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## Serving Queer and Trans Parent Families Through Research: A Conversation with Associate Editor Shain Wright

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## Serving Queer and Trans Parent Families Through Research: A Conversation with Associate Editor Shain Wright

### Abstract

Recently, NWJTE had the opportunity to sit down with Shain Wright, the Associate Editor of NWJTE and also doctoral candidate at Washington State University, in the Cultural Studies and Social Thought in Education program. Shain researches intersections between queer and trans families and social systems. Specifically, Shain explores the discursive erasure of queer and trans families in education, and families' resiliency, joy, and sense of community. With Shain's work on the NWJTE, we wanted to showcase their cutting edge work and thought generating research that acknowledges and celebrates queer and trans parent families.

### Keywords

Queer fertility, Trans fertility, Queer families, Trans Parent Families, Service Research

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## Introduction

**Maika Yeigh, Editor (MY):** I appreciate your time to have this conversation. I was hoping we could start by just talking a little bit about your research. What are you working on right now?

**Shain Wright, Associate Editor (SW):** I am doing a portfolio style dissertation, which consists of three published articles, bracketed with an introduction and a conclusion that are really reflexive. The first of the three chapters is about biohacking fertility.

**MY:** Can you say more about biohacking? I'm not familiar with that term ...

**SW:** Biohacking is any do-it-yourself citizen science. It could be taking herbs and supplements to improve your health, or it could be some really extensive procedures such as implanting horns in your head. But when I am talking about biohacking fertility I'm talking about tracking your ovulation, doing an at-home insemination, tracking body signs for fertility, taking supplements without doctor supervision, or even inducing lactation in a body that is not gestating. Inducing lactation is an example that my family used to provide breastmilk for our first child. My mom induced lactation by following a regime of supplements and herbs for weeks and was pumping multiple times a day during that time to produce milk.

With that example in mind, I began looking at the ways that trans and genderqueer people use social media to create knowledge communities and share information about how to biohack their own fertility to meet their family planning goals. The crux of this research is really about the dominant narrative regarding transitioning, and the de facto expectation that when you transition medically then you are giving up reproductive rights or that you don't have an interest in using your own biological gametes to reproduce. This stems from my own experience as a trans person biohacking my fertility and experiences such as going to my doctor and being told, "I don't *know* if you can get pregnant after being on testosterone."

I faced medical professionals who did not have answers about my body and fertility, instead I relied on my queer and trans community. My partner and I went to a queer midwife who recommended a Facebook group which is how I found multiple communities on social media that sustained me and my partner as we were family planning. It made me really curious to learn about how other trans and gender queer people are navigating this complex medical system that not only erases our existence, but it also erases our desire to have children biologically or creates barriers to having biological children even if our existence is not erased. For this project I recruited participants from seven different Facebook groups related to trans, genderqueer, and queer identities and pregnancy or family planning. I wanted to be intentional about reducing the burden on participants so I did a content-analysis of their Facebook posts. For the nine participants I collected all of their posts to their respective Facebook groups. One participant happened to be in two groups, so I collected ten sets of data. Some people had as few as 12 Facebook posts and others had as many as 500. In total, I collected 1155 Facebook posts.

**MY:** That is a lot of data!

**SW:** Yes, it was very extensive. Emotional too, because a lot of people are dealing with fertility issues, and miscarriages. Folks also talked about medical infertility versus situational infertility, the difference between having medical circumstances leading to infertility versus social circumstances where people do not have access to everything they need to create a baby (eggs, sperm, a uterus etc.).

After collecting the Facebook posts, I did the content-analysis and identified themes throughout the data. Then I interviewed six of the nine participants to hear feedback on the initial themes that I found and to ask additional questions. I was particularly proud of my compensation method; I offered a hand-knitted hat to every participant to represent my own investment in the project and to demonstrate that I am investing just as much as what I ask of them for a one hour interview.

Ultimately I found some of what I was expecting: that people do use social media groups to biohack and meet their family planning goals. More than that though, I found that people come together to access knowledge and to give back. The sense of reciprocity in this community is huge. People want to give back and offer support in a lot of different ways, from sharing personal knowledge and responding to people's Facebook posts, to creating new groups to meet emerging needs, or creating Zoom meet-ups, and taking leadership by offering to be an admin or moderator for the group. People were very generous with their time and their resources, including sharing unused materials like pregnancy tests or Pre-Seed, which is a lubricant some people use to preserve sperm. When people had unused materials that were new, they would post offering, "Does anyone need this? Can you pick it up in [this area of town]?" That sense of reciprocity was huge in the community.

