Birthing Beyond the Binary: An Interpretative Phenomenological Analysis of Perinatal Mental Health Experiences among Genderqueer and Nonbinary Birthing People

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ABSTRACT

Background: There is a paucity of literature exploring genderqueer and nonbinary birthing people's perinatal mental health experiences in the UK. It is important to have a nuanced understanding of genderqueer and nonbinary birthing people's experiences of psychological distress and wellbeing in the perinatal period due to the gendered assumptions surrounding pregnancy, birth, and parenthood.

Aims: To explore genderqueer and nonbinary birthing people's experiences of psychological distress and psychological wellbeing in the perinatal period. To understand genderqueer and nonbinary birthing people's experiences of support in the perinatal period, and how this relates to their experiences of psychological distress and wellbeing.

Method: Semi-structured interviews were used to explore the accounts of seven genderqueer nonbinary birthing people's experiences in the perinatal period. Experiences were analysed using Interpretative Phenomenological Analysis.

Results: Analysis resulted in four overarching Group Experiential Themes: navigating shame and the emotional tides of distress; rebuilding identity under the heavy burden of the cishet gaze; feeling understood, connected to others; and creating safety in an unsafe world.

Conclusion: Genderqueer and nonbinary birthing people discussed their experiences of psychological distress and wellbeing in the perinatal period in relation to a loss and subsequent rebuilding of identity, bodily and social dysphoria, and their felt sense of connection with others. Participants also highlighted the impact of erasure and anti-trans prejudice within services on their mental health. The findings encourage the dismantling of traditional gendered notions of pregnancy, birth, and parenthood. Perinatal services must change to ensure the support they provide is inclusive, safer, and more supportive for genderqueer and nonbinary birthing people.

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LIST OF ABBREVIATIONS

GQNB = Genderqueer and Nonbinary
LGBTQIA+ = Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual+
MH = Mental Health
OCD = Obsessive-Compulsive Disorder
PNP = Perinatal Period
PNMH = Perinatal Mental Health
PTSD = Post-Traumatic Stress Disorder
TNB = Transgender and Nonbinary

1. INTRODUCTION

1.1. Overview

This chapter begins by defining relevant terminology. Following this, the prevalence and impact of psychological distress in the perinatal period (PNP) and service provision in the UK are outlined. Literature related to the lived experience of birthing people is explored, emphasising the need to consider a person's intersectional identity and the operations of power that impact their subjective lived experience. Biopsychosocial, feminist, and queer theories are outlined, and their relevance to perinatal mental health (PNMH) experiences is discussed. The lack of literature about genderqueer and nonbinary (GQNB) birthing people's experiences of psychological distress in the PNP is exemplified through a scoping review, providing evidence to support the research aims.

1.2. Terminology

The language that is used to communicate ideas is intertwined with cultural and societal norms (Berger & Luckmann, 1966). It allows us to convey knowledge and make sense of experiences whilst contributing to how our contexts are shaped (Renzl, 2007). Language holds power – the power to reinforce prejudice and pathologise experiences (Collins & Clément, 2012), and the power to produce new meaning, disrupt social inequality, and challenge discrimination (Durrheim, 1997; Foucault, 1978). Whilst recognising that words can change in meaning over time, the language used in this thesis has been selected carefully, endeavouring to convey understanding in an open, respectful way. Alternative terms may also be used, some of which could be equally as appropriate or more so for some, however those outlined below will be used for consistency.

1.2.1. Gender

The construct of gender is one that is frequently misunderstood. The two-gender classification system, and the notion that gender is synonymous with a person’s biological sex determined at birth is rooted in Western colonial ideals (Lugones, 2007; O’Sullivan, 2021).

Gender is instead an expansive idea that is socially constructed (Lorber, 2018). It encompasses gender expression, gender identity, and gender roles. Gender is something that can be explored and played with – something that can change over time. It is more than the limited binary of man/woman. Behavioural and psychological stereotypes associated with gender constructs are embedded within social norms and culture. These prescriptive understandings of gender reinforce the gender hierarchy, perpetuating stigmatisation, discrimination, and inequality (Bonvillain, 2021).

1.2.1.1. Trans/Transgender. Trans, or transgender, describes those who understand their gender as different from the one they were assigned at birth. For example, someone whose biological sex was classified as female, and as a result they were assigned the gender of girl, later understanding their gender as boy, or man and vice versa. Being trans is not a homogenous experience, some people socially transition, some medically and physically transition, some do both and some do neither (Stonewall, 2022). Therefore, trans is an umbrella term to represent varying experiences of deviating from the gender a person was assigned at birth.

1.2.1.2. Genderqueer and Nonbinary. Although there are many trans people that understand their gender within the concepts of man/woman, there are also people, some of whom are trans, who understand their gender identity outside of the traditional two-gender binary, or who do not identify with a gender at all. A person who was assigned female/girl, or male/boy at birth might later understand their gender as somewhere between or beyond these constructs (Stonewall, 2022). This can be defined by many terms meaning slightly different things to different people – GQNB are often used. Additional terms that people may use to denote a similar experience include but are not limited to: gender non-conforming; genderfluid; queer; agender; demifluid; transmasc; transfemme. Whilst recognising the validity of other terms, GQNB will be used as an umbrella term in this thesis.

1.2.1.3. Cis/Cisgender. Cis, or cisgender, describes those whose gender assigned at birth based on their sex is the same as how they would describe themselves today. It is a term that is used to describe people who are not trans. Some GQNB people may describe themselves as cis (NCTE, 2023).

1.2.2. Queer

The term queer bares cultural significance in that it was once used in a derogatory way. However, its meaning has shifted over time. For many, queer now represents fluid multifaceted experiences of gender and sexual orientation (Velasco & Paxton, 2022). LGBTQIA+ identifies those who are lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Both ‘queer’ and ‘LGBTQIA+’ mirror the merging and homogenising of sexual and gender identities that is often seen throughout society (Browne et al., 2011). However, the use of fixed categories in LGBTQIA+ fails to represent a vast range of intersectional experiences and subjective understandings, ignoring the fluid nature of gender and sexual orientation (Rupp et al., 2016). As such, the term queer will be used as an umbrella term used to indicate that a person’s sexual orientation and/or gender identity is not heterosexual and/or cisgendered.

1.2.3. Cisheteronormativity

Cisheteronormativity is a system of beliefs that assumes heterosexuality and cisgenderedness are the superior identity (HRCF, 2020). Cisheteronormative perspectives believe in a two-gendered system, where gender aligns with sex. It values patriarchal gendered norms where people are attracted to those of the ‘opposite’ gender, present as either feminine or masculine, and follow a typical family life cycle (Marchia & Sommer, 2019; Kramer, 2011). Centring the values and culture of cisgendered heterosexual people reinforces the stigmatisation of those who are not. This results in social, institutional, and psychological consequences such as violent and persistent discrimination (van der Toorn et al., 2020).

1.2.4. Anti-queer Prejudice

Anti-queer prejudice is a term used to describe the hateful actions and discrimination towards the queer community on systemic and individual levels throughout society. Though the word homophobia is commonly used, its etymology suggests discrimination occurs due to fear (Herek, 2004), locating the problem within the queer community rather than the individual and/or system which is perpetuating harm.

1.2.5. Anti-trans Prejudice

Similar to homophobia, transphobia commonly describes hatred and prejudice towards trans people and groups. For the reasons outlined above, the term anti-trans prejudice will be used.

1.2.6. Racialised

The term racialised denotes the individual and group-based categorisation that occurs through society based on the social construct of race (Dalal, 2002). Although typically it is used to refer to people who are racialised as Black or Asian, people are also racialised as White. Recognising this disrupts White identities being viewed as the norm. ‘Racialised minoritised’ will be used when referring an overarching grouping of those racialised as Black and/or Asian. The verb minoritised represents the operation of Whiteness. Moreover, the term minority does not accurately reflect the global majority position that is held (Campbell-Stephens, 2021).

1.2.7. Perinatal Period

Pregnancy, birth, and the following year has been coined the PNP (NHS, 2018). Antenatal denotes the time preceding birth, and postnatal denotes the time following birth. It is a time of high vulnerability involving many physical, social, and psychological changes for both the parent(s) and child (Blount et al., 2021). The second year of a child’s life is also important (Marmot, 2020) as profound changes continue and parent/child vulnerability persists. As such, NHS PNMH services are available to those who are pregnant or have given birth up to 24 months prior (NHS, 2019). Therefore, in this thesis the PNP is defined as pregnancy, birth, and the following two years.

When referring to experiences of those who give birth, the term birthing person/parent will be used. When referring to their partner(s), non-birthing person/parent will be used. This is because not all people who give birth are women, and not all partners are men. When discussing individual pieces of research, the terminology of the paper will be retained.

1.2.8. Mental Health

The human experience of distress, positive affect, and individual and social functioning have been made sense of in various ways (Rogers & Pilgrim, 2021). This has resulted in a plethora of terms to describe experiences related to suffering that are often used interchangeably – at times to describe different constructs (Herron & Mortimer, 1999).

Experiencing increased distress, reduced positive affect, and reduced functioning has been medicalised. Understanding distress as an illness or disorder that needs to be treated with psychotropic medication perpetuates the idea that it has underlying biological causes (Deacon, 2013; Rapley et al., 2011). This has led to stigmatising capitalistic notions of those who experience psychological distress as having a deficit and/or being unable to contribute to society (Bolton, 2008; Thangaduari & Jacob, 2014).

Instead, mental health (MH) encompasses psychological and social wellbeing. It refers to both the distressing and pleasant affect that we experience as part of life: the experiences that support quality of life, those that are stressful but do not impact functioning, and those that are distressing and impact functioning (Horwitz, 2007). Changes in MH are conceptualised as understandable and related to the systems and context in which people live in both as individuals and as part of social groups (Rapley et al., 2011). MH is therefore flexible and dynamic (Galderisi et al., 2015). Throughout the thesis, psychological distress (states of emotional suffering) and psychological wellbeing (states of positive affect, connection, and purpose) will also be used when discussing MH experiences (Winefield et al., 2012).

1.2.9. Perinatal Mental Health

PNMH refers to the changes in people's psychological wellbeing and experiences of psychological distress throughout the PNP. This is often conceptualised as diagnosable psychiatric conditions e.g. Perinatal Depression, Perinatal Anxiety, Perinatal Obsessive-Compulsive Disorder (OCD), Postpartum Psychosis, and Postpartum Post Traumatic Stress Disorder (PTSD) (Mind, 2020). Understanding MH and its relationship to external stressors and context allows for a more dynamic and adaptable understanding, moving away from the notion of distress as an illness (Horwitz, 2007; Rapley et al., 2011). As such, the term PNMH will also signify the range of experiences that do not meet diagnostic criteria. The language that participants use to describe their PNMH experiences will be adopted throughout.

1.3. Perinatal Mental Health: Prevalence

There is an increased risk of psychological distress in the PNP. Birthing people are vulnerable to experiencing a worsening or reoccurrence of pre-existing MH conditions (Altemus et al., 2012; Martini et al., 2015; Munk-Olsen et al., 2009), whilst also being vulnerable to experiencing psychological distress for the first time (Forray et al., 2010; Jones et al., 2014; Phillips et al., 2007). Approximately 20% of birthing people are affected by diagnosable PNMH conditions (Howard et al., 2014), with more recent UK-based research indicating prevalence at 27% (Howard et al., 2018). The PNP is also a time of increased vulnerability for non-birthing partners, with approximately 10% experiencing psychological distress (Darwin et al., 2021). Around 50,000 people in the UK are in contact with specialist PNMH services at any one time (NHS, 2023a).

It has been suggested that in the UK between 8-14% of birthing people experience perinatal depression and 11-19% experience perinatal anxiety (Howard et al., 2018), with trends increasing over time (Pearson et al., 2018). Other experiences are less common: the incidence of perinatal OCD is thought to be between 1-4% (Fairbrother et al., 2016; Howard et al., 2018), postnatal psychosis, between 0.089-0.26% (Vanderkruik et al., 2017), and postpartum PTSD, between 2.44-4.45% (Yildiz et al., 2016). Some of those who experience psychological distress in the PNP experience suicidal ideation (Bright et al., 2022) and self-harm (Ayre et al., 2019), with suicide as the leading cause of death up to one year postpartum for birthing people (Khalifeh et al., 2016; MBRRACE-UK, 2023).

Understanding the prevalence of psychological distress in the PNP is complex, as reflected in the inconsistent data (Howard et al., 2014; O’Hara & Wisner, 2014; Paschetta et al., 2014). Many statistics reflect only those who have been able to access services or whose distress reaches diagnostic thresholds (Bridle et al., 2022). Services are difficult to access for many, with inaccessibility increasing for marginalised groups based on racialisation (Prady et al., 2021), sexual orientation, and gender (Greenfield, 2022). Barriers include biased policy, poor resources, and stigmatisation (Smith et al., 2019). As stigma associated with experiencing psychological distress in the PNP persists (Smith et al., 2019), PNMH experiences may be underreported. The true prevalence may be higher than 20%.

The prevalence of psychological distress in the PNP varies depending on the social and cultural context of the birthing person (Howard et al., 2014). Risk factors include but are not limited to: having fewer socioeconomic resources (Yang et al., 2022); a lower education level (Furtado et al., 2018); a lack of social support (Huschke et al., 2020); previous experiences of psychological distress (Paschetta et al., 2014); experiencing domestic violence (Barker et al., 2012) and stressful life events during the PNP; and past experiences of abuse or childhood trauma (Bayrampour et al., 2018).

In the UK, there is a lack of data concerning the prevalence of psychological distress in the PNP for queer birthing people. Most data collection, statistical reporting, policy, and research about the PNP describes women and mothers (e.g., Martin, 2012; NHS, 2019). This fails to capture the experiences of the queer community. Research consistently demonstrates higher rates of psychological distress within queer communities (Stonewall., 2018), with even more distress being evident for transgender and nonbinary (TNB) people (Newson et al., 2021). Higher rates of depression and marginalisation may increase the risk of perinatal psychological distress for TNB birthing people (Wisner, 2018).

1.4. Impact of Psychological Distress in the Perinatal Period

The impact of psychological distress in the PNP is vast. Psychological distress during pregnancy can impact the physical and cognitive development of the foetus (Christian, 2012; Kotelchuck et al., 2017; Rondo, 2007) and has been associated with complications during pregnancy and birth for the foetus (Paschetta et al., 2014) and birthing person (Runkle et al., 2023). This increases the risks of early labour (Montagnoli et al., 2020; Ståhlberg et al., 2020) and foetal death (King-Hele et al., 2009).

These in-utero experiences have been associated with worse psychological (Bucci et al., 2016; Davis & Sandman, 2012), neurodevelopmental (Rogers et al., 2020), and health outcomes for the child once born (Sandman et al., 2012). Although the evidence is mixed (McNamara et al., 2019), some literature suggests a relationship between perinatal psychological distress and disruptions in the child-caregiver bond (Filippetti et al., 2022; McFarland et al., 2011), potentially impacting the child's psychological, social, behavioural, and emotional outcomes throughout their life (Arguz Cildir et al., 2020).

Adverse health outcomes related to antenatal psychological distress increase the risk of postnatal psychological distress for the birthing person (Anderson & Cacola, 2017; Misund et al., 2013), potentially leading to long term psychological distress (Freeman et al., 2018) and suicidality (Johannsen et al., 2016; MBRRACE-UK, 2023). Postnatal psychological distress can also impact partner relationships (Reay et al., 2011), access to employment (Reay et al., 2011), and sexual functioning (Çankaya & Alan Dikmen, 2023; Chivers et al., 2011; Fitzpatrick et al., 2021). Moreover, increased fear and paranoia may hamper trust, making it harder to seek help (Forde et al., 2020).

1.5. Social Support in the Perinatal Period

The significant physical, emotional, and psychological changes that occur during the PNP contribute to the unique and varied support needs that birthing people have during this time. Birthing people may require additional emotional and practical support from their social circles and services to meet their psychological, physical, and spiritual needs (Sufredini et al., 2022). Birthing people seek this support through community groups and spaces, their peers, and services and organisations (Al-Mutawtah et al., 2023).

Social support is required for a variety of reasons. A birthing person and non-birthing partners may need help in accessing the information that they need to attend to their own and the foetus or infant's psychological and physical health (Leahy-Warren et al., 2012). For some, social support may also reduce the burden of managing the practical demands of pregnancy and childcare, which are particularly prevalent in the transition to parenthood (Kay et al., 20224). For others, social support is crucial for maintaining psychological wellbeing, supporting birthing people in connecting with others who have similar experiences and reducing social isolation (Collins et al., 2021; Manley et al., 2018), making it easier to manage common stressors in the PNP (McLeish & Redshaw, 2017).

The link between social support and the experience of PNMH for birthing people is well established. Research highlights lower levels of social support from partners and peers is related to increased low mood, anxiety, and self-harm (Bedaso et al., 2021; Kay et al., 2024). Alternatively, increased perceptions of social support not only reduce the severity and risk of experiencing psychological distress in the PNP overall (Bayrampour et al., 2015). Increased social support helps birthing people feel cared for and connected to others (Renbarger et al., 2021). It also increases their capacity to cope with challenging situations (Al-Mutawtah et al., 2023).

The PNP is considered an essential time for communities to come together. This can be seen across cultures and time, with families and communities enacting traditions to welcome new life and support birthing people (Dennis et al., 2007; Selin & Stone, 2009). The importance of social support in the PNP has been emphasised for birthing people across a variety of identities (Edge & Rogers, 2005; Leal et al., 2021; Wahn & Nissen, 2008). For those who are marginalised, social support may be even more crucial due to the systemic barriers that they face in services (MBRRACE-UK, 2021; Pezaro et al., 2023). As such, it is important to understand what support a person has around them throughout each stage of the PNP.

1.6. Service Provision in the Perinatal Period

In the UK pregnant people are entitled to antenatal and postnatal care through statutory services (DoH, 2009). This involves appointments with a midwife throughout pregnancy, birthing support at hospital or home, and health visits post-birth to assess the baby and birthing person’s physical and MH needs (NHS, 2022).

Birthing people can be referred to PNMH services throughout pregnancy and up to two years following birth (NHS, 2019). These services include community PNMH teams and inpatient parent-baby MH units depending on the severity and risk related to the psychological distress. PNMH services offer evidence-based psychological therapies and psychotropic medication to support the birthing person and the caregiver-infant relationship (NICE, 2020).

Perinatal services consistently fail birthing people (Kirkup, 2022). Reports highlight key factors that contribute to the lack of safety and effective perinatal care in the UK (Independent Maternity Review, 2022; Kirkup, 2015). These include: unsatisfactory clinical competence of staff; poor working relationships; unhelpful hierarchical structures; poor risk assessment; inadequate responses to serious incidences; and dangerous staffing levels.

Services are more dangerous and ineffective for marginalised and minoritised birthing people. In line with reports of institutionalised racism within the NHS (Bradby & Nazroo, 2021; Woodhead et al., 2022), when compared to birthing people racialised as White, birthing people racialised as Black or Asian are four and two times more likely to die during childbirth respectively (MBRRACE-UK., 2021). Racism, cultural insensitivity, and stereotypical, prejudicial views (Darwin et al., 2022) leave minoritised racialised birthing people unsafe when accessing perinatal care (Birthrights, 2022; Awe et al., 2022). Consequently, PNMH care cannot be accessed at the same rate and level as White birthing people (Conneely et al., 2023; Moore et al., 2019; Watson et al., 2019).

Similarly, experiences of perinatal services are worse for queer birthing people (McCann et al., 2021). Queer birthing people are likely to experience anti-queer prejudice throughout their perinatal journey (Dahl et al., 2013). Services are lacking in the knowledge and awareness needed to support queer people generally (McCann et al., 2021) and even more so TNB birthing people (Botelle et al., 2021; Pezaro et al., 2023). Cisheteronormative service structures lead to increased stigma and a lack of resources to provide appropriate support (Pezaro et al., 2023). This results in less satisfaction with care (Stacey et al., 2021), poorer perinatal outcomes (LGBT Foundation, 2022), and increased fear when accessing services (Greenfield & Darwin, 2021). Harmful experiences have resulted in more TNB people giving birth at home (LGBT Foundation, 2022), and queer people hiding their identity to protect themselves (Goldberg et al., 2017; Wilton & Kaufmann, 2001).

The inadequacy of UK statutory services for birthing people has prompted increased government funding. This funding aims to enhance training for professionals, ensuring effective, compassionate, and personalised perinatal care (NHS, 2016; NHS, 2023b). The funding is also being used to expand specialist PNMH provision across the UK (NHS, 2019). Despite this, further efforts are required to understand the unique experiences of marginalised groups to ensure the effectiveness and safety of services for all birthing people.

1.7. Theories of Psychological Distress in the Perinatal Period

Theoretical frameworks can support how we make sense of experiences of distress in the PNP and why they may vary between different groups.

1.7.1. Biopsychosocial Theory

Biomedical explanations argue that individuals have a genetic predisposition to experiencing psychological distress in the PNP (Mahon et al., 2009). Arguably the rise of stress hormones during pregnancy increases inflammatory markers, resulting in dysregulation of the hypothalamic-pituitary-adrenal system (Bierhaus et al., 2003). This has been linked to perinatal anxiety (Bauer et al., 2020). While less common, increased exposure to stressors in the PNP has been linked to experiences of confusion, suspicion and fear, and hearing, seeing, smelling, and/or feeling things that cannot be experienced by others (Aas et al., 2020). Additionally, the rise of reproductive and stress hormones during pregnancy and subsequent fall following birth is said to destabilise mood, potentially resulting in postnatal depression and psychosis (Glynn et al., 2013).

Understanding perinatal psychological distress through a biomedical lens is reductionist (Deacon, 2013). Failing to recognise the psychosocial and economic factors that influence the experiences and outcomes related to PNMH (Carona et al., 2023; O’Connor et al., 2016; Yang et al., 2022) compounds blaming narratives that harm those who experience psychological distress (Peckover, 2019). Furthermore, biomedical models fail to explain variances in experience (Howard et al., 2014). As such, biopsychosocial theories – those that consider the relationship between biological factors (hormonal changes, genetics), social factors (relationships, discrimination, social support, education, income, access to healthcare), and psychological factors (stress, prior psychological distress, self-esteem) – have been put forward. Although research has highlighted an interaction between these risk factors (Yim et al., 2015), the biopsychosocial model can be criticised for ignoring the person’s phenomenological individual lived experience of psychological distress.

Furthermore, the model lacks recognition of how different psychosocial factors influence birthing people, especially those with marginalised intersectional identities.

1.7.2. Feminist Theories

Feminist perspectives offer alternative ways of understanding perinatal psychological distress that consider systemic context. Psychological distress is understood as a normal and expected response to birth and the transition to parenthood (Jebali, 1993). Radical feminist theories consider patriarchy – the system in which men are valued as the superior gender – as the main cause of oppression (Rowland & Klein, 2013). In Western cultures, 'motherhood' is rooted within patriarchal values. The pressure for birthing people to meet unrealistic expectations of being a 'perfect mother' (Roberts, 2018; Meeussen & Van Laar, 2018) can contribute to experiences of psychological distress in the PNP.

Radical feminist theories focus solely on the influence of patriarchy on women, ignoring the additional operations of power that influence the experience a birthing person has depending on their intersectional identity (Rowland & Klein, 2013). Moreover, it neglects to explain why only some birthing people experience psychological distress. By only acknowledging the experiences of women, radical feminism erases the experiences of TNB birthing people.

Transfeminism is a branch of feminist thought that challenges biological essentialism and patriarchal, cissexist, and heterosexist structures (Bettcher, 2017). Transfeminism understands gender outside of the binary and recognises a person's right to bodily autonomy whilst acknowledging the influence of cultural narratives about gender on how bodies are perceived (Faye, 2021). As such, transfeminist thought may be useful when deconstructing the experience of psychological distress in the PNP for GQNB birthing people.

A central aspect of transfeminist theory draws on intersectional feminist approaches derived from Black feminist thought (Crenshaw, 1989). Intersectional feminist theories argue that a person's experience of the world is shaped by political and societal inequalities related to different aspects of their identity (Crenshaw, 1991). Social location on multiple facets of identity – e.g., racialisation, gender, class, sexual orientation – interconnect and interact, resulting in unique, complex experiences of privilege and oppression (Crenshaw, 1989; Krizsan et al., 2012). Systemic structures and institutions perpetuate intersectional power relations as both are shaped by historical, political, and cultural contexts (Crenshaw, 2006).

