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The Outlawed Nipple: Breastless Parents and the Desire to Conform to Normative Motherhood

Maternal feminist theory and normative motherhood are influenced by a repronormativity that assumes all birthing people will breastfeed or chestfeed their infants. However, there is a predominant absence of a critical analysis of breast and chestfeeding from maternal theory and normative motherhood. Many new parents—for example, trans parents who have had chest masculinization surgery and parents who have had double mastectomies—do not have the privilege or ability to breast or chestfeed. For these breastless parents, the dilemma they face is intensified by normative motherhood discourses that essentialize good parenting as hetero-normative and repronormative, along with "breast is best" propaganda espousing erroneous health benefits. In this article, I argue that breastfeeding mandates are ubiquitous and misguided, in part due to an unspoken and assumed aspect of normative mothering, which has diluted the way health and perinatal care systems support breastless parents. This article centres repronormativity and transnormativity, ideologies entrenching the gender binary into its most rigid form, as intrinsic structures to normative motherhood. Understanding these concepts illustrates the harm inflicted on gender-nonconforming (or maternal nonconforming) identities embodying parenting. To combat this embodied shame and discrimination, I outline a conceptual framework for transnormative parenthood delineated by queer, intersectional, and ambivalent dictates.

> Is there something inherently queer about pregnancy itself, insofar as it profoundly alters one's "normal" state, and occasions a radical intimacy with—and radical alienation from—one's body? How can an experience so profoundly strange and wild and transformative also symbolize or enact the ultimate conformity? Or is this just another disqualification of anything tied too closely to the female animal from the privileged term (in this case, nonconformity or radicality)?
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> —Maggie Nelson, *Argonauts*, 15

Maternal theory exposes the social role and oppression that mothers experience based on their gender, biology, and obligatory reproductivity. It also critiques normative motherhood (parenthood), which is laden in repronormativity and assumes all birthing people will breast or chestfeed their infants. However, maternal theory lacks a critical analysis about how normative motherhood affects discourses on breast and chestfeeding. I imagine that breast and chestfeeding is absent from the critical discourse of maternal theory for a few reasons: 1) it is extremely divisive, and there is no unifying belief system; 2) everyone has an opinion about it (a strong opinion); and 3) if people were to look into the health benefits that support the "breast is best" mantra they would be disappointed. These reasons are perfectly fine; my problem is when dogma becomes policy and practice. Many new parents do not have the privilege or ability to breast or chestfeed and intensifying this inability through normative motherhood discourses of good parenting, wrapped in best health outcomes is harmful and discriminatory. In this article, I argue that breastfeeding mandates are ubiquitous, misguided, and influenced by normative mothering; these mandates have diluted the way health and perinatal care systems support breastless parents. For trans parents who have had chest masculinization surgery and parents who have had mastectomies, the inability to breast and chestfeed places these parents in precarity and excludes them from normative mothering. My research goal is to outline the conceptual framework for transnormative parenthood, delineated by queer and intersectional dictates. This would allow families and parents to locate themselves within a framework rather than be marginalized by heteronormative practices featured in normative motherhood. Furthermore, a transnormative parenting framework would assist perinatal and healthcare providers to better understand the needs and diversity of embodied parenting experiences that exist beyond the gender binary of repronormativity—from transmasculine and nonbinary to other breastless gestational bodies.

In this article, I centre repronormativity and transnormativity as intrinsic structures to normative motherhood. Understanding these concepts will illustrate the harm inflicted on gender-nonconforming identities that embody parenting. I will introduce the politics of breastfeeding and how reproductive ideologies cement the gender binary into its most rigid form. I use a series of narrative examples and qualitative studies featuring the experiences of transmasculine and nonbinary gestational and nursing parents to highlight how they negotiate their gender and parenting identities. Courtney Jung provides historical and scientific context to how breastfeeding and the "breast is best" mantra has become a political tool used in healthcare mandates, feminism, and infant feeding propaganda. Andrea O'Reilly's work on normative motherhood analyzes how the dictates of normative motherhood imply the inclusion of breastfeeding and subsequently define bad mothers