While I expected most folks to set aside the medical establishment in order to engage in this biohacking community, folks in these communities both engage in the traditional medical system and alternative methods pretty evenly. Participants weaved in and out between working medical professionals, fertility clinics, and then back into the biohacking, do-it-yourself methods. What was interesting was that they used this biohacking community to get access to information to bring back to their medical professionals and to question them, challenge them, to push back, and to shape their own treatment plan. That was really fascinating to me, especially because my family and I were able to largely avoid the medical establishment throughout my pregnancies. We went through a midwife and did a home birth—that was how far we wanted to be removed from the traditional medical establishment. My experience was not representative of everyone, especially having 'low-risk' pregnancies, we were able to largely avoid medical facilities. This is not to say that everything was smooth or easy in our family planning. Understanding the breadth of experiences, recommending social media groups for support, and raising awareness about the need for additional research were the founding reasons why I wanted to do the biohacking project. Given that rationale, I think it is especially important to highlight how valuable these

online communities are to folks who navigate family planning relying on the medical establishment as well as those who do things at home.

**MY:** That is a fascinating study, Shain! And shines light on important *absences* in our system, in our society. How does that connect with your second project?

**SW:** The second project looks at midwifery programs. Of my nine participants in the biohacking project, three of them elected for a home birth – 33%. When we look at national data, only 1.26 percent of people in the country have home births. Even though it is a small study and it is not a random sample, the stark difference was, and still is, thought provoking. I was curious to see how often trans and gender queer people choose to have home births or choose to use birthing centers compared to traditional hospitals.

There is not a lot of literature on this, but I found one other study that showed similar data, around 22% - 26% of trans and genderqueer people choose home births. This shows there is evidence that trans and genderqueer people may desire home birthing or birthing centers over hospitals. This made me curious how home birth midwives are prepared to serve trans and genderqueer people; Thus, I am doing a curriculum analysis of direct-entry midwifery programs. There are two accrediting bodies for midwifery programs in the United States and one of them primarily accredits direct-entry programs. Direct-entry means the program is designed for folks who are not already a nurse, and will not necessarily become a certified nurse before finishing their midwifery program. The other accreditation body focuses primarily on graduate programs and nurse-midwifery programs – folks who typically work in hospitals after graduating. Since I aim to look at home births, this project focuses on direct-entry programs.

There are nine direct-entry institutions that are accredited by the accrediting body I am looking at. For these nine institutions, I consider their websites, course catalogs, and student handbooks. In addition, one of the programs has paid access to their full curriculum, in an effort to increase accessibility to midwifery knowledge. I am doing a deep dive in that curriculum to look at the learning objectives, specifically, where those objectives include diversity. Within diversity, some objectives explicitly identify sexual orientation and/or gender identity. Within that curriculum I'm looking for two things; One is developing cultural awareness or humility; and the second is trans-specific pregnancy/birthing/lactation related content. Trans-specific content would be knowledge around the impact of a gender affirming treatment on sperm count, pregnancy, or lactation. For example, if you have had a double mastectomy, and then become pregnant and a lobule remains that produces milk without the ducts to move the milk out of your body, mastitis, an infection, can manifest. I met with multiple doctors and midwives when our family was deciding on our first midwife. Two of the three midwives did not mention any trans-specific care considering my medical history, specifically my double mastectomy. The third midwife was trans and had worked with trans gestators before. As a result they voiced concern about potential mastitis, and encouraged us to be aware of this possibility regardless of the midwives we would ultimately work with. None of the medical professionals I had worked with

or met with voiced this concern, and I believe it is because no one else was aware of that possibility. That is an example of content-specific things that birth workers should be aware of if working with patients who have engaged in gender affirming medical treatments.

The content analysis of direct-entry midwifery programs will review program catalogs and student handbooks in addition to the case study of one program. I anticipate finding both quality investments in trans-related content, self-awareness and cultural humility, in addition to some performative allyship (diversity statements or DEI statements that are not supported with action). I am curious to explore what the execution of these commitments look like in curriculums. While I expect to find that there is a gap in many curriculums, I don't think programs don't want to meet the needs of trans and genderqueer people, instead I expect that there is a lack of understanding regarding what content to include. Additionally I expect to see a layer of fear in engaging with this content. I'm seeing a lot of that fear in my literature review, hesitancy in covering topics related to the queer and trans community because people are afraid to 'get it wrong'. I haven't collected all my data for this project, only time will tell if those themes from the literature are prevalent in the programs I'm analyzing.

**MY:** Do you think the reason that more trans and gender queer parents go to midwives is because of the medical establishment and that it's a system that is so unclear about the needs ...

**SW:** I think it is split between that lack of actual knowledge about trans bodies and trans fertility and social components. There is not a lot of previous research on trans parents and trans gestators. Previous research mostly looks at lesbians who have been pregnant or given birth. This literature can serve as a sort of proxy, or provide a starting point for understanding birthing experiences for trans and genderqueer folks.