Ignoring the operation of power on a person's experiences in the PNP perpetuates the inequalities experienced by marginalised and minoritised birthing people. Transfeminist and intersectional feminist theories recognise the unique experiences that GQNB birthing people may face, acknowledging the intersecting powers that the patriarchy, ableism and disablism, classism, cisheteronormativity, and White supremacy can have on a birthing person. Minority stress theory can be used to understand how intersecting operations of power and resulting prejudice increase the stress that GQNB birthing people experience, increasing vulnerability to psychological distress in the PNP (Meyer, 2003).

1.7.3. Queer Theory

Queer theory understands identity as something that is in continuous construction (Butler, 2006), refusing the notion of fixed essentialist social categories (Barrett, 2002). Rejecting the homogenisation of people based on one characteristic (e.g., gender) means that the phenomenological experiences of those who do not fit into hegemonic conceptualisations are recognised (Yep, 2016). Cultural and political binary understandings of gender confine us all, only serving to defend the status quo and embed prejudice and stigmatisation for any who do not fit into categories that are considered the norm. Drawing on queer theories to understand psychological distress in the PNP for GQNB birthing people can support the contextualised production of knowledge that notes the pervasive harm of cisheteronormativity on people's MH in the PNP.

Exploring the lived experiences of GQNB people goes against anticategorisation in queer thought. However, theorists recognise the need to embed activism and research within some categorisation to represent the lived experiences of marginalised people and the material harm they experience on individual and systemic levels (Gray & Cooke, 2018).

1.8. Perinatal Mental Health: The Lived Experience

Phenomenological philosophy highlights the importance of understanding how people experience the world (Mapp, 2008). It emphasises the significance of lived experiences and meaning making as valuable insights when addressing human suffering (Carel, 2012; Ritunnano et al., 2023). Conceptualising experiences as something to be diagnosed and treated can lead to dehumanisation (Svenaeus, 2023). This contributes to sanitisation, detachment, and desensitisation of lived experiences of psychological distress. This can lead to difficulties in individuals recognising their embodied experiences, hindering help-seeking (Bosco, 2019). Attending to phenomenology and considering the impact of perception on embodied experiences develops our sense-making (Merleau-Ponty, 1962), consequentially altering individual and system-level responses as a person's experience is understood within their social and political context (Laverty, 2003).

1.8.1. The Lived Experience of Cis-Women

Having a child can be a time filled with pleasure for many. Cisheteronormative society sees parenthood as a key moment in an adult's life (Hansen, 2012), viewing motherhood as integral for a woman's fulfilment (Chrisler, 2013). Despite this, the PNP is a multifaceted experience consisting of numerous adjustments that can impact a person's wellbeing, contributing to perinatal psychological distress (Lazarus & Rossouw, 2015).

The transition to parenthood involves complex shifts in a person's understanding of their own identity (Darvill et al., 2010), roles in society (Shrestha et al., 2019), and the autonomy and power they have (Mauthner, 1999). This can be experienced as a monumental loss of their former self and life (Lazarus & Rossouw, 2015). During the PNP, expectations of 'motherhood' that are informed by cultural norms are placed onto the pregnant person (Law et al., 2021). The pressure to be a 'perfect mother' (Meeussen & Van Laar, 2018) encompasses being the main caretaker, placing the child's needs first (Newman and Henderson, 2014), and never expressing dissatisfaction with the role (Woodward, 1997). This may involve leaving full-time work to work part-time or not at all (Harkness et al., 2019), having less leisure time (Craig & Brown, 2016), undertaking the physical and mental load of household labour

(Dean et al., 2022), and attending to all the emotional and practical needs of the child(ren) (Craig, 2006).

For those that strive to meet these norms and for those who reject these norms, these traditional gendered perceptions of parenthood have been linked to feelings of loss (Staneva et al., 2015), a pervasive sense of loneliness and social isolation (Adlington et al., 2023; Taylor et al., 2021), a fear of judgement (Young et al., 2022), and increased feelings of guilt and shame (Henderson et al., 2016; Gallegos, 2007; McGrath et al., 2013). Moreover, this pressure to meet unachievable expectations can cause increased worry about getting parenting ‘right’ (McCarthy et al., 2021), reduced self-efficacy (Henderson et al., 2016), fatigue (Metzger & Gracia, 2023), and burnout (Meeussen & Van Laar, 2018). Although attitudes surrounding motherhood have shifted slightly over time (Heffernan & Wilgus, 2018), these experiences of psychological distress are common for many and have been linked to the constructs of perinatal depression and anxiety (Lazarus & Rossouw, 2015; Thomason et al., 2015).

Alongside the burden of societal ‘motherhood’ narratives, pregnant people also often experience the pressure to maintain an idealised body (Watson et al., 2015). A culture of thinness can influence a person’s ability to adapt to their changing pregnant body (Skouteris, 2012) and increase the pressure to be a certain weight post-pregnancy (Hodgkinson et al., 2014). Although some report a positive body image in the PNP (Loth et al., 2011), dissatisfaction with body image has been linked to worse PNMH (Riquin et al., 2019).

Much of the research about psychological distress in the PNP represents White, middle class, heterosexual, cisgendered women’s experiences. Those holding marginalised intersectional identities may experience changes in PNMH more often (Greenfield & Darwin, 2021; Howard & Kalifeh, 2020; Moore et al., 2019), with their experiences varying from those represented in most research.

Disabled pregnant people’s experiences may be influenced by widespread ableism and disablism in Western cultures (Brown et al., 2022). Systemic barriers faced by disabled people giving birth (Malouf et al., 2017) as well as ableist neoliberal narratives surrounding ‘motherhood’ stigmatise those with disabilities and the ways in which they parent (Malacrida, 2009; Malouf et al., 2017).

Additionally, those who are living in poverty may be more likely to experience psychological distress in the perinatal period (Womersley et al., 2021). Poor social support, a lack of physical safety, and reduced access to food and shelter can increase stress, leaving those who are pregnant at a higher risk of experiencing psychological distress (Faulkner et al., 2020).

Those who have prior and ongoing experiences of severe and enduring psychological distress when becoming pregnant have emphasised further pressures that impact their psychological wellbeing in the PNP (Dolman et al., 2013). Some highlight fear and distress related to local authority involvement (Diaz-Caneja & Johnson, 2004). Additional demands include the difficulties of caring for yourself and another at the same time, and worrying about how your wellbeing may impact the child (Diaz-Caneja & Johnson, 2004). As a result, the pressure to be a ‘perfect mother’ is compounded by the stigma associated with severe psychological distress and the resulting experience of guilt (Forde et al., 2020; Dolman et al., 2013).

Research has suggested that racialised minoritised birthing people are more likely to experience psychological distress in the PNP (Womersley et al., 2021). The lived experience may also differ for people who are from marginalised racialised groups as meaning making and cultural understandings of psychological distress vary (Watson et al., 2019). For birthing people racialised as Black, alternative meaning making around psychological distress in the PNP is a protective factor (Edge & Rogers, 2005). Services lack of cultural sensitivity has been shown to impact racialised birthing people’s recovery and experience of psychological distress in the PNP (Wittkowski et al., 2011), with systemic racism contributing to increased birthing trauma (Williams et al., 2023).

Distress in the PNP differs for queer birthing people. Navigating highly gendered cisheteronormative spaces and societal ideas about parenthood erases their experiences (Darwin & Greenfield, 2019) and increases loneliness and isolation in the PNP (Soled et al., 2022). Feelings of exclusion and invisibility have been noted in bisexual mothers (Ross et al., 2012), lesbian mothers (Hammond, 2014), and TNB people (Greenfield & Darwin. 2021). Feelings of erasure are not unwarranted as queer experiences, particularly those of TNB people, are underrepresented within the literature, service understanding, and service provision (Darwin & Greenfield, 2019; Greenfield &

Darwin, 2023). For some, this lack of adequate or affirming perinatal care and the burden of cisheteronormative assumptions about pregnancy, birth, and parenting can increase fear of birth (Hallström et al., 2022) and psychological distress (Kirubarajan et al., 2022).

Although the examples above have been presented by highlighting one part of a person's identity, experiencing discrimination about numerous aspects of your identity simultaneously may pose a greater risk to wellbeing (Crenshaw, 1991). Those who are multiply marginalised will have an intersectional experience of distress in the PNP (Bower-Brown & Zadeh, 2021), which is commonly under researched.

1.8.2. The Lived Experience of Trans and Nonbinary Birthing People

Although there is a growing body of research pertaining to queer birthing people's experiences of the PNP, the literature homogenises the community, assuming similar experiences across sexual and gender identities (Kirubarajan et al., 2022). While people in the queer community are oppressed by similar powers and structures, the lived experience of people with minoritised sexual orientations differs from those with minoritised gender identities (Bauer et al., 2009; Harris, 2014; Nagoshi et al., 2014).

Although there is limited data focusing directly on PNMH experiences, research centred on TNB birthing people in the global north highlights the role of dysphoria in perinatal psychological distress (Greenfield & Darwin, 2021). The changing nature of the body during pregnancy increases uncomfortable feelings of feminisation (Falck et al., 2024). More often, dysphoria comes in a social capacity – distress related to being perceived as woman or mother because of the pregnant body (Greenfield & Darwin, 2021). Increased distress has been linked to structural barriers, including the lack of medical information available to support TNB people through pregnancy and birth (Botelle et al., 2021; Falck et al., 2024). Distress in the PNP may also pertain to experiences of anti-trans prejudice within parenting spaces (Bower-Brown & Zadeh, 2021) and perinatal services (Pezaro et al., 2023; Roosevelt et al., 2021), with a lack of gender-affirming perinatal care being associated with increased perinatal anxiety (Pow, 2023).

The limited literature that focuses on non-cisgendered experiences homogenises gender identities under the trans umbrella. Psychological distress can differ for binary trans people and GQNB people (Stanton et al., 2021). GQNB people can experience invalidation and erasure of their gender by healthcare systems, binary trans people, and cisgender people (Johnson et al., 2020). Although transgender men and GQNB people may have similar experiences in the PNP, the lack of literature centring solely on GQNB people's specific experiences PNMH experiences in the UK (Greenfield & Darwin, 2021; Riggs & Bartholomaeus, 2018) hinders the capability of services to provide effective gender-affirming care for GQNB birthing people.

1.9. Scoping Review: Genderqueer and Nonbinary Birthing People's Perinatal Mental Health

A scoping review was conducted using Peters et al's., (2020) protocol with the aim of outlining the current literature relevant to GQNB birthing people's PNMH in the UK, and to identify the gaps in the literature to inform the development of this research (Arksey & O'Malley, 2005). Although scoping reviews are not as rigorous as systematic reviews due to the lack of methodological consistency (Davis et al., 2009), it was deemed most appropriate due to the scarcity of relevant literature (Arksey & O'Malley, 2005).

Population, concept, and context are needed to define the scoping review question (Pollock et al., 2021). For the current scoping review, the question is: what is known in the literature about GQNB birthing people's experiences of psychological distress and MH in the PNP in the UK?

The data included in the scoping review was limited to the UK for multiple reasons. Firstly, the scope of the research is limited to a UK context. Moreover, there are large variations in the provision of perinatal health and MH services globally. In the UK, most people giving birth access healthcare through the NHS, which has a distinctive culture and way of working. Although patients are protected from medical costs when accessing care, services are stretched and underfunded (Mallorie, 2023). Some countries healthcare systems are not universally provided, whilst others are better funded than the NHS. Additionally, each country has different policies and procedures that impact TNB people's experiences. The prejudice GQNB people experience in the UK (Ellis et al., 2016) is therefore related to the sociopolitical cultural context of the UK. As such, the data collected in other countries related to GQNB birthing people's perinatal experiences may not be generalisable to UK settings, making it harder to synthesise the findings of the scoping review. For global systematic and scoping reviews related to TNB birthing people's experiences and PNMH, please see: Greenfield & Darwin, 2021, Soled et al., 2022, and Thomas et al., 2024.

1.9.1. Search Strategy

The databases used to identify relevant literature included: Academic Search Ultimate, APA PsycInfo, and CINAHL via EBSCO HOST. These were used to search for articles relating to MH and psychological distress in the PNP for GQNB birthing people. 'OR' and 'AND' operators were used to find literature using various terms (Appendix A). Google Scholar, ResearchGate, and the UEL repository were used to search for grey literature. Reference lists of relevant literature were screened.

In the initial search strategy articles were deemed eligible if they focused on GQNB birthing people's experiences of psychological distress or MH in the PNP. Articles were excluded if they were not based in the UK, if they did not distinguish between GQNB participants and transgender men and/or cisgender women, and if they were not written in English. Duplicates were removed. Subsequently, titles and abstracts were screened using the eligibility criteria, with all remaining studies being analysed by full text. This extraction process led to no articles being identified as eligible for the scoping review (Appendix B). As no studies considered GQNB birthing people's experiences separate from binary transgender people's experiences in the UK, the eligibility criteria was altered to include studies that homogenised TNB people's experiences. Four studies were deemed eligible to be included in the scoping review (Appendix C).

1.9.2. Overview of Selected Studies

Each study will be presented, followed by a summary and critical evaluation holding quality principles in mind (Lockwood et al., 2015).

1.9.2.1. Exploring the healthcare experiences and support needs of chestfeeding or breastfeeding for trans and non-binary parents based in the United Kingdom (Jackson et al., 2023). A qualitative approach was used to explore TNB parents' experiences of bodyfeeding across England, Scotland, and Wales in the PNP. The research aimed to produce knowledge of TNB people's experiences, as they are typically erased and overlooked in healthcare settings. Semi-structured interviews were conducted with seven participants. Four participants were trans men, two were nonbinary people, and one was a trans woman. The sample was predominantly racialised as White.

An inductive approach and reflexive thematic analysis were used to identify three themes: 'doing the right thing for the baby', 'experiencing bodily changes and the support desired', and 'experiences of healthcare professionals'. Participants reflected on the functionality of bodyfeeding. The production of milk met their baby's physical needs, with this shared experience facilitating emotional connection. Experiences of anxiety and impact on self-worth were considered in relation to the pressure to successfully bodyfeed. Psychological distress was reported in relation to bodily changes and increases in dysphoria, with some respondents focusing on the utility of their chest to manage this distress. Analysis highlighted areas of development for services, centring on the need for gender inclusive communication. Healthcare professionals lack of in-depth knowledge impacted the care TNB parents received around bodyfeeding whilst continuing gender affirming medication, as well as their ability to attend to the psychological needs of TNB parents.

1.9.2.2. P-502 Trans and/or non-binary (TNB) parents' experiences during the perinatal period (Bower-Brown, 2022a). Drawing on the data of prior research (Bower-Brown, 2022b; Bower-Brown & Zadeh, 2021), qualitative methods were used to explore TNB UK-based parents' experiences in the PNP. This study aimed to provide new insight in this area as most research is USA-based (Greenfield & Darwin, 2021). Ten people's interview transcripts were included. Participants were trans women, trans men, and nonbinary people. Six participants had given birth. The sample was mostly racialised as White, with increased diversity in class, relationship structure, and disability status.

Reflexive thematic analysis was used to identify three themes: 'Nothing was gender neutral: Institutional discrimination', 'Interpersonal discrimination and inclusion', and 'Being pragmatic, being a pioneer: TNB parent's navigation strategies.' Participants highlighted the impact of cisnormativity on their experiences of services and parenting spaces, with a lack of knowledge, a lack of gender-affirming services, and structural discrimination and exclusion increasing psychological distress. Societal narratives and norms increased anticipatory fear when accessing services. This additional stress was reduced for those who did not use fertility clinics. Further analysis revealed the usefulness of detachment as a coping strategy for the distress experienced when bodyfeeding.

1.9.2.3. Experiences of Pregnancy and Birthing for Trans and Non-Binary People in the UK (Coe, 2023). A study of twelve TNB birthing people across England and Wales was conducted to explore TNB people's experiences of perinatal services and how this impacts access to care. All participants were racialised as White but were reported to be diverse in relation to disability status, relationship structure, and prior experience of psychological distress.

Reflexive Thematic Analysis resulted in two overarching themes: 'Navigating assumptions of womanhood' and 'Empowered autonomy: Personal narratives of choice, control, and safety'. The first theme had two subthemes: 'The embodied experience of pregnancy' and 'In/visibility: Please understand who I am'. Participants shared how cisnormative understandings of pregnancy impacted their experience of services and how welcome or safe they felt. Further reflections considered the positive effects pregnancy had on their psychological wellbeing, with TNB birthing people feeling empowered in their birthing capacity. Rewriting and queering narratives of birth enhanced the joy that some birthing parents experienced. Participants also shared experiences of dysphoria with bodily changes during pregnancy and social perceptions of their pregnant body increasing psychological distress. Experiences of exclusion and invalidation made services harder to access, with some participants suggesting hesitancy in accessing perinatal services in future pregnancies. Furthermore, sensationalising reactions to transmasc pregnant people caused discomfort and increased anxiety when disclosing pregnancy and accessing perinatal services. Psychological safety was further hindered by fear of and experiences of misgendering and poor gender inclusive medical knowledge, with reports of a lack of gender-affirming care increasing anxiety and leading to flashbacks. Participants also reported the pressure to advocate for themselves. This increased burden and stress and at times resulted in TNB birthing people coping by ignoring marginalisation and discrimination they experienced and/or by accessing non-NHS based perinatal care.

1.9.2.4 Trans + Non Binary Experiences of Maternity Services: Survey findings, report and recommendations (LGBT Foundation, 2022). A mixed-methods study aimed to highlight TNB birthing people's experience of perinatal services. 121 participants completed the survey, with respondents representing diverse samples across gender, sexual orientation, disability status, racialisation, employment status, and religion. Respondent locations were not provided.

The survey highlighted the increased fear experienced in the TNB community when considering accessing perinatal services, with some who did access services experiencing disrespect and anti-trans prejudice. Respondents described how these experiences were triggering, increasing the anxiety they felt in perinatal services. Some highlighted the lack of understanding about dysphoria impacting the MH care they were provided with. Similarly, babies tongue ties were dismissed or missed due to healthcare workers perceptions about bodyfeeding for TNB participants. For some, gender-affirming care led to a better experience, especially when they were given private rooms and appropriate language was used.

Four TNB participants were recruited for interviews, two of whom were from racialised minoritised backgrounds. Analysis resulted in two sub-themes: 'Racism and Transphobia in Perinatal Care' and 'Concealing Gender'. Respondents reflected on cisheteronormativity increasing their fear when accessing services, with some giving birth at home or avoiding services as much as possible to reduce their exposure to anti-trans prejudice. For racialised minoritised participants, this was further compounded by systemic racism and dehumanisation. Participants also noted the impact of dysphoria on their wellbeing, highlighting the need for trans-inclusive spaces and knowledge within perinatal services.

1.9.3. Key Themes

All studies noted the distressing experience of perinatal services for TNB birthing people. The importance of receiving gender-affirming care was emphasised. Those experiencing erasure, anti-trans prejudice, microaggressions, and inadequate professional competency related to their gender reported increased stress and fear when accessing perinatal services. A gap in professional knowledge made it harder for TNB birthing people to access adequate support to reduce dysphoria related distress or to manage physical health complications arising in the PNP (Bower-Brown, 2022a; Coe, 2023; Jackson et al., 2023; LGBT Foundation, 2022). Lack of support for social dysphoria and distress related to bodyfeeding seemed to increase the sense of isolation TNB people experienced, maintaining psychological distress in the PNP (Coe, 2023; Jackson et al., 2023).

Another key theme identified centred TNB birthing people's narrative of pregnancy and birth. Respondents reflected on the happiness experienced through pregnancy. This involved TNB birthing people recognising the birthing capacity of their bodies, and re-narrating birth and pregnancy by drawing on queer narratives beyond 'womanhood' (Coe, 2023). Participants considered their protective role as a parent, prioritising the needs of their babies (Jackson et al., 2023) and enjoying the emotional connection they experienced with themselves and the baby (Coe, 2023; Jackson et al., 2023).

A final theme identified the coping strategies that TNB employed to manage psychological distress in the PNP. For many, this included disconnecting from distressing experiences in perinatal services to protect themselves. This led to avoiding services (Bower-Brown, 2022a) and choosing to give birth at home (LGBT Foundation, 2022). For others, this involved concealing their gender to focus primarily on the pregnancy and birth (Bower-Brown, 2022a; Coe, 2023; LGBT Foundation, 2022). Other participants coped through self-advocacy when accessing services (Bower-Brown, 2022a). At times, this led to increased psychological distress as efforts to navigate cisheteronormative structures and anti-trans prejudice whilst in the highly vulnerable state of pregnancy and birth increased burden and stress (Coe, 2023; LGBT Foundation, 2022). Psychological distress experienced when bodyfeeding was managed through considering the utility of their chest (Jackson et al., 2023); others managed through detachment (Bower-Brown, 2022a).

1.9.4. Critical Evaluation

The scoping review highlights a significant gap in the research examining GQNB birthing people’s experiences of psychological distress in the PNP in the UK. This is mirrored in global research (Greenfield & Darwin, 2021), with most studies in this area exploring experiences of conception (Ellis et al., 2015; Fischer, 2021), birth and pregnancy (Bower-Brown, 2022a; Falck et al., 2024; MacDonald et al., 2016), perinatal services (Coe, 2023; Hoffkling et al., 2017; Jackson et al., 2023; LGBT Foundation, 2022; van Amesfoort et al., 2023), and parenthood (Bower-Brown & Zadeh, 2021).

Exploring UK-based TNB people’s experiences of the PNP and bodyfeeding provides insight into how services can better meet TNB people’s perinatal needs in physical and MH services. Each study generated knowledge of how TNB people may make sense of some of the psychological distress they experience in the PNP, particularly in relation to bodily and social dysphoria on mood, anti-trans prejudice, and reduced gender-affirming care on anxiety and trauma. Although the main areas of exploration in these studies were not psychological distress, the findings contribute to the development of a nuanced understanding of PNMH. Despite this, there is a large gap in the research that directly focuses on PNMH experiences and how these are made sense of by those who live them.

In all three qualitative studies, participants were mostly racialised as White. In one, no information was given about positionalities in relation to other social locations (Jackson et al., 2023), with the other studies reporting diverse samples in relation to class, disability status, and relationship structure (Bower-Brown, 2022a; Coe, 2023; LGBT Foundation, 2022). As such, the themes reported may not capture the intersectional experiences of those who are marginalised, minoritised, and discriminated against, reducing the transferability of the studies. Experiencing racism and anti-trans prejudice simultaneously may increase psychological distress and the likelihood of worse physical outcomes (LGBT Foundation, 2022). A lack of representation of minoritised racialised GQNB birthing people in these studies follows trends in many other areas of research (Onwumere et al., 2024). Failure to account for the experiences of marginalised racialised NGBQ birthing people perpetuates the momentous impact of Whiteness and racism (MBRRACE-UK, 2023; Watson et al., 2019).

Participants experiences were homogenised in different ways: in two studies (Bower-Brown, 2022a; Jackson et al., 2023) participants experiences were not separated in terms of birthing status. In all studies, participants experiences were not separated in relation to their gender identity under the trans umbrella. How a person makes sense of their gender may not fit into a category or label – a person may not separate their identity as a transgender man from a nonbinary person, and so including all trans genders makes space for this flexible understanding. Moreover, people with differing gender identities within the trans umbrella may have similar experiences of services. Amalgamation may also be based in convenience. Stricter inclusion criteria may have resulted in fewer participants, potentially impacting the ability to achieve data saturation (Braun & Clarke, 2021). For example, the robustness of LGBT Foundation's (2022) qualitative research must be contemplated. A small sample size and omission of the analysis method mean that results should be considered cautiously.

Grouping TNB people's experiences results in nuanced understandings of binary and nonbinary trans birthing people's experiences being missed. This was exemplified in Coe's (2023) research, where nonbinary birthing people felt more able to conceal their gender identity than transgender men. Although this was considered a coping strategy, it meant they were not allocated Continuity Care midwives as frequently, potentially impacting the quality of their care.

