A new type of family: Transmen as fathers thanks to donor sperm insemination. A 12-year follow-up exploratory study of their children

Un nouveau type de famille : des hommes d’origine transsexuelle deviennent pères grâce à un don de sperme. Douze années d’étude prospective exploratoire du devenir de leurs enfants

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Abstract

Objective. – In France, female-to-male transsexuals who have obtained a change of civil status have the right to request donor sperm insemination (DSI) for the woman with whom they live. Because this was met with some reluctance, a trial program with a follow-up study was devised with the agreement of the ethical committee. The aim was to check the quality of parenthood and the development and quality of life of the children.

Patients and methods. – These couples were considered to be similar to any couple requesting medical assistance to procreate. There is always an interview with a specialist in psychology before gametes are given. In these cases, there was a second one with a professional who worked with transsexuals. Usually parents are left free to choose to disclose or not the gift of gametes; but in this situation, since everybody in the father’s environment as a child was aware of his background history, these parents were advised to tell the truth about the DSI and the father’s transsexual past. A follow-up was proposed every second year. Parents and children were not volunteers participating in a research program; they came for a consultation from which they expected some help in their particular situation. The parents had interviews with a psychiatrist and two psychologists, the children were observed in their playing and drawing, and one standard measure (the Brunet-Lézine Scale) was used.

Results. – Forty-two children born to 32 couples were followed up from 2000 to 2012 and the program is still on-going. Though without a penis, the transmen are considered by their wives as men; the wives are not homosexual; the couples are stable (there have been only three separations); the children are very well cared for and have good relationships with their fathers, they seem normal, happy, without any major difficulty, without any gender identity variant. Fathers (with one exception) spoke easily of the DSI, but had some difficulty with their transsexualism – although willing to talk about it, they found it hard to put into appropriate words. They were helped by one father, who wrote and illustrated a booklet, telling of his childhood experience in simple words. The children coped well with this disclosure.

Conclusion. – This trial program brought positive results. It may continue and others may be set up in spite of persistent prejudices. The “therapeutic alliance” with these couples is now good enough to allow for research beyond pure observation – with a protocol and standard measures to appreciate the mental health, gender identity and quality of life of these children as they become adolescents.

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Keywords: Transsexualism; Transmen fathers; Donor sperm insemination; Follow-up study of children; Gender identity

Résumé

But de l’étude. – En France, les transsexuels féminin-vers-masculin qui ont obtenu un changement d’état civil ont le droit de demander une insémination artificielle avec donneur pour la femme avec laquelle ils vivent. En raison des réticences rencontrées, un programme d’essai avec une étude prospective de suivi fut mise en place avec l’accord d’un comité d’éthique.

 Patients et méthodes. – Ces couples furent pris en considération comme tout couple demandant une assistance médicale à la procréation avec don de gamètes. En France lors d’un don de gamètes, il y a toujours un entretien psychologique. Dans ce cas, il y eut un second entretien avec un professionnel ayant l’expérience du travail avec des transsexuels. Habituellement, on laisse aux parents le choix de faire connaître ou non le don

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de gamètes; dans ce cas, toute personne dans l’environnement de l’enfant du père connaissant son histoire, il fut recommandé de dire à l’enfant la vérité au sujet de l’insémination artificielle avec donneur et de l’origine transsexuelle du père. Un suivi tous les deux ans fut proposé. Les parents n’étaient pas restés comme des volontaires pour une recherche. Ils venaient avec leurs enfants pour une consultation dont ils attendaient une aide éventuelle dans leur situation particulière ; la consultation comprenait des entretiens des parents avec un psychiatre et deux psychologues et une observation de l’enfant, avec dessins et jeux, et une mesure standardisée du développement (échelle de Brunet-Lézine).

Résultats. – Quarante-deux enfants nés de 28 couples ont été suivis de 2000 à 2012. Le programme continue. Bien que dépourvu de pénis, ces hommes d’origine transsexuelle sont considérés par leur femme comme des hommes ; les femmes ne sont pas des homosexuelles, les couples sont stables (trois seulement se sont séparés) ; un grand soin est pris des enfants, qui ont de bonnes relations avec leur père ; les enfants apparaissent normaux, heureux, sans aucune difficulté majeure, sans variante de l’identité sexuée. Tous les pères (sauf un) ont ainsi parlé de l’insémination artificielle avec donneur, mais ils ont éprouvé quelque difficulté à parler de leur transsexualisme ; ils étaient très désireux de le faire, mais ne parvenaient pas à trouver les mots pour le dire. Ils furent aidés par un des pères, qui avait écrit et dessiné un petit livre, où il racontait son expérience d’enfant en termes simples. C’est accepté par les enfants sans problème.