(parents) as also the breastless. The dictates comprising O'Reilly's normative motherhood framework are essentialization, privatization, individualization, naturalization, normalization, idealization, biologicalization, expertization, intensification, and depoliticization (487). On the other hand, Damien Riggs and colleagues have articulated how trans parents negotiate the demands of repronormativity against experiences of gender dysphoria and Carla Pfeffer has explored how queer families further negotiate access to privileged healthcare and legal systems aimed at maintaining heteronormative family making by implementing forms of queer invisibility. Beth Haines analyses the experiences of fifty trans families through an intersectional framework that considers the dynamic between one's gender and parenting identities. Kori Doty, A. J. Lowik, and Kinnon MacKinnon have each examined contemporary and historical understandings of repronormativity and transnormativity. Some trans parents will temporarily detransition to undertake gestational and nursing forms of parentage; furthermore, transmasculine parents taking on biological embodiments of parenting may enter unintentional detransitions as their parenting and gender identities conflict within repronormativity (Valdes and MacKinnon).

Next, I fold the detransitioner and the parent together through a literary example from Torrey Peters's novel *Detransition Baby*. Peters's novel speaks to how detransitioners can continue to live as queer and trans people. To believe that detransitioning is a return to normal points to an undying adherence to the gender binary that functions within transnormativity. The diversity of embodied parenthood is further reflected in Saige Whesch's first-person narrative of their journey as a nonbinary gestational and nursing parent in "Tales of My Infinite Chrysalis." Finally, this article concludes with an analysis of Trevor MacDonald et al.'s study on transmasculine individuals' experiences with lactation, chestfeeding and gender identity, which provides first-hand experiences of how twenty-two transmasculine parents negotiated their gender identities along with their parenting choices in an environment that constantly trapped them in the harmful interplay between repronormativity, transnormativity and normative motherhood.

The American Academy of Pediatrics (AAP) has actively used policy to promote a mothering prototype formulated by normative motherhood narratives. In 2012, the AAP announced that breastfeeding was a "public health issue and not a lifestyle" (qtd in Jung 98); this statement repositioned breastfeeding from a "personal parental choice into a civic obligation" (99). This politicization of the mother's body is evident in breastfeeding culture and the adopted social mantra that "breast is best." According to O'Reilly, a normative mother is a woman, cisgender, hetero, and the birth mother; she stays at home to raise the children and is depoliticized (478). Here, the mother's political agency is oppressed. She is unable to contribute to the

politics dictating how she should mother, while her body and mothering methodology are simultaneously over politicized and adjudicated. This loss of maternal political agency is harmful and is evident in social norms, community support groups, and the systematic network of maternal care (Bobel 436-37). In 2010, the surgeon general published the *Call to Action to Support Breastfeeding*, which identified "environmental effects as one important reason to choose breastfeeding. Human milk is a 'renewal resource,' and breastfeeding 'reduces the carbon footprint by saving precious global recourses and energy" (qtd. in Jung 64). This conflated social responsibility implies a loss of agency over the reproductive body and requires birthing parents to breast or chestfeed not only for the potential health benefit to the infant, but also to end the climate crisis.

This call to action also situates breastmilk as a product, which can be marketed, leveraged, and manipulated: "The truth is that in the United States, breastfeeding has become much more than simply a way to feed a baby. It is a way of showing the world who you are and what you believe in" (Jung 50). In "Maternal Ambivalence," Sarah Adams describes sensations and experiences of the body when pregnant and how the temporary inhabitation of an infant inside a body can blur the physical and psychological boundaries between the mother and infant (556). She emphasizes how the blurring of boundaries between infant and mother continues through breastfeeding, as they are linked through a physiological process that emmeshes their beings into one, together producing milk (556-57). Adams's sentiments about the experience of pregnancy and breastfeeding highlight the conflation of the biologicalization of normative motherhood, emphasizing how good mothers (parents) are the biological vessels for nourishing their children. Breastfeeding is also promoted through its intrinsic health benefits for both the mother and the child, including lowering the risk of breast and ovarian cancer for the breastfeeding mother (Adams 557). Health organizations, doctors, midwives, and lactation consultants all extol the benefits of breastmilk as an extraordinary health elixir:

> Breastfeeding and breast milk are credited with reducing the risk of ear infections, gastrointestinal infections, lower respiratory tract infections, necrotizing enterocolitis, high blood pressure, obesity, cardiovascular disease, diabetes, asthma, allergies, cancer, celiac disease, Crohn's disease, eczema, infant mortality, and sudden infant death syndrome (SIDS). Breastfed babies are also said to have higher IQs and to be more emotionally secure. (Jung 72)

This is an extensive list. There is no other product in the world with such a list of health benefits, and if there were, our immortal neoliberal capitalistic culture would find a way to extract, market, and sell it. However, this list may only represent the biopolitical mandate of normative motherhood, ensuring

that social reproduction is undertaken in a feminine, moralistic, and purist way.