1.9.5. Research Rationale and Clinical Relevance

The impact of experiencing psychological distress in the PNP is vast (Runkle et al., 2023). The increased rates of psychological distress (Jones et al., 2019) and experiences of trauma (Mizock & Lewis, 2008), discrimination, and prejudice (Stonewall, 2018) in GQNB communities suggest a higher risk of experiencing psychological distress in the PNP (Gedzyk-Nieman & McMillan-Bohler, 2022). Furthermore, iatrogenic harm due to the erasure of GQNB identities (Fiani & Han, 2020), stigma within perinatal healthcare systems (Pezaro et al., 2023), and eugenicist ideologies about trans pregnancy (Lowik, 2018; Toze, 2018) may increase the likelihood of birth trauma (Pow, 2023; Svanberg, 2019). UK perinatal services are not fit to meet the physical and psychological needs of TNB birthing people (LGBT Foundation, 2022). As a result, TNB birthing people are made more vulnerable at a critical time. There is no literature to date that prioritises the exploration of GQNB PNMH experiences in the UK, despite the increased risk of psychological distress. Understanding GQNB birthing people's experiences is vital for providing safe and effective gender-affirming physical and MH care in the PNP, particularly in the context of poorer physical health (Scandurra et al., 2019) and MH (Jones et al., 2019) outcomes for GQNB people and increased societal and governmental anti-trans prejudice in the UK (Home Office, 2021; House of Commons Library, 2023; Renz, 2017).

1.9.6. Research Aims and Questions

This research aims to explore GQNB birthing people's experiences in the PNP through the following research questions:

1. What are GQNB birthing people's MH experiences in the PNP?
2. What are GQNB birthing people's experiences of support in the PNP?
3. How do GQNB birthing people make sense of their experience of psychological distress and wellbeing in the PNP?

2. METHOD

2.1. Overview

The exploration of ontological and epistemological positioning justifies the qualitative design and methods of exploration used in this research. Ethical considerations are highlighted. The procedure, materials, and analysis are outlined, followed by researcher reflexivity.

2.2. Philosophical Assumptions

2.2.1. Ontology

Ontological philosophy is concerned with assumptions around reality (Denzin & Lincoln, 2017). It asks questions about what exists and what there is to know. Ontological positions fall on a spectrum between realism and relativism. Realism suggests that knowledge is independent of the mind and cannot be influenced by perspectives, culture, or language (Descartes, 1641/1911), resulting in one objective truth (Jenkins, 2010). Realists believe that experiences of psychological distress are universal and have objective causes as suggested in biomedical models (Deacon, 2013).

Relativism argues that experiences of the world are shaped by language, history, and culture (Lincoln et al., 2011). As such, there is no access to a singular truth, as multiple realities exist (Levers, 2013). Relativists believe that psychological distress is shaped by our perception of subjective experiences embedded within social and cultural contexts (Foucault, 2001).

2.2.2. Epistemology

Epistemological philosophy is concerned with the nature, scope, and production of knowledge (Denzin & Lincoln, 2017). Epistemological theories of knowledge differ in their assumptions of what can be known, how we come to know something, and the validity and reliability of said knowledge (Willig, 2019). Like ontology, epistemological assumptions exist on a spectrum.

Objectivists believe that knowledge is produced through interaction with an objective reality, denying the impact of beliefs and perceptions (Crotty, 1998). Constructivists argue that knowledge is produced and mediated through subjective individual, social, and cultural interpretations of the world (Ernest, 1998). Therefore, knowledge is relative to a person's experience – what may be true for one person may not be true for another (Crotty, 1998).

Some philosophers suggest that epistemology and ontology are related but separate issues (Kant, 1781/1899). Others argue that recognising their interconnectedness supports a deeper understanding of how we relate to the world (Davidson, 2008; Heidegger, 1927/1996). Interconnection argues that perspectives on what exists are shaped by the ways that we perceive and acquire knowledge. Similarly, how we generate knowledge is interconnected with our beliefs about reality.

2.2.3. Researchers Position

Understanding the intra-action between "ethics, knowing, and being" (Barad, 2007, p. 185) highlights the relationship between ethico-onto-epistemological entities, challenging traditional ontological and epistemological positions (Barad, 2007). Agential realism asserts that the material world and social construction of experiences co-occur to create reality (Barad, 2007).

Emphasis is given to the objective material harm caused by power dynamics, systemic discrimination, and social inequalities, as well as the impact of personal and cultural narratives when philosophising on the construction of reality.

Agential realism recognises the intra-action and co-construction of an individual's agency, sociocultural factors, family dynamics, and cultural narratives on shaping experiences of psychological distress. Dynamic interactions between constructs produce real experiences, which are understood through individual subjective interpretations and intra-actions between cultural, historical, and social contexts (Barad, 2007). Agential realists argue that we have the capacity to make changes in the world (Barad, 2007), and therefore hold the responsibility to have an intersectional praxis with an aim to reduce oppression (Townsend-Bell, 2011).

Agential realism can offer a valuable perspective in understanding psychological distress in the PNP for GQNB birthing people. It recognises the intra-action of cisheteronormativity and anti-trans discrimination, personal beliefs, challenges in healthcare systems, family dynamics, support structures, and legal and policy frameworks on a person's multifaceted experience. The relationship between factors co-constructs the material reality of the embodied experience of psychological distress, resulting in varied experiences depending on a person's unique context.

2.3. Design

A cross-sectional qualitative methodology was selected to explore the experiences of, and context surrounding, GQNB birthing people's psychological distress in the PNP (Robson, 2002). Qualitative methods allow for an in-depth exploration of an individual's subjective experiences (Barker et al., 2015). Shifting how we understand and respond to people's experiences depending on their context can cause wider systemic and cultural changes (Laverty, 2003).

The use of individual semi-structured interviews generates depth and richness when studying experiences. An adaptive approach supported the exploration of the nuanced and multifaceted experience, allowing unexpected insights to emerge (Fusch & Ness, 2015). A one-to-one setting offered privacy, individual pacing, and a focus on ideographic experiences, potentially supporting the sharing of sensitive information.

2.3.1. The Analytical Approach: Interpretive Phenomenological Analysis (IPA)

Agential realism accepts the varied nature of existence whilst also recognising the existence of an external reality (Barad, 2007). Phenomenological philosophy suggests that understanding that realities are shaped by an intra-action of factors means that to uncover the meaning behind a construct we must generate knowledge about experiences as they are lived (Van Manen, 1997). Moreover, the impact of a person's cultural and historical background on how they make sense of their experiences needs to be recognised (Heidegger, 1927/1996). The individual and the experience are seen as co-constructing each other (Heidegger, 1927/1996). Studying phenomena and being aware of interpretative influences can bring to light aspects of an experience that support individual and societal sense-making (Wilson & Hutchinson, 1991).

IPA has the primary aim of developing a detailed understanding of an experience as it is lived (Smith & Fieldsend, 2021). This is done through eliciting information about how a person perceives and makes sense of their subjective experience (Pietkiewicz & Smith, 2014). The hermeneutical approach suggests that people may not always be consciously aware of how they are making sense of their experiences (Staiti, 2012). Interpreting a person's narrative of phenomena through their social, political, and cultural histories can bring to light new understandings of these intersectional experiences (Neubauer et al., 2019). Exploring complex ideographic experiences across a small group can aid understanding of the nuances of the phenomena whilst providing insights into shared elements of the experience (Smith et al., 2021).

An agential realist stance posits that researchers take an active role in the co-construction of knowledge, with their actions, beliefs, and contexts influencing data collection and interpretation (Barad, 2007). Meaning is created not only through the subject's individual interpretation but also through the researcher's interpretation of their experiences. This is in line with IPA, which recognises that the researcher's assumptions influence how experiences are made sense of (Gadamer, 1976; Laverty, 2003). The analytical process is a dynamic double hermeneutic (Smith & Osborn, 2008). As such, researchers must use reflexive processes to actively recognise and name their biases (Smith et al., 2021).

2.3.1.1. Considering Alternative Approaches. Thematic Analysis is an approach used to identify reoccurring patterns in qualitative data (Braun & Clarke, 2006). It is widely used as it has a clear protocol and is flexible as it is not wedded to a specific theory or epistemology (Braun & Clarke, 2013; Braun et al., 2018). Thematic Analysis could have been appropriate however, the focus on patterns across datasets may have resulted in individual experiences becoming lost within the analysis (Smith et al., 2021). IPA’s theoretical focus on phenomenology lends itself to a more in-depth analysis of individual experience and so was deemed more appropriate.

Discourse analysis was less appropriate than IPA due to its emphasis on language as a tool to construct reality (Willig, 2008). IPA was also selected over grounded theory and narrative analysis as the research questions aimed to explore experiences as they are lived rather than to generate theoretical explanations (Glaser & Strauss, 1976) or consider stories surrounding the studied phenomena (Willig, 2013).

2.4. Ethics

2.4.1. Ethical Approval

Ethical approval was sought from and agreed to via the Research Ethics Committee at the University of East London (UEL), School of Psychology (Appendix D). The British Psychological Society (2021) Code of Human Research Ethics guided the recognition of and attendance to ethical considerations throughout.

2.4.2. Informed Consent

An information sheet (Appendix E) detailing the research rationale, potential risks and benefits of participation, and withdrawal procedures was given to potential participants upon expression of interest. Prospective participants had the opportunity to ask questions about participation before signing the consent form (Appendix F). This form reiterated key points from the information sheet to promote informed consent. Participants were reminded of their right to withdraw at any point during the interview and up to three weeks following the interview's conclusion.

2.4.3. Confidentiality and Anonymity

A data management plan was approved by the UEL Research Data Management Team outlining procedures to enhance confidentiality and anonymity in compliance with data protection legislation (Appendix G). This contains information pertaining to the storage of data and the removal of identifying information throughout data collection and analysis.

Participants consented to anonymous extracts of the transcript appearing in the final thesis, with pseudonyms being used in the research write-up and any publication or dissemination.

2.4.4. Remuneration

Due to funding restrictions, all participants could not receive remuneration for their time. Participants were given the option to enter a draw to win one of three £30 vouchers. Participants were advised of the sensitive information they would have to give to receive the voucher in advance.

2.4.5. Harm Reduction

2.4.5.1. Recruitment. Participants in mainstream research are usually nondisabled and racialised as White (Onwumere et al., 2024; Rios et al., 2016). As recruitment aimed to encourage a sample that represented intersectional experiences, a targeted approach was used. Community networks on social media that specifically support people who are marginalised through racialisation and disability were approached to ask for their support in advertising the research. To ensure participants were aware of the researcher's social location, some information and a picture were included on the advert and shared when contacting networks and organisations. Advertisement wording (Appendix H) was checked with the research supervisor to assure sensitivity.

Recruitment occurred at an incredibly volatile time for the GQNB community due to increases in anti-trans legislation and a rise in anti-trans hate crimes (Lopez, 2023). It was important to be considerate of the needs of potential participants, especially those who were already vulnerable due to prior experiences of psychological distress. Ensuring flexibility about interview times, rescheduling, and offering compassion when speaking to potential participants was vital to ensure participation was not more of a burden than it needed to be. This involved encouraging prospective participants who were in active crisis to seek support and prioritise their wellbeing over participation.

2.4.5.2. Interview. Participants had the opportunity to choose their pseudonyms to safeguard against discomfort as some GQNB people change their name. Moreover, exploration of sensitive issues surrounding psychological distress, gender identity, and discrimination meant that participants could potentially experience distress when speaking about their experiences. Participants were encouraged to take breaks if needed, and their wellbeing was considered throughout. Participants did not disclose levels of distress that required further intervention, however, some reflected on the difficulty of speaking about these topics. Following a verbal debrief, participants were sent a debrief sheet (Appendix I) signposting relevant supporting services and detailing the researcher's and supervisor's contact information should they want to get in touch. No participants reached out to discuss their participation following the termination of the interview.

2.5. Participants

2.5.1. Inclusion Criteria

People could take part if they:

- Did not identify as a man or woman;
- Gave birth in the UK over 6 months ago;
- Experienced changes in their MH through the PNP;
- Were over 18 years old;
- Spoke English.

An upper limit on the time since birth was not initially imposed for potential participants. This was due to envisioned difficulties with recruitment. If prospective participants had given birth over 7 years ago, the researcher would have taken this to supervision to discuss suitability. All prospective participants gave birth under 5 years prior to participating in the research.

Although IPA highlights the need for homogeneity within the sample, it is important to note that it does not require all participants to hold exactly the same identity. Instead, IPA aims for a sample that shares a common experience or characteristic relevant to the research question to ground the analysis within a shared context (Smith et al., 2021). As the potential pool for participants is smaller, it is important to minimise restrictions on participation to aid recruitment and support the development of research in this area. Consequentially, the sample was not restricted regarding class, ethnicity, sexual orientation, location in the UK, or disability.

2.5.2. Recruitment

Participants were recruited using purposive sampling, as they could only take part if they had lived experience of the phenomena being explored (Clifford, 1997). Advertisements were placed on social media platforms including X (Twitter), Facebook, and Instagram using a poster and alternative text (Appendix H). Groups and birthing workers that support queer and GQNB birthing people and multiply marginalised queer birthing people were contacted and asked to share information about the research on their platform. Further recruitment occurred through community spaces, charities, and organisations for queer birthing people. A snowballing approach was used to reach further potential participants. Participants were given the option of a face-to-face interview in London, or an online interview using Microsoft Teams, to reduce location restrictions. All participants opted for an online interview.

2.6. Materials

2.6.1. Demographic Information

Optional demographic questions were asked at the beginning of the interview to contextualise participants' experiences within their intersectional identities (Appendix J). The data was used to consider if the research is representative of the wider GQNB population. Demographic questions were open to allow for self-description, ensuring that participants were not limited by pre-selected categories.

2.6.2. Interview Schedule

The semi-structured interview schedule (Appendix K) was developed in line with the research aims and relevant literature. The interview aimed to explore participants' experiences of pregnancy, birth, and the postnatal period in relation to psychological distress and wellbeing, access to support, and how they made sense of these experiences. Two GQNB people were consulted during its development. One consultee met the research inclusion criteria but lived in another country. The other had not given birth but had experience conducting research with GQNB people. This ensured that consultation did not prevent anyone from participating in the research.

Feedback from the consultations led to additional demographic questions (e.g., assigned gender at birth), follow up questions (e.g., asking about PNMH diagnoses), and slight amendments to the interview structure. This was shared with the research supervisor, who provided further support in structuring the schedule to improve question flow.

2.7. Procedure

2.7.1. Interview Pilot

A pilot interview was carried out with a pregnant person who lived outside the UK. They described their demographics as nonbinary, queer, multiracial, between 30-40 years old, with a disability. When providing feedback on the interview, they shared that the questions felt appropriate and were well paced. They reflected that the time and space to process their experiences was emotive and restorative. The interview schedule was not altered following the pilot.

2.7.2. Recruitment

Following advertisement, interested participants contacted the researcher via email. Further information about the study was shared along with the participant information sheet and consent form. Participants were asked to reach out with any questions, which were answered in due course. Participants were offered a phone call to discuss participation. One person took this offer up. Once the completed consent form was returned, the participant and researcher arranged a suitable time for the individual interview. As some interviews were organised in advance, participants were reminded 24 hours before via email.

2.7.3. Individual Interview

An interview checklist (Appendix L) was followed to ensure consistency. At the beginning of the interview, participants were asked if they had read the information sheet and if they had any questions. Participants' consent forms were checked. They were reminded about confidentiality and their right to withdraw. The inclusion criteria were checked, and participant details were confirmed for loss of connection, dissemination, and pseudonym choice.

Once recording had started, participants were asked demographic questions. Following this, the interview schedule was followed. The interviews were flexible to allow space for participants to share and reflect on their experiences openly. Follow-up questions increased depth through the exploration of unexpected topics. Interviews lasted between 60-90 minutes. At the end of the interview, a verbal debrief was offered, and space for questions was held. Participants were reminded of their right to withdraw. Following termination of the interview, participants were sent a debrief sheet.

2.7.4. Transcription

Transcription occurred three weeks after the interview had taken place to allow participants the opportunity to withdraw their data. The Microsoft Teams transcription was edited whilst listening to the interview multiple times. Transcriptions were checked for accuracy.

Verbatim transcriptions were generated following adapted transcription guidelines (Banister et al., 2011; Potter & Wetherell, 1987; Appendix M). The transcription was punctuated to aid reading. Some paralinguistic elements were noted to gain a deeper understanding of the interaction (Bailey, 2008). Data related to pitch, tone, volume, and nonverbal communication was omitted as this level of detail was not necessary for IPA (Smith et al., 1999).

2.7.5. Analysis

Smith et al's., (2021) guidelines outlining the iterative and inductive process of IPA were followed. Evidence of this process can be found in Appendix N.

2.7.5.1. Reading and Re-reading. The transcripts were listened to and then read multiple times to immerse the researcher in the data. Repeated exposure to the data forces the researcher to engage, slowing down and taking in the participant’s story.

2.7.5.2. Exploratory Noting. As the researcher became more familiar with the transcript, they began to make notes and comments about areas of interest within the data. Different layers of interpretation occurred as the researcher explored beyond the superficial, analysing unexpected ideas, reading between the lines, and commenting on meaning-making. Exploratory notes focused on linguistic and conceptual features of the data, considering context to understand participants’ meaning-making processes. Self-reflexivity was vital in understanding the double hermeneutic process where multiple avenues of meaning are explored.

2.7.5.3. Constructing Experiential Statements. At this stage, the analysis centred on the exploratory notes. Statements were made that captured the participant’s experiences and how they have been made sense of, as well as the researchers interpretations. Summarising the exploratory notes transformed them into experiential statements, fragmenting the interview data.

2.7.5.4. Searching for Connections Across Experiential Statements. This stage was concerned with mapping patterns of experiential statements across the individual dataset. Similarities and differences were considered. This was done manually by separating the experiential statements from the transcript and physically exploring clusters of statements to understand how they may be related to each other.

2.7.5.5. Naming and Consolidating Personal Experiential Themes (PETS). PETS were created for each participant by giving a descriptive title to the clusters of experiential statements that have been generated. PETS are superordinate themes that can contain subthemes.

2.7.5.6. Continuing Individual Analysis of Other Cases. The process outlined above was repeated for all participants. The researcher stayed absorbed in the ideographic experiences, taking care to not reproduce analysis from previous participants and allowing novel entities to emerge.

2.7.5.7. Working with PETS to Develop Group Experiential Themes (GETS). In the final stage of analysis, patterns across all individual PETS were explored to generate GETS. GETS highlight experiences and meaning-making that may be shared between participants and those that are unique. Considering similarities and differences at this level required a flexible and dynamic process where analysis zoomed into subthemes and out to wider GETS. Ensuring that the analysis was grounded within the individual's experience involved staying connected to the transcripts by going back to the data that was used to generate PETS.

2.7.5.8. Supervision. Supervision was used to discuss and reflect on the analytic process. Using this space to consider researcher perceptions assisted in the development of a clear narrative and rationale for the interpretations made.

2.8. Reflexivity

Analysis is not an objective process (Barad, 2007). Researchers' experience, context, beliefs, and assumptions will shape how they make sense of phenomena, and as such, they are actively involved in the co-creation of knowledge (Smith et al., 2021).

Researchers must show both epistemological reflexivity and personal reflexivity (Willig, 2013). In line with IPA, findings are understood not as an objective truth but as one possible interpretation of the phenomena (Smith & Osborn, 2008). A diary was kept throughout the research to support ongoing reflexive recognition and exploration of the researcher's positioning and responses to the material (Appendix O).

Engaging in a Social GGRRAAACCEEESSS (Burnham, 2012) activity helped to reflect on my positioning and social location on multiple facets of identity (Appendix P). Although the factors in the model are separated, I understand my experiences through an intersectional lens (Crenshaw, 1989). The interactions and intra-actions between my social locations will have influenced my experience of the world in complex ways, privileging and underprivileging me simultaneously.

My racialisation as White, level of education, and economic stability have shaped my experience of the world, increasing my access to resources and opportunities. Clinical psychology perpetuates Whiteness and Western ideals. My lived experiences and engagement with training will have influenced the conceptualisation of this research. Reflecting on the power I hold is crucial in attending to the potential for perpetuating oppression through the research process. For example, although I am genderqueer, it was important to not assume similarities in experience between myself and participants, centring their ideographic intersectional experiences throughout analysis.

My political beliefs centre on community, the importance of redistribution of wealth and power, the value of equitable services, and the need for systemic change that attends to the impact of ableist, cisheteronormative, and imperial powers to combat discrimination. I am critical in my thinking about psychological theories, noting the vast impact of power and capitalism in how they have been generated and applied within services. These values influence how I make sense of people's experiences and the resulting implications discussed.

3. RESULTS

3.1. Overview

This chapter outlines the themes that were constructed following analysis of GQNB participants PNMH experiences. The analysis resulted in four overarching GETS, each containing subordinate themes that illustrate participants' idiographic experience and how they make sense of it, encompassing areas of convergence and divergence between participants (Table 1). The themes are presented in a narrative form, including quotes from participants to centre their voice within the researcher's interpretation (Smith et al., 2021). It is important to note the researchers attempt at meaning making is one possible interpretation of the data (Pietkiewicz & Smith, 2012). How the reader perceives the analysis will be influenced by their own sense-making of the researchers interpretation as they draw on their personal understanding of the world (Smith et al., 2021). A summary of the GETS with exemplar quotes are presented in Appendices Q and R.

Table 1

Themes

Group Experiential Theme	Subordinate Themes
Navigating shame and the emotional tides of distress	Distress as destabilising Distress as shameful
Rebuilding identity under the heavy burden of the cishet gaze	'I literally couldn't be anything else': a disrupted sense of self To perceive and be perceived: the embodied experience of dysphoria Reconnecting to identity as a restorative process Power in rescripting pregnancy, birth, and parenthood
Feeling understood, connected to others	'I craved being held': isolated from community (In)Consistent (un)caring experiences of support Finding comfort in a valued partner Community as a healing force
Creating safety in an unsafe world	Invisible to the system Navigating visibility: 'people see you and they can't really' Queering services in the face of oppression

3.2. Sample

Seven people volunteered to participate. This sample size is in line with recommendations for research using IPA as it allows for depth of individual analysis and capacity for meaningful comparison of group data (Smith et al., 2021). Demographic characteristics are presented in Table 2. All participants were living in the UK, identified under the GQNB umbrella, were assigned female at birth, and had given birth in the UK up to four years prior. At the time of interview, participants were aged between 23 and 43 years old (m = 32.86).

Table 2

Participant Demographics

Participant	Gender	Sexual Orientation	Social Class	Ethnicity	Neurodiverse or Disabled	Age range
Jocelyn	Demifluid	Queer	Middle Class	White	Yes	40-44
Alex	Nonbinary	Bisexual	Working Class	White British	No	20-24
Lora	Queer	Queer	Middle Class	White British	No	30-34
Ari	Nonbinary	Pansexual	Lower Class	White	No	20-24
Charlie	Trans nonbinary masculine	Queer	Middle Class	White British	Yes	35-39
Theo	Nonbinary	Pansexual	Working /Middle Class	White European	Yes	30-34
Sam	Nonbinary trans masc	Pansexual	Middle/ Working Class	White British	Yes	40-44

As mentioned, homogeneity of the sample is important for IPA. Although the sample share the experience of being GQNB birthing people, it is important to note that they vary in their experience related to age, class, sexual orientation, gender label, and neurodiversity. The rich detail gathered in the interviews will allow exploration of how the lived experience of being a GQNB birthing person may differ in relation to different social locations for each participant (Smith et al., 2021).

Richer detail about each participant's life has been omitted from the sample outline to heed the potential risk of identification as the potential pool of participants is limited. This is particularly important as some of those who participated are active in the community, increasing their risk of identification. Due to the sensitive nature of the topic, less detail has been shared to respect participants right to privacy.

3.3. Navigating shame and the emotional tides of distress

This theme explores participants experience of distress in the PNP.

3.3.1. Distress as destabilising

A central part of the participants description of psychological distress was that it felt destabilising, impacting how they were able to live their lives. Both Sam and Alex highlight the emotional fluctuations they experienced through the PNP. "*You kind of spiral in and out of feeling a little bit better and then, like, really, devastatingly bad again" (Alex)*, "*my mental health was kind of quite <u>up and down</u> in pregnancy quite, I think I was a very, very <u>emotional"</u> (Sam).*

'Devastatingly' and 'spiral' suggest an overwhelming sense of hopelessness within intense emotional experiences. The cyclical descriptions indicate the difficulty in finding stability and coping with the distress. Sam's repetition of 'very' indicates the severity of the experience. This contrasts with their use of 'I think' which suggests that memories of the distress are hard to access, potentially due to how difficult it was at the time.