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Mots clés : Transsexualisme ; Pères d’origine transsexuelle ; Insémination artificielle avec donneur ; Étude prospective de suivi ; Identité sexuée

1. Introduction

In France, infertile couples can apply for medically-assisted reproductive technology with donor sperm in the sperm banks called centre d’études et de conservation des œufs et du sperme/center for the study and preservation of eggs and sperm (CECOS). These centers are regulated by an Act of the French Parliament (Loi de Bio-éthique, 1994, revised in 2011) [1]. According to this Act, a man and a woman living together as a couple, married or not, can benefit from this procedure.

After receiving medical and surgical treatment, a female-to-male transsexual, (PtM, transman) has his civil status modified accordingly. He is thereafter a man in the eyes of the law and of society at large. He can marry a woman; the couple can apply for medically assisted reproduction and donor sperm insemination (DSI).

The CECOS, however, took the decision to refuse DSI to the partners of transsexual males. Indeed, most of the professionals working in those CECOS, although they had never interviewed a transsexual person, considered transsexualism to be a severe form of psychosis. That is contrary to the viewpoint of the great majority of specialists working with transsexual persons (see a full discussion of this problem in Chiland [2–4]). Nevertheless, the CECOS professionals were worried that a child born to and brought up by such a couple, in which the father is not a biological male, might not develop normally, and, more specifically, that such a child might be unable to construct an appropriate gender identity.

In fact, throughout the world, there have been practically no follow-up studies of children born to these families. Only one center, described by Baetens et al. [5], had in 2005 a small series of nine couples who applied to the centre for reproductive medicine of the Dutch-speaking Brussels free university, five of whom were accepted. Recently in 2012, a team from Ghent (Stuyver et al. [6]) presented a 10-year study of 34 children, focusing simply on the question of the disclosure of the DSI and of the “transition” made by the father, without, however, presenting any data on the quality of fatherhood or on the child’s development.

The follow-up studies of children born thanks to DSI in fatherless families, with heterosexual or lesbian mothers [7–9] show that these children do have a normal development – but this is a quite different situation. In the case of families with transmen, there is a father; the question is whether a person without a penis, born a female, could behave as a father and not as a second mother and could enable the children to have a normal development.

2. Method

Transmen who come with the project of becoming fathers thanks to DSI have already been through a long journey. Their story begins in childhood with a refusal of their biological sex and the growing conviction that they cannot live other than in the role of a man. They finally discover that it is possible to get a hormono-surgical transformation (as it is called in France), and a change of civil status. They have to find an appropriate center, they must be at least 18 years old, and they have to undergo a minimum observation period of two years before having surgery. They have to build their life, earn their living, find a partner and have with her the project of becoming parents. All of this takes time, so that those who in the end do have a child are no longer very young (the average age is 36, ranging: 28–49).

Those transmen were treated for several years in a specialized center, they all received hormones and surgery (mastectomy, hysterectomy, ovariecotomy; only three-quarters of them had phalloplasty). The CECOS has nothing to do with the diagnostic and treatment of these persons, who come to the centers only in order to have a baby. They have had their fill of interviews, tests, scales and so on. They do not want to be the subjects of a research project (whether remunerated or not). The follow-up must be for them an opportunity to be helped and to help those with the same condition. The method chosen was, therefore, purely observational, without questionnaires, scales and so on. Only one third of those involved live in Paris and the suburbs, the others come from some distance away (all over France, in fact). They come when the child is one year old and then every second year for a two-hour consultation; the relationship is more what is expected from a family doctor than from a scientist.

