin focused much of their interviews on advocating for other SGM individuals, and while Joyce shared mainly how she advocates for Kingston, she describes advocating for him as a Black boy, who will become a Black man, joining a population that is not only marginalized, but hunted in the United States.

---

<sup>9</sup> Justified punishment is also considered under the umbrella of setting back someone’s interest when harm has occurred, such as provider malpractice.

## Justice and Becoming

Devin speaks to the fact that they would sacrifice “to shift in their body” to have more resources for Gili, and the only reason they are able to seek gender affirming care is because of social programs, intended to give equal access to health care to all.

I think right now the only reason that I'm able to do it is because Obama gave us health care, and then Kaiser it's free. I don't think I would be able to have, even if I had the money, the guilt of spending money on myself to shift in my body would never, there's no way I could do it. There's always something else- (Devin)

The obligation of general beneficence is controversial, because it may be demanding and require sacrifice. Devin was ready to make a sacrifice and be beneficent towards Gili, but there was no experience shared by any participant about a provider being beneficent towards them or their families. When considering nonmaleficence in the case of these interviews, negligence is one of the most common themes of harm in the interviews. Negligence is, “the absence of due care, in the professions negligence involves a departure from the professional standards that determine due care in a given. Beauchamp and Childress go on to state that,

Negligence covers two types of situations: 1) intentionally imposing unreasonable risks or harm (advertent negligence or recklessness) and 2) unintentionally but carelessly imposing risks of harm (inadvertent negligence).

The second situation is more pertinent to these interviews, as participants were consistently uninformed about their medical care, risks, and outcomes.

## Justice and Becoming

Professional standards are used as a tool to measure harm, negligence, etc. But what are they when it comes to MTE and healthcare for trans populations overall? Consider the gaps in literature identified in the introduction of this paper. If providers do not have accurate standards of care, I argue that they are in a position where nonmaleficence is not entirely possible. Even with good intentions, without strong and known standards, identifying best practice towards a patient may be impossible, or may put patients who are trans in the position of becoming the educator on professional standards. In this situation, shared decision making with patients may be especially pertinent for providers. However, in the absence of literature and training, if the trans patient is in the educator role while working with a provider, it puts more stress and ownership on the patient.

Devin discusses having to be their own laboratory in the absence of representative literature. Although there is humor to this comparison, the consequences of patients being their own researcher, advocate, and then provider could increase risk to the patient. Alternatively, it is assumed that Devin has chosen this course of treatment for themselves because it is safer and more dependable than seeing a healthcare provider.

Yeah, I think we have to do our own work. And this is something was, my daughter's epilepsy, we are our own, like, test group, our own. Like testing, I don't know, we have to use our own bodies as our own lab. And, that's certainly true for trans people. Every trans person has a different experience. Surely there's things that play into that like age. You know, hereditary things you know, and other health concerns. Our weight, all of those play a big part. So, we can't just like say, Oh, this other trans person told me that, without considering all those other details. (Devin)

## Justice and Becoming

In the case study within a case study Devin provides about their experience with breast/chest pain, we again see the consequences of professional standards. Starting at age 16, while Devin was considered a “woman” according to the literature on hormone levels, their provider changed their birth control without their consent. When Devin began to experience breast pain after the change in birth control, they sought treatment. Their provider, after running tests, informed them that they were within the normal hormone range and so their provider would not treat them for their pain. This was debilitating to Devin, they described their (untreated) condition as, “having a shoebox of pain on my chest”. However, when Devin transitioned in the eyes of the medical literature, they fit the “professional standards” for treatment, and their pain was addressed.

When I was 16 my mother had put me on birth control because she thought I was going to have sex. And, of course I didn't want, you know, I didn't consent to it anyway. And then the doctor changed it by half strength. Just for fun, just like, well, you might not take it at the same time every day, and just did that. I lactated for two years and then had breast pain for 16 years. And the moment that I started testosterone was the moment that my tits stopped hurting.