Similarly, Jocelyn's description conveys detachment from their experience of psychological distress. "*On reflection, yeah it was [laughter], it was absolutely, (.) it was horrendous in places" (Jocelyn).* With space to consider their feelings, they were able to connect with how upsetting this time was. In this moment, laughter may have been protective, allowing them to relate to their experience from a distance.

For Theo, psychological distress hindered their ability to care for themself and their baby. Detachment and disconnection from life prevented them from being able to step into their parental role.

> *I would still struggle to go out, to remember to feed myself, to remember to feed ***, to remember to change them (.), to remember to just, like, interact with them at <u>all</u>…I went in with an idea of like, 'OK, this is what I'll do' and then it was just completely blown apart by like, the horrific postnatal depression (Theo)*

Theo's use of 'blown apart' conveys a sense of sudden and devastating disruption of their expectations of parenthood. Their experience of early parenthood was drastically altered by the distress.

Like Theo, Ari also found that experiencing intense emotion made it hard for them to care for their baby. Instead of disconnecting from caring for their child, they tried to cope and create safety through disconnecting with their emotional experience.

> *I would kind of (.) get really like angry, but then I would like sh, sort of close down because you can't, it it's hard to sort of feel all those emotions and look after a baby as well, so you tend to kind of shut, like I shut them out (Ari)*
>
> *suicidal ideation come into your head, even though it, I knew I wasn't gonna do it, it just pops into your head because you're <u>so stressed</u> (.) you don't know what else to think about…I was just <u>completely overwhelmed</u> (Ari)*

Instead of providing the stability they sought, disconnection resulted in unsettling intrusive thoughts. Ari's description suggests that suicidal ideation manifested due to their desire for the distress to stop rather than wanting their life to end. Alternatively, stigma surrounding suicidal ideation may have influenced how able they felt to speak about the distress they experienced.

For Lora, the experience of psychological distress also felt uncontrollable. The abrupt change in providing nutrition for the baby was a catalyst for the overwhelming numbness they experienced.

> *I pumped for, for five months, I think and then as soon as I stopped, like the day I stopped, I couldn't get out of bed. I like, it was like I got hit by a truck…I couldn't (2) like <u>feel</u> anything (Lora)*

The metaphor of being hit by a truck signifies the sudden and intense physical and emotional impact of this experience. Lora's description conveys a sense of powerlessness as the distress disrupted their typical routine and capacity to experience emotion.

Charlie highlights the disorientating effect of psychological distress. The inner turmoil they experienced impacted their ability to cope or find a way out, highlighting the overwhelming nature of distress in the PNP. “*I didn't know which way was up, like my whole, the, the room of my head had been flipped upside down and I couldn't work out any directions” (Charlie).* Charlie’s sense-making suggests that their experience of trauma left them feeling vulnerable and uncontained. “*Had I not had all of the traumatising stuff going on during my pregnancy (2) I would have had a better birth…because we know the birth is better when somebody feels strong and safe and confident” (Charlie)*. Their use of ‘we’ indicates a collective understanding of the impact of trauma on birthing people.

3.3.2. Distress as shameful

Psychological distress in the PNP was experienced as shameful. Participants described a sense of self-stigma, the need to hide their distress from others, and judgement from society. Lora highlighted the impact of social perceptions on experiences of psychological distress. “*It's a lot easier to talk about something that like you've overcome or like people I think find it easier to hear that as well, that like I was feeling rubbish and then I found a fix” (Lora).* Emphasis on other people hearing their experience suggests the silencing effect of stigmatisation. Lora felt unable to speak as other people would not be able to tolerate their distress. Suggestions of ‘a fix’ allude to the perception that people experiencing psychological distress are broken or damaged.

Alex’s experience with sharing their distress with services further highlights the silencing effect of stigmatisation. “*I was about to tell her and I looked down and I saw that she already wrote like really good and put a little smiley face in the box and then I just froze” (Alex)*. Staff’s assumption that they were ok increased Alex’s shame surrounding distress. The smiley face in the box is a sinister mirror of the mask that Alex had to wear when accessing support as services failed to make space for their experience of distress.

Theo’s narrative further highlights the perpetuation of stigma on a systemic level. *“It's one of those stories you can only tell after a certain time has elapsed because then you can't get in trouble with CPS [laughter] (Theo), “immediately it's like abuse and your kids are gonna get taken off you” (Theo).* Distress is deemed something to hide due to the punitive and authoritarian feel of helping services. Although Theo makes light of the ‘trouble’ through laughter, the seriousness is indicated later with the mention of social care intervention. Instead of being able to be honest, Theo was silenced by fear of judgement and loss.

Sam’s experience with services further highlights this dynamic. Instead of being able to share who they were and the distress they were experiencing, they had to fight to fit services perceptions of what a good birthing parent looked like. As cisheteronormative assumptions are embedded within services, their experience of stigma was compounded by their gender identity. “Y*ou’re just desperately trying to prove yourself” (Sam).*

Charlie highlights the experience of shame and stigma surrounding distress within the family. “*I was like, having the kids and having these meltdowns, trying to hide. I'd like, go into another room and self-harm and then come back out to, like, perform wellness again” (Charlie)*. They desired to maintain the caring parental role and shield their loved ones from witnessing their pain. The performance of wellness as a neurodivergent birthing person was protective as the mask prevented them from being rejected by society. This acceptance, however, hinged on stigmatising and shaming views of distress, neurodivergence, and disability, signalling that Charlie was not allowed to show their true emotional experience as it was deemed unacceptable, causing further harm.

For Alex and Ari, this shame was internalised. “*I was kind of like almost felt like I was a bad, like a bad parent like feeling like that” (Alex)*, “*I was scared. Like, am I abandoning her?” (Ari)*. They questioned their capacity to meet the demands and expectations of parenthood as a birthing person in society whilst experiencing distress. Shame, therefore, perpetuated distress as it generated additional fear.

3.4. Rebuilding identity under the heavy burden of the cishet gaze

This theme explores participants sense of self and identity in the PNP.

3.4.1. ‘I literally couldn’t be anything else’: a disrupted sense of self

Distress in the PNP was linked to a loss of sense of self. Participants described the early parenting role engulfing their identity as they were restricted in what they could do. *"You turn into a bit of a robot…you're just doing it to sort of (2) um (.) you know, survive and keep your baby healthy" (Ari).* Ari's use of 'robot' suggests a monotonous and automatic provision of care that was central to their parenting role. They prioritised the baby's needs, despite their diminished sense of self. This sentiment was shared by Jocelyn, who described a sense of restriction in early parenthood.

> *she was never off my boobs, you know and like I felt like, like a cow rather than a person…I lost my identity as a whole as well as being a nonbinary person. I lost it all for a time (Jocelyn)*

Jocelyn describes a sense of dehumanisation due to the intense physical demands of caring for a newborn. Feeling reduced to a provider of nutrition not only erased their sense of personhood, but also created disconnection from their gender identity. Similarly, Alex felt consumed by the caregiver role. "*I was just stuck being a parent 24/7 because my baby needed to feed 24/7, so I literally couldn't be anything else, so I just felt like I was stuck in that" (Alex).* They describe being trapped at all times, unable to reconcile a sense of self outside of this experience.

For Theo, this loss of personhood was isolating. The parenthood identity became oppressive as they grappled with connecting to the role due to experiencing psychological distress. Their desire for acknowledgement indicates the social nature of relating to yourself. "*I sort of wanted someone to acknowledge that I was like (2) a person outside of being a parent especially with how much I was struggling to parent, I didn't feel like a parent" (Theo).* For Theo, validation felt necessary for self-acceptance.

Sam highlights the intersectional nature of this loss of sense of self as a nonbinary trans masc birthing person. *"You just become a vessel to carry and then on top of that if you're trans like it's a whole extra kettle of fish where you're really doubly not seen" (Sam)*. 'Vessel to carry' suggests the only role of a pregnant person is to grow another, rather than to be and connect with who you are. The use of 'doubly not seen' highlights the impact of social perceptions, where GQNB people experience an additional loss of identity as cisheteronormative biases assume pregnant people to be women throughout society.

Lora did not experience a loss of self that the other participants described. As Lora was a surrogate, they did not have to contend with a new parental identity. Instead, pregnancy allowed for a new experience with their body that transformed narratives about who they were and what they were able to do.

> *I have a lot of like pain and like back ache and things and that (.) has like, made me feel quite disconnected from my body, whereas pregnancy was something that I, um, like made me feel <u>like my body could do this</u> (Lora)*

Connection to their body was restorative. Prior narratives of the self that were embedded within pain shifted to narratives of the self as capable.

3.4.2. To perceive and be perceived: the experience of dysphoria

Participants described their experience of misalignment with their identity in pregnancy and parenthood. For some, the nature of dysphoria was linked to body changes. Jocelyn described these changes as feminising, creating a sense of unease as their body felt incoherent with their gender. "*My body was <u>so</u> feminine. I had big boobs I had wider hips. I'd put on weight. I'd got all these curves I didn't want…it was just not my. ugh, I, I hated it" (Jocelyn).* Expressions of disgust exemplify the unsettling nature of these body changes.

Changes to the body in pregnancy caused dissociation and a disconnect from the experience of pregnancy for Alex. "*I'd like look down at my pregnant self and I'd be like ohh, that's my child and my stomach, but I was like (.) it was really strange because it kind of felt like an out of body experience" (Alex).* Pregnancy felt surreal and disturbing as the body felt misaligned with their gender.

For Lora, body changes contributed to dysphoria through the lack of accessibility to gender affirming clothes. "*I found it really hard to find clothes that felt like <u>me</u>…maternity clothes are quite like <u>floral</u> and like <u>pretty and feminine</u>. And that's not like how I want to present" (Lora)*. Lora's self-expression was limited due to society's binary perception of gender and pregnancy. The femininity described in maternity clothes reinforces the notion that pregnancy is an experience for women, creating a misalignment in how Lora understands their gender and societal perceptions of their gender due to biological essentialist ideas.

For Charlie and Theo, a sense of security and comfort within their bodies pre-pregnancy protected them from body related gender dysphoria. "*My body* *had masculinised to a degree that I felt very comfortable with" (Charlie)*, "*I've got a lot of different trauma, but like, my body is not one of them. So I actually quite enjoyed being pregnant" (Theo).* For Theo, security in their body was related to how they made sense of their gender, drawing on the understanding that GQNB people do not have to experience bodily dysphoria to be GQNB. Alternatively, for Charlie, security was fostered by prior gender affirming medical interventions. These experiences highlight the differences in how GQNB people can relate to their bodies and find gender euphoria.

Alex described surprise at the nature of the dysphoria they experienced. The functionality of their chest protected them from pre-existing body dysphoria.

> *when I was feeding my baby, it kind of it re- it sounds really strange, it kind of eased a little bit because it felt very u- like utilitarian like I, they had a purpose that I was using it for (Alex)*

Alex was able to focus on the practical task of feeding their baby, connecting this to their role as a parent. Disconnecting from the discomfort they typically felt in relation to the chest was unexpected, signalling the pre-emptive distress they may have felt during pregnancy when considering chest feeding.

The nature of dysphoria was also social; participants experienced discomfort in how they were perceived due to societal assumptions about who can and who should become pregnant. Despite Charlie and Theo's bodily experiences being central to their identity as a parent, the lack of acknowledgement of their birthing role due to perceptions of their gender invalidated both their gender identity and their embodied birthing experiences.

> *I would go out into the world as somebody who looks very masculine, holding my baby, and people would congratulate my sister…they don't see me as the entire person who's bleeding with lochia, who's got tears from giving birth, who's gone through pregnancy. They don't see that they see 'oh, isn't it nice to see a dad out with the baby' (Charlie)*
>
> *I appreciate that you think that I am the dad, but I'm also the person that gave birth to them. I'm also the person that, like, has all those hormones and the emotions and feeling like crap (Theo)*

They highlight a disconnect between the language that is used to understand pregnancy and parenthood and their experiences as GQNB birthing people. Not having this language in society made it harder for them to communicate their experience and be understood by those around them, creating a deep sense of invisibility.

Cisheteronormative narratives of pregnancy and parenthood trapped Jocelyn and Alex in roles that did not fit their experience. "*When people, sort of impose labels on you…it's taking part, bits of me away again" (Jocelyn)*, "*I felt like I was trying to fit into a box that I just didn't fit in and there was nowhere for me to go" (Alex)*. Jocelyn's description highlights the oppressive nature of these common narratives as social perceptions chip away at their sense of self. For Alex, narratives of motherhood created disconnection and an experience of rejection from society. Social dysphoria increased distress as Alex felt like they did not truly belong in a birthing parent role due to their gender identity. "*It just felt like I was like, like pretending to be someone in a play" (Alex).* Instead, they had to act the part that society expected them to.

Sam recognised the impact of rigid cisheteronormative narratives of pregnancy and parenthood for all those who give birth. "*Lots of women are very much damaged by now being women and mothers it fucks them up…the enforcement of it like and me being enforced to be a mother was just ironic" (Sam)*. Their use of 'ironic' highlights the stark incongruity in societal assumptions surrounding pregnancy and birth and who they are. The perception of Sam as a woman means that the damage they describe impacts them through various operations of power – misplaced misogyny, cisheteronormativity, and anti-trans prejudice.

3.4.3. Reconnecting to identity as a restorative process

Participants spoke about the healing effects of reconnecting to the parts of their identity that had been overshadowed by pregnancy and parenthood. Jocelyn described the process as a gradual deterioration and subsequent restoration of the self. "*It's like a lego house…it was being taken apart brick by brick. But then it was being built back up brick by brick, by brick" (Jocelyn)*. Reconnection to the self was an active process that involved lots of small changes to regain stability. For Jocelyn, this involved prioritising bodily autonomy by stopping breastfeeding. "*I stopped early because I was like. I wanted my body back. I wanted to reclaim myself" (Jocelyn)*. As they felt their body was taken away from them, reclaiming ownership over their body was a powerful conscious decision to prioritise their wellbeing.

Charlie and Sam described the need to create space for themselves and resist oppressive ideas that they had to focus solely on providing care for their children. *“Straight after the birth, I went to Mandarin lessons…that kind of inspired me to go to back to that uni…despite what people think we should or shouldn't be doing” (Sam).*

> *I am gonna go to work. I am gonna do something that isn't to parent…that gives me that space to recover. And so that when I am spending time with them, I'm more of myself (.) rather than an echo, a ghost, a shell (Charlie)*

For Charlie, taking space to reconnect to their sense of identity outside of parenthood was healing. Through work, they were able to build their self-esteem and preserve their sense of individuality, which in turn made their time with their children more meaningful.

Sam’s act of resistance was a first step in building their self-worth and financial security. “*There was a chance that I would be OK in my head cause, like, if you're not accepted if you're trans, you're not accepted if you don’t have money” (Sam).* Sam understands their experience through an intersectional lens, noticing the compounding effects of marginalisation based on gender and class. Rebuilding their sense of self fostered feelings of societal acceptance. Accessing higher education meant that they would be regarded as a valued member of a neoliberal society that prioritises self-reliance and productivity, easing the prejudice they experience in other areas of life.

For Alex, reconnecting to their sense of self was about regaining who they were pre-pregnancy. “*When things go back to normal and I could, like, start doing things that I did, like, before pregnancy, I kind of felt more like myself again” (Alex)*. Alex describes getting back to a sense of familiarity, highlighting the loss that they experienced through pregnancy and early parenthood. This self-restoration was a slow process. ‘Kind of’ feeling like themself again indicates a continual adaptation through parenthood.

Lora regained their sense of self through connecting to the joyous part of who they are. They highlight the extraordinary power of the body to bring them back to their former emotional experience.

> *I'd kept my placenta…I chopped into small pieces and fried it [laughter], and that worked wonders…the fact that I hadn't felt any joy at all, and it*

> *was just like this tiny, like, it was giving me the ability to <u>feel happy again</u> (Lora)*

Feeling happiness was exciting, it felt like a magical moment that fostered hope for the future. Lora understood these emotional changes on a biological level. "*I think whatever it was like hormonal imbalances sorted itself out" (Lora)*. The adjustment and adaptation of physiological changes post birth fostered restoration and stabilisation in Lora's life.

For Theo, psychological distress was reduced through fostering a stronger connection to their parental identity. With the support of services, Theo was able to find a balance between caring for their child and for themself. "*We did some baby massage and like (.) just they would be there while I was looking after *** to sort of (.) if I needed a break, they could just like hold *** for a bit" (Theo)*. Services provided space for Theo to navigate the transition to parenthood alongside psychological distress. They were able to find comfort in the parenting role through bonding with their child in a supportive environment.

Ari described connecting with the parenting role as a process that takes time. "*I've learned how to sort of (.) deal with you know, think like if, um, if ***'s upset, you know, you kind of like I, I just get, like an instinct" (Ari)*. Parenting became an intuitive process. Familiarity with their child and confidence in managing their role fostered stability as they were able to cope with the everyday stressors that come with parenting.

3.4.4. Power in rescripting pregnancy, birth, and parenthood

All participants found ways to resist cisheteronormative narratives and affirm their identity through rescripting and queering narratives of pregnancy, birth, and parenthood. Jocelyn, Lora, and Charlie experienced wonder and amazement at their bodies capacity to sustain new life. "*I felt like, um, a person who was growing another person" (Jocelyn)*, "*It felt um, like yeah, like a thing <u>my body was designed to do</u>" (Lora)*, *"It felt like a really natural thing for my body to be doing" (Charlie).* Connecting to their birthing capacity beyond gendered narratives of pregnancy fostered ideas of a shared humanity in the process of reproduction. This understanding was empowering and affirming as it rejected anti-trans and anti-queer narratives that attempt to erase and obscure GQNB birthing people's identity and experiences.

For Alex, rescripting cisheteronormative narratives occurred through a connection to who they are as an individual outside of gendered assumptions of parenthood. “*I feel a lot more comfortable in like (.) parenthood cause I feel like I, I'm me. I've always done my own, my own thing. And I'm like, I love my child. I look after my child” (Alex)*. Integrating their narrative of lifelong resistance to conformity within their parenthood role – to love and care for their child – combats the cisheteronormative narrative that they were oppressed by.

Similarly, Sam rescripted oppressive narratives through connecting to how they were able to adapt and provide care despite ableist notions of parenthood.

> *I was feeding them like loads of times of the day, they were lying on me, I was cuddling them in the way I could, do you know what I mean? They were on my chest like, we were doing skin to skin like we were completely active around it all (Sam)*

Sam resists the notion that being a disabled parent means that you can’t care for your child by highlighting all the ways they were able to meet their child’s physical and emotional needs. Being ‘completely active’ highlights Sam’s connection to their parental role.

This connection to the parenthood role outside of gendered assumptions was exhibited in Theo’s account. “*They started kicking and moving, I found that really like cool. It felt really weird, but like enjoyable weird” (Theo)*. Deconstructing gender and pregnancy helped them connect to the joy of pregnancy and parenthood. ‘Enjoyable weird’ suggests the novelty of this new and exciting experience that they embraced.

For Ari, deconstruction and rescripting of narratives centred around their relationship to language and identity. *“To my daughter I'm, I'm mama. Just because you know to me, I like the sound of that word” (Ari)*. Ari has been able to deconstruct what ‘mama’ means: for them, it is a sound and a name from their daughter. It doesn’t represent who they are or hold societal assumptions about what a ‘mama’ is. Their inclusion of ‘for me’ emphasises their understanding that other GQNB people may have different relationships with language.

Charlie comments on the deconstruction of motherhood as a process. For them, ‘mother’ does not capture their experience of parenthood. “*I knew I could never be, quote unquote mother to my children. I eventually got to a* *space of recognising I could still do mothering, provide the nurture, provide the care regardless of what name I use" (Charlie)*. They attempt to rectify linguistic erasure of their experience by connecting to the different roles that they take on whilst parenting. They understand 'mother' as a social construct that can be broken down in various ways.

Jocelyn found joy in their child queering their parental name. Accidental gender affirmation from their child brought a sense of playfulness and ease. "*She'll call me things like Mr Mama and I'm like I'm cool with that" (Jocelyn)*. Deconstructing language around parenthood and resisting restrictive narratives fostered a sense of acceptance and validity of GQNB birthing people's experiences through the PNP.

3.5. Feeling understood, connected to others

This theme explores participants distressing and healing experiences of isolation and connection during the PNP.

3.5.1. 'I craved being held': isolated from community

All participants described a sense of isolation and disconnection from others during the PNP, which exacerbated their experiences of psychological distress. Jocelyn described the physical barriers to community due to the coronavirus pandemic. *"It was so hard…lockdown prevented so much…I couldn't do the usual hand the baby to someone while I take a shower kind of thing" (Jocelyn)*. Jocelyn had less time and space for self-care due to the unexpected separation from others. This differed from their expectations of support, making the loss even more significant.

Charlie also expressed an unmet desire for community support. "*I just needed somebody else to look after him (.) for a while (2) while I recovered. I needed someone to look after him but near me" (Charlie)*. A lack of support compromised Charlie's physical health as they did not have what they needed to manage their disability. Yearning for someone to care for their child close by emphasises their desire to maintain their parental role whilst caring for themself.

Lora described their support system diminishing due to other people's discomfort with psychological distress. Isolation increased as others couldn't understand Lora's experience, feeling powerless to help. *"Nobody cared about* *me…people like withdrawing because they don't know how to help. Which then (.) doesn't help" (Lora).* Others withdrawing, and a focus on the baby left Lora feeling abandoned and uncared for.

For Ari, the transition to parenthood was a catalyst for reduced social connection. Their experience of parenthood caused a monumental shift in priorities, leading to a loss in long-lasting friendships. This left Ari feeling alone as they had no one to relate to. "*I don't understand how they can (.) how their lives work <u>without</u> a child, but they don't understand how my life works <u>with</u> a child" (Ari)*. An inaccessibility of in person relationships with other GQNB birthing people increased Ari's sense of loneliness as a shared experience with both intersections of their identity was difficult to find. *"In real life I never knew anybody that was (.) nonbinary <u>and</u> pregnant and for me it was kind of quite isolating" (Ari)*.

A lack of connection with other GQNB birthing parents also left Alex feeling vulnerable. Restrictive understandings of what it means to be a birthing parent and what it means to be queer created uncomfortable feelings of difference when they accessed birthing parent spaces and queer spaces. *"A lot of the spaces I didn't feel like <u>were</u> for me…everything is like so gendered (2) and…other queer people are really surprised to find out that I'm a parent" (Alex).* With no one to relate to Alex felt like they didn't belong, leaving them to navigate early parenthood alone. Discomfort related to gendered perceptions of pregnancy blocked their ability to relate to women who gave birth. *"I just didn't connect with anything they were saying and I really felt like I was an <u>impostor</u>" (Alex).*

Theo shared sentiments of feeling disconnected from others in queer spaces. "*There's a lot of different like experiences…I don't always feel like I kind of fit in <u>there</u> either, but (2) because like I haven't had top surgery or anything" (Theo).* Their description highlights the diversity of experience within the queer community despite perceptions that there is a conventional way to present as a GQNB person. Restrictive gender stereotypes left Theo feeling isolated and rejected.

Charlie desired collective support and compassion beyond gendered notions of care. "*I craved being held by, by womanhood and by my community of sisters and siblings who have (.) got that <u>vibe</u>…it was about being able to <u>nurture</u> and look after me" (Charlie).* They convey a deep sense of longing for belonging and reciprocity. Images of being ‘held’ emphasise the lack of emotional intimacy Charlie experienced through their perinatal journey.

Sam highlighted the impact of class on access to an understanding community. Although they found a queer parent space, their differences in experience of the world left them feeling isolated and detached from others. “*<u>We didn't fit in on any level</u>…like we're too queer for the queers? Like, I don’t know [laughter]. Like, <u>we're not even that queer</u> like, but we're just kinda like, and we don't have money” (Sam)*. For Sam, middle class queer spaces conformed to normative family values, exacerbating their sense of loneliness as they felt ‘too queer’, too different.

3.5.2. (In)Consistent (un)caring experiences of support

Participants had varying experiences of care from services throughout the PNP impacting their experiences of connection. For Ari, living in a small town made it easier to access care. “*The level of care is a lot more <u>independent</u> and focused on like the individual <u>person</u>…that helped me <u>get</u> what I needed when I needed it rather than having to sort wait for it” (Ari)*. Accessing support in good time helped them feel cared for and safe. The well-resourced services were able to get to know Ari, tailoring the support to their individual needs.