In 1996, a paediatrician and professor in the Faculty of Medicine at McGill University, Dr. Michael Kramer, was the lead researcher on a clinical trial called the Promotion of Breastfeeding Intervention Trial (PROBIT). It was "the largest and most authoritative study of the effects of breastfeeding to date" (Jung 73). The PROBIT study used research subjects in Montreal, Toronto, and Belarus. In Belarus, "although most new mothers initiated breastfeeding at birth, the vast majority introduced formula soon thereafter and had stopped breastfeeding entirely by three months" (Jung 79). It is important to highlight that studies examining the benefits of breast and formula feeding will have "markedly different results in a developing country," (Jung 79) primarily when considering access to clean water and nutrition. The PROBIT participants were set up into two study groups. In the first group, mothers breastfed exclusively, and infants were kept with their mothers after birth. In the second group, infants were formula fed exclusively and were separated from their mothers after birth (Jung 80). The health outcomes for both groups were then tracked and recorded over time. My fundamental issue with this research model is how and why they chose to separate the formula-fed infants from their mothers. This narrative coincides with a layer of "breast is best": breastfed babies have a bond with their mothers and are "more emotionally secure" (Jung 72). However, I would suggest that the emotional security that infants experience is not from the breastmilk itself but from the embrace, warmth, sounds, and bond created in skin-to-skin contact—all achieved regardless if your nipple is made of skin or silicone. In the end, the PROBIT study shows that "babies breastfed for three or six months … protective effects exist only while a mother is actually breastfeeding and for about two weeks after she stops … [and] had no effect on ear infections or respiratory tract infections" (Jung 85).

In 2017 I had healed from a double mastectomy and completed chemotherapy following a breast cancer diagnosis in 2014. From the beginning of 2018 and through the nine months of my pregnancy, I would come up against the heteronormative, maternal-normative, repro-normative systems of maternity care that lean into the dictates of normative motherhood. The shame, loss, and discomfort I have with my body and the removal of my breasts was always my own to battle, now this loss was reshaped into my inability to perform as a good mother. I was a mother with no breast, no milk ducts, and only one nipple to feed my infant and this was caught with constant disapproval. A lactation consultant entered my room some hours after my daughter was born. I had rested and it was time to feed. I had many questions. I had never prepared a bottle of formula before, and I wanted to make sure I knew the correct proportions, the best temperature, how much to feed, how to hold my baby,

and how to prevent gas. I told the consultant I would not be breastfeeding. She turned and left the room, without a word.

The development of the lactation consultant as a profession is an example of the medicalization of breastfeeding and a biopolitical arm of motherhood. Breastfeeding advocacy has been around at least since the 1950s with the La Leche group, initiated by two white women breastfeeding their infants in public. The group was formed as a provocative feminist politic, reflecting the right to choose how women, mothers, (white, cis, and straight) can use their bodies and feed their children. The intrinsic white feminist politics of Le Leche group combined with years of misguided health benefit propaganda, delivered to us by healthcare professionals and packaged in normative mothering, has been harmful to mothers, women, and parents and digs into the deliverance of their maternal regret and safety. I would suggest that the breastfeeding mandate we are familiar with is compounded by the biologicalization of normative motherhood, whereby the normative mother not only has blood ties as the "cisgender birthmother as the real and authentic mother" (O'Reilly 478) but also utilizes her biology, its products, and appendages in ways that fulfill their purpose based on normative regulations. As O'Reilly has pointed out, mothers who do not fulfill the dictates of normative motherhood are "de facto bad mothers" because they are "young, queer, single, racialized, trans, or nonbinary" (478) and are therefore excluded from normative motherhood.

