

An Examination of ‘Just in Case’ Arguments as they are Applied to Fertility Preservation for Transgender People

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Introduction

The release of the seventh version of the World Professional Association for Transgender Health’s (WPATH) *Standards of Care* in 2011 for the first time introduced what is widely agreed to be an important area of focus for clinicians who work with transgender people, namely reproductive health.¹ This new focus on reproductive health in the WPATH *Standards of Care* was unequivocal in its stance on the rights of transgender people, and the attendant clinical responses that are then treated as a corollary of this.

It will of course be obvious to anyone concerned with the rights of transgender people that this emphasis on reproductive health is important, given previous clinical approaches which pathologised transgender people as parents and which saw the forgoing of genetic parenthood as a necessary part of gender transition (De Sutter et al 2002). My concern in this chapter, however, is with how the move towards recognizing transgender people’s reproductive rights in the *Standards of Care* operates under the assumption of endorsing fertility preservation ‘just in case’ the person decides to have children in the future, when the case at stake is a genetically related child.

My suggestion that the case at stake is a genetically related child is derived from the *Standards of Care* themselves, which note in the section on reproductive health first

that many transgender people “want to have children”, before then noting that hormone therapy or surgery “limits fertility”, and that as such clinicians “should discuss reproductive options with patients prior to initiation of... medical treatments” (p. 50). Read together, to me these three statements rely on a slip between ‘wanting to have a child’ and ‘fertility’, a slip that by default positions transgender people’s potential desire to become parents within a pronatalist logic whereby the only form of production or generativity that is valued is that which involves genetic reproduction.

It is of course difficult to question the ‘just in case’ logic indicated above without being misread as opposing the rights of transgender people to reproductive health care. As troubling as the risk of being misread is, as a mental health clinician who works with transgender young people, in this chapter I nonetheless suggest that it is vital that alongside advocating for the rights of transgender people to fertility preservation and the potentially ensuing need for rights to access assisted reproductive technologies, we must also advocate for a focus on alternate pathways to parenting children, in addition to the importance of discussing and acknowledging that many transgender people may not want to have children. Importantly, this is not to suggest that transgender people are dupes (or any more likely than any other group of people to be dupes) of pronatalism. Rather, it is to suggest that within a context of pronatalism, it is important that discussions of parenthood do not default to assumptions of genetic reproduction, or indeed do not default to a presumption that all people should want to become parents.

In what follows in this chapter I expand upon my concerns above via a consideration of the literature on transgender people and reproduction, specifically focused on fertility preservation. From this literature I suggest that some of the

ambiguities that would seem apparent with regard to transgender people's decisions about parenthood are minimized through the over emphasis indicated above upon fertility as the presumed corollary of future parenthood. I then examine two narratives of fertility preservation – one from a media report focused on the experiences of a Canadian transgender man, and one from an interview with an Australian transgender man – both of which suggest to me the importance of an approach to clinical practice that emphasises a focus on ambiguities in terms of decision making about reproduction, rather than a singular directive towards fertility preservation at all costs. I conclude the chapter by considering additional factors related to reproductive rights for transgender people that also require attention.

Background Literature

A key starting place with regard to the limited body of research on transgender people and reproduction is a study undertaken by De Sutter and colleagues (2002). This early study explored the attitudes of a sample of transgender women with regards to fertility preservation (specifically sperm storage), with the majority of the women surveyed indicating that “sperm freezing should be offered to all [transgender] women” (n.p.). This finding, it would appear, has since served as the underlying motivation to the emphasis upon fertility preservation in the *Standards of Care*, and in subsequent research. Yet looking at other findings from the study we can see ambiguities with regard to the attitudes of the women in the sample.

Specifically, only half of the sample reported a preference for having a child in the future who was genetically related to them. Almost all of the sample reported that infertility arising from hormones or surgery was not a reason to delay gender transition.

Only half of the sample indicated that had sperm freezing been available to them, they would have done so, though younger women were more likely to indicate that they would have done so than were older women (some of whom already had children). Finally, a third of the women indicated that storing sperm and using it to conceive a child would be psychologically distressing.

To me, the additional findings that sit around the ‘core’ finding with regard to the importance of offering fertility preservation paint a picture of considerable ambiguity, and suggest that a drive towards genetic relatedness may not be a central concern for many transgender women, that for some women this may be about distress arising from the requirements of sperm freezing, and that for many transgender women gender transitioning is a higher order life goal than is having genetically related children. In a survey undertaken by myself and colleagues (Riggs, Power and von Doussa 2016), we similarly found that only a very small number of the transgender or gender diverse people we surveyed hoped to have children to whom they were genetically related in the future, with those who hoped to have children (a minority) instead indicating that donor materials would be used or that a child would be fostered or adopted.