For both Ari and Jocelyn, there was a sense that professionals took time to listen to them and get to know them. “*She monitored me through everything. She, again I saw her like every month we had a chat. It wasn't just a case of here’s your pills, off you go…I got lucky with this particular GP…she was always there” (Jocelyn)*. The reliable and consistent support that the GP offered was containing. Jocelyn implies that this level of care is unusual to receive, and that typically there is a dismissive attitude towards MH support.

For Theo, experiencing good care and connection helped them seek support again. “*I tried getting that support again for *** but the person that I really like connected with um, they had their own mental health stuff going on so they weren't working” (Theo)*. Their description implies that their good experience of support was attributed to one member of staff rather than the service. Perhaps the culture of the service as a whole did not feel attuned to their needs or experience, making it unsafe to access without this staff member.

Lora described feeling uncared for by services. The support they received reduced rapidly once they had given birth, making it harder to reach out for psychological support as they felt isolated. "*If someone had've like phoned me to check in…cause, yeah postnatal depression isn't like a weird thing…just, I dunno, book in an appointment just in case" (Lora)*. They understand postnatal depression as a common experience, signalling the need for preventative and cautionary care to truly support those who have given birth.

Charlie built on this image of uncaring services. Despite knowing what help they needed to feel supported, services dismissed their care needs, offering dangerous treatment options without a comprehensive care plan. Charlie was left to navigate their distress alone. "*I'm asking really hel, clearly for like space for somebody to sit with me, listen to me and work out a plan, not (.) um, just stick me on a medication that has previously put me in hospital" (Charlie)*. Charlie's experience highlights the lack of collaborative person-centred care within services, despite it being central to NHS values. This is exemplified by the lack of an appropriate response to their communication of suffering as a neurodivergent person.

> *because I can say to somebody, <u>even</u> in the moment 'I am in <u>crisis</u> right now, I am <u>breaking</u> and I want to <u>die</u>' so they're like, 'mmhm, yeah, I hear the words of how big that is', but they're not, they don't get the sense of urgency (Charlie)*

Charlie's linguistic expression of distress is dismissed as unserious despite their clear communication due to the lack of emotionality when expressing the distress. Their access to care was reduced due to the systemic prioritisation and recognition of neurotypical communication styles.

For Sam, poor care is a systemic issue that intertwines with societal prejudice. Services failing to provide appropriate care was one way of maintaining the status quo when they did not conform to the norm.

> *there's violence in society, but you don't <u>feel</u> it until you're on the edge of <u>something</u> and like being trans you're so close to being on the <u>edge</u> and then being pregnant, you're even closer to the edge and you're <u>breaking</u> all these rules of what you shouldn't be doing (Sam)*

They discuss how different intersections of your identity can increase marginalisation and isolation. Their narrative carries imagery of being pushed out and excluded. To fight against this, Sam and their partner had to vehemently advocate for themselves. "*we're like…'you <u>do not understand</u> what could happen and the stress we'll be under like it is just not OK, it's not OK for us, it's* *not OK for our baby'"* *(Sam)*. For Sam, services not understanding their experience of the world could have led to dangerous support decisions.

For Alex, this lack of safety and understanding within services perpetuated the isolation and psychological distress they were experiencing. "*I feel like my experience with my mental health was actually really negatively affected by not feeling safe to talk about how I was feeling" (Alex).*

3.5.3. Finding comfort in a valued partner

Participants discussed the impact of their partnered relationship on their wellbeing and sense of connection. Both Alex and Theo describe a sense of togetherness. They navigated parenthood alongside their partner, which built a sense of security. "*It's just the two of us against the world which I don't mind so much" (Theo)*, "*he's a God send, like I feel so much like I couldn't be a parent without him" (Alex)*. Alex suggests that their ability to be a parent was dependent on the support and union they have with their partner. Their acknowledgement of their partner's necessity emphasises the trust that they have within the relationship.

Ari's partner was instrumental in them accessing further psychological support. "*My partner kind of (.) like just sort of gently nudged me towards going to the doctors" (Ari)*. Their use of 'gently' emphasises the loving and caring nature of their relationship. Ari's partners encouragement helped them connect to their distress and recognise their need for support in a non-judgemental way. Similarly, Lora's description suggests a nurturing relationship with their partner.

> *massively like in all ways like listening to me and like taking care of me and cooking for me when I wasn't up to doing it myself and that kind of thing. Um, and like, encouraging me to try things as well (Lora)*

'massively…in all ways' indicates the containment that Lora's partner was able to offer them in their time of need.

Jocelyn's partner was central to their wellbeing through shared parenting duties. *"He got regular hours so we got into a regular routine to again, that's another thing towards the end that was really helping pick me up" (Jocelyn)*. Their partner's engagement with their parenting role supported the family to continue building predictability, stability, and containment. Over time, sharing the caring duties gave Jocelyn space to reconnect to themself and lift their mood.

Charlie also described the necessity of sharing parental duties. Their description indicates that they were expected, as the birthing person, to bear all of the responsibilities, creating feelings of isolation in the partnered relationship.

> *I had to say to my husband that he needed to step up. So initially he wouldn't have both children at the same time so it then became that I was kind of forcing him to do [laughter] a little bit more and a little bit more (Charlie)*

Achieving an equal split of duties required resisting patriarchal norms through self-advocacy. Although eventually this fostered positive wellbeing, it was a difficult process, as exemplified through their comment ‘forcing’.

Ari also described the difficulty in achieving a connected and helpful parental system. Although they had to figure out what worked for them as a couple, their description indicates that they were able to find a way over time.

> *we sort of work together, um (.) but (.) yeah, because er we, we have like a system as well…the first few months is probably the hardest for a <u>couple</u> which I think it definitely was because we were figuring out that system of like what we both needed at the time (Ari)*

Their use of ‘at the time’ suggests that navigating this parental dynamic is a continual process which changes through the different stages of parenthood.

Sam suggests that their wellbeing was interconnected with their partners. “*When I think of my mental health, we sort of came as a package” (Sam)*. They describe a close connection with their partner. The use of ‘we’ suggests a bidirectional influence of wellbeing. The shared experience highlights the distress that nonbirthing partners can also experience through the PNP, indicating the importance of addressing distress using a systemic approach.

3.5.4. Community as a healing force

Participants highlighted the importance of being surrounded by others who supported them and understood their experiences. For Charlie, knowing people who shared similar experiences to their own helped them feel understood. **“***The one thing I need more than anything else is community. Nobody else gets what it's like (.) to be (.) trans (.) and (.) pregnant” (Charlie)***.** For Charlie, a shared experience fosters implicit understanding. Community is a place where you will be accepted for who you are without having to explain yourself. Community being ‘the one thing’ highlights is essentialness to reducing isolation in the PNP.

This sentiment was echoed by Alex, who described the importance of community in feeling assured in their sense of self. “*It just felt really (.) like affirming to be surrounded by more queer people and like queer parents, because I didn't even know anyone like me existed…that just made me feel like more comfortable in myself again” (Alex)*. Connecting with other GQNB birthing parents helped Alex make sense of their experiences. Community was a healing force, reducing isolation and dysphoria. Alex was able to find somewhere they fit in, helping them recognise the validity of their experiences.

For Jocelyn, community and restoration occurred in a mutual and reciprocal way.

> *they understood like how much it sort of, the body changes and said they were able to then (.) like give me the reassurance that I needed that I was, what I was feeling was (.) normal…we could be there for each other (Jocelyn)*

Affirmation reduced the isolation and distress that Jocelyn experienced in relation to their body changes. Having someone to relate to normalised their emotional experience, reducing the stigma and shame connected to psychological distress.

Lora was also able to find solace in community. Connecting with others was a beacon of hope, guiding them out of the depths of psychological distress. “*Having like talked to people who have experienced the same thing like, does like, make you feel like you can do it” (Lora)*. Community fostered motivation to overcome what was a huge hurdle in their life.

Although Ari was not able to find a queer parenting community, they noted the importance of having parents around them who they could connect with. *“It's like the one thing that you know you have to have like other parent friends” (Ari), “if I meet another parent, it's like oh we both have kids. Like we're not the same as each other, but we both have kids” (Ari)*. They were able to create community by focusing on connecting through the shared aspects of their identity, reducing isolation.

For Sam, feeling understood and connected to others was experienced through their relationship with trans staff. Sharing Sam’s identity meant that they were able to understand Sam’s needs and advocate on their behalf, creating a network of resistance that supported them through difficult experiences with services in the PNP. *“This was like an absolute Gods, I think without that, I don't know, it would have been even more hell on earth like [laughter] it was like, and they were brilliant” (Sam)*. Sam describes feeling fortunate to receive this support. It felt like a gift that provided immense relief from ‘hell on earth’.

For Theo, a supportive network helped them have the time to connect with their partner. “*Just like helping look after the kids…it actually gives us a nice like just the two of us time” (Theo)*. As the transition to parenthood involved a shift in priorities, having protected space to nurture the partnered relationship reduced psychological distress. This felt special to Theo. It was only possible with the support of others who were able to care for the children.

3.6. Creating safety in an unsafe world

This theme explores participants felt sense of safety within services during the PNP and how participants forged and continue to create safety in perilous environments.

3.6.1. Invisible to the system

An important feature of participants safety within services was their experience of systemic erasure as GQNB birthing people. Alex and Ari highlighted the lack of representation of people who do not fit the cisheteronormative mould. “*Everything says woman, absolutely everything” (Alex)*, *“It was always just a mum, a dad and a baby, and there was never anything different” (Ari)*. This constant normative image contributed to feeling unsafe and othered when accessing perinatal services.

Systemic erasure contributed to hospitals feeling too dangerous for Charlie to access. Erasure on multiple levels meant that they would not be understood. *“I know in hospitals I would be misgendered both by the space and by the people…it didn't feel safe” (Charlie).* As a result, they were not able to access the same level of healthcare as cisgendered people.

For Lora, systemic erasure was shown when computer systems failed to function outside of binary understandings of conception. “*She said that the like maternity system couldn't cope with someone not being like female in the* *system" (Lora)*. The computer system not coping with difference mirrors societal responses to GQNB people.

Computer systems failing to account for Sam's transness within test results left them in a vulnerable position where their physical health was compromised, highlighting the extent of the neglect of physical and mental healthcare for TNB people within the NHS. "*I just haven't had any hormones in at the right levels for a very long time…I got a very severe skin reaction that made me, it could have made me go blind" (Sam).*

A lack of research and knowledge about GQNB birthing people's experiences meant that Charlie and Sam were given inaccurate information about their reproductive capacity. "*I didn't even know if I could get pregnant because I'd been told that taking testosterone would make me infertile" (Charlie),* "*it turns out I could have a baby, heck, and the menopause is something that you should really look into and find out about. Just not telling me I might be going through it" (Sam)*. Epistemic erasure left Sam feeling uncared for and unsafe as they navigated a complicated system.

This was similar for Lora, who felt they could not trust the advice of professionals in services due to the lack of accessible and inclusive information about the use of chest binders. "*I didn't have like a whole load of faith in her [laughter] for that to be like research backed or anything" (Lora)*. This meant that Lora did not have the appropriate information to maintain safety when using gender affirming strategies through the PNP.

Similarly, a lack of knowledge about GQNB people's experiences exacerbated the distress Alex experienced in relation to dysphoria. Alex's discomfort with naming dysphoria was perpetuated by services not picking up on their description of distress. "*I knew it was dysphoria, but I almost couldn't name it as that…I'm like, like naming all the things that were like to do with like my dysphoria and they were like, 'oh no, it's fine'" (Alex).* A lack of shared understanding restricted Alex's access to psychological support.

For Theo, professionals limited understanding of the nuances and multifaceted nature of GQNB people's experiences impacted how they were treated in services. "*They were really like 'is it OK if we do this like is it really OK? Are you gonna be comfortable? What do you want, like a chaperone?'…and it's like, just like treat me like a normal person" (Theo)*.

Restrictive gender stereotyping and poor training meant that staff's attempts at inclusive care left Theo feeling misunderstood, alienated, and uncomfortable.

Systemic erasure and anti-trans prejudice was also overt. Blunt rejection and exclusion from PNMH services left Charlie vulnerable as they navigated debilitating distress alone. "*I texted the prenatal mental health team and the reply I got was (.) 'This is a service for pregnant women'" (Charlie).*

3.6.2. Navigating visibility: 'people see you and they can't really'

All participants described their experiences of navigating visibility within perinatal services. For some, choosing to remain private about their gender helped them feel safer. "*I'm not going to add that added uncomfortable feeling of talking about this to these midwives that I've never met before" (Alex).*

> *I didn't want the additional stress of explaining cause, with my care, I very rarely saw the same doctor or midwife…it would be going to again, explaining, and that's just taking time out of me getting the information that I want (Jocelyn)*

Inconsistent care meant that Alex and Jocelyn would have had to have repeated conversations about their gender identity, which they anticipated would be uncontaining and difficult.

For Lora, the lack of safety surrounding gender disclosure was linked to the pathologisation of queerness. Disclosure of their gender may have resulted in prejudiced perceptions about their ability to be a surrogate. "*They assessed me psychologically to make sure that I was like, prepared for being a surrogate…so it felt like something that I couldn't really tell them about" (Lora).*

Theo experienced continual misgendering despite disclosing their gender. They chose to preserve their energy and reduce the emotional labour they exerted by not educating staff who misgendered them. "*Just easier to not say anything, can just let them assume what they're going to assume (2) but then and again, that's also tiring" (Theo)*. Regardless, Theo experienced an emotional toll. Painful rejections and alienation depleted their energy levels when they were already vulnerable. Sam builds on this experience of not 'really' being seen. "*People see you and they can't really" (Sam).* Services lack of understanding about the lived experiences and nuance in GQNB people lives results in generalisations, misunderstandings, and stereotypes.

The pain of misgendering during birth was buffered against through assertive communication. Lora's experience exemplifies the extent to which GQNB birthing people must go to fight for appropriate and safe care.

> *I had to like make it really obvious to like whoever turned up, so I had a sign on the door…that was like the most important thing…it was just about how I wanted to be I talked to, talked about (Lora)*

Language was a powerful tool to protecting their story and experience of birth.

In stark contrast to Theo and Sam, Ari's experience of communicating their gender was a gateway to receiving affirming perinatal care. Disclosure hinged on the development of a safe relationship that helped Ari feel understood and cared for, emphasising the value of staff asking questions and making room for conversations about gender in perinatal services. "*More of the doctors that I was seeing that were deliberately correcting themselves…it definitely made me feel better. Um (2) like even just to know that there was one person that was that took an interest" (Ari).*

For others, visibility was linked to concerns and experiences of being sensationalised and dehumanised. "*I was also terrified of being Britain's first pregnant man again" (Charlie)*. *"We were sensationalised quite a lot…I was trans, seen as a trans man, like and it's the first trans person they'd ever met" (Sam)*. Staff's exaggerated reactions to witnessing pregnancy outside of womanhood meant that both Sam and Charlie were placed into the role of educator throughout their perinatal journey.

> *I said to all of them, I said 'you will have had a trans person. You would have had a queer person. You've had a nonbinary person. You just wouldn't have known it, no one's gonna be telling you, like, and even if you know it, no one's asking' (Sam)*
>
> *I spent the whole of my pregnancy, my birth, and my postnatal period having to educate every single member of staff I came into contact with…it was also scary because I didn't know if I was gonna receive transphobia (Charlie)*

Their access to services was no longer about gaining care and support. Visibility resulted in prejudice and the heavy burden of emotional labour.

When considering gender disclosure, Charlie described recognising that visibility was integral to supporting their child in strengthening and rescripting narratives about gender diverse family making.

> *I had the realisation that I could never keep my transness to myself again…my transness wasn't just mine anymore, it was also my child's. Because her narrative of how she came to the world, her story, hinged on my transness (Charlie)*

Privacy was no longer an option as Charlie prioritised a shared powerful family script over perceived safety.

3.6.3. Queering services in the face of oppression

Participants described the need for and process of systemic change to create safety within services. Participants emphasised the necessity of education and training to deconstruct cisheteronormative narratives in services to make them more inclusive for GQNB birthing people. "*A lot of doctors in the sort of general medical system, don't tend to really know about sort of trans and nonbinary healthcare" (Ari)*, "*I don't know how we can make the changes and space for people (2) if those midwives aren't there learning themselves (.) and feeding that knowledge back to people" (Alex)*. Change is seen as an ongoing process. Staff are integral to facilitating cultural shifts. Although learning is done on an individual level, knowledge can be filtered down through the system to create waves of change.

This is echoed in Jocelyn's narrative, where consistent and open-minded staff are seen as the starting point in the creation of safety within services. *"Ask (.) what my gender is, and then talk about the gender. And then it would be on record from the word go (.) and then you wouldn't need to keep explaining" (Jocelyn)*. For Jocelyn, this change needs to go beyond the surface level of just asking, but also taking time to understand what that means so that more subtle and nuanced ideas about gender can be built on in services.

Theo describes how these subtle and nuanced understandings of family-making and gender can create services that go beyond providing for birthing women. "*I want all those different experiences to be there" (Theo)*. Inclusive and safe support for Theo is not separate spaces for different people. Instead, they value an expansive approach where each person's experience is welcomed, recognised, and respected.

The process of change feels slow. Both Sam and Lora highlight the need for services to catch up with cultural shifts that are happening outside of the NHS. "*Someone who is aware that people who aren't women can get pregnant* *[laughter] which is so like, such a, such a low bar, but like not one that we've cleared" (Lora)*, "*things have shifted so much that the medical professional and psychologists are gonna have to (.) sort themselves out like, because it's going to be a massive gap" (Sam)*. Although the changes are considered small – starting a conversation or understanding that gender is not binary – the failure to provide services in line with this has devastating effects. The 'massive gap' illudes to the stark disparity in physical and MH care and outcomes for GQNB people compared to cisgendered people.

Being part of the process of change was an important part of how some participants related to themselves, created safer communities, and built hope for the future. "*I feel it strongly enough that I've set up a business to try and make the change [laughter]" (Charlie), "It's really good to just feel like I'm able to do something like that might help…you're like, just hoping that things will be different for the future" (Sam).*

> *before I didn't really feel as important to be like as representative and I was like, really (.) dismissive of who (.) I was trusted to, you know, to be like myself with. But now I'm kind of getting to the point where I'm like. If we need the world to be better place, I kind of have to get over that uncomfy feeling (Alex)*

Visibility is considered central to facilitating cultural change in the face of oppression, as it helps those with lived experience regain control over the narratives of their experience. For Alex, holding onto this power by being what they did not have for someone else could disrupt the painful isolation that many participants experienced.

4. DISCUSSION

4.1. Overview

The findings of this research contribute to our understanding of GQNB birthing people's PNMH experiences. The analysis is discussed in relation to the research questions, drawing on relevant literature and theories to support sense-making. Critical evaluation is offered, situating the results within the research strengths and limitations. Implications are outlined, alongside recommendations for practice, policy, and future research. Reflections on the process are shared.

4.2. Main Findings

GQNB birthing people described their experience of perinatal psychological distress in a variety of ways. Destabilising experiences of psychological distress were related to the loss and rebuilding of identity. Being engulfed by the parenting role and experiencing social and bodily dysphoria contributed to feelings of isolation, overwhelm, and invisibility. This was exacerbated by how connected GQNB birthing people felt to others, with many finding it difficult to find an understanding community. Experiences of prejudice, erasure, and abandonment from services further contributed to experiences of distress and shame. Navigating cisheteronormative systems meant that GQNB birthing people had to continually assess their safety within services, impacting how they were able to receive both physical and MH care.

Participants found that reconnecting to their sense of self and rescripting narratives of pregnancy, birth, and parenthood increased their felt sense of visibility and acceptance within their perinatal experiences. This, alongside finding and connecting with other GQNB birthing people, reduced psychological distress. Shared experiences and stories bolstered feelings of understanding and self-worth. Additionally, experiencing validation, consistency, and advocacy from healthcare professionals supported a reduction of psychological distress when accessing services. For some, their experiences led to involvement in activism and social change.

The findings provide valuable insight for professionals, individuals, and communities to better understand GQNB birthing people’s experiences in the PNP. They also generate practical recommendations for clinicians, services, and policymakers to improve perinatal care for GQNB birthing people and their families.

4.2.1. What are GQNB birthing people’s MH experiences in the PNP?

Literature surrounding cis-women’s PNMH experiences highlights the variety of ways in which psychological distress is experienced (Bennett et al., 2007; Furber et al., 2009). *Navigating shame and the emotional tides of distress* illustrates participants descriptions of an array of experiences, from heightened stress to emotional numbness. Participants narratives of distress outline some similarities in PNMH experiences in birthing people despite gender identity. They also offer insight into the diversity of experience for GQNB birthing people outside of diagnostic categories (Law et al., 2021), highlighting the importance of understanding a person's subjective lived experience.

The development of identity is an important process that supports a person to gain clarity over who they are and their place in society (Erikson, 1959). This process is revisited during the PNP as new parents reprocess and reidentify their sense of self within their new role (Bailey, 1999; Smith, 1999). Central to the literature surrounding cis-women's experiences of psychological distress in the PNP is a loss of self to the parental identity (Jackson et al., 2021; Jewell et al., 2024; Staneva et al., 2015). This is captured in *'I literally couldn't be anything else': a disrupted sense of self* where participants described experiences of dehumanisation, restriction, and a loss of sense of self as their personhood was diminished by the early parenting role. Like cis-women, in this research, GQNB birthing people experienced an enforced loss of identity related to oppressive patriarchal norms as they were expected to carry the burden of domestic duties as the birthing person (Green, 2015). Fixed essentialist categories perpetuated a loss of identity, increasing isolation and loneliness as participants were no longer seen for who they were outside of the parenthood role.

As many GQNB people have had to grapple with understanding their identity among a lack of validation and recognition of their gender within communities (Darwin, 2020), services (Bower-Brown et al., 2023; Freeman & Stewart, 2022), and legislation (Newman & Peel, 2022; Renz, 2021), this loss of identity may be an even greater challenge. In *invisible to the system*, participants described feeling like they didn't fit within predetermined moulds of pregnancy or parenthood. They were not perceived correctly by others, and consequentially experienced erasure of their gender identity. As Sam describes, being "*doubly not seen"* increased their emotional and social loneliness (Weiss, 1973), as cisheteronormative ideals perpetuated psychological distress and their struggle for social legitimacy. This was echoed in other GQNB birthing people's accounts in *'I craved being held': isolated from community*. These findings make a significant contribution to the development of a nuanced understanding of GQNB birthing people's experience of a loss of personhood in relation to PNMH.

Participants described a connection between perinatal psychological distress related to identity and their experiences of social dysphoria – the psychological distress experienced when being perceived or treated in ways that misalign with your gender (e.g., being misgendered). Merleau-Ponty's (1962) philosophy of the body conceptualises dysphoria as interference of the lived experience of the body (body dysphoria) in social contexts (social dysphoria). In *to perceive and be perceived: the embodied experience of dysphoria*, participants describe their experience of "*being the person who's bleeding with lochia, who's got tears from giving birth, who's gone through pregnancy*" (Charlie) being invisibilised by societal perceptions of them as "*the dad"* (Theo). Additionally, as in pre-existing literature relating to TNB birthing people's experiences (Coe, 2023; Greenfield & Darwin, 2021), participants described that being perceived as mother or woman increased social dysphoria. Pre-determined perceptions of pregnancy and parenthood increased isolation as they felt like there was "*nowhere for [them] to go"* (Alex). Participants navigation of social environments challenged traditional gendered ideas, increasing their awareness of the limitations and impact of these norms and expectations as they experienced an embodied disconnect between their internal sense of self and the way they were perceived and treated.

Existing literature surrounding the experience of psychological distress in the PNP highlights the role of the body and social perceptions in perpetuating distress. For cis-women, this is often described in relation to cultural norms and ideals surrounding thinness (Lovering et al., 2018; Rodgers et al., 2024). This was not replicated in research exploring TNB birthing people's experiences (Bower-Brown, 2022a; Coe, 2023), where participants distress was instead related to the perceived 'feminisation' of the body in pregnancy. *To perceive and be perceived: the embodied experience of dysphoria* echoes these results, highlighting the distressing experience of 'feminisation' for some participants. Interestingly, this was not the experience of all participants. Alex highlighted a reduction in body dysphoria as their body was serving a purpose – to grow or feed another. This is reminiscent of Jackson et al's., (2023) paper where TNB people coped with dysphoria when bodyfeeding by focusing on the functionality of their chest. Jackson et al's., (2023) participants drew on these narratives as a coping strategy, whereas in this research, participants sense-making around functionality prevented the overall experience of psychological distress related to body feeding. In line with queer theory (Butler, 2006), this sense of empowerment derived from embracing a dynamic relationship with their body and identity as participants resisted norms and fostered meaning through self-determination. The variety of accounts emphasise the diversity of GQNB people's experiences, highlighting the importance of resisting transnormative narratives that homogenise TNB people (Conlin et al., 2019).

