

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

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Abstract

Maternal feminist theory and normative motherhood are influenced by repronormativity, which among other things, assumes that all birthing people will breastfeed or chestfeed their infants. 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 heteronormative 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 as two 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-non-conforming or maternal non-conforming identities embodying parenting. To combat this embodied shame and discrimination, a conceptual framework for transnormative parenthood delineated by queer, intersectional, and ambivalent dictates is outlined.

Keywords

Maternal feminist theory, repronormativity, motherhood

Introduction

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)? (Nelson 2015, 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 and 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 suggest 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 investigate 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. It is this policy-driven biopolitics of breastfeeding

and reproductive ideologies that cements the gender binary into its most rigid form. The inability to breast- and chestfeed situates trans parents who have had chest masculinization surgery and parents who have had mastectomies in precarity and excludes them from normative mothering. Therefore, I will outline a conceptual framework for transnormative parenthood that is delineated by queer and intersectional dictates. This framework would allow families and parents to locate themselves, rather than continue their marginalization by heteronormative practices featured in normative motherhood. Additionally, 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. This article centres repronormativity and transnormativity as intrinsic structures to normative motherhood. In examining these concepts, I illustrate the harm inflicted on those with gender-non-conforming identities who embody parenting.

According to Kori Doty and A.J. Lowik (2021), 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 a child with her body. Furthermore, a distillation of transnormativity is a “set of binary and medicalized standards against which we hold trans people accountable” (Doty and Lowik 2021, 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. 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 manness” (Doty and Lowik 2021, 20). There is no room here for additional visions of parenting embodiments beyond those defined within reproductive normativity. Lowik and Doty identify “failing at motherhood” as an essential “threat to womanhood” (2021, 16); to fail to enact a gendered identity based on transnormativity or repronormativity is to either fail at womanhood or fail at queerhood.

To grasp the formulation of transnormativity, Kinnon MacKinnon (2018) investigates how the medicalization of trans people has generated a pathology and formulated the constructs of transnormativity. They describe 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. Trans experiences are, therefore, pathologized as mental disorders “complete with biomedical treatment” (MacKinnon 2018, 78). Individuals diagnosed with gender dysphoria or gender variance are then intervened upon with the 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 normalization of non-normative 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 non-normative gender expressions, but they are expressed differently. The power of medicalization is the authority to distinguish the difference between what is considered ‘normal’ (or ‘healthy’) versus ‘abnormal’ (or sick/ill), and then develop systems and medicine to diagnose, intervene, and fix. Throughout this process, the expert emerges as an authoritative gaze holding the power to “define trans experiences as mental illness”; MacKinnon describes this as “gatekeeping” and a fundamental part of the “pathologisation of trans identity” (2018, 78). Fundamentally, 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. Thus, the medicalization and pathologization of trans identities have created the determinants of transnormativity and further reinforced “the notion that there are only two genders” (80).

It has been suggested that de-medicalization 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” (MacKinnon 2021, 81). Subsequently, de-medicalization 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.

The Biopolitics of Breastfeeding

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, repronormative 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, but 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 useless nipple to feed my infant, and this was met 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 (white, cis, and straight) women and mothers can use their bodies and feed their children. The intrinsic white feminist politics of the Le Leche group—combined with years of misguided health benefit propaganda packaged in normative mothering rhetoric delivered to us by healthcare professionals—has been harmful to mothers, women, and parents, and digs into the deliverance of their maternal regret and safety. I 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 2021, 478)—but also utilizes her biology, its products and appendages, in ways that fulfill their purpose based on normative regulations. As Andrea O’Reilly (2021) 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” and are therefore excluded from normative motherhood (478).

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” (Jung 2015, 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 (2021), a normative mother is a cisgender, heterosexual woman; the birth mother that 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 2021, 436-7). 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 ‘renewable resource,’ and breastfeeding ‘reduces the carbon footprint by saving precious global resources and energy’” (qtd in Jung 2015, 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.

Furthermore, 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 2015, 50). Because of this, many scholars and researchers promote the intrinsic health benefits of breastfeeding for both the mother and the child, including Sarah Adams (2021) who claims breastfeeding will lower the risk of breast and ovarian cancer for the breastfeeding mother (557). In the political project of “breast is best,” health organizations, doctors, midwives, and lactation consultants all extol the benefits of breastmilk as an extraordinary health elixir. Jung (2015) shares:

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. (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 immoral, neoliberal, and 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 pediatrician 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 2015, 73). The PROBIT study used research subjects in Montreal, Toronto, and Belarus and were set up into two study groups: in one 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 (80). The health outcomes for both groups were then tracked and recorded over time and the study showed that for “babies breastfed for three or six months [...] the 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” (85). Therefore, the policy-driven health benefits of breastfeeding far outweigh the benefits proven by science. However, the PROBIT study raises the question: why did they choose to separate the formula-fed infants from their mothers? If the researchers wanted to maintain consistency across the research groups, wouldn’t keeping infants and mothers together be a part of that? This narrative, that formula-fed babies do not need to be held by their mothers or held when they are fed, contributes to the “breast is best” rhetoric, suggesting that breastfed babies have a bond with their mothers because of breastfeeding and breastmilk, and are “more emotionally secure” (72). However, I 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 of your nipple being made of skin or silicone.

Trans and Nonbinary Parenting

In “Tales of My Infinite Chrysalis,” Saige Whesch (2021) shares their story as a nonbinary Papa Zazza (or Dad) who carried, birthed, and nursed their infant. Whesch describes 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” (107-8). 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 parts 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.