However, many trans and nonbinary parents, likewise bad parents, work to fulfill the dictates that comprise normative mothering. In "Normative Resistance and Inventive Pragmatism," Carla Pfeffer contextualizes "passing," or the dynamics of visibility and invisibility for queer families. For example, when a pregnant person is read as feminine and in a heteronormative partnership, they are presumptively protected by legal marriage and the biologicalization of normative motherhood (Pfeffer 591). Pfeffer notes this occurrence as a "trans loophole," whereby the invisibility of the couple's queerness and biopolitics is used as a pragmatic tool to access legal rights and privileges (and ultimately safety) (591). This social negotiation of normative mothering and the trans loophole points to the assimilative desire of trans families to be good parents based on normative outlines. Trans people can find themselves in a particularly confounding position when wanting to start a family that places their identity and desire for family in a vulnerable state of collapse due to the biological determinism and gender normativity of normative motherhood. Haines et al. outline the experiences of trans parents as they negotiate their identities and their family bonds. They illustrate the importance of an intersectional framework when "trans parents reconcile their parenting and trans identity" (239). This intersection is a complex one, as "the parenting role is … a social location of power and privilege ... [while] a transgender

identity is typically an axis of oppression" (239). The dynamic between the axis of power and privilege found in the makeup and visibility of heteronormative family making, with the axis of oppression seen in transgender identities, is a confounding intersection whereby the identity of the parent can dislodge them from the privilege of their family. Haines et al.'s article is a research study based on surveys completed by fifty families in the United States and focused on families with a parent who transitioned after having children. Transitioning parents witnessed how their transition and gender identity were impacting their family, which compounded a painstaking internalized transphobia (241). It is as if the visibility of the parent's transition and the change within the heteronormativity of the family exposed their access to invisibility and the "trans loophole." Only one parent in this research noted that they detransitioned "specifically and temporarily for the sake of their family" (241). Many trans parents will detransition to fulfill normative parenting while also experiencing dysphoria: "Trans women may choose to induce lactation ... [while] for transmasculine people, chestfeeding can often represent a delicate balance between feelings of dysphoria and the sense that chestfeeding gives purpose to the body" (Riggs et al., "Trans Parenting" 811). To this extent, what is the impact of breastfeeding mandates, which identify pregnancy, birth, and breastfeeding as feminine, on transmasculine parents who detransition to breast or chestfeed an infant? In the chapter "Trans Parenting" from *Maternal Theory,* Riggs et al. outline how the history of repronormativity has marginalized trans parents.

> Historically, reproductive bodies were solely presumed to be cisgender (i.e., not transgender) women's bodies and all such women were assumed to want to be able to reproduce and would be able to reproduce. Marginalized by these assumptions are, for example, transgender men and/or nonbinary people assigned female at birth who may be gestational parents. (Riggs et al., "Trans Parenting" 807)

The exclusion of transmen from aspects of normative mothering or parenting, like essentialization and naturalization, while simultaneously fulfilling a majority of the other calls to action, dangerously marginalizes them. As Riggs et al. have indicated, pregnancy and parenting are gendered and the desire to parent is also highly linked to one's gendered identity: "All such women were assumed to want to be able to reproduce and would be able to reproduce" (807). These prevailing assumptions are wrapped within normative motherhood and are fundamental to repronormativity and transnormativity.

According to Kori Doty and A. J. Lowik, repronormativity (short for reproductive normativity)

> refers to the ways in which female assigned bodies and women's identities, in particular, are maternalized…. Like heterosexuality,

> reproduction becomes compulsory … it is the scaffolding on which other binaries of parenting and reproduction are constructed, and this scaffolding is the racist, sexist, cisheterosexist, and colonial foundation on which nations are built. (16)

Repronormativity carries with it, like normative motherhood, the assumed naturalized condition of a person assigned female to reproduce and care for that child with her body. Furthermore, a distillation of transnormativity is a "set of binary and medicalized standards against which we hold trans people accountable" (17). These standards include the enactment and visibility of trans binaries—trans women and trans men—meaning that according to transnormativity, transitioning requires someone to fully live as the "opposite" gender to which they were assigned at birth, taking on all the performative, hormonal and surgical attributes that come with a successful transition, including gendered heteronormative reproductive contributions. In "Pathologizing Trans People," MacKinnon outlines the history that has pathologized trans identity and formulated the constructs of transnormativity. He describes medicalization as an intervention to "align the body" with socially accepted norms, and pathologization as the calculation of a consistent deviation from the normative baseline (MacKinnon 78). Trans experiences are, therefore, pathologized as mental disorders "complete with biomedical treatment" (78). Individuals diagnosed with gender dysphoria or gender variance are then intervened upon with technology that medicalization provides, such as hormone replacement therapies (HRT) or "gender-confirming surgeries, also termed sex reassignment surgeries (SRS)" (78). Both HRT and SRS technologies "contribute to the normalisation of nonnormative expressions of sex and gender … and render deviant bodies into a normative gender binary system" (78). An important aspect of both medicalization and pathologization of a trans identity is the mobilization of power; each contains the same goal to normalize nonnormative gender expressions, but they are expressed differently. The power of medicalization is the ability to distinguish the difference between what is considered normal (healthy) versus abnormal (sick/ill) and then develop systems and medicine to diagnose, intervene, and fix. While also privileging an expert with the power to "define trans experiences as mental illness," MacKinnon describes this as gatekeeping and as a fundamental part of the "pathologisation of trans identity" (78). Specifically, clinicians have the power to "verify, scrutinize and diagnose the authenticity of trans identities" (79), which has engrained and fortified not only the pathologization of gender variance but also its stigma. The medicalization and pathologization of trans identities have created determinants of transnormativity and further reinforced "the notion that there are only two genders" (80). It has been suggested that demedicalization could diminish the over pathologization and stigmatization of trans identities and experiences, which would first involve the removal of