I had tests done, I had, like all this other stuff, you know, for a long time. And then I would revisit it every now and then. And some years, it would be worse than others. Some years, I would wake up screaming at night, and didn't know it until somebody else told me. It's like, having a shoe box of pain on the front of your body. And so, as a woman, I would not get health care for that because I'm within the normal range in my

## Justice and Becoming

hormonal levels and my prolactin levels. But as a trans person, suddenly I have an answer. (Devin)

There are international guidelines for healthcare providers that providers are to discuss reproductive healthcare and options with patients considering HRT (Feigerlová et al., 2019). This is especially important as the majority of patients who begin HRT, are of reproductive age. Joyce, a young woman of reproductive age, was not given options, which goes directly against these guidelines. During the interview, she then perceives the reason for her providers not discussing reproductive options with her as providers seeing “us”, trans women as a group, as less than human.

Well, I'm looking at my own experience, I would say they could really start by just discussing it. You know, that would be great. So, you know, discussing it with us as I just been taking for granted that we actually want families and can have family because I think sometimes, they're not aware of that. Or they look at us as something other than human, you know? But beyond that, I would say, letting us know what options are available to be able to have our own families on our own terms. If that means preserving sperm, if that means using a surrogate, whatever the options might be that we can have. Letting us know, because I think sometimes some of us may want to have a family and know what kind of health care is available for that, but options are not discussed with us such as in my case, you know, nobody's ever actually, a medical professional has never sat down with me and had any discussion about reproductive care and all that. (Joyce)

## Justice and Becoming

Joyce's experience with her providers neglecting to offer her standard practice and reproductive health care, and to even ask about her family, raises concerns in contrast to the care she was offered and able to access. Perhaps her reproductive options were considered extraordinary treatments, unusual or uncustomary, which fall under the considerations of professional standards. While withholding ordinary treatments, those treatments that are useful or customary, is considered problematic, withholding extraordinary treatments is often up to the discretion of the provider.

There is not enough information in the interviews to confidently determine that Joyce or Devin's providers considered reproductive preservation or healthcare extraordinary treatment or standard practice. However, it is worth asking why this treatment was not offered or fully explained to Joyce. This may also connect to the lack of research and understanding of professional standards. Even without explanations from Joyce's providers about why her care was conducted in this manner, inadvertent negligence towards Joyce's life and family resulted.

Joyce was able to access HRT and gender confirmation surgery, both critical and essential care, but also both care that will effectively sterilize an individual. As a member of the community, researcher, and advocate, I question why care that the effects of sterilization were available, when a conversation about reproductive options were not. The actions of Joyce's provider imply that HRT and gender confirmation surgery were their standard practice, and an ordinary treatment, while reproduction and the steps to support Joyce in reproducing, was extraordinary, or plain neglected.

The trouble with measuring nonmaleficence in these circumstances is that it requires knowing the intention of the harm, and if it was directly inflicted or not. Joyce has not had a healthcare provider ask her about her family, and she sees a provider every few weeks to receive

## Justice and Becoming

HRT, which she has for over two years. Devin has providers say that they are unable to treat their pain. Nina reflected that providers may have withheld information about her transition and reproductive options from her. It may not be an intentional thing to overlook Joyce's family, Devin's pain, or Nina's mental health risks after surgery, but the impact is dangerous and does not align with BPE.

## Justice

These interviews provide many experiences of inequality, in response to this I will focus on distributive justice as I deconstruct BPE with these narratives. Distributive justice, "the fair, equitable, and appropriate distribution determined by justified norms that structure the terms of social cooperation. It refers broadly to the distribution of all rights and responsibilities in society, including civil and political rights" (Beauchamp & Childress, 1983). With the use of distributive justice, inequality is a problem of justice, and not all inequality is unjust.

### *Application of Findings, Justice*

Experiences of equality and justice are notably absent in these accounts. There is significant material on inequality, barriers to the same rights and access as mothers of the cisgender experience, and discrimination rooted in stigma, sexism, racism, and transphobia. Considering the way that intersectionality creates a woven experience of inequality for these trans mothers, there was never an equal playing field to parent on.