The literature shows that lesbians experiencing pregnancy understandably desire their doctors to acknowledge their family structure. There is also a documented concern from lesbian gestators that they have a heightened sensitivity to comments from their medical professionals, leaving patients wondering if they are taking comments personally, or if their doctor or medical provider is being rude and/or offensive. Then there is this added layer of having to educate your professional over and over.

**MY:** Oh, geez. That sounds really frustrating.

**SW:** Absolutely! Yet, having to educate your medical provider as a trans person happens all the time. The example I gave earlier, where my doctor was not sure if I could become pregnant or sustain a pregnancy after hormone replacement is really common. This lack of understanding came up with at least one of my participants in the biohacking study. The patient went to a *fertility clinic* and their doctor said, "I don't know if you can get pregnant" to which the patient said, "I am telling you that I can. I just need to get off of testosterone ...".

Again, there is the educating component and then there is the social component. These aspects can also be intertwined, as in the case of unwanted gendering in delivery rooms. I see a lot of Facebook posts with strategies to educate nurses in a delivery room; “Here’s a sign I’m putting up in the delivery room” and the sign includes their name and pronouns. Basically saying don’t call me “mom”, call me [another parent name]. When we were pregnant with our first we were told that if we had a hospital birth then we would meet with one OBGYN throughout our whole pregnancy and then when we go into labor we get whichever doctor happens to be on call. As a trans person, I am not interested in having some stranger come in not knowing my gender, not knowing my identities. I’m concerned with that provider being more interested in trying to figure out and explore or understand these factors (gender, identity) instead of focusing on my health and the health of my baby. That was the primary reason we decided to birth outside of a hospital, which might be what other people are experiencing, or it might be that social aspect of wanting to be seen, recognized, and accepted.

**MY:** I heard a news story recently about Black women and childbirth, and how worries center on dying in childbirth. When I had my children, as a white woman, that was not at the forefront of my thinking. In listening to you, and thinking about groups that have been traditionally marginalized in the medical field ... I hear you say that you know medical professionals are trying. It feels like there are these huge swaths of people in our country whose needs aren’t being met ... when we have these DEI statements, and we have these words that we all agree with. How do we operationalize that for everyone? It feels like as a medical system, it’s just *so behind*.

**SW:** Absolutely, I’ve been thinking about race and ethnicity a lot throughout these projects, and finding that most of the groups I’m looking at are predominately white. I am curious to understand how people of color who are trans and genderqueer are meeting their family needs since I don’t see this population predominately represented in the Facebook groups I am on as a white person. Ultimately, I think the medical system is still behind because medical professionals, and educators don’t know how to build knowledge in these areas. My recommendation for individuals, based on my experience, is to find your community and support system. I’m big on Facebook groups because that is where I find my community as a queer trans person, and along different intersections of my identities. I recently joined a queer PhD Facebook group.

There is also Facebook group for queer and trans midwives. Returning back to your question and the midwifery curriculum project, it is common for faculty to rely on their friends and family to do presentations and be a guest speaker or lecturer. I think that is problematic. Instead, we need to be pulling from queer and trans midwives who have that content and cultural knowledge, from their experience working and serving queer and trans people. Further, we need to compensate these birth professionals for providing that knowledge and then standardize teaching this information across the medical field. At least that’s where I think we need to start. I have interviewed a trans midwife for part of the biohacking project and I asked what types of

research they think are needed in this area and they were easily able to ramble off ten topics. They have insight into what their patients have experienced and what their needs are and things to focus on. But I don't think just asking people to come and guest lecture or to share that information for free is fair or effective. We need to recognize the incredible amount of labor they have put into building knowledge which has to be compensated.

**MY:** And it also needs to be a cornerstone. Having a one-off speaker does not demonstrate a commitment or allow in-depth learning. It feels like medical preparation programs need to move toward commitment by offering specific coursework... You have a third paper; how does that connect with your other work?

**SW:** My third paper is tangentially related to my other projects, and is centered on the question, "How do we – as trans and queer individuals – prepare our children to enter into public schools which value and centers heteronormativity and cisnormativity?". I think about this a lot with my kids. My oldest just started preschool and I'm concerned about the hidden curriculum being presented even at this young age. The conversations I've had with my oldest kiddo to prepare them, includes practicing pushing back when someone says "that's a boy thing" or "that's a girl thing" or, "why don't you have a mom and a dad?" which has already been asked at preschool pick up. I am also a second generation queer person – my mom is a lesbian –so I was raised in the queer community and those are questions I was asked as a youth throughout school. We do a lot of other things to prepare our kids, mostly conversations, role playing conversations, and creating representation where it doesn't exist. As we started developing a library for our kids, I took white-out to our books and replaced 'mom' or 'dad' with my parent name, Momo. I wrote my way into their stories.