In addition to the relative lack of interest reported by participants in these studies with regard to having genetically related children in the future, previous research also indicates a number of problems associated with fertility preservation as faced by transgender people. These include finding discussions of reproductive organs and materials normatively associated with an individual’s assigned sex to be distressing, and the emotional and physical costs for transgender men of undertaking ovarian hyperstimulation and egg retrieval (Armund et al 2017; Jones et al 2016; Mitu 2016).

An additional concern indicated in the literature is with regard to transgender adolescents. At present, the retrieval and storage of testicular or ovarian tissue is possible, though the use of such tissue to produce gametes is only in the trial stages with non-human animals. As such, and as Johnson and Finlayson (2016) emphasise, parents must make decisions on behalf of their children about potential future desires. As I noted in the introduction of this paper, this 'just in case' approach automatically assumes that the corollary of a desire for children is a desire for genetically related children, thus situating young transgender people within a pronatalist logic well before they might otherwise have considered how or if they wish to have children (see also Fyler et al 2014).

This type of situating of young transgender people is evident in a recent paper by Nahata and colleagues (2017), who report on a retrospective case review of 73 young transgender people who had attended one US pediatric endocrine unit. From their review Nahata and colleagues found that of the 73 young people, only two had undergone fertility preservation, 45% indicated that if they had children in the future they would foster or adopt, and 21% said they never wanted children. In concluding their paper, Nahata and colleagues in a sense bemoan the low rates of fertility preservation amongst their sample, suggesting that mental health impairments and/or age might have prevented the young people from fully understanding their decisions, in a sense implying that young people might regret not choosing the 'just in case' option.

To be clear, and as I indicated in the introduction to this chapter, my point is not that transgender people should not have the right to fertility preservation. Clearly it is the case that some transgender people desire to have children, and for whatever reasons (as is true for any group), some desire children to whom they are genetically related.

Nonetheless my concern, as expressed in the introduction, and expanded upon through a consideration of the literature, is that the recommendation of *fertility preservation* counseling contained in the WPATH *Standards of Care* is based on one specific finding that is not necessarily indicative of the desires of all transgender people. In the following section I consider two narratives that add further weight to both the importance of transgender people's reproductive rights, but also the need to present a balanced view of future pathways to parenthood (including the validity of not having children).

Two Narratives

The first narrative that I present here is taken from the aforementioned research project that I conducted with colleagues. Above I reported on findings from a survey we conducted (Riggs, Power and von Doussa 2016), but in the same project we also interviewed people (see von Doussa, Power and Riggs 2015 for an overview of our method including ethics approval for the interviews). One gay transgender man whom we interviewed – ‘Tom²’ – specifically spoke about regrets related to not having undertaken fertility preservation:

One thing I do regret about my physical transition is I feel I rushed into having a hysterectomy and oophorectomy operation, without considering the consequences for my ability to have biological children. Looking back, it stands out to me that I didn't have any counseling at all around the implications for biological parenthood or options I could take before having the operation. I think I had always made the assumption that being trans automatically ruled out biological parenthood so when nobody else raised the possibility, I just accepted that my operation was a part of the transition process. However in the years since I've become more aware of trans

guys being biological parents, not just prior to physical transition. I'm not sure that I would actually do any of these things myself, but I would like to have been aware that there was the option prior to having the operation.

Tom's narrative highlights the ambiguity or dilemmatic nature of many transgender people's accounts of fertility and parenthood in the context of gender transition. On the one hand, Tom rightly notes that he was never offered counseling – a significant oversight on the part of his clinical team. On the other hand, however, Tom notes that even if he were aware of his options he might not have taken advantage of them. Being a retrospective account premised upon reproductive infertility Tom, it would appear, is pushed to a degree towards the salience of genetic relatedness, precisely because that is now unavailable to him. For me, this highlights that whilst clearly Tom should have received more adequate counseling, it should not be treated as an *a priori* that such counseling would solely have focused on fertility preservation as a route to parenthood, nor that it should have presumed that he wanted children at all.

The second narrative comes from a piece written for *Advocate* by Alex Abramovich (2016), a heterosexual transgender academic. Alex's narrative differs from Tom in that he was able to undertake fertility preservation, albeit not until after he had commenced testosterone:

For as long as I can remember, I have wanted children. For most of my life, I thought that I would carry my child, but those feelings changed shortly after I came out as a trans man and started taking testosterone. Producing a genetically related child was still important to me, but I was no longer able to see myself carrying a pregnancy. After discussing all of our options, my wife, Caroline, and I decided

that the closest we would ever get to creating another human together would be to fertilize my eggs with donor sperm and to then implant the embryo into Caroline for her to carry the baby. Unfortunately, fertility preservation, or what is more commonly referred to as “egg freezing,” was not presented to me as an option prior to starting testosterone. This meant that I would have to wean off of my masculinizing hormones so that my ovaries would be able to ovulate again. As I went off of testosterone and prepared myself for the worst, I had no idea just how difficult this would all be... But as excruciating as all this was, what continued to be the most difficult thing to deal with was the fertility clinic’s treatment.