Nina's ex-wife trapped her in a "rough" relationship by threatening to out her as trans to her employer, the local and conservative school district. Because there were not legal protections



## Justice and Becoming

for her, Nina was in a position to risk losing her job, and suffer economic losses, and the loss of her “kids” (her students)<sup>10</sup>.

The only reason I was still with my ex for a while was she had threatened that if I didn't stay with her that she would send pictures to my employer, and I'm teacher, of me as a woman. So, I stayed with her two extra years out of absolute terror. I live in the south, you would get fired. It's just not a question. But that's just a fact. And she knew it. She knew that if any of this became public knowledge, I'm done for. I was someone who had a lot of problems and finally got myself together, kept a steady job was considered pretty damn good at it. And it all could just crumble. So, I submitted. (Nina)

This was an experience of inequality in worker protections, and a barrier to fair opportunity. Including fair opportunity as a requirement of justice, BPE asks us to consider the question of what properties have served as unjust bases of distribution (Beauchamp & Childress, 1983)? Joyce, Nina, and Devin all point to gender as a property that has served as unjust base of distribution of resources.

And so, as a woman, I would not get health care for that because I'm within the normal range in my hormonal levels and my prolactin levels. But as a trans person, suddenly I have an answer. I don't know what that means, but it just adds to my thought of like, women don't have health care, and nobody cares. I mean, if we can make tits bigger, and if we can make people have more babies and we can make women more desirable to the

---

<sup>10</sup> Until June 13<sup>th</sup> of 2020, there were not federal legal protections for workers on the basis of gender and sexuality (*Supreme Court Delivers Major Victory To LGBTQ Employees*, n.d.).

## Justice and Becoming

male gaze, then there's tons of money and funding and all of that. But you'll see where men don't really have an interest. There's no funding and we don't care. (Devin)

Because for a lot of kids, I'm working in a very conservative area. And they hate people like me. Then they end up loving me, and they don't know what to make of themselves. That's one of the greatest accomplishments because they are like, I really like this person, and yet. I stayed in the same school, not transfer schools. I was there, and it, oh yeah, you get the talking, get people say and all those things. Some people absolutely hate me and if they end up in my classroom, they end up going, "God damn it! I like this woman!".

(Nina)

Nina mentions the barriers created by living in the South multiple times, including her concern about losing her job if outed. When compared with other states and regions in the United States Nina's protections as a worker is an issue of justice. United States federal policy does not provide fair opportunity and intentionally or unintentionally contributes to unfair discrimination.

I would either maybe save some of, just depending on how expensive that is. Or just plan on adoption, but that's the problem, you can't adopt if you're trans not in (Southeastern state). Who the fuck will let me adopt? They don't even want to let gay and lesbian couples adopt. It's a shitstorm in the South. (Nina)

Devin also notes the way state Medicaid changes how they and Gili can access medical care, as it limits their options.

## Justice and Becoming

I used to go to a place that was covered by insurance. When I was going to take my daughter there, I'm like, how much does an office visit cost? She has Medicaid. They're like, it starts at \$650 to walk through the door. And so we ended up at Planned Parenthood, because they're the only people that will take Medicaid, and they only take Medicaid on one day a week at each location. (Devin)

Nina, Devin and Joyce, express many similar experiences of injustice, but Joyce, the only Black mother interviewed in this study, has charged herself with a unique role protecting Kingston from the injustice of white supremacy, police, and racism. Joyce fears that white supremacy in the United States will steal Kingston's opportunity to be his authentic, tender, creative self as he grows to become a Black man. She shared this concern at the beginning of our interview, when she first spoke of her role as Kingston's Godmother.