So I wonder, how do we prepare our children? I wanted to build a project that did not focus on the deficit but focused on celebrating queer and trans families. I looked at a couple of studies and there is, again, not a lot of research on the things I'm focusing on, mostly studies that are tangentially related. In some of those studies there is a small body of work about children of queer parents being bullied, especially in middle school years.

**MY:** Is that scary to read about? When you think about your own children going to school?

**SW:** Yeah, my partner and I talk about that a lot and also where we live and raise our children. We moved out of a suburban area because of housing prices but we don't really want our kids to go to school where we are now. There is a school two blocks away and we're concerned that there won't be many other children with queer parents. We talk about that a lot but we don't have any solutions yet.

A tiny thread in some of the studies I've read is that children who have seen other family structures that are similar to their own have a higher self-esteem. It can essentially be a protective factor. That is the piece I wanted to focus on, I wanted to flip everything else on its



head. My entire project is centered on how being in community *is* the protective factor, *community* is the supportive piece. I designed a project that is a six-week workshop series that would bring together 5-10 families where at least one parent is trans or genderqueer. Families can be any arrangement – one parent, multiple parents, one kid, multiple kids – there is no restriction beyond having one parent who identifies as trans or genderqueer. I have a shell outline for the workshops, but ultimately participants will decide what workshop activities we will do.

The workshops I propose are two hours long with the first hour consisting of separate workshop activities for parents/guardians and their children. I have examples of what I think people might be interested in but ultimately the groups will decide. For example, the children and youth may decide that the most important thing is just to be together and connect, resulting in all activities focused on having fun, being collaborative, or artistically representing their families. The parent group activities will similarly be directed by participants and may be centered on education, legal rights, or support and community. For example a guest speaker teacher who comes in and talks about their experiences and resources, or a lawyer who discusses legal rights for families, or perhaps parents simply need that same community and support I anticipate the children need.

During the second hour of workshops I propose that families would come back together and enjoy a community dinner with a focus on being together and seeing families like their own. I began laying the groundwork for this project with the Q Center in Portland, Oregon and other regional nonprofits, and recently submitted a grant proposal for this project. Though if it is not funded I will still likely do the project but not as research, instead as community building project.

Ultimately, my third paper is focused on my reflexive process as I developed the *Building Trans Parent Community* project. Specifically, I am exploring the difference between my desire, or need considering my position as a student, to have my research be academically-oriented compared to simply serving my community. Whether it is valued academically is less important to me than the service and impact on the community. I do think there is research value here, and I have ideas about different alterations I could make to the data I would collect. Again, I anticipate that building community is the most protective factor and the most important aspect of this project.

Through this project I am developing a manuscript; “Queering the Researcher” which explores a service orientation instead of an academic orientation in research projects. This manuscript is a set of guiding questions to ask yourself as a researcher, as an academic, when you’re initiating a project that can help to explore your orientation toward your work, and ideally disrupt it. These are questions I am asking myself to reorient my work to serving my community. “Queering the Researcher” is still being developed, but will constitute the last of the three articles in my portfolio dissertation, bracketed by an introduction chapter and a conclusion to thread everything together. The introduction and conclusion are much more reflexive and show my journey through my education, and my development as an academic and scholar.

**MY:** It is interesting thinking about service and the intersection with research. Throughout this all, you've alluded to how personal this is. And it is also so clear that you have taken these experiences and are pushing forward to make changes. Where do you think that comes from within you?

**SW:** I've been in the queer community my whole life, I was raised in the queer community. There is a lot of desire to serve as a result. There is also a lot of fear about what my children will experience. I would say that's the bulk of where my push comes from, trying to build something better for my kids. trying to protect them as we build that. Thinking about the *Building Trans Parent Community* project, I don't think my kids have met in person – partially because of COVID but also because we live in a rural area and all of my community is on Facebook– other trans or genderqueer parents. My oldest child is four and they haven't met other kids who have families like theirs. That is where that project comes from, and that is where that drive comes from to build that community. It's my desire to build that for my kids. For my other pieces, it is about my own experience and feeling like there is not a platform to talk about these things or when there is a platform it is problematic and erases our existence as trans and queer people or erases the way we are resilient and thrive. I want to showcase the way we support each other, the ways we thrive in the face of these barriers, and highlight our joy. I want to celebrate our families and our community. The biohacking project does that by demonstrating how people form communities and create knowledge to meet their needs. I'm trying to emphasize that positivity, especially in the face of all this previous research that is so pathologizing or just completely ignores our existence.

**MY:** Shain, I so appreciate the work you are doing. It is impactful in so many ways. And thank you for taking the time to talk with me about it.

**SW:** Thank you Maika, it was fun to share these projects and talk about my work!