The findings suggest a complex interplay between social dysphoria and bodily dysphoria. For some, cisheteronormative conceptualisations of pregnancy contributed to dissociation from their body as they struggled to integrate the bodily experience of pregnancy within their experience of their gender. Some made sense of this distress through their relationship with language. Not having the words to explain or relate to what was happening contributed to experiences of psychological distress as dominant discourses failed to capture their lived reality. Participants accounts provide novel insights into GQNB birthing people's experiences, highlighting the inhibiting impact of linguistic erasure and hermeneutical injustice on GQNB birthing people's capacity to be understood by both themselves and others (Freeman & Stewart, 2022; Richardson, 2022).

In *distress as shameful* participants described how their experiences of feeling disconnected from their baby, guilt associated with distress, and feeling inadequate in their role contributed to their feelings of isolation and shame. For some, this shame and stigma was internal, whereas others experienced stigmatisation from people and services. GQNB birthing people's experiences of shame were often related to cisheteronormative ideas about a birthing person's parental role. Whilst some expressed distress related to not fitting preconceived notions of a 'mother', others described the oppressive nature of these expectations for anyone who gives birth. This is in line with existing literature, which highlights the destructive impact of these norms on cis-women (Adlington et al., 2023; Constantinou et al., 2021) and TNB people (Bower-Brown, 2022b; Fischer, 2021). As queer theory and transfeminist discourse would suggest, these essentialist gendered beliefs around birthing and parenthood erase GQNB birthing people's experience, oppress birthing women, and fail to consider the experience of both cis and trans women who cannot or who choose not to give birth.

In *rebuilding identity under the heavy burden of the cishet gaze,* participants attempted to alleviate psychological distress through reconnecting to their individual identity. Participants experiences align with self-determination theory, which highlights the importance of autonomy and competence for psychological wellbeing (Ryan & Deci, 2000). Participants taking time for themselves and doing "*something that isn't to parent"* (Charlie) increased their self-esteem and self-worth. The positive benefits participants of going back to work and engaging in activities outside of parenting have also been demonstrated for cis-women (Lewis et al., 2017; Perkins et al., 2018), reinforcing the argument that cisheteronormative ideals can harm anyone who gives birth.

GQNB birthing people made efforts to deconstruct and de-essentialise narratives of pregnancy and parenthood, finding ways to queer their parenting role (Bower-Brown, 2022b). This reduced distress as rescripted narratives fostered identity alignment. This resonates with transfeminist discourse, which challenges biological essentialism and cisheteronormativity to promote inclusive and affirming reproductive experiences for GQNB birthing people (Erickson-Schroth, 2014). In line with narrative theory, the stories participants told themselves and others about their experiences held an important function (White & Epston, 1990). Stories which promoted resilience and supported coherent meaning-making reduced psychological distress. For Lora, this was understanding pregnancy as something their *"body was designed to do"*, whereas for Charlie, this was about deconstructing the word mother and recognising that they "*could still do mothering, provide the nurture, provide the care".* Narrative theory may also explain Lora's reports of a reduction in pre-existing psychological distress through the PNP, as pregnancy served as an opportunity to rescript narratives around their bodies capabilities.

Rescripting narratives around pregnancy, birth, and parenthood also served to resist ontological oppression (Richardson, 2022). Collective identity and solidarity in healing amidst oppressive systems and power imbalances in society was important for participants wellbeing (Watkins & Shulman, 2008). Being able to critically confront oppressive ideologies empowered participants to engage in action in the pursuit of social justice as demonstrated in *queering* *services in the face of oppression* and *power in rescripting pregnancy, birth, and parenthood,* potentially increasing their sense of belonging and purpose (Prilleltensky, 2008). The positive effects of engaging in social action on wellbeing have been highlighted in several studies exploring marginalised people's experiences (Dinizulu et al., 2024; Montagno & Garrett-Walker, 2022), highlighting the importance of attending to intersectionality when addressing issues related to psychological distress in the PNP.

4.2.2. What are GQNB birthing people's experiences of support in the PNP?

The association between psychological distress in the PNP and experiences of support is well established. Reduced and/or distressing experiences of support are linked to increased psychological distress for both cis-women (Bridle et al., 2022; McCarthy et al., 2021) and TNB birthing people (Bower-Brown, 2022a; Coe, 2023; Pezaro et al., 2023; LGBT Foundation, 2022). This research contributes to our understanding of what this looks like for GQNB birthing people in the PNP. As demonstrated in *(in)consistent (un)caring experiences of support, invisible to the system,* and *navigating visibility: 'people see you and they can't really',* a lack of support and discrimination from services increased GQNB birthing people's sense of isolation, loneliness, and fear, whereas consistent, timely, and affirming support from services increased containment and validation. Unsurprisingly, all participants highlighted difficult experiences with services, reflecting GQNB people's experiences throughout the system (Rajunov & Duane, 2019). Regardless, participants expressed a desire for connection and care, experiencing distress when support did not meet their expectations. This aligns with a relational understanding of psychological distress in the PNP, which highlights the importance of interpersonal relationships and social support for positive wellbeing (Mauthner, 1994).

Some made sense of their experiences within the context of staff shortages and real-term funding cuts throughout the NHS (AAPG, 2022; Phillips, 2024), highlighting inconsistent care and increased offers of psychotropic medication instead of psychological support as key indicators of this. Others considered their experiences through an intersectional lens. Participants highlighted the impact of cisheteronormative values and anti-trans rhetoric and policy on their experiences of perinatal services, recognising that they were more likely to experience "*violence in society*" (Sam) due to their gender.

Invisible to the system represents the impact of systemic erasure on staff's access to suitable resources, impacting their ability to understand GQNB people's experiences and provide appropriate psychological and medical support. Reduced visibility and understanding about GQNB birthing people's experience resulted in a lack of inclusive perinatal spaces, restricting participants connection with others. This left participants feeling like "*an impostor"* (Alex) as they "*didn't fit in on any level"* (Sam). Consequentially, participants had to continually assess their safety and navigate decisions around visibility in 'women' centred spaces. *Navigating visibility: 'people see you and they can't really'* highlights the difficult decisions participants had to make. Some decided to conceal their identity as they felt this would reduce the likelihood of experiencing further psychological distress, mirroring the experience of TNB birthing people (Coe, 2023) and queer birthing people (Goldberg et al., 2017; Wilton & Kaufmann, 2001). Those who were unable to or chose not to conceal their identity were frequently met with misgendering, sensationalism, and a lack of understanding (Coe, 2023). Akin to the minority tax (Rodríguez et al., 2015), GQNB birthing people were burdened with the task of educating those they encountered about their experiences, increasing psychological distress when already vulnerable.

Participants described how these experiences led to increased isolation, fear, and a felt sense of abandonment throughout their perinatal journey as services minimised and overlooked their pain. Discrimination left GQNB birthing people feeling unsafe and unable to access care as they would be "*misgendered both by the space and by the people"* (Charlie). The results resonate with the literature pertaining to queer birthing people (Soled et al., 2022) and TNB birthing people's experiences (Bower-Brown, 2022a; Coe, 2023; Greenfield & Darwin, 2021; Pezaro et al., 2023). For participants who were disabled or had a long-term illness, this was further exacerbated by ableism and disablism, which for some led to life-threatening health complications. As posited by minority stress theory, the unique stressors that each GQNB birthing person experienced depending on their intersectional identity will have had a compounding negative effect on their physical and MH (Meyer, 2003), putting those who are multiply marginalised at increased risk of experiencing psychological distress in the PNP.

Contrary to these distressing experiences with services, some participants expressed the benefits of accessing PNMH care. Support alleviated psychological distress and increased their bond with their child. Participants accounts suggest that professionals within perinatal services play a significant role in increasing feelings of acceptance when accessing care. For Ari, professionals starting conversations about gender and communication preferences, trying to adhere to this and advocate for other professionals to do the same throughout their care, increased feelings of being seen and safe, buffering against psychological distress. Jocelyn's description builds on this, signalling consistency as a key factor in feeling safe in services. Jocelyn describes that they "*got lucky",* emphasising that this standard of care is not a common experience, highlighting the need for systemic changes to perinatal services.

The role of community connection and family support are critical factors in mitigating and addressing psychological distress in the PNP (Kay et al., 2024). In *'I craved being held': isolated from community* participants shared a profound sense of loneliness as their access to other GQNB birthing people was limited or non-existent. This left GQNB birthing people feeling socially and emotionally isolated as they were unable to connect with others who they felt would truly understand their experience, echoing the results from research exploring Canadian GQNB birthing people's experiences (Fischer, 2021). In keeping with the argument that connectedness with community and relating to a social group enhances feelings of belonging and psychological wellbeing (Tajfel & Turner, 1979; Tebbe & Budge, 2022), when participants were able to connect with similar others, they experienced a sense of validation, acceptance, and collective strength. In *community as a healing force*, Alex described the affirming experience of connecting with other GQNB birthing people, noting that it helped them feel *"more comfortable in [themself] again".* Participants emphasised the necessity of shared understanding as "*nobody else gets what it's like"* (Charlie). Connecting to similar others gave participants "*the reassurance that [they] needed that [they were] normal"* (Jocelyn), identifying an important role for formal and informal peer support for GQNB birthing people.

As highlighted in *finding comfort in a valued partner,* practical and emotional support from partners were important influences in reducing perinatal psychological distress. This is in line with existing literature, which suggests that relationship satisfaction and quality are associated with experiences of distress in the PNP (Antoniou, 2021). Although this is not the case for all GQNB people, some can have complicated relationships with their family due to experiences of rejection and stigmatisation (Galop, 2022). Therefore, close supportive relationships where GQNB birthing people can feel safe and understood may be even more important. In this research, close relationships were integral for managing the practicalities of coping with psychological distress and parenting, rebuilding a sense of self, and feeling accepted and connected to others. Sam considered perinatal psychological distress as a shared experience with their partner, contributing to our understanding of the interconnectedness of birthing and nonbirthing partners' PNMH (Chhabra et al., 2020; Howat et al., 2023). As GQNB birthing people's partners may face similar barriers depending on their intersectional identity, it would be helpful for MH support offered in a systemic way. This may serve to normalise the experience and reduce localisation of the 'problem' within the birthing person.

As explored in *feeling understood, connected to others,* and c*reating safety in an unsafe world*, participants experience of isolation and invisibility were caused and perpetuated by a lack of access to supportive and understanding services and communities. Shame and fear of judgement further prevented GQNB birthing people from speaking to others about their experiences of psychological distress, exacerbating this isolation and invisibility. The silencing effect of stigma has been found in previous studies related to PNMH (Aldington et al., 2023; Law et al., 2021). This is a vicious cycle. Internal and external stigma led to self-silencing, resulting in reduced help-seeking and increased withdrawal, causing further isolation and psychological distress (McDermott et al., 2018). The findings therefore contribute to our understanding of the interconnected relationship between loneliness, PNMH, and stigma (Adlington et al., 2023).

4.2.3. How do GQNB birthing people make sense of their experience of psychological distress and wellbeing in the PNP?

As previously discussed, participants made sense of their experiences of psychological distress and wellbeing in the PNP in numerous ways. Some participants understood their experiences through environmental factors, trauma, relationships, and increased stress. Others considered the role of hormonal changes, aligning with the medical model of psychological distress. All participants highlighted the complex and multifaceted interplay between their internal experience and the social, cultural, and political context of their PNP. Participants considered their intersectional identity to understand the impact of the patriarchy, cisheteronormativity, ablism and disablism, and classism on their experience of services, their perception of themselves, and how others perceived them. Participants noted how different operations of power decreased their sense of connection to themselves and others, causing distress and intense feelings of invisibility and isolation.

Participants drew on their sense-making to guide their healing, reconnecting with themselves, rescripting oppressive narratives of pregnancy, birth, and parenthood, and fostering communities and connections where they felt safe. They also bolstered their wellbeing by contributing to the dismantling of oppressive structures. Arguably, GQNB birthing people's experiences of psychological distress and wellbeing in the PNP were therefore made sense of as an understandable response to their surrounding context rather than individual pathologisation.

Understanding psychological distress in different ways reflects the multitude of conceptualisations within the MH professions (Butlin et al., 2019). Participants sense-making may have been affected by their lived experience of the phenomena through reflecting on the process of change and what worked for them. Their sense-making may have also been influenced by dominant discourses expressed by professionals within the health care system.

4.3. Implications

The findings highlight the importance of understanding GQNB birthing people's nuanced PNMH experiences, emphasising the need for inclusive and affirming services to address psychological and physical needs during the PNP. Implications across multiple systemic levels must be considered.

4.3.1. Clinical Practice

Perinatal services conceptualise gender in a binary way when supporting birthing people, preventing access to appropriate perinatal and PNMH support. GQNB birthing people feel less safe to reach out for support whilst being open about their gender identity, and when they do, the support is not always inclusive, respectful, or understanding of their gender or experiences. Clinical psychologists and perinatal workers need to challenge their ideas about gender, deconstructing cisheteronormative ideals which are held tightly within society and psychology as a profession (PSC, 2021; Richards, 2017). Moreover, when GQNB people do share their identity within services, it is important to offer compassion, care, and respect. To mitigate the risk of prejudice and homogenisation, clinicians should take time to create a person-centred care plan with the individual they are seeing (Hadjiioannou & Saadi, 2023), considering what they need to feel psychologically safe in physical and MH perinatal services.

Sexed language is embedded within reproductive healthcare services. As such, it is important for those who work in perinatal care services, including doctors, midwives, nurses, healthcare assistants, and admin, to use gender inclusive language to increase the safety of accessing care for GQNB birthing people (Pezaro et al., 2024). The results also highlight the importance of reproductive healthcare services embedding true person-centred care by considering each person’s individual needs as they enter and transition through each stage of service provision (LGBT Foundation, 2022). A nuanced understanding surrounding affirming approaches to perinatal care needs to be developed as GQNB people relate to their gender and birthing experiences in different ways. Taking a trauma-informed approach where individuals preferences for care are asked about and adhered to wherever possible can increase a person’s sense of control and safety when accessing perinatal services (Roosevelt et al., 2021). Birthing workers must make every effort to not dehumanise marginalised birthing people through sensationalism or anti-trans prejudice, educating themselves and others around them when they witness harm occurring.

Clinical psychologists working within PNMH must understand the differences in experience that GQNB birthing people may have (e.g., body dysphoria, social dysphoria, and a double loss of identity) so that they are able to offer bespoke interventions for GQNB birthing people. Psychologists being well versed and comfortable in speaking about these experiences will help those who disclose their gender and experiences in continuing to access psychological support. Feeling understood by your therapist helps build a good therapeutic rapport, contributing to good psychological outcomes (Lambert & Barley, 2001). The disparity in MH outcomes for GQNB people highlights the importance of building a good therapeutic relationship when supporting those who experience psychological distress in the PNP (Newson et al., 2021).

Participants spoke about the value of spaces where they could connect with other GQNB birthing parents. Services and psychologists may offer group interventions and spaces to foster collective healing through shared stories, meaning making, and collective resistance (Gillis & Parish, 2019; Wade, 1997). A narrative approach may be considered as participants spoke about the value of creating and rescripting cisheteronormative narratives in reducing psychological distress.

Participants discussed the value of having someone in your care team who is trans or GQNB. As the clinical psychology workforce is predominantly White, middle class, cisgendered and heterosexual (HCPC, 2023), having a facilitator that holds a shared identity may not be possible. Diversification of the workforce is needed; however, this must be done alongside attending to the cisheteronormative values that clinical psychology holds to reduce the risk of harming TNB trainee clinical psychologists. In the meantime, clinical psychologists need to learn about the sociocultural, historical, and political factors that impact GQNB people. Recognising the systemic oppression of GQNB birthing people whilst deconstructing ideas of gender and pregnancy without homogenising GQNB people’s experiences is important in providing safe and effective gender affirming PNMH care.

4.3.2. Service, Local, and National Policy

The insidious impact of anti-trans and anti-queer prejudice is perpetuated by governmental policies and practices which continue to dehumanise and deny the experience of queer and TNB people, for example, a failure to initially include TNB people in the conversion therapy ban (Mind, 2022) and a failure to include GQNB people in the gender recognition act (Fairbairn et al., 2022). This ongoing systemic erasure, stigmatisation, and discrimination against GQNB people at all ages throughout society embeds anti-trans and cisheteronormative ideals that harm GQNB birthing people at a very vulnerable time in their lives. Local and national policy must be modified to attend to these biases and fight against these agendas, contributing to systemic changes that recognise and support GQNB people's reproductive rights (Morison, 2021).

To bolster the legal protections of GQNB birthing people in the face of discrimination, the gender recognition act must be reformed to legally recognise GQNB people's gender. This will ensure that legal processes can be followed should they be required. The recognition of GQNB people on a national scale may trigger changes in how demographic data is collected from services. Capturing data that reflects TNB people's access to and experience of services will support robust evaluation that can inform policy to address any disparities identified. Clinical psychologists can support this process by lobbying for change, using their leadership skills to facilitate action, whilst also engaging with service evaluation and research to further our knowledge of GQNB birthing people's access to perinatal services.

Furthermore, policies can be developed within services at local and national levels that promote inclusive language, using an additive approach to transform perinatal services from those that support women to those that provide care for any birthing person. A shift in public and professional attitudes towards GQNB birthing people through the recognition of their gender and perinatal experiences is also fundamental. Services must be accessible for anyone who is pregnant, ensuring that computer systems allow for people's gender to be recorded properly on the system without impacting their medical results or access to care. A system wide approach is needed to foster safety when accessing care for TNB people at any stage in their life.

Conversations are the starting point for these changes to occur. Services adjusting their triage process to ensure they are asking and speaking about gender may support GQNB people in feeling safer to share their gender identity. Moreover, pregnancy and birthing services, parenting classes, support groups, and MH provisions need to be inclusive of all gender identities and family structures. Expansive groups and spaces that welcome everyone must be truly inclusive with their language and understanding of people's experiences, addressing anti-queer and anti-trans prejudice that arise within these spaces. Creating group spaces for GQNB birthing people may serve to help reduce the isolation that many participants identified. Specialist service provision may also involve creating additional roles, for example, gender inclusion midwives who provide additional support at home and in hospitals to trans and GQNB birthing people throughout their perinatal journey (NHS, 2024). Restructuring of services can be envisioned with GQNB and trans birthing people and professionals to reduce the impact that cisheteronormativity has on service transformation. Using an intersectional approach to build these services will support the recognition and attendance to the multifaceted experience of any birthing person.

To support these changes, educational programmes must be in place for healthcare providers, policymakers, and the public to increase understanding and reduce stigma and discrimination at a local and national level. Funding should be allocated to education and training sessions for every perinatal service to support the development of specialist support. Protected time is necessary to increase engagement with continued professional development and training. Embedding this learning within initial training programmes of all healthcare and MH care professionals will support the development of an inclusive and anti-oppressive workforce, as naming and questioning cisheteronormativity can begin to erode the power it holds (Butler, 2006).

4.4. Critical Evaluation

Evaluation of qualitative research is essential to enhance the credibility of findings and situate them within the context in which they were developed. This is imperative when interpreting the findings to draw meaningful conclusions.

4.4.1. Quality

Yardley's (2000) principles of good qualitative research were used to guide and evaluate the research.

4.4.1.1. Sensitivity to context. The research was contextualised within relevant and current literature. Theories were used to explore this literature, which was built on and revisited through analysis (Johnson, 1997). This relied on interpretation that was embedded within participants ideographic accounts. Sensitivity to participant context throughout the analysis was enhanced by asking for descriptions of their identity rather than giving a selection of prescriptive labels to choose from. Although participants used common identifiers, creating space for participants to make sense of their own socio-cultural context helped foster a shared understanding with the researcher, influencing the interpretation of participants narratives. Researcher context was attended to through ongoing reflexivity and consideration of how their experiences and understanding of the world influenced their relation to existing literature and participants' stories.

4.4.1.2. Commitment and rigour. Commitment is exemplified through extensive engagement with the literature surrounding the topic. Although the researcher does not have experience of birthing, they share identity characteristics with the participants and have a vested interest in contributing to systemic change surrounding supporting those living the experience. Carrying out a pilot interview helped the researcher align the research methods with GQNB people's needs and desires. As this was the researchers first experience of conducting IPA, supervision and engagement with literature fostered competence.

Rigour was addressed through extensive emersion within the rich dataset that was generated through lengthy and detailed discourse. Following IPA's guidelines (Smith et al., 2021), and quality indicators (Nizza et al., 2021) resulted in an in-depth analysis of participants ideographic accounts and areas of convergence and divergence among the group, facilitating a balance of depth and breadth within the analysis. Participants multifaceted experiences are understood beyond common sense explanations through the attendance to psychological theories and constructs within the analysis.

4.4.1.3. Transparency and coherence. To foster transparency, evidence of alignment with IPA methodologies within the analytic process has been included (Appendix N). Furthermore, research questions centred around sense-making and lived experience are coherent with the philosophical underpinnings of IPA. This fits within the framework of agential realism, as the researcher recognises that their construction of meaning is one possible interpretation of the data. Supervision was used to check for coherence and reflect on motivation to engage with the topic, the impact of values and biases on sense-making, and the external constraints impacting the analytic process.

4.4.1.4. Impact and importance. This research is one of the few to explore UK GQNB birthing people's PNMH experiences, contributing to a growing field of literature. Findings highlight socio-cultural and systemic influences, supporting the development of a nuanced understanding of and attendance to GQNB birthing people's experiences in the PNP. Ideas for change are considered through implications for practice, policy, and future research. Participants reflection on the personal impact of contributing to the research highlights the helpfulness of spaces to process experiences and contribute to necessary systemic changes.

4.4.2. *Limitations*

4.4.2.1. Power. The influence of power was acknowledged and attended to through consultation with GQNB people during the interview schedule development, following the participants lead during the interview, ensuring participants knew their rights, and providing a summary of participants individual PETS and GETS following research completion. Disclosure of the researchers gender identity may have also reduced the power imbalance. Instead of participants feeling observed and studied, they may have felt more comfortable sharing their experiences due to the researchers 'insider' knowledge about what it is like to navigate the world as a GQNB person. This may have limited fear of being researched by an 'outsider' or someone who would be perceived as not being able to understand and therefore unable to represent participants' stories (Berger, 2013).

Ideally, the researcher would have adopted a participant-led approach, collaborating with the GQNB birthing community from the beginning. Limited time and funding, alongside managing multiple other aspects of training, restricted this possibility, contributing to the power imbalance between the researcher and participants (Karnieli-Miller et al., 2009).

Being a novice at IPA meant that learning how to do IPA was an ongoing process. This, alongside the researchers ‘insider’ position may have meant that it was difficult to reduce the influence of the researchers interests and experiences on the analysis. This could have obscured novel and unexpected findings, influencing the production of knowledge. Despite this, some of the themes generated did not fit with the researchers assumptions. Keeping a reflexive diary was a helpful tool to consider these processes throughout the research.

4.4.2.2. Recruitment and sample. IPA aims to understand the experiences of participants as individuals rather than to produce findings that are transferrable to an overarching group of people (Smith et al., 2021). As such, homogeneity of the sample is a core tenet in IPA (Smith et al., 2021). Although participants form a homogenous sample, it is worth noting that the sample may have been restricted within the broader subgroup of GQNB birthing people.

Participants were diverse in relation to class, relationship structure, age, and disability. However, like prior research (Bower-Brown, 2022a; Coe et al., 2003), all participants were racialised as White. Consequently, the results cannot speak to the experiences of racialised minoritised birthing people. Academia and psychology have a longstanding history of perpetuating and causing harm through racist ideologies, a lack of resistance to Whiteness, and a failure to appropriately consider racialised minoritised people’s experiences in a variety of areas (Patel & Keval, 2018). Racialised minoritised birthing people may not have felt comfortable speaking to a White researcher about their experiences due to fears of being misunderstood, misrepresented, or experiencing racism (Few et al., 2003; Keating et al., 2002; Keating & Robertson, 2004). Although groups that specifically supported queer racialised minoritised people were approached, only one replied. The research advertisement may therefore not have reached all potential participants.