After the approval of the Ethical Committee, a trial program was drawn up by Pierre Jouannet, at that time the director of the Cecos in the Cochin hospital, and is now carried out by Jean
Philippe Wolf, the current director. Transsexuals whose legal and administrative status had been modified would be able to make an appointment at the Cochin hospital Cecos, just like any other men with fertility problems; their request would be similarly accepted, with three adjustments:

- instead of one interview with a psychiatrist or a psychologist, as is usual in France in the case of DSI, these couples would have a second interview with a psychiatrist or a psychologist experienced in working with transsexual persons; those who do not have this experience cannot easily differentiate between features specific to transsexualism and those indicative of some psychiatric problem;
- each couple was advised to be prepared to tell their child the truth about DSI and about the transsexual origin of the father. Whether DSI should be kept secret or not is a much-debated question. Usually, the CECOS leave it to the infertile parents to decide for themselves whether or not they should talk about having had recourse to DSI, and to whom; relatives in their immediate circle, for example, might know nothing of their infertility or hypo-fertility. But in the case of a transman the situation is different: everybody in his family and childhood environment knows that he was born a female and therefore cannot father children by himself. Thus in the child’s immediate circle, many people are in a position to reveal to the child the circumstances surrounding his or her birth; such a disclosure from anyone other than the father himself might well prove to be traumatic. Moreover, it has been shown that, in general, it is better to disclose DSI, and that the earlier this disclosure takes place, the better [10];
- these couples are offered a follow-up study of their children when they are one year old, and every other year thereafter (none of the 36 couples in which the woman became pregnant refused the idea of a follow-up). The interviews take place at the Necker-Enfants Malades hospital in Paris, in the child and adolescent psychiatry department. Parents and children are seen by a child psychiatrist, a psychologist, and a psychomotor therapist. It is a way of giving the parents some support if they need it, as well as being an opportunity for gathering information.

At each stage in the follow-up, data are collected in the interviews of both parents with the psychologists, then with the psychologist. A detailed observation of the interactions and behavior of the children is carried out by the two psychologists, initially while their parents are present, then without the parents. For the youngest children, the revised Brunet-Lézine infant psychomotor development scale [11], which covers ages 2 to 72 months, is used. In addition, the children are asked to make drawings (of a person, of a family, of anything they want to draw). They also play interactive games with the psychologists.

3. Results of the trial program

3.1. The parents

The transmen who took part in the program come from all walks of life and are the most highly adapted among the transsexual community in their professional, social and personal life: they are all employed, in various kinds of occupation, from lorry driver to magistrate; none of them is on social benefit; they are not isolated, they have friends and a social life; they are not militants proclaiming a trans-identity, they take on board their transsexual transition and want to live their life incognito in their role and identity of men.

In this program, initiated in 1999, only one couple out of 68 was not accepted; this was because the woman was too old (the same rule as for the general population). Only 36 became parents, of 47 children in all (among the others, some are known to have tried but failed to have a baby, the others probably decided not to go on with the idea; no direct information could be gathered because of their came from different parts of France, or because they spontaneously gave no information as to their decision and the motives behind it). In this report, the first children followed-up were born in 2000, the last ones in 2011; 42 children from 28 couples were followed-up from 2000 to 2012. One couple no longer participates; they had two children, of whom one was seen once. The other four couples out of the 36 mentioned are to be followed-up later.

There were discussions about the partners of the transmen. These women consider their partner to be a man. Their previous relationships were heterosexual (and, except in one case, not homosexual); three had no previous relationships at all. One woman expressed her feeling very well: “My man is not a woman, he is not a man like the others, he is a constructed man”. Even though he is not a biological man, such a person can construct his identity as a man through identifying with the masculine and paternal values of his culture; that is not mere theory, but an actual finding. Moreover, all the women said that their men were gentler than their previous partners. They said also that they were satisfied (or fairly satisfied) with their sexual intercourse.

The 28 couples interviewed are particularly stable: three of them separated, which is a very low rate (11%) – the last available statistics of the Institut d’études démographiques/National institute for demographic studies (INED) on the Internet [12] give a rate of divorce of 44.7% for the general population (if separations of non-married couples were included, the percentage would be even higher). By the end of 2012, the couples interviewed had been living together for 3 to 25 years (average: 14 years).

At their child’s birth, the father was between 30 and 50 years of age (average: 38), the mother between 26 and 40 (average: 34).

The interval between the first interview leading to the acceptance of their request and the birth of their first child was from 1 to 4 years (average: 2 years). The women do not belong to a selected population of infertile women and for one third of the children, the mother became pregnant at the first insemination.