You know, like I said, Kingston is a very sensitive young man. And Kingston is an African American young man. The reason I'm saying that is because this society has a way of hardening young Black men. And making them have to be these really tough individuals, who almost completely lose touch with their emotional intelligence because they have to survive in a very harsh society. When you look around, even with what's happened very recently with George Floyd, who was viciously murdered by the police. It's just like they grow up in a world where there's not a lot of tenderness. So, with Kingston, I try to be very tender. Because I realized, he's cute now, but one day, he's gonna grow up and be a young Blackman. And I want to make sure that as a mother figure, that I give him the space he needs to be the man that he's going to be, but to be able to still remain sensitive. (Joyce)

This quote is evidence that human life, an invaluable resource, is not valued equally in the United States. Police violence disproportionately harms and kills Black people<sup>11</sup>, and the right to parent without fear of violence from police is an issue of reproductive justice. Joyce's protection of Kingston as a Black boy, protecting him emotionally, caring for his tender nature, is a testament to how deep injustice is for Black MTE and their children. For Joyce to speak of Kingston's tender nature as something to be guarded and nourished, resisting the monster of racism stands alone among descriptions of care in these interviews. Nina and Devin shared struggles they had navigating state systems such as adoptions, Medicaid, supportive services for people with disabilities, and fear of losing work, but they never voiced fear of losing their children. White supremacy is a risk factor in the health of Joyce and Kingston. Blackness is marked and dehumanized, resulting in injustice, harm, and death. Joyce is taking care of Kingston in the present with her guard up knowing the unjust world he will grow into. She is navigating systems of power and oppression as they haunt and threaten her family.

Stryker's description of transgender studies as a field describes the nuance of difference, as it is constructed and operates. This description is one that can apply intersectionally, as race and ability are based on similar systems of power that operate in the lives of individuals. I end with this quote to prompt further research interrogating how systems of power are operating in Joyce, Nina, and Devin's lives and impacting their relationships to self and to their kin.

(Transgender studies) without ever losing sight of the fact that “difference” and “hierarchy” are never mere abstractions; they are systems of power that operate on actual

---

<sup>11</sup> For the past four years, 1,000 people have been killed by police annually. Black men, who make up 6% of the United States population, account for 26.8% of victims of police violence (*Brown*, 2017).

bodies, capable of producing pain and pleasure, health and sickness, punishment and reward, life and death. Transgender studies has a deep stake in showing how the seemingly anomalous, minor, exotic, or strange qualities of transgender phenomena are in fact effects of the relationship constructed between those phenomena and sets of norms that are themselves culturally produced and enforced. (Stryker et al., 2006)

### Conclusion

The result of Principlism in the lives of MTE is that these tools for ethical care become instruments for further marginalization. So, what could justice in medical settings for MTE look like in the face of these limitations? How do we seek justice as ethicists if our framework is failing those we may define as vulnerable, those these principles were, in many ways, intended to protect? Stryker's statement on progress sums up that if we are at least aware of the prejudice and discrimination, aware of the cracks in our systems that fail MTE and SGM, we can make progress and address them.

Significant changes have indeed taken place. At the very least, where once there was *pure* ignorance and prejudice of trans issues, we now see *informed* prejudice and discrimination, which is more easily addressed through the courts and legislature. (Stryker et al., 2006)

The experiences of Joyce, Nina, and Devin are reflective of SGM populations that are deprioritized among academic research, health interventions, and public policy. Gaps in literature, like the binary of language, leaves people out, and leaves healthcare providers

## Justice and Becoming

unedicated about how to best care for SGM patients. It leaves SGM populations without representation to self-educate through alternative education sources, such as online forums, novels, Hollywood movies, and zines. In the absence of information, those seeking answers become resourceful, or they no longer search and are not informed. This can influence quality of care and quality of life.

The opportunity to deconstruct and critique the uses of BPE yielded that these mothers' experiences just run afoul of these principles. If providers and the medical system are unable to support people at the social margins, it is not just unhelpful, it is dangerous. Unintentional negligence allowed Nina, Joyce, and Devin to fall through the cracks. This good intention is the justification for violence, as it overlooks intervening in the lives of MTE and offers us instead compassion to those who are treated as less than human. These lives will fall through the cracks and end up further in the margins.