Whilst, unlike Tom, Alex was still able to access his own gametes, like Tom he was not adequately informed about this prior to commencing testosterone, which clearly had negative consequences for him. Also unlike Tom, Alex was very clear that he had always wanted children who were genetically related to him. This prioritizing of genetic relatedness, however, led Alex and his partner down a path where the retrieval of his gametes was necessary, and which brought for him considerable hardship, in terms of the emotional effects of both ceasing testosterone and undergoing hyperstimulation, and the often negative responses he received from clinic staff (specifically in terms of misgendering).

Without for a moment wanting to discount Alex’s right to self-determination, I can only wonder if this might have been different had Alex been given appropriate counseling prior to commencing testosterone. Might he have decided that using donor sperm and his partners ovum would be better for him than the process he undertook? Or might the retrieval of his gametes prior to commencing testosterone have (likely) been a

less distressing process than once he had commenced (and then had to interrupt) testosterone? Regardless, Alex's narrative is clearly different to Tom's in that Alex was not operating on a 'just in case' principle. Nonetheless, there is a degree to which the norm of genetic relatedness did play a key role in his experience, suggesting that counseling in relation to fertility preservation might usefully move beyond advising that fertility preservation is possible, so as to include discussions about alternate routes to parenthood, in addition to the potential emotional and definite financial costs of fertility preservation.

Conclusions

This was not an easy chapter to write. As a cisgender clinician who works with young transgender people, part of my work involves raising questions about possible future parenthood. I do this not just because it is in the *Standards of Care*, but because for me it constitutes part of informed consent, something that, it might be suggested, both Tom and Alex were denied. At the same time, however, as a researcher critical of pronatalist injunctions and the norm of genetic relatedness (Riggs and Bartholomaeus 2016), I would not be acting according to my own ethics if all I advised my clients to do was to undertake fertility preservation 'just in case'. In my research more broadly, I am particularly interested in how those positioned outside the norm of genetic relatedness (i.e., cisgender gay or lesbian couples) are potentially 'pushed' towards ways of becoming parents that repeat the genetic norm, as a way to approximate the norm and thus secure a somewhat safer place within it (Riggs and Due 2017). If so, this I entirely empathise with and understand. But my question in this paper has been whether or not this is the most psychologically affirming response for all people?

From an ethical position, advocating the adoption of a place within the norm is likely to produce distress for transgender people for whom the costs of fertility preservation are prohibitive. Storage fees – until such time as the individual decides to use or dispose of frozen gametes – are not inconsiderable, and well beyond the means of many transgender people in the context of multiple other expenses. As such, there is a sense in which following the *Standards of Care* in countries where fertility preservation comes with a range of ongoing costs is not necessarily the most ethical approach. This does not mean that it should not be raised, but the question must be what it means to raise someone's hopes, only for them to be then left unfulfilled. In the case of adolescents, and as Johnson and Finlayson (2016) note, if parents encourage fertility preservation and then are responsible for the costs, what does this mean once adolescents come of age and then are potentially responsible for the costs? This type of 'just in case' may be even more distressing if, for example, the young person is not longer able to afford the storage fees.

Additionally, and as De Roo and colleagues (2016) note, as with any form of reproduction, assisted reproductive technologies come with no guarantee of success. Whilst we see gametes and embryos stored for longer and longer periods of time, there is no research to indicate that they can be stored indefinitely with successful outcomes upon thawing. Again, then, what are the ethics of adopting a 'just in case' approach if the case in point has a low likelihood of being fulfilled? What does this do to prepare transgender people for the possible heartbreak of infertility? Certainly, the argument in favor of fertility preservation is to potentially mitigate such heartbreak, but it is no guarantee against it. An ethical conversation about reproduction, parenthood, and fertility for transgender people, then, must involve the potential failures of assisted reproductive

technologies, hence again the importance of considering in advance desires and motivations to parenthood along with alternate pathways.

Of course focusing on the potential failures of assisted reproductive technologies is only one part of the story. Another equally important part of the story to focus on is the potential desire *not* to have a child. As Nahata and colleagues (2017) note, research has consistently found less of a desire for children amongst transgender people as compared to cisgender people. As they also note, this may be a product of gender dysphoria, but it may also be a product of a differential investment in reproduction. As such, it is one thing to raise the topic of fertility preservation with transgender clients, but it is another thing to impose an investment in reproduction upon transgender clients, even if under a ‘just in case’ logic. Recognizing that *not* desiring to have children is a legitimate desire is thus as important as facilitating access to fertility preservation if it is desired.