3.2. The children

Children ages are given in Fig. 1. An average of 3.5 children was born per year. The sex ratio M/F (28 boys and 14 girls) is 2 in 2011 (general population: 1.03–1.07). The surplus of boys is
regularly decreasing through the years. In a very small sample, it is just pure chance that, at the beginning there were only boys or more boys. With the next births (the program is going on), it could be expected that the sex ratio will be in or near the normal range.

Fathers who found it difficult to cope with the idea of having themselves a female identity often wanted a girl, but were nevertheless very happy with their boy or boys. The mere fact of becoming a father was for them a miracle, and they were very devoted to their children.

The children, seen by three experienced professionals, seemed normal and happy, in marked contrast to the children usually seen in their everyday practice. All the children demonstrated a secure attachment. Even the youngest children had no difficulty in staying alone with the two psychologists; after evidencing quite normal anxiety, they could then be reassured.

In all the children, psychomotor development is normal; some are perhaps slightly more awkward than others. The age at which they started to walk lies within the normal limits of distribution, none was retarded. Their psychomotor development, assessed via the Brunet-Lézine Scale, is comparable to the distribution in the general population: average 102.5 for 39 children, with no developmental quotient under 80 (for three children the measure in not available) (Fig. 2).

Speech and language have developed normally in all but two of the children; these two are still young, and the second follow-up will show how this is evolving (the parents were advised to be attentive towards any possible problem in this area). Those who are of school age (14 children between 7 and 12 years) have no particular difficulty with their schoolwork; they easily learned to read and their results in other school subjects are usually satisfactory. They all have a clear body image, and differences between sexes and between generations are easily acknowledged.

For two children, the parents consulted a child psychiatrist. One required some supportive treatment as a result of his father’s breakdown (a severe depression requiring hospitalization). He was the only father in the group who had a breakdown; this led to the couple divorcing. The help that their son received enabled him to continue to attend school normally; his personal development, too, was as good as could be hoped for, given the ups and downs of his family life. The other child was exceptionally gifted, but school bored him. After a thorough assessment of his cognitive ability, he was given a few sessions of supportive counseling; his teachers were attentive towards his undoubted gifts and kept his interest alive – he could then cruise along at a speed that suited him well.

These children look like ordinary little boys and girls, not young androgynes or transgenders. None of them showed anything like a “gender identity variant” in what they said or did, in their manners, in the choice of their clothes, hairstyle, toys, friends, and so on.

4. Discussion

This to our knowledge is the first report of a follow-up study of children who were conceived via DSI in couples in which the father is a transman – and our study has been on-going for the past 12 years.

The main conclusions that can be drawn from this are that the children concerned are healthy, happy, and doing well, and that their fathers behave just like fathers do in contemporary society: games, sport, authority. … They are not a “second mother” and are clearly differentiated from the mothers; they feel particularly involved in the care of their children, as do most people who have had to struggle to have children [7–9].

DSI is the way these couples can achieve pregnancy (the only other possibility of becoming parents would be through adoption). Most couples were delighted at the possibility of achieving this unexpected parenthood. That is why they willingly accepted involvement in the follow-up study, with the feeling that it could help other couples to get the same opportunity more easily. The transmen thought for years that they could never become fathers, so these children are deeply loved by them. It is perhaps easier for a FtM transsexual father to take on board the fact that he had no spermatozoa to offer than it is for a “sterile” man to do so. The fathers in our sample were not distressed by or ashamed of being sterile; they had suffered from not having been born biological males. For a very long time, they had thought that they would never be able to father a child, but now their hitherto impossible wish has been fulfilled. Their children are treasured;
the parents have no ambivalent feelings towards the genitor, just
grateful.