Representation and diversity among healthcare employees is often offered a progressive solution to the challenges of distributive justice and genuine connection to those at the margins. I offer the challenge to consider how pathology of SGM populations may corner providers who are themselves at the margins. Providers who see their own community unrepresented and resist pathologizing patients may put their license at risk, those who refuse to employ diagnosis codes may find themselves charged with clinical malpractice. The decision not to code will also have economic consequences for the provider, as insurance needs a diagnosis to be billed. This problem is pervasive.

Further research on how MTE perceive motherhood in relation to themselves will deepen understanding of the population's motherhood experiences, family and kinship building methods, and access to reproductive health care. The insight gifted to us by Joyce, Nina, and Devin

## Justice and Becoming

provide our field with a starting point for this future research, and an alternative framework, or at least traits that could be applied to mitigate harm when caring for others.

With Kingston, Joyce described the importance of listening, spending time, and preserving tenderness and sensitivity. Nina uplifted the power of representation in her classroom, and collaborative decision making with her Kevin. Devin protected joy, rites of passage, and showed how creativity and community are lifesaving and powerful forces. I offer the solution that to support those in the margins, we must engage with frameworks such as Principlism critically, and enact them lightly. And, we need to trust mothers of the trans experience, and their expertise.

I will end with a quote from Joyce, where she shares advice she would give to future mothers. I ask you to read this quote twice, and the second time, replace the word “mother” with “provider”.

You know, when you are a mother, you need to be to your child, what you needed. I think sometimes we have a way of perpetuating hurt. You know, as they say, hurt people hurt people. But your child doesn't need to be a victim of your childhood trauma. And so, whatever you needed as a child, whether that was attention, whether it was more hugs, whether it was adventure, whatever it was, provide that for your child. Because they will thank you later.... And be kind to them...Don't just focus on being a provider for your child. Be a friend. Be someone they can talk to so that when they no longer need you to provide, you're still relevant. (Joyce)

## Justice and Becoming

Dogmatic application of such principles by providers will cause well intentioned harm. Joyce, Nina, and Devin have provided a gift to this field by sharing their knowledge of how-to best care for others, the field of bioethics and providers would be wise to heed their advice and improve upon their oath of do no harm.



References

- Alpert, A. B., CichoskiKelly, E. M., & Fox, A. D. (2017). What Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Patients Say Doctors Should Know and Do: A Qualitative Study. *Journal of Homosexuality*, *64*(10), 1368–1389.  
<https://doi.org/10.1080/00918369.2017.1321376>
- Beauchamp, T. L., & Childress, J. F. (1983). *Principles of biomedical ethics*.  
<https://doi.org/10.1097/00004850-199100620-00013>
- Broussard, K. A. (2020). *Explaining Anti-Transgender Prejudice Through Dehumanization* [Ph.D., Saint Louis University].  
<http://search.proquest.com/docview/2409166165/abstract/2845B6D0EB874252PQ/1>
- Butler, J. (2001). Doing Justice to Someone: Sex Reassignment and Allegories of Transsexuality. *GLQ: A Journal of Lesbian and Gay Studies*, *7*(4), 621–636.
- Campaign, H. R. (n.d.). *Glossary of Terms*. Human Rights Campaign. Retrieved June 18, 2020, from <https://www.hrc.org/resources/glossary-of-terms/>
- Carrillo, J., & Houston, J. M. (n.d.). *Exploring Cultural and Linguistic Aspects within the Lesbian, Gay, Bisexual, Transgender, and Queer Youth Community*. 98.
- de-Castro-Peraza, M.-E., García-Acosta, J. M., Delgado-Rodriguez, N., Sosa-Alvarez, M. I., Llabrés-Solé, R., Cardona-Llabrés, C., & Lorenzo-Rocha, N. D. (2019). Biological, Psychological, Social, and Legal Aspects of Trans Parenthood Based on a Real Case—A Literature Review. *International Journal of Environmental Research and Public Health*, *16*(6), 925. <https://doi.org/10.3390/ijerph16060925>
- Definition of REAL*. (n.d.). Merriam-Webster. Retrieved September 29, 2020, from <https://www.merriam-webster.com/dictionary/real>