diagnostic language like gender identity disorder (GID) and gender dysphoria (GI) "from psychiatric manuals" (81). Subsequently, demed-icalization has been contended as unethical due to how diagnostic language in turn leads to access to HRT and SRS, which have improved the lives of many trans people (81). On the other hand, detransitioning embodies a series of demedicalized steps; however, the dangerous assumption about detransitioners is their adherence to transnormativity, and an abandonment of their queer identity. Detransitioning is fundamentally nonlinear and ambiguous, it is intentional and unintentional, it is temporary and shifting.

In January 2023, Kinnon MacKinnon and Daniela Valdes published "Take Detransitioners Seriously" in *The Atlantic*. This article outlines how people who detransition or alter their gender transition from the bounds of transnormativity have been villainized within the communities that once supported them and are used as fodder for anti-trans platforms: "Some trans-rights advocates have likened detransitioners to the ex-gay movement or described them as anti-trans grifters. In fact, many detransitioners continue to live gender-nonconforming and queer lives" (MacKinnon and Valdes 3). This observation of detransitioners who "continue to live gender-nonconforming and queer lives" is significant because it points to the transnormativity that blinds many trans-activists and the ambiguity of detransitioning. The confusion and fear surrounding detransitioners is evident in many other detransition narratives, such as the novel *Detransition Baby* by Torrey Peters. Ames, one of the main characters, detransitions from a transwoman, taking on more male characteristics, and enters a straight-like relationship with a cisgender woman, and yet Ames continues to identify as a trans and queer person (as they always have even throughout their adolescence before transitioning). In the book, Ames is shocked when his girlfriend, Katrina, becomes pregnant—as doctors had informed him that he was sterile due to six years of estrogen injections and testosterone blockers while living as a "transsexual woman" (Peters 25). In his shock and surprise, Ames is forced to come out to Katrina as a detransitioned transwoman to explain his surprising fertility. While Katrina manages the information that her baby "daddy" was once a transwoman, she also is explicit that she does not want to be a single parent and needs Ames to commit to fatherhood; otherwise, she "would schedule an abortion" (34):

> Ames, for his part, wanted to stay with Katrina, and he could envision himself becoming a parent, but not a father. He knew, however, that Katrina didn't have the queer background to allow for that distinction, and that despite all his best intentions, she would default to the assumptions inherent in a man and a woman raising a child together. Unless he could find a way to escape the gravity of the nuclear family, no matter what he called himself, he'd end up a father. (Peters 34)

Ames must negotiate the vision of his parenthood to sustain a family with a straight cisgender woman that does not inevitably force him into heteronormative fatherhood. To do this, he decides to include his ex-partner and trans mother, Reese. Reese and Ames (Amy) were together for many years and had tried to have children in their partnership as two transwomen with no success. Ames believes that having Reese join as another mother to the baby Katrina carries will uphold and maintain his internal trans identity, the queerness he needs to parent. Reese is convinced Katrina will not agree to Ames' queer family vision, yet Reese quips, "Actually, *this,* might be the most trans way of getting me pregnant" (42). Detransitioning is not a departure from a gendered identity but rather a new expression of it. According to MacKinnon and Valdes, many trans and nonbinary community activists believe (fear) that detransitioners threaten their access to the gender care they have: "Detransition has become a political cudgel to challenge any gender care for young people" (MacKinnon and Valdes 3). They emphasize that these fears are most pronounced in detransition narratives containing sentiments of regret, which also seem to be the narratives most featured in the media (3). Detransitioners receive this backlash from the community based on a fear that to detransition is to not be trans or be queer; in some way, it invalidates a community of people. However, the constructs of these fears are not generated from detransitioners but from a history of trans identity pathologized through medicalization and political and healthcare systems, upholding the constructs that shape transnormativity.