Participants described their distress in line with the constructs of perinatal anxiety, depression, and PTSD. Participants did not disclose psychological distress related to the constructs of OCD, disordered eating, or psychosis. Research demonstrates that these experiences of psychological distress are less common (Cantwell, 2021), potentially explaining the lack of representation in the sample. The increased stigma surrounding psychosis and disordered eating may have also meant that those who have these experiences may have felt less inclined to volunteer for fear of experiencing further shame and stigma. Those experiencing psychological distress related to psychosis are more likely to receive MH care in inpatient settings (Roxburgh et al., 2023). As such, the results do not provide insight into what this experience may be like for GQNB birthing people.

Recruitment was achieved through a voluntary capacity. Those who were more interested in the topic may have been more willing to take part. Some participants were engaged in activism. This may have influenced the development of themes centred around change. Participants engagement in social change may have meant that they had more time and space to process some of their experiences with other people. Arguably, their sense-making could have been influenced by group hermeneutic interpretations as seen in focus groups (Montague et al., 2020), focusing on both their idiographic experience and their experience within a marginalised group, as seen through participants use of the collective ‘we’. Regardless, generated themes stay close to participants individual experiences and stories aligning with IPA’s approach.

A further limitation concerns the language used to advertise and define the scope of the research. As GQNB was used as an umbrella term to capture any gender outside of the gender binary, participants understood and related to their gender in a variety of ways. This meant that how participants made sense of their experiences in relation to their gender also differed. Understandings of gender can also fluctuate and develop over time – in the future, GQNB may mean something very different to how it is understood in this research. As highlighted by the participants, being GQNB is not a homogenous experience. The findings need to be applied tentatively, taking into consideration each person’s preferences rather than making sweeping generalisations that may lead to dehumanising experiences within services and communities.

Whilst these considerations do not diminish the valuable insight this research provides about GQNB birthing people’s experiences, they are important to hold in mind when drawing on the knowledge to create systemic change and guide future research.

4.5. Further Research

Although the findings of this research align with research exploring TNB birthing people's perinatal experiences, some of which touch on psychological distress and wellbeing (Bower-Brown, 2022a; Coe, 2023; Greenfield & Darwin, 2021; Jackson et al., 2023; LGBT Foundation, 2022; Pezaro et al., 2023), it was important for experiences outside of the gender binary to be considered independently to allow for the development of nuanced understandings of the experience. Close examination of these experiences may allude to the experiences of a wider group; however, transferability cannot be claimed (Smith et al., 2021). As such, future research may aim to replicate findings with a larger sample of participants from a range of areas in the UK.

Future research must address the absence of racialised minoritised participants in this research and the existing literature surrounding GQNB birthing people's PNMH. This is especially important as racialised minoritised GQNB birthing people may experience the same discrepancy in care that result in devastating outcomes for racialised minoritised birthing women (MBRRACE-UK, 2023). The lived experience of psychological distress is influenced by experiences of marginalisation and identity for racialised minoritised people (Beauboeuf-Lafontant, 2007; Edge & Rodgers, 2005; Hackett et al., 2020). As such, neglecting to understand racialised minoritised GQNB people's experiences – especially when literature may be used to alter service provision and policy – will only serve to perpetuate discrimination and harm.

Contributing to a multifaceted intersectional understanding of GQNB birthing people's PNMH experiences means that future research must also prioritise engaging participants who experience severe and enduring psychological distress, and experiences aligned with the constructs of postnatal psychosis, OCD, and disordered eating. This could contribute to the knowledge that is needed to transform parent-baby units and perinatal inpatient facilities to support GQNB birthing people who are experiencing less common PNMH concerns.

There is also an underrepresentation of nonbirthing people in PNMH literature (Greenfield & Darwin, 2021). The limited research is dominated by cisheterosexual men and cisgendered lesbian women's experiences. To ensure that the whole family is supported in maintaining wellbeing and managing psychological distress, future research could explore the experiences of GQNB nonbirthing partners or nonbirthing partners where the birthing person is GQNB. This is particularly important as GQNB birthing people have identified their partner(s) as integral to their psychological wellbeing in the PNP.

Additional medical research is needed to understand how to effectively support GQNB birthing people who have undergone medical transition (e.g., top surgery, hormone therapy) with their perinatal needs. This will support professionals across disciplines in providing appropriate and evidence-based information and care. Future research may also be necessary to evaluate the effectiveness of current psychological interventions offered to GQNB birthing people. This evidence may support the funding of the development and coproduction of psychological interventions which consider and address factors that can impact GQNB birthing people's PNMH.

4.6. Researcher Reflections

Researcher reflexivity is crucial when conducting ethical qualitative research to understand the impact of the researchers social location on each stage of the research process. Having a shared gender identity with prospective participants increased my motivation to engage with this topic. Immersing myself in literature about GQNB people's experiences not only highlighted the underrepresentation of GQNB people in research, but also meant that I was exposed to anti-queer and anti-trans literature. The frustration and upset that I felt meant that I had to ensure I was taking breaks throughout this process to look after my own wellbeing.

I believe that my partial 'insider' position as genderqueer facilitated participant recruitment. Despite this, I felt vulnerable throughout this process. Awareness of ever-increasing anti-trans rhetoric and hate crimes towards queer people in the UK meant that I was conscious of the criticism this research may face online. Moreover, conducting the interviews and listening back to the transcripts was difficult at times due to the upsetting and harmful experiences that participants endured. Connecting with my own community was protective through this process. Additionally, the positive encouragement I received from those who initially participated supported my continued motivation to engage in the research. A parallel process occurred as some participants and I felt like we had to become more visible in our identities to support the change we wanted to see in the world, increasing my desire for this research to be helpful.

I simultaneously hold an ‘outsider’ position, having not experienced pregnancy, birth, or parenthood. Although IPA is centred around researchers interpretations of participants sense-making, I am mindful about how some of the interpretations would have been altered by my lack of lived experience. I strived to stay close to the participants experience through maintaining the integrity of their narratives throughout the analysis and write up.

The operation of power is usually subtle and obscure, and is perpetuated by indifference and ignorance (Lyotard, 1984; Foucault, 2019). My engagement with participants emphasised the importance of language within the processes of power. My position of power meant that I could perpetuate the harm that I was trying to disrupt. I had to question my assumptions and take a critical approach to the work I was doing, continually reflecting on my social privilege as a White middle class person with access to higher education (Savage, 2015).

The process of this research has reinforced my desire to challenge norms in society, services, and my own clinical practice. It has changed my relationship with psychology for the better, reinforcing the need to be active in contributing to liberation and social change.

4.7. Conclusion

To the researchers knowledge, this is one of the only pieces of research that explicitly explores GQNB birthing people’s PNMH experiences in the UK. The findings help to alleviate the paucity of research in this area, emphasising the importance of intersectional conceptualisations of experiences within the PNP. The findings suggest that the PNP is a time of increased vulnerability for experiences of psychological distress for GQNB birthing people.

GQNB birthing people may experience psychological distress related to body and social dysphoria, isolation, a double loss of identity, and exclusion and erasure within services. GQNB birthing people’s experiences of psychological distress are embedded within the sociocultural political contexts in which they are experienced, where cisheteronormativity, stigma, and anti-trans prejudice are pervasive. The findings illustrate the importance of consistent and validating care alongside regaining power through connecting with community and rescripting stories around pregnancy, birth, and parenthood.

The research provides important insights for clinicians, researchers, and the wider community alongside GQNB birthing people and their families. It is within our ethical duty to use individual agency to affect change following the production of knowledge (Barad, 2007). Attending to the needs of those most marginalised in society makes a better world all (Faye, 2021). As such, a collective effort must be made to combat oppression and create change on multiple systemic levels to meet people’s intersectional PNMH needs.

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Appendix A: Literature Search Terms

Literature search to identify relevant papers included the following search terms:

“nonbinary” OR “non-binary” OR “non binary” OR “genderqueer” OR “gender queer” OR “gender fluid” OR “genderfluid” OR “gender nonconforming” OR “gender nonconformity” OR “gender-nonconforming” OR “gender non conforming” OR “transmasculine” OR “transmasc” OR “gender diverse” OR “enby” OR “trans” OR “queer” OR “gender neutral”

AND

pregnancy” OR “pregnant” OR “prenatal” OR “antenatal” OR “perinatal” OR “maternal” OR “birth” OR “parenthood” OR “birthing parent” OR “postnatal” OR “maternity” OR “parent” OR “gestation” OR “gestational parent”

AND

“mental health” OR “mental illness” OR “mental disorder” OR “psychiatric illness” OR “psychological distress” OR “emotional wellbeing” OR “psychological wellbeing” OR “psychological health” OR “psychological well being” OR “perinatal anxiety” OR “perinatal depression” OR “postnatal anxiety” OR “postnatal depression” OR “perinatal mental health” OR “postnatal psychosis”

<u>Inclusion Criteria:</u>

- Studies that focus on nonbinary and genderqueer birthing people aged 18+
- Studies that explored psychological wellbeing, psychological distress, or mental health of birthing parents in the perinatal period
- Studies that were conducted in the UK

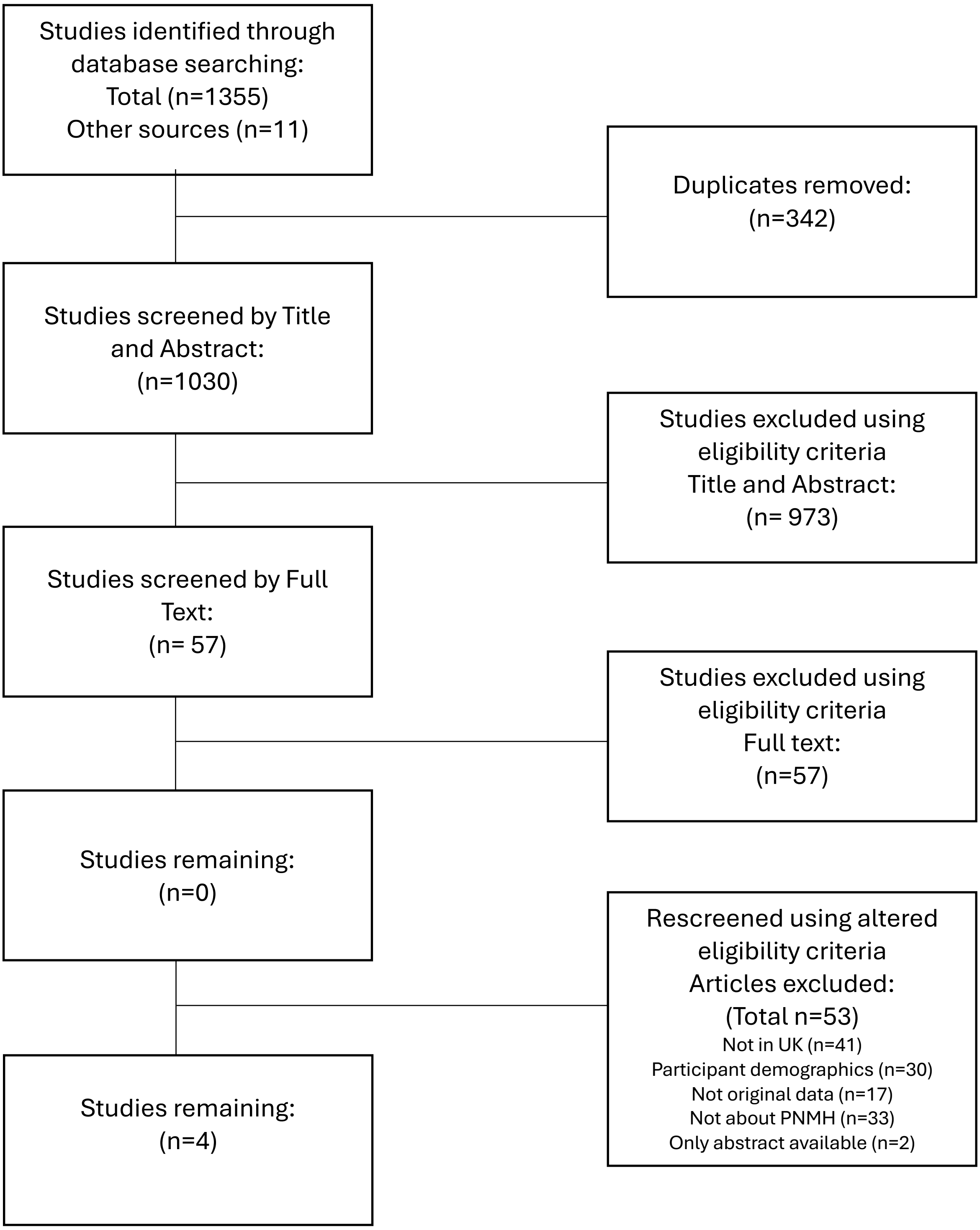
<u>Exclusion Criteria:</u>

- Studies that are not in English
- Studies that do not have nonbinary and genderqueer birthing people as participants
- Studies that do not separate nonbinary or genderqueer people from transgender men or cisgender women
- Studies that do not consider psychological distress
- Studies that are opinion, guidelines or literature reviews

<u>Revised Exclusion Criteria:</u>

- Studies that are not in English
- Studies that do not have nonbinary and genderqueer birthing people as participants
- Studies that do not separate nonbinary, genderqueer and transgender participants from cisgender women
- Studies that do not consider psychological distress
- Studies that are commentary, guidelines, or literature reviews

Appendix B: Literature Search Flowchart



Advanced Search Ultimate - 468
APA PsycInfo - 661
CINHAL Complete – 224
Google scholar/RG - 8
Reference searching - 9
UEL repository - 0

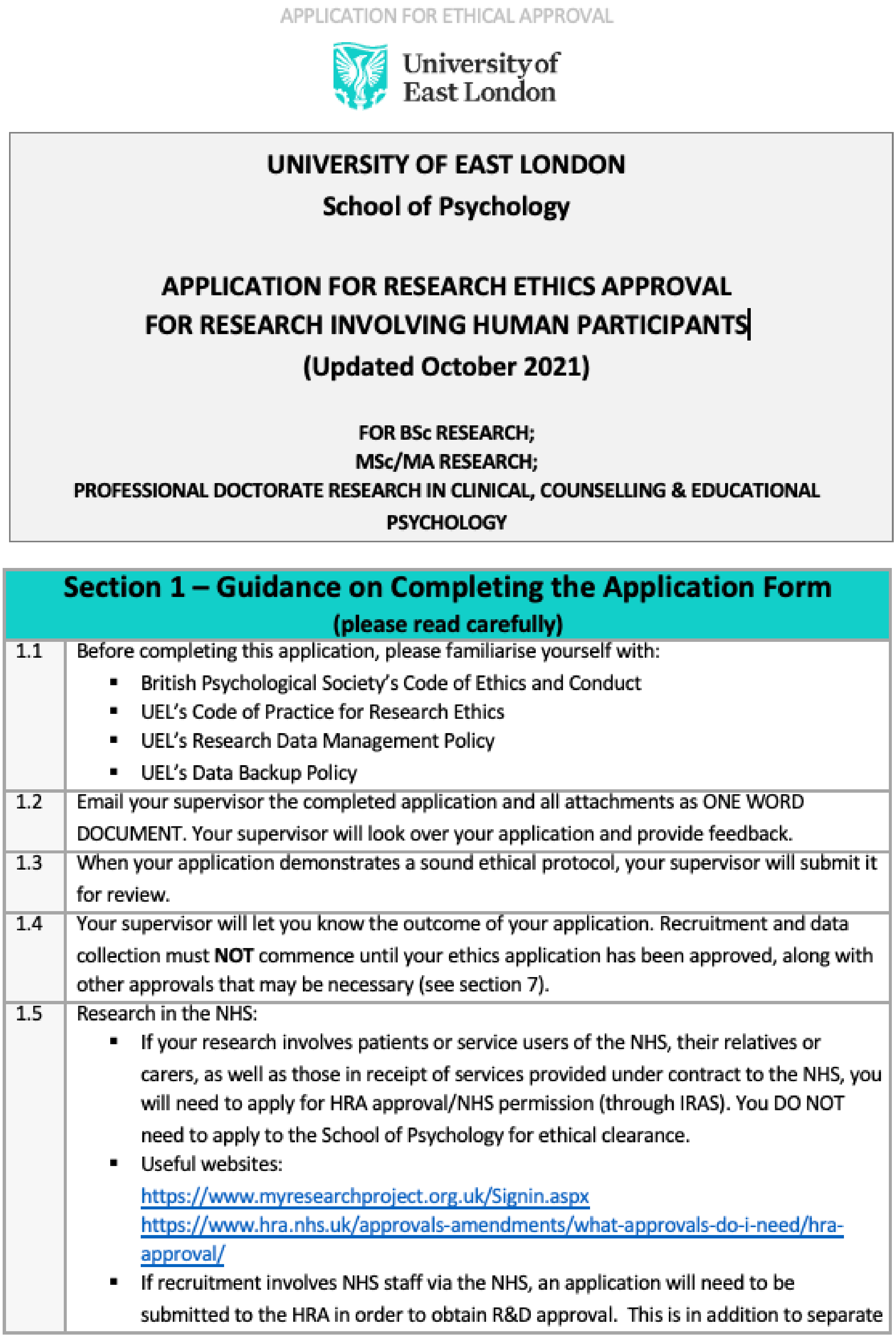
Appendix C: Overview of Studies Included in Scoping Review

Overview of Studies Included in Scoping Review

Title	Authors	Country	Participants	Method	Results
Exploring the healthcare experiences and support needs of chestfeeding or breastfeeding for trans and non-binary parents based in the United Kingdom	Jackson et al., (2023)	United Kingdom across Scotland, England and Wales	Total n=7 Trans man n=4 Trans woman n=1 Non-binary n=2 Korean Irish n=1 White British n=3 White British/Irish n=1 White European n=1 White Irish n=1 Not specified n=1 Ages 24-41 (mean = 33)	Qualitative approach Semi-structured interviews Reflexive Thematic Analysis	Three themes identified 1. Doing the right thing for the baby 2. Body changes and desired support 3. Experience of healthcare professionals
Trans and/or non-binary (TNB) parents' experiences during the perinatal period	Bower-Brown (2022)	UK	Total n=10 Trans women, trans men, nonbinary people Gestational parent n=6	Qualitative approach Semi-structured interviews from two other research projects Reflexive Thematic Analysis	Three themes identified 1. Nothing was gender neutral: Institutional discrimination 2.Interpersonal discrimination and inclusion 3. Being pragmatic, being a pioneer: TNB parent's navigation strategies
Experiences of Pregnancy and Birthing for Trans and Non-Binary People in the UK	Coe (2023)	UK England n=11 Wales n=1	Total n=12 Nonbinary/Trans man n= 1 Trans man n= 2 Nonbinary n=2 Queer n=1 Nonbinary/Agender n=1 Nonbinary/Genderqueer n=1 Nonbinary/Genderfluid n= 2 Transmasc n=1 Genderqueer n=1 White British n=12 Mean age 33	Qualitative approach Semi-structured interviews Reflexive Thematic Analysis	Two themes identified 1. Navigating assumptions of womanhood 2. Empowered autonomy: Personal narratives of choice, control, and safety

Trans + Non Binary Experiences of Maternity Services: Survey findings, report and recommendations	LGBT Foundation (2022)	UK	Total Survey n=121 Man n=24 Woman n=1 Nonbinary n=31 Agender n=3 Genderqueer n=3 Genderfluid n=2 Bigender n=1 Transmasculine n=14 Demi-boy n=1 In another way n=3 Not disclosed n=38 Asian or Asian British Indian n=2 Black or Black British African n=7 Mixed White and Black African n=3 Mixed White and Black Caribbean n=9 Other Mixed Background n=2 White British n=44 White Irish n=9 Not disclosed n=45 Total Interviews n=4 Nonbinary n=3 No gender identity n=1 Black African n=1 Indian British n=1 White British n=1 White n=1	Mixed Methods Qualitative Survey Qualitative – Semi structured Interview	Key Survey Findings for TNB people: 30% did not access healthcare support during pregnancy 54% who freebirthed would have found a midwife helpful 80% who freebirthed were not confident in accessing services 41% felt they were spoken to respectfully about their gender when accessing services 28% were not treated with dignity or respect during labour <50% felt their decisions about feeding were respected Two themes identified: 1. Racism and Transphobia in perinatal care 2. Concealing Gender

Appendix D: University of East London School of Psychology Ethics Application, Approval, and Change of Title Request Form



University of
East London

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form
(please read carefully)

1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate

	approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	**Evelyn Ruby Unwin Smith**
2.2	**Your supervisor's name:**	**Hina Dadabhoy**
2.3	**Name(s) of additional UEL supervisors:**	**Lorna Farquaharson** 3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Professional Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	**20/05/2024** Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	**Mental Health and Emotional Wellbeing in the Perinatal Period: The Experiences of Genderqueer and Nonbinary Birthing Parents**
3.2	**Summary of study background and aims (using lay language):**	**Literature suggests that the perinatal period – pregnancy and the first 12 months following childbirth - is an important time in the transition to parenthood, involving numerous physical, psychological, and social adjustments (Blount et al., 2021). Research has demonstrated a profound impact on the mental health of people who give birth. The prevalence of perinatal mental health are predicted to affect 1/5 people who give birth in the UK (Howard & Khalifeh, 2020). Increased distress in the perinatal period has been linked to poorer outcomes for both the person giving birth and the child (Howard & Khalifeh, 2020). This includes increased risk of premature labour and pregnancy complications (Grote et al., 2010), suicide (Khalifeh et al., 2016) and self-harm (Johannsen et al., 2020). Moreover, postnatal distress may affect infant-caregiver attachments (Atkinson et al., 2000) and emotional and behavioural outcomes for the child (Rutherford et al., 2019). Despite the field of perinatal mental health care research growing, much of the research and policy surrounding perinatal mental health centres on White, middle class, heterosexual, cisgendered women's experiences. The minority stress theory (Meyer, 2003) suggests that the higher levels of stress experienced by minoritised individuals due to discrimination, marginalisation, and stigmatisation at both the individual and systemic levels contribute to the increased mental health distress that minority groups experience. It could therefore be suggested that the experiences of minoritised people who give birth differ from those who are White, middle class, heterosexual and cisgendered. Furthermore, research that**

		explores LGBTQ+ peoples experiences in the perinatal period often homogenises the different gender identities. There are problematic gaps in understanding the experiences of genderqueer and nonbinary people who give birth. Decreasing this gap seems particularly important given the reports of increased distress and worse health outcomes experienced by genderqueer and nonbinary individuals (Newson et al., 2021). The qualitative research proposed attempts to understand genderqueer and nonbinary peoples potentially unique experiences in relation to mental health and the perinatal period through conducting interviews with genderqueer and nonbinary people who have given birth. It is hoped that the data may aid the development of gender affirming perinatal services whilst supporting clinical psychologists and practitioners to provide gender affirming care in perinatal mental health services.
3.3	**Research question(s):**	**1.How do Genderqueer and Nonbinary people experience the perinatal period? 2. What influences the mental health and wellbeing of Genderqueer and Nonbinary people in the perinatal period? 3. What are Genderqueer and Nonbinary peoples experiences of mental health support in the perinatal period?**
3.4	**Research design:**	**Qualitative study using individual, semi-structured interviews.**
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	**The proposed research aims to recruit a sample of 10-12 participants based on recommendations for Qualitative research (Fugard & Potts, 2015). Racialised minoritised GQNB people will be encouraged to participate to ensure that the data does not only reflect White GQNB peoples experiences. To participate in the research individuals must: identify as GQNB; have been pregnant; have identified as GQNB whilst pregnant; have given birth in the UK; speak English; be 18+ years; have experienced an impact on their emotional wellbeing and/or mental health in the perinatal period. Individuals cannot participate in the research if they identify exclusively as a man or**

		woman.
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	**Recruitment will be conducted through charities and organisations, and social media platforms (twitter, Instagram, and Facebook). Snowballing will also be used to facilitate recruitment.** **Recruitment materials can be seen in Appendix D. The following organisations have been contacted and have agreed to support with recruitment: **REDACTED** Social media networks that have open recruitment rules on Facebook include **REDACTED**. **REDACTED** have agreed to put a recruitment poster in their Centre. Should recruitment prove difficult through the aforementioned channels, plan B will involve contacting birthing workers through social media or organisations including **REDACTED** to advertise the project, as well as contacting researchers in the field who may be able to provide contact details for organisations that have not been considered previously. Please see written consent obtained from different groups contacted for plan A recruitment strategy in Appendix F.**
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	**Socio-demographic information collected: age; gender; ethnicity; sexual orientation, social class, number of children, years since given birth to last child. The broad topics explored in the interview guide will include peoples experience of the perinatal period and transition to parenthood, alongside the impact on their mental health and wellbeing and support they accessed in this time. Please see the interview schedule in Appendix E.**
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	**Semi-structured interviews will be conducted in person or online via Microsoft Teams subject to participant choice. The information sheet and consent form will be sent to the participants prior to the interview. The interviews will take place only if the participants give consent. I will conduct the semi-structured interview following the interview schedule. At the end of the interview, I will revisit consent to use the interview data, debrief the participants verbally and also give them the debrief sheet. Please see Appendix A, B and C**

		the semi-structured interview following the interview schedule. At the end of the interview, I will revisit consent to use the interview data, debrief the participants verbally and also give them the debrief sheet. Please see Appendix A, B and C for the information sheet, consent form and debrief sheet.	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?		
3.10	**Will participants be reimbursed?**	**YES** ☒	**NO** ☐
	If yes, please detail why it is necessary.	**To compensate and remunerate participants for their time in participating and sharing their experiences. This offer may help show how the researcher values the participants time. Vouchers may also encourage participation.**	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	**Participants to have the option to be entered into a raffle for one of three £30 vouchers – three participants in total will be given vouchers supplied by the UEL.**	
3.11	**Data analysis:**	**Following data collection, Braun and Clarke's (2006) 6-stage model of reflexive thematic analysis will be used. The researcher will become familiar with the data whilst transcribing, and actively engaging with the content of the interviews holding a reflexive position keeping in mind their political understanding and genderqueer identity (Braun & Clarke, 2019). Thoughtful engagement with the data will support the researcher to generate codes and themes, taking time to review, define and name themes before producing the report (Braun & Clarke, 2019).**	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.			
4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.	Please detail how data will be anonymised	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	**During transcription, each participant's name will be replaced by a pseudonym of their choice (as to avoid harm from using a name that may cause distress to the individual due to the potential of participants having changed names as can be frequent with transgender and genderqueer and nonbinary people). All identifying information (e.g., name of organisation) will be replaced or removed.**	
4.3	**How will you ensure participant details will be kept confidential?**	**Any personal data that is collected will be held securely and processed in accordance with the UKGDPR and the Data Protection Act 2018. Participants will not be identified by the data collected, on any material resulting from the data collected, or in any write-up of the research. This will be achieved through giving each participant a unique pseudonym of their choice (and removing all identifying information during transcription). Consent forms and interview transcripts will be stored in different folders.**	
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	**The data will be stored on my UEL's password protected OneDrive account in a folder that is not synchronised on any devices. Data will be sent to the supervisor as a backup during the study and stored on the supervisor's OneDrive account. Consent forms will be stored as password-protected files in a separate folder to other research data on UEL OneDrive.**	
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	**I will have access to the raw data. My supervisor will have access to the anonymised data. Examiners may also have access to the anonymised data if requested.**	
4.6	**Which data are of long-term value and will be retained?**	**The anonymised transcripts are of long-term value.**	