## Justice and Becoming

Dige, M. (2019). Lessons of Reproductive Ethics for Principlism. *Etikk i Praksis - Nordic Journal of Applied Ethics*, 1, 5–20. <https://doi.org/10.5324/eip.v13i1.2726>

Drescher, J. (2015). Out of DSM: Depathologizing Homosexuality. *Behavioral Sciences*, 5(4), 565–575. <https://doi.org/10.3390/bs5040565>

*DSM History*. (n.d.). Retrieved August 31, 2020, from <https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm>

*Evidence Brief: Health Equity Implications of Police Violence | UNC Center for Health Equity Research*. (n.d.). Retrieved October 6, 2020, from <https://www.med.unc.edu/cher/evidence-brief-health-equity-implications-police-violence/>

Fejgerlová, E., Pascal, V., Ganne-Devonec, M.-O., Klein, M., & Guerci, B. (2019). Fertility desires and reproductive needs of transgender people: Challenges and considerations for clinical practice. *Clinical Endocrinology*, 91(1), 10–21.

*Godparent | Definition, History, & Role*. (n.d.). Encyclopedia Britannica. Retrieved August 30, 2020, from <https://www.britannica.com/topic/godparent>

Grant, J. M., Motter, L. A., & Tanis, J. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. <http://dataspace.princeton.edu/jspui/handle/88435/dsp014j03d232p>

Jill F. Kilanowski PhD, F., RN, APRN, CPNP. (2017). Breadth of the Socio-Ecological Model. *Journal of Agromedicine*, 22(4), 295–297. <https://doi.org/10.1080/1059924X.2017.1358971>

Jones, B. P., Williams, N. J., Saso, S., Thum, M.-Y., Quiroga, I., Yazbek, J., Wilkinson, S., Ghaem-Maghani, S., Thomas, P., & Smith, J. R. (2019). Uterine transplantation in

- transgender women. *BJOG: An International Journal of Obstetrics & Gynaecology*, 126(2), 152–156. <https://doi.org/10.1111/1471-0528.15438>
- King, J. (2016). *The Violence of Heteronormative Language Towards the Queer Community*. 7, 6.
- Lewis, S. (2015). Qualitative Inquiry and Research Design: Choosing Among Five Approaches. *Health Promotion Practice*, 16(4), 473–475. <https://doi.org/10.1177/1524839915580941>
- Liu, W., Schulster, M. L., Alukal, J. P., & Najari, B. B. (2019). Fertility Preservation in Male to Female Transgender Patients. *Urologic Clinics of North America*, 46(4), 487–493. <https://doi.org/10.1016/j.ucl.2019.07.003>
- Lunn, M. R., Obedin-Maliver, J., & Bibbins-Domingo, K. (2017). Estimating the Prevalence of Sexual Minority Adolescents. *JAMA*, 317(16), 1691–1692. <https://doi.org/10.1001/jama.2017.2918>
- Meyer, I. H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin*, 129(5), 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>
- Ndumbe-Eyoh, S., Morrison, V., Abdi, S., Hankivsky, O., & Travers, A. (2016). *Public Health Speaks: Intersectionality and health equity*. National Collaborating Centre for Determinants of Health. <https://nccdh.ca/resources/entry/public-health-speaks-intersectionality-and-health-equity>
- Queer Terminology: LGBTQ Histories and the Semantics of Sexuality. (2016, June 9). *NOTCHES*. <http://notchesblog.com/2016/06/09/queer-terminology-lgbtq-histories-and-the-semantics-of-sexuality/>

Rauprich, O., & Vollmann, J. (2011). 30 Years Principles of biomedical ethics: Introduction to a symposium on the 6th edition of Tom L Beauchamp and James F Childress' seminal work. *Journal of Medical Ethics*, 37(8), 454–455.