Transnormativity includes aspects of repronormativity involving the attrition of loss, whereby the individual is willing and desires to relinquish any reproductive stakes their biology may hold. This mentality is spherically layered with repronormativity, which locates pregnancy and breastfeeding as something cisgender women do and transmen (as men) do not: "A trans woman, as a woman, it is reasoned, will/should ultimately yearn for the reproductive capacities associated with cisgender women, namely gestational motherhood; a trans man, as a man, it is reasoned, will/should ultimately reject a gestational role as demonstrative of his man-ness" (Lowik and Doty 20). There is no room here for additional visions of parenting embodiments beyond those defined within reproductive normativity. Lowik and Doty identify an essential "threat to womanhood" as "failing at motherhood" (16), and like the threat felt by trans activists from detransitioners, to not enact a gendered identity based on transnormativity, or repronormativity is to either fail at womanhood or fail at queerhood. Whesch shares their story of pregnancy, birth, and nursing in "Tales of My Infinite Chrysalis." Whesch is a nonbinary Papa Zazza (or Dad) who carried, birthed, and breastfed their infant. Throughout their perinatal care, Whesch worked to remain closeted and then later states that they got "too tired and busy to not be out" (109). For

many reasons, Whesch struggled to nurse and had to switch to formula to supplement the baby's diet. The reasoning expressed by Whesch is telling, because while the health issues that arose for them prohibited their ability to nurse, their tone is defensive to justify why they stopped breastfeeding. Their lactation issues eventually resolve, and they describe nursing as a "snuggly lactation relationship…[that] evoked something powerful and primal that predates any social constraints" (107). They felt their body, existence, and connection seep past the boundaries of their gender. Whesch reflects, "As accomplished and genderless as nursing felt, I began to wonder what a flat, sculpted chest would be like…. Producing any amount of comfort and milk directly from my chest made me proud of my mammal body" (107-08). Here, Whesch describes a fundamental aspect of the negotiation between gender identity and parenting identity: The pride they felt in the parts of their body that were purposeful and comforting were also the pieces of them that caused pain and discomfort. They also reflect on the satisfaction they felt in nursing while simultaneously envisioning a chest masculinization surgery. Here, a form of embodied parental ambivalence emerges, an evolution from maternal ambivalence, where biological capacities are divorced from gender identity—to admire and despise the body parts that nurture and torture.

In a 2016 study about transmasculine individuals' experiences with lactation, chestfeeding, and gender identity, MacDonald et al. interviewed twenty-two transmasculine parents (in North America, Europe, and Australia) about their experiences with pregnancy, birth and chestfeeding, or nursing and how they negotiated dysphoria, misgendering, and essentializations of repronormativity throughout perinatal care. The goal was to highlight how transmasculine gestational parents also need lactation support (like cis, breasted, and pregnant women) and that healthcare professionals should be equipped to provide this care as they can potentially cause the most harm. Most of the participants, seventy-three percent, chose to chestfeed: "Of 22 participants, 16 chose to chestfeed for some period of time" (MacDonald et al. 1). Similar to Whesch's story, these participants experienced an embodiment of nursing, and a distinction between gender and biology or nursing, that contradicts repronormativity and transnormativity alike: "Nine of the … participants had chest masculinization surgery before conceiving their babies," and these surgeries provided "immense relief" or dramatically lessoned experiences of gender dysphoria (4-5). In some cases, the relief that the chest masculinization surgery provided allowed two participants to find the space to even consider and choose "to become pregnant" (5). A chest masculinization surgery differs from a mastectomy; it does not remove all the mammary glands (that produce milk) to prevent the chest from looking sunken in (4). Therefore, post-top-surgery transmen who become pregnant may lactate, and chest tissue may grow back in pregnancy (6). Considering these surgical details, no study