Fears about the gender identity of children born thanks to
DSI, legally acknowledged and brought up by FtM transsexual
fathers are based on a misunderstanding about how gender
identity is constructed. It does not result directly from the fact of
having biological components, male or female, specific to one
or other of the sexes. The reluctance to inseminate the partner
of an FtM transsexual was based also on a mistaken conception
of transsexualism. It has to be admitted, all the same, that tran-
ssexualism is still something of an enigma. Gender identity is the
outcome of a complex process of psychological construction as
shown in the special issue of Neuropsychiatrie de l’Enfance et
de l’Adolescence [13–18]. We have known this since the 1950s,
thanks to studies of intersexed children, starting with the papers
published by Money (in 1955) – these led to the distinction
between biological sex on the one hand and psychological and
social gender on the other [19]. That process is not simply a mat-
er of “identification” in the sense of becoming an exact replica
of the father or of the mother. Children construct an image of what
they want to be, a composite image with elements that conform
to those of the father or to the mother as they are perceived, oth-
ers that conform to an idealized picture of the man or the woman
they invent, elements that represent a counter-identification with
the father or mother (“above all, not to be like them”) and ele-
ments that they have borrowed elsewhere – one’s identity feeds
on all kinds of psychological interactions. A transsexual father
was born, biologically, a woman and became, psychologically
and socially, a man by identifying with the masculine and paten-
tal values of his culture. It is of course difficult for people to give
up the idea of the “primacy of the phallus” or the notion accord-
ing to which what makes someone into a man, psychologically,
is the fact that he does have a penis. But these fathers are not
psychotic; at most they have constructed “a creative defense”,
as Pfäfflin put it in 1994 [20], against psychosis.

In answer to the point raised by Stuyver et al. in 2012 [6], who
do not systematically advise such parents to tell the truth about
their origin to their children, we would point out that mental
health professionals know the traumatic effects of the revelation
of family secrets by a third party. The parents in our program
did agree to tell their children the truth – this was not a problem
as regards the DSI, but only for one father who feared that he
would nor longer be recognized as the father of his children,
a quite common fear in case of DSI. Some mothers began the
disclosure while speaking to the baby in their womb; as soon as
the children began to speak, some fathers told the children that
they went to the hospital to get red or pink “pailletes”; it was not
a solemn disclosure, it was part of their everyday life.

The parents were often in difficulty, however, when they tried
to explain to the children why they were going to the Necker-
Enfants Malades hospital, but the most embarrassing element
concerned the father’s initial transsexualism. Some of the moth-
ers were worried that this might lead to undermining the father’s
standing in their children’s eyes. Generally speaking, the fathers
themselves had no problem with their transsexualism, but they
did not know quite how to talk to their children about it. In fact,
they took baths with their children – who of course could then
see their father in the nude – without feeling in the least embar-
rassed, even those who had no phalloplasty. One of them wrote
a booklet, with drawings, that he called “My own little book”. He
made use of it in discussions with his children. In this booklet, he
spoke in simple words about his childhood, about how, although
he was looked upon as a girl, he behaved like a boy, about how
he played with boys’ toys and with boys rather than with girls,
and so on. Transsexual persons are reluctant to speak about the
childhood that they have lived through in a sex they disliked
intensely, but in this simple way it became much easier. With
that father’s permission, the booklet was given to other fathers;
they used it, and were very happy and very grateful towards
the father who had given them “the words to say it out loud”.
Some children said after having read the book in presence of
the parents and the psychiatrist during a follow-up that they had
already understood the situation; apparently they coped well,
and obviously they had good relationships with their father.

The parents were worried in case their children talked about
their background to people in the vicinity, because they were not
sure how other children, school staff, and so forth, would handle
what they were being told. The children seemed to understand
that anxiety.

We do not know whether the children in our sample will feel
any pain – and, if so, what kind of pain – because of the fact
that they are the children of fathers who have made a “transition”
from having been a biological girl to becoming, psychologically
and socially, a man. What each child experiences will depend
on his or her own personal world and relationships and on the
attitude of the environment (prejudices or acceptance). Things
have evolved; none of these couples was rejected by those in their
immediate circle, contrary to the fear expressed by Baetens et al.
in 2003 [5]).

5. Conclusion

For the moment, all we can say is that there is absolutely no
reason to regret having facilitated the birth of these deeply loved
children who are developing well, who present no anomaly in
their development and who appear to be happy. It is of course
ture that what the children know will take on new meanings at
different stages in their life. Even though they seem to have had
no difficulty in accepting what they were told, later on, they will
understand it differently and it might even be as though they
were hearing it for the first time.

Perhaps at some stage in their life – adolescence in particular –
the children involved may have some difficulty with DSI and
their father’s transsexualism. For the moment, this is not the
case: none of the children seems to be in difficulty as regards
the circumstances of his or her birth. This study will be extended,
with the aim of further supporting these couples and monitoring
the children through their adolescence. Other CECOS are now
opening a program for such couples.

Disclosure of interest

The authors declare that they have no conflicts of interest
concerning this article.
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