<https://doi.org/10.1136/jme.2010.039222>

Schneider, F., Scheffer, B., Dabel, J., Heckmann, L., Schlatt, S., Kliesch, S., & Neuhaus, N. (2019). Options for Fertility Treatments for Trans Women in Germany. *Journal of Clinical Medicine*, 8(5), 730. <https://doi.org/10.3390/jcm8050730>

Shea, M. (2020). Forty Years of the Four Principles: Enduring Themes from Beauchamp and Childress. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, 45(4–5), 387–395. <https://doi.org/10.1093/jmp/jhaa020>

Stryker, S., Stryker, A. P. of G. and W. S. S., & Whittle, S. (2006). *The Transgender Studies Reader*. Taylor & Francis.

*Supreme Court Delivers Major Victory To LGBTQ Employees*. (n.d.). NPR.Org. Retrieved July 29, 2020, from <https://www.npr.org/2020/06/15/863498848/supreme-court-delivers-major-victory-to-lgbtq-employees>

ten Have, H., & Gordijn, B. (2010). The language of medicine and bioethics. *Medicine, Health Care and Philosophy*, 13(3), 191–192. <https://doi.org/10.1007/s11019-010-9275-y>

*TGNC Guide*. (n.d.). Retrieved August 31, 2020, from

<https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis>

*The Social-Ecological Model: A Framework for Prevention |Violence Prevention|Injury*

*Center|CDC*. (2020, January 28).

<https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html>

- Wagner, J., Sackett-Taylor, A. C., Hodax, J. K., Forcier, M., & Rafferty, J. (2019). Psychosocial Overview of Gender-Affirmative Care. *Journal of Pediatric and Adolescent Gynecology*, 32(6), 567–573. <https://doi.org/10.1016/j.jpag.2019.05.004>
- Wood, S. M., Salas-Humara, C., & Dowshen, N. L. (2016). Human Immunodeficiency Virus, Other Sexually Transmitted Infections, and Sexual and Reproductive Health in Lesbian, Gay, Bisexual, Transgender Youth. *Pediatric Clinics of North America*, 63(6), 1027–1055. <https://doi.org/10.1016/j.pcl.2016.07.006>

## Appendix

### **Figure 1. Interview Appointment Outline and Interview Guide**

Total Time: 90 Mins

1. Introduction to Study, Establishing Rapport, 10 mins
2. Consent Process, 15 mins
3. Interview, 60 mins
4. Completion of Interview & Compensation, 5 mins

“Mothers Within Our Rights”, Trans Women’s Experiences of Motherhood

Summary of overall goals: The goal of this pilot qualitative study is to advance understanding of the reproductive health and wellbeing of transwomen in a Southeast metropolitan area, with a focus on the reproductive health experiences of parenting, mothering, and family building. This research aims to answer the question, how is motherhood embodied and enacted in the daily lives of transwomen?

Opening:

1. Tell me the story of how you became a mother.
  - a. How would you describe motherhood?

Specific Aims:

1. Explore the influence of gender identity on motherhood, reproductive healthcare, and family building.
2. Describe systems -level barriers and facilitators to motherhood and family building among trans women in a Southeast metropolitan area.
  2. They say it takes a village to raise a child, how would you describe your village? Your community?
    - a. Who are the supportive people in your life?
  3. Who are the mothers you look up to?
    - b. Why do you admire them?
    - c. What have they taught you about being a mother?
  4. How has motherhood changed your life?
    - d. Probe about challenges and joys
      - i. What challenging decisions have you needed to make as a mother?
  5. How does your gender identity influence your experience as a mother?
3. Explore the perceptions and experiences of reproductive healthcare and motherhood among trans women in a Southeast metropolitan area.
  6. How have your medical providers asked about your family?
  7. How have medical providers discussed reproductive health with you?
  8. What reproductive health or fertility options have you considered?
    - a. Probe about barriers
  9. What advice would you give to medical providers?

**Closing**

10. If you could do it all over again, how might you do things differently?

- 11. What advice would you give to future mothers?
- 12. What did I not ask about that you would like to share?

**Figure 2. Social Ecological Model** (*The Social-Ecological Model*, 2020)



**Figure 3. Minority Stress Model** (Meyer, 2003)