participant indicated that a surgeon properly informed them about their mammary, lactation, or potential chest tissue regrowth. Many believed that their surgeons prescribed to a transnormative medicalization, "born in the wrong body" (5), gender identity, and therefore ignored significant healthcare needs and information their patients required. This is an example of when ideology interferes with good practice and how the pervasiveness of repro-normativity, transnormativity, and normative motherhood presides in the minds of healthcare providers, causing vast gaps in essential care. Furthermore, there is a history of trans people adhering to the mandates and policies of normative health and gender care to receive the medical attention they require without additional delays. All the study participants who had top surgery before conception did not ask their surgeons or doctors any questions about their desire to conceive or what impact the surgery would have on their ability or inability to lactate (5). The study participants who had chest masculinization surgery and who planned to chestfeed stated that the decision was simple due to the "health benefits and utility of chestfeeding," while others also echoed "bonding and attachment as reasons to chestfeed their infants" (8). Another participant described how supportive their local La Leche group was; I argue that their support rested in the participants' potential temporary femininization and their choice to chestfeed. This same participant articulated how they wanted to hold their child to their chest, offering nourishment and nurturing (8). However, as I have noted above, nourishment, nurturing, embrace, and comfort all occur regardless if you breast or chestfeed.

Furthermore, MacDonald et al. notice that as with other pregnant cisgender women, these participants experienced "pressure from healthcare, friends and family to chestfeed their infants" (8). This kind of social, parental, and embodied shame to use the body for the benefit of a newborn is misguided, as it ignites slippages into gender dysphoria and misgendering distress. One participant received advice from their lawyer, who said, "You have to breastfeed" and to make sure they did it in front of healthcare providers and social workers to maintain that the child was theirs (8-9). This participant had planned on pumping and then feeding with a bottle but had to chestfeed, forced to latch. This prescription to maintain custody through chestfeeding and to do so publicly forces people to use and display their bodies in a way that causes them deep distress. Many chestfeeding participants described a need to maintain privacy when chestfeeding to protect themselves from potential misgendering. Seven of the sixteen participants who chestfed experienced dysphoria and got through it by covering and hiding their bodies with clothing and focusing on its temporary utility (9). The researchers also noted that many "participants suggested a need for health care providers to communicate respect for different feeding choices other than chestfeeding, and that providers should neither assume a desire to chestfeed nor push for it" (11). It is

confounding that health and perinatal care providers will avoid conversations about mammary and lactation during preop chest masculinization appointments but then encourage chestfeeding when a transman conceives. It is incredibly hypocritical not to discuss the outcomes of chest masculinization surgery for trans and nonbinary people, as it presupposes transnormativity, and then to suggest chestfeeding, as it adheres to the "breast is best" mantra for infant care and repronormativity.

Parenting (mothering), pregnancy, and nursing have always been visioned within or against normative motherhood. Unless a new framework is created that includes an inclusive understanding of diverse embodiments of parenthood, these parents will continue to be outlaws of normative motherhood. In this article, I have articulated how healthcare mandates, trans care clinicians, and perinatal care providers have enforced breast or chestfeeding as the best option regardless of ability, disability, desire, gender, or choice to do so. In some cases, the mandate to conduct chestfeeding was so pronounced that outsiders felt the parent's gender identity increased their vulnerability to custodial rights; therefore, chestfeeding was used as a legal tool or "trans loophole" to access the privileged rights of those in accordance with repronormativity. While a conceptual framework based on the design of normative motherhood called transnormative parenthood may seem to adhere to additional structures of the gender binary, my goal is otherwise. As I see it now, the dictates of transnormative parenthood would include embodied ambivalence, time as it pertains to temporality, the "trans loophole," visibility and invisibility, nursing, and repronormativity encased around normative motherhood. Furthermore, for medical professionals, surgeons, clinicians, perinatal care workers to have insight into the problematics they may pose to trans, nonbinary, nonnormative, or nonconforming parenting embodiments they must be aware of: 1) the history of medicalization and the pathologization of trans identity that has led to a pervasive transnormative ideology within healthcare; 2) how pressure on diverse parenting embodiments to execute repronormativity is divisively harmful to the parents' health, and, therefore, greater understanding to the first point may mitigate perinatal and gender care health providers from this proclivity; and 3) if parents like Whesch can exist in a temporary embodied ambivalence and experience the purpose and despair of their chest for the betterment of their infant, then the community support around them must also outstretch to meet them within this ambiguity. Audre Lorde echoes an ambiguity of pain as she embodies both its visceral experience and its passing in *The Cancer Journals*: "I must let this pain flow through me and pass on. If I resist or try to stop it, it will detonate inside me, shatter me, splatter my pieces against every wall and person that I touch" (5).

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