Parenting encases the ambiguity of nurture and torture, or comfort and displeasure, and for trans parents this can be felt with acute attunement. In "Trans Parenting" (2021), Damien Riggs and colleagues share that "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" (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? Riggs et al. further 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. (807)

The exclusion of trans men from aspects of normative mothering or parenting, like essentialization and naturalization, dangerously marginalizes them. As indicated in Riggs et al.'s analysis, pregnancy and parenting are gendered, and the desire to parent is also highly linked to one's gendered identity. These prevailing assumptions are wrapped within normative motherhood discourses and are fundamental to the maintenance of repronormativity and

transnormativity in our social climate.

Trans people can find themselves in a particularly confounding position when wanting to start a family, a position 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. Carla Pfeffer (2012) contextualizes the negotiation of gender and parenting identities against repronormativity, stating, "normativity structures contemporary citizenship, socially compelling gay and lesbian individuals to 'pass' as conventional in order to access sociocultural and material benefits" (578). For example, when a family is read as a heteronormative partnership, they are presumptively protected by legal marriage and the biologicalization of normative motherhood and repronormativity. Pfeffer notes this occurrence as a "trans loophole," whereby the biopolitics at play and the invisibility of the couple's queerness is used as a pragmatic tool to access legal rights and privileges, and offers "...though not failproof, safeguard for forming and protecting some trans families" (591).

The 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. Simultaneously, an intersectional framework emerges when "trans parents reconcile their parenting and trans identity" (Haines et al. 2014, 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. Beth Haines and their colleagues (2014) focus on the experiences of trans parents who transitioned after having children as they negotiate their identities and their family bonds. It is as if the visibility of the parent's transition and the change of the visible heteronormativity of the family exposes their access to queer

invisibility and the ‘trans loophole.’

The Biopolitics of Chestfeeding

A study published in 2016 focused on transmasculine experiences of lactation, chestfeeding, and gender identity. Trevor MacDonald and their colleagues (2016) interviewed 22 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 the essentializations of repronormativity throughout perinatal care. The goal of the project was to highlight that transmasculine gestational parents also need lactation support (like cis, breastfed, 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 in MacDonald et al.’s study chose to chestfeed. Like in 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 lessened their experiences of gender dysphoria (MacDonald et al. 2016, 4-5). In some cases, the relief that the chest masculinization surgery provided allowed 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 (which produce milk) to prevent the chest from looking sunken in. Therefore, post-top surgery transmen who become pregnant may lactate, and chest tissue may grow back in pregnancy. Considering these surgical details, no study participant indicated that a surgeon properly informed them about their mammary, lactation, or potential chest tissue regrowth.

Many participants in MacDonald et al.’s study believed that their surgeons prescribed to a transnormative, medicalized, “born in the wrong

body” (5) gender identity, and therefore ignored significant healthcare needs and information their patients required. This is an example of ideology interfering with good practice and the ways in which the pervasiveness of repronormativity, transnormativity, and normative motherhood in the minds of healthcare providers causes vast gaps in essential care. None of the participants in MacDonald et al.’s study who had top surgery before conception asked 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; this points to the history of trans people needing to adhere to the mandates and policies of normative health and gender care to receive the medical attention they require without additional delays.

Furthermore, MacDonald et al. noticed that participants experience, as pregnant cisgender women do, “pressure from healthcare, friends, and family to chestfeed their infants” (2016, 8). This kind of social, parental, and embodied pressure to use the body for the benefit of a newborn is misguided, as it ignites slippages into gender dysphoria and misgendering distress. One participant was told by their lawyer, “you have to breastfeed,” and was advised do so in front of care 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 deep distress.

Many chestfeeding participants described a need to maintain privacy when chestfeeding to protect themselves from potential misgendering. Seven of the 16 participants who chestfed experienced dysphoria, and got through it by covering and hiding their bodies with clothing and focusing on its temporary utility. The researchers also noted that many “participants suggested a need for healthcare 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” (MacDonald et al. 2016, 11). It is confounding that healthcare and perinatal care providers will avoid conversations about mammary and lactation during pre-operative chest masculinization appointments but then encourage chestfeeding when a trans man 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 because it adheres to the “breast is best” mantra for infant care and repronormativity.

Conclusion

Parenting, pregnancy, and nursing have always been envisioned within or against normative motherhood. Unless a new framework is created that centres an inclusive understanding of diverse embodiments of parenthood, many 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 normativity motherhood. Furthermore, for medical professionals, surgeons, clinicians, perinatal care workers to have insight into the problematics they may cause for trans, nonbinary, non-normative, or non-conforming parenting embodiments, they must be

aware of the following: 1) the history of medicalization and the pathologization of trans identity that has led to a pervasive transnormative ideology within healthcare; 2) how the pressure on diverse parenting embodiments to execute repronormativity is divisively harmful to the parents’ health, and how a greater understanding of 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 this ambiguity of pain as she embodies both its visceral experience and its passing in *The Cancer Journals* (1980): “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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Jones has presented her research at several university conferences including Chapman University in Orange, California, Concordia University in Montréal, Québec, and York University in Toronto, Ontario. Her work has been published in the *Journal of the Motherhood Initiative for Research and Community Involvement*, and she has an upcoming chapter titled "Water, Oil, Breast Milk: natural resources from mother (earth)" coming out in 2025 in *Mothers, Mothering, and Climate Change*.