Finally, research by Moody and Smith (2003) suggests that having children can be a protective factor against suicidality for transgender people. Wanting to stay alive for one’s children can serve as a buffer against suicidal ideation. But is this how we want to think about children – as tools to mitigate against transphobia and cisgenderism? And does it warrant imposing a pronatalist logic upon transgender people who may be considering their future parenting options? Moody and Smith’s research did not make these points, so it is important not to put words into their mouths. However, and to return to the introduction to this paper, it is important to be mindful of the slippages between children, and fertility, and expectations about both in a context where, for many transgender people, there are more ambiguities than there often are certainties. If I have learnt anything in my clinical work, it is that attempting to combat dysphoria, distress, or

discrimination through recourse to certainties about an idealized perfect world or future is most often likely to fail. Rather than a blanket injunction to fertility preservation, then, it would seem better to have honest conversations about the many roads that may lie ahead, and to try and reach a place where an informed decision can be made on the basis of an in depth conversation about life as a transgender person in its totality, rather than segmenting reproduction off as one box to tick.

References

- Abromovich, Alex. 2016. "Trans Men Need the Competent Fertility Care I Never Got." *Advocate*. Accessed August 16, 2017.
<http://www.advocate.com/commentary/2016/3/09/trans-men-need-competent-fertility-care-i-never-got>
- Armuan, Gabriela, Cecilia Dhejne, C., Jan I. Olofsson, and Kenny A. Rodriguez-Wallberg. 2017. "Transgender Men's Experiences of Fertility Preservation: A Qualitative Study." *Human Reproduction* 32 (2): 383-390.
- De Roo, Chloë, Kelly Tilleman, Guy T'Sjoen, and Petra De Sutter. 2016. Fertility Options in Transgender People. *International Review of Psychiatry* 28 (1): 112-119.
- De Sutter, P, K Kira, A Verschoor, and A Hotimsky. 2002. "The Desire to Have Children and the Preservation of Fertility in Transsexual Women: A Survey. *International Journal of Transgenderism* 6 (3): 97-03.
- Eyler A. Evan, Samuel C. Pang, and Anderson Clark. 2014. "LGBT Assisted Reproduction: Current Practice and Future Possibilities." *LGBT Health* 1 (3): 151-156.

- Johnson, Emilie K., and Courtney Finlayson. 2016. "Preservation of Fertility Potential for Gender and Sex Diverse Individuals." *Transgender Health* 1 (1): 41-44.
- Jones, Celia A., Lawrence Reiter, and Ellen Greenblatt. 2016. "Fertility Preservation in Transgender Patients." *International Journal of Transgenderism* 17 (2): 76-82.
- Mitu, Khadija. 2016. "Transgender Reproductive Choice and Fertility Preservation." *AMA Journal of Ethics* 18 (11): 1119-1125.
- Moody, Chérie, and Nathan Grant Smith. 2013. "Suicide Protective Factors Among Trans Adults." *Archives of Sexual Behavior* 42 (5): 739-752.
- Nahata, Leena, Amy C. Tishelman, Nicole M. Caltabellotta, and Gwendolyn P. Quinn. 2017. "Low Fertility Preservation Utilization Among Transgender Youth." *Journal of Adolescent Health* 61 (1): 40-44.
- Riggs, Damien W., and Clare Bartholomaeus. 2016. "The Desire for a Child Amongst a Sample of Heterosexual Australian Couples." *Journal of Infant and Reproductive Psychology* 34 (5): 442-450.
- Riggs, Damien W., and Clemence Due. 2017. *A Critical Approach to Surrogacy: Reproductive Desires and Demands*. New York: Routledge.
- Riggs, Damien W., Jennifer Power, and Henry von Doussa. 2016. "Parenting and Australian Trans and Gender Diverse People: An Exploratory Survey." *International Journal of Transgenderism* 17 (2): 59-65.
- von Doussa, Henry, Jennifer Power, and Damien W. Riggs. 2015. "Imagining Parenthood: The Possibilities and Experiences of Parenthood Among Transgender People." *Culture, Health & Sexuality* 17 (9): 1119-31.

World Professional Association for Transgender Health. 2011. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*.

Author Note

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Notes

¹ I begin by acknowledging that I live on the lands of the Kaurna people, and I acknowledge their sovereignty as First Nations people. I would like to thank Sarah Ferber, Nicola Marks, and Vera Mackie for inviting me to attend the roundtable for which this chapter was initially developed, and to all of the attendees for their insightful feedback on an earlier version. Thanks must also go to Henry von Doussa and Jennifer Power for our collaborative project on trans and gender diverse people's experiences of, and thoughts about, parenting in Australia.

² This is a pseudonym.