	(e.g., anonymised interview transcripts, anonymised databases)		
4.7	**What is the long-term retention plan for this data?**	**Anonymised research data will be securely stored on my supervisor's UEL's password-protected OneDrive account for a maximum of 3 years, following which all data will be deleted. All identifiable information will be destroyed as soon as the allowed withdrawal period is over, and transcripts have been created unless there has been an agreement with the participants to receive an update from the researcher on the outcomes of the study.**	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	**Emotional distress from discussing sensitive topics including pregnancy, birthing, mental health and distress, gender and gender identity, and support structures. These will be minimised by providing information to the participant to ensure they are able to give informed consent prior to participation.**	

		Furthermore, participants will be provided with a debrief sheet detailing resources available for further support. The researcher will also be attuned to the participants needs, offering breaks if distress is high during the interview and allowing participants to choose whether they would like to answer a question if it may cause too much distress for them. There is also a potential risk specifically to racialised genderqueer and nonbinary birth parents who participate. As a White researcher I may cause unintended harm through the wording of recruitment that specifically encourages racialised participants to consider participation. In an attempt to minimise this harm racialised peers and genderqueer or nonbinary people will be consulted with when considering the wording in the recruitment materials. Moreover, there is a risk to harm due to potential discussions about the intersection of race or disability coming up in the semi-structured interviews for participants who may identify in these ways. To minimise this the researcher will ensure that intersectional services are offered during the debrief as well as attuning to the individuals needs during the interview, offering breaks and exploring sensitively. The researcher will also engage in ongoing self-reflection and education to ensure that they are able to explore these topics as sensitively and respectfully as possible to minimise potential harm caused.	
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	**Please see Appendix G. Risk to online identity – as participants have my own personal details they may be able to look me up online. To mitigate against this all social media profiles are already private, with minimal personal information shown.** **Emotional impact of conducting interview of someone in distress – mitigate against this by debriefing with supervisor if challenge arises.** **Emotional impact of conducting research that is part of my own identity – to be reflective of this**	

		throughout the process with my supervisor. To continue in personal therapy to mitigate emotional impact of work that can be distressing at times.		
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	**Online – Microsoft Teams as well as on the UEL campus**		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	**YES** ☐		
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.			

	▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☐	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the**	**YES** ☐	**NO** ☐

	duration of the research project?		
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	Please enter your DBS certificate number	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** - If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). - For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☒	**NO** ☐
	If yes, please provide their details.	*****REDACTED*****	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	**YES** ☒	
7.2	**Additional guidance:** - Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. - If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However,		

	such as ‘my’ or ‘I’ with ‘our organisation’ or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Evelyn Smith**
8.3	**Student's number:**	**2195631**
8.4	**Date:**	**13/04/2023**
Supervisor’s declaration of support is given upon their electronic submission of the application		

Appendix G: Risk Assessment

UEL Risk Assessment Form

Name of Assessor:	**Evelyn Smith**	**Date of Assessment:**	**28.01.2023**
Activity title:	**Mental Health and Emotional Wellbeing in the Perinatal Period: The Experiences of Genderqueer and Nonbinary Birthing Parents**	**Location of activity:**	**Online on Microsoft Teams or UEL Campuses at Stratford and USS depending on participant preference.**
Signed off by Manager: (Print Name)	**H. Dadabhoy**	**Date and time: (if applicable)**	**From April 2023 – January 2024**

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc.). If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

Semi-structured interviews for research project. The data will be collected via face to face or online semi-structured interviews using Microsoft Teams or at the University of East London campus. The interviews will last approximately 60-90mins. Estimated number of participants: 10-12.

Overview of FIELD TRIP or EVENT:

N/A – research study

Guide to risk ratings:

a) Likelihood of Risk	**b) Hazard Severity**	**c) Risk Rating (a x b = c)**
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	**Who is at risk?**	**Existing Controls**	**Likelihood**	**Severity**	**Residual Risk Rating (Likelihood x Severity)**	**Additional control measures required (if any)**	**Final risk rating**
Emotional distress from discussing sensitive topics including pregnancy, birthing, mental health and distress, gender and gender identity, and support structures. Emotional distress due to potential discussions where people are discussing their experiences from an intersectional lens particularly for those who are multiply marginalised i.e. those who are racialised or considered disabled.	Participants	Appropriate information shared with potential participants so that informed decisions can be made about participation. Debrief and information sheet providing details of resources available for further support around the topics. The resources shared will include support that is tailored towards individuals with disabilities or those who are racialised. Researcher offering breaks and allowing participants to choose if they want to discuss certain topics.	2	2	4	Researcher being vigilant and attuned to participants distress levels during the interview. The researcher will discuss this with the participant at the beginning of the interview to make a shared plan with the participant. The researcher will also engage in ongoing self-reflection and education to ensure that they are able to explore these topics as sensitively and respectfully as possible to minimise potential harm caused.	2
Potential harm caused due to wording of recruitment encouraging racialised participants to take part	Racialised prospective participants	Consult with racialised peers and genderqueer and nonbinary participants when considering the wording. Use supervision to reflect on wording prior to consultation	1	1	1		1
Being unable to find the interview room if doing a face-to-face interview at UEL	Participants	Researcher to meet participant at Student Hub Researcher to provide participant with clear instructions on how to get there and where to meet	1	1	1	Researcher to call participant if they have not arrived at the agreed meeting point within 10 minutes of the agreed time.	1
Risk to online identity	Researcher	All social media profiles on highest privacy and security settings so minimal personal information is shown	1	1	1		0
Emotional impact of conducting interview of someone in distress	Researcher	Debrief with supervisor should distressing interview take place	1	1	1		1
Emotional impact of conducting research that relates to genderqueer identity	Researcher	Reflect on own identity throughout research with supervisor To use personal therapy space should research cause significant distress	1	1	1		1

Review Date

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details

Reviewer:	**Matthew Jones Chesters**
Supervisor:	**Hina Dadabhoy**
Student:	**Evelyn Ruby Unwin Smith**
Course:	**Professional Doctorate in Clinical Psychology**
Title of proposed study:	**Mental Health and Emotional Wellbeing in the Perinatal Period: The Experiences of Genderqueer and Nonbinary Birthing Parents**

Checklist

(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐

If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options

APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records.

	Minor amendments guidance: typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	APPROVED

Minor amendments

Please clearly detail the amendments the student is required to make

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should	☐

	not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**M Jones Chesters**
Date:	**16/05/2023**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	Please type your full name
Student number:	Please type your student number
Date:	Click or tap to enter a date

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Evelyn Smith**
Programme of study:	**Professional Doctorate in Clinical Psychology**
Title of research:	Mental Health and Emotional Wellbeing in the Perinatal Period: The Experiences of Genderqueer and Nonbinary Birthing Parents

Name of supervisor:	**Dr Vicki Collin**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Mental Health and Emotional Wellbeing in the Perinatal Period: The Experiences of Genderqueer and Nonbinary Birthing Parents
New title:	Birthing Beyond the Binary: An Interpretative Phenomenological Analysis of Perinatal Mental Health Experiences among Genderqueer and Nonbinary Birthing People
Rationale:	One of my participants is not a parent so the title including parents does not reflect their experiences. The new title indicates the qualitative nature and type of analysis used within the study. I also do not use emotional wellbeing throughout the write up of the thesis so the change in language feels appropriate. Using among and not using 'analysis of the perinatal mental health' ensures that I am not implying that the analysis covers all nonbinary and genderqueer peoples experiences and that the analysis is a reflection/interpretation of the group of people that have participated.

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature

Student: (Typed name to act as signature)	**Evelyn Smith**
Date:	**08/04/2024**

Reviewer's decision

Title ~~change~~ approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the research study and will not impact the process of how the data are collected or how the research is conducted.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**08/04/2024**	

Appendix E: Participant Information Sheet

Version: 1
Date: 08.04.2023

PARTICIPANT INFORMATION SHEET

Mental Health and Emotional Wellbeing in the Perinatal Period: The Experiences of Genderqueer and Nonbinary Birthing Parents

Contact Person: Evelyn Smith
Email: u2195631@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?
My name is Evelyn Smith. I am a genderqueer postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?
I am conducting research into genderqueer and nonbinary birthing parents experience of the perinatal period (pregnancy, birth and the following two years) in relation to their mental health and emotional wellbeing. Genderqueer and nonbinary are being used as umbrella terms for anyone who does not identify as only a man or woman. Research in this area may be used to support services to provide better gender affirming care for gender diverse people in the perinatal period. Considering the strengths in the community may act as a resource for prospective and pregnant genderqueer and nonbinary people.

Why have I been invited to take part?
To address the study aims, I am inviting genderqueer and nonbinary birthing parents to take part in my research. If you are over the age of 18, have been pregnant and given birth in the UK whilst identifying as genderqueer or nonbinary, speak English, and have experienced an emotional impact on your emotional wellbeing and/or mental health in the perinatal period you are eligible to take part in the study. You are not eligible to take part in the study if you identify exclusively as a man or woman.

It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?
If you agree to take part, you will be invited to a a semi-structured individual interview either online via Microsoft Teams or at the University of East London (whichever you prefer). The interview will be an informal conversation and will probably feel like an

informal chat that lasts approximately 1-1.5hours. The interviews will be audio recorded, anonymised and securely stored. You will be asked about your experience of the perinatal period, your wellbeing in this time, your thoughts on what impacted your wellbeing and any support (formal or informal) that you received.

Participants will have the option of entering a draw for one of three £30 vouchers. To enter this draw participants will have to provide their name, date of birth, national insurance number and address. Participants who decide to enter the draw must be aware that the vouchers are considered taxable income and as such must consider the impact of receiving the voucher on their current financial arrangements.

Can I change my mind?
Yes, you can change your mind at any time during the interview and withdraw without explanation, disadvantage, or consequence. If you would like to withdraw from the interview, you can do so by informing me at the time. This will be discussed with you at the beginning of the interview. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?
The interview involves discussing a potentially distressing topic. We will check in on your wellbeing throughout the interview and take measures to reduce distress as much as possible. Please see the debrief sheet that contains a list of support providers that you can contact following the interview if needed.
If you need support now, please contact either your GP or helplines such as:

Mind: https://www.mind.org.uk/ - Mindline Trans+- 0300 330 5468
- https://bristolmind.org.uk/help-and-support/mindline-transplus/

Gendered Intelligence Support Line - 0330 355 9678 -
https://genderedintelligence.co.uk/projects/supportline.html

If I am concerned about risk to harm to self or others, confidentiality may need to be broken and I will work with you as much as possible to plan to help you stay as safe as possible.

How will the information I provide be kept secure and confidential?

At the beginning of the interview, you will be asked to choose a name for yourself (pseudonym) which will be used to anonymise the data collected in the interview. When transcribing the data, I will remove any identifiable information. Once the interview has been transcribed the recording will be deleted and the transcription will be stored securely in password protected documents on my Microsoft OneDrive for Business and Sharepoint – personal contact details will be stored separately and will be deleted once analysis of the data has commenced. The transcripts will be stored for 3 years following data collection, after which it will be deleted. Anonymised data will be available to the researchers supervisor, examiners and in the final thesis report.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the ‘public task’ condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as ‘special category data’ in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?
The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository: https://repository.uel.ac.uk. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs and on social media. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally due to personally identifying information will either be removed or replaced.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Hina Dadabhoy for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?
My research has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Evelyn Smith: u2195631@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Hina Dadabhoy. School of Psychology, University of East London, Water Lane, London E15 4LZ,
(Email: h.dadabhoy@uel.ac.uk)

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix F: Participant Consent Form
Version: 1
Date: 08.04.2023

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Mental Health and Emotional Wellbeing in the Perinatal Period: The Experiences of Genderqueer and Nonbinary Birthing Parents

Evelyn Smith
u2195631@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may stop and withdraw from the interview at any time during the interview, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study even if I have completed the interview.	
I understand that the interview will be recorded using Microsoft Teams with transcription on.	
I understand that my personal information and data, including audio/video recordings and transcripts from the interviews for the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I would like to be entered into the draw to win one of three £30 vouchers, and understand that to do so I will need to provide my name, address, national insurance number and date of birth.	
I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

……………………………………………………………………………………………

Participant’s Signature

……………………………………………………………………………………………

Researcher’s Name (BLOCK CAPITALS)

……………………………………………………………………………………………

Researcher’s Signature

……………………………………………………………………………………………

Date

……………………..………………………………………………………………

Appendix G: Research Data Management Plan

UEL Data Management Plan

Completed plans must be sent to researchdata@uel.ac.uk for review

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	**Evelyn Smith**
PI/Researcher ID (e.g. ORCiD)	0009-0004-8980-3439
PI/Researcher email	U2195631@uel.ac.uk
Research Title	Birthing Beyond the Binary: An Interpretative Phenomenological Analysis of Perinatal Mental Health Experiences among Genderqueer and Nonbinary Birthing People
Project ID	
Research start date and duration	Point of ethical approval to May 2024 Duration – approx. 1 year and 1 month
Research Description	The proposed research aims to explore gender diverse (genderqueer, nonbinary) birthing parents experience of the perinatal period in relation to their mental health. There is an increased risk of experiencing mental health difficulties in the perinatal period, which have been shown to contribute to poor outcomes for both the person giving birth and the person birthed. Despite the field of perinatal mental health care research growing, there are problematic gaps in understanding the experiences of genderqueer and nonbinary people who give birth. This seems particularly important given the reports of increased distress and worse health

	outcomes experienced by genderqueer and nonbinary individuals. The qualitative research proposed attempts to decrease this gap in knowledge through conducting interviews with genderqueer and nonbinary people who have given birth, with an aim to understand their unique experiences of distress in the perinatal period. The data will be analysed using reflexive thematic analysis, drawing on the researchers' individual experiences, queer theories, and intersectional feminist praxis. It is hoped that the data may aid the development of gender affirming perinatal services whilst supporting clinical psychologists and practitioners to provide gender affirming care in perinatal mental health services. The proposed research aims to develop the understanding of Genderqueer and Nonbinary (GQNB) people's mental health in the perinatal period through investigating: 1. What are GQNB birthing people's MH experiences in the PNP? 2. What are GQNB birthing people experiences of support in the PNP? 3. How do GQNB birthing people make sense their experience of psychological distress and wellbeing in the PNP? The findings of this research could have positive implications for clinical psychologists working in perinatal mental health services in the UK, supporting the transformation of individual practice and services in providing gender affirming and inclusive mental health care for GQNB people by highlighting current strengths and potential areas of development. Moreover, a resource may be developed for prospective GQNB parents detailing community support and mental health care provisions for GQNB people in the perinatal period.
Funder	The University of East London
Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	04.04.2023
Date of last uPdate (of DMP)	12/04/2024

Related Policies	Research Data Management Policy UEL's Data Backup Policy UEL Data Protection Policy UEL Code of Practice for Research UEL Code of Practice for Research Ethics The Data Protection Act UEL Statement on Research Integrity UEL Statement on Research Ethics
Does this research follow on from previous research? If so, provide details	No
Data Collection	
What data will you collect or create?	Demographic data of 7 participants (age, gender, ethnicity, sexual orientation, number of children, years since given birth, social class) will be collected to provide context to the interviews. This data will be stored in an Excel spreadsheet which will be password protected and saved on the researchers UEL OneDrive. Personal data e.g. Names, telephone numbers, email will be collected prior to interviews as contact details will be required to organise interviews. These details will be kept on a password protected document on the researchers UEL OneDrive Both files approximate size 10KB. Personally identifiable information will be kept in separate files to the audio and transcript files of the data. Personal data such as participants names and signatures will be collected on consent forms. Consent forms will be scanned and saved as individual .Pdf files (one per participant). Hard copies will be shredded. Consent forms will be saved as individual password-protected files and stored in a separate folder to other research data on the researchers UEL OneDrive. Approximate file size 200KB. Data will be collected via interview recordings in .mp4 format. This will contain special category data. The recordings will be stored individually on the researchers UEL OneDrive, alongside the transcript generated by Microsoft Teams in vvt format. Following this the researcher will transcribe the recordings which will be saved in Microsoft Word (UEL), approx. file size 100MB. All identifiable information removed. Following transcription, the individual interview recordings will be deleted.

How will the data be collected or created?	Semi-structured interviews will be conducted and recorded online via Microsoft Teams, or in person at the Stratford University of East London site in a meeting room. They will be used to collect qualitative data and some of the demographic information. Both the online and in-person meetings will be recorded using Microsoft Teams and automatically transcribed via Microsoft Teams. The researcher will then review and edit the automated transcriptions. The individual interviews will last between 60-90minutes. Transcription will be completed and saved as a word document (.doc format). Recordings will be stored following the file-naming convention: [ProjectCode]-[InterviewerInitials]-[ParticipantNumber]-[Location]-[Date].Ext Following transcription, the anonymised transcripts will be printed to allow for annotation as part of analysis. The experiential statements will be stored on password protected Microsoft Word documents stored in the researchers UEL OneDrive. The experiential statement documents will be printed to allow for manual reorganisation of the data to allow for themes to emerge during analysis. Once analysis has been completed the annotated transcripts will be scanned and uploaded to the researchers UEL OneDrive account. The hard copies that only include anonymised data will be discarded in confidential waste bins. Only anonymised data will be included in the documents that are printed. All documents will be password protected and stored on the researchers UEL OneDrive. Consent information and some demographic data will be collected via the consent forms – paper consent forms will be transported securely by the researcher, scanned and uploaded and then discarded immediately following interview completion.
Documentation and Metadata	
What documentation and metadata will accompany the data?	Participant information sheet, recruitment advertisements, a blank consent form, debrief sheet, demographic information list, participant contact information, and an interview schedule. These will be kept on the researchers UEL One Drive.
Ethics and Intellectual Property	

Identify any ethical issues and how these will be managed	Ethical approval will be sought from the University of East London School of Psychology Ethics Committee. Prior to agreeing to taking part in the study, potential participants will be given a copy of the information sheet to ensure that informed consent to participate can be gathered. The participant information sheet will contain information regarding the nature of the research project, expected ethical considerations and how their data will be used for the project write up, kept secure, anonymised, and confidential. The information sheet will also detail any plans for dissemination including the UEL reciprocity. In line with GDPR and the Data Protection Act, all data will be kept securely by being saved on the lead researchers UEL OneDrive for business account, accessible to the researcher only through a password protected user account using Multi-Factor authentication and accessed via the researcher’s password protected laptop. Personal data will only be kept for the necessary time period i.e., the duration of the project and for up to three years after the completion of the project. The only time personal identifiable data may be shared will be when transferring it over to the project supervisor (Dr Vicki Collin) for secure storage after the project has been completed. This will be shared through the UEL OneDrive for Business secure links. The majority of the data will be anonymised through the use of pseudonyms with identifiable information (names, places, precise dates) being removed. If participants want to withdraw from the study (they will have three weeks following completion of their interview), their data will be able to be identified through the participant contact information spreadsheet which will contain a key for identification. If participants have requested for their data to be withdrawn, all data collected for their participation will be destroyed. All information that is identifiable will be kept separately in a secure document. Following the completion of data collection and the beginning of analysis, the spreadsheet containing the identifying key will be deleted making the data anonymised. In line with GDPR guidance, the data will only be used for the purposes that it was obtained and future dissemination activities.

	If emotional distress occurs during the interview, the researcher will manage this in line with their processes from clinical work. The supervisor will always be aware when interviews are taking place. All participants will be signposted to relevant services during debrief, and if a participant decided they would like to finish prior to completion of the interview they will also receive a debrief,
Identify any copyright and Intellectual Property Rights issues and how these will be managed	**N/A**
Storage and Backup	
How will the data be stored and backed up during the research?	7 recordings made using Microsoft Teams will be stored by default on the Microsoft Stream Library. The recordings of the interviews will be deleted once transcripts have been anonymised, checked, and saved. The anonymised transcripts alongside the experiential statements and personal and group experiential themes produced will be stored on the secure and encrypted UEL OneDrive. The files will be accessed on a personal, secure and password protected laptop. Only the researcher and supervisor will have access to the files (and examiners during examination). The 7 consent forms will be sent and returned via a secure email address. The signed consent forms will be saved in individual password protected documents on the UEL OneDrive in a separate folder to the transcripts to protect participant anonymity. The Demographic information collected during the interview will also be stored in password protected excel file in a separate folder on the UEL OneDrive, to ensure anonymity. Personal data such as participants contact details will be stored on a password protected excel file, separate to the audio and video files and transcripts to maintain anonymity. Data is not expected to exceed the UEL personal OneDrive allowance of 1TB. All anonymised data will be stored in a backup location on the researchers UEL Sharepoint.

How will you manage access and security?	Only the researcher, supervisor and examiners will have access to the OneDrive Data files, however the researcher will be the only person with primary access as the files will be stored on their personal UEL OneDrive which is password protected with multi-factor authorisation. The OneDrive will only be accessed via the researchers password protected laptop. No one else will have access to the research data. Any data shared with the research supervisor or examiners will be done so through the faculty of the OneDrive for Business via Secure Links. The Data will not be shared with anyone else. Following the completion of the interview, consent forms will immediately be transferred to digital data and saved on the researchers UEL OneDrive, with physical copies being shredded and disposed of in confidential waste bins.
Data Sharing	
How will you share the data?	The final write up of the research project will contain anonymised data from the interview transcripts and relevant demographic data. This document will be shared publicly on the UEL Research Reciprocity. The full anonymised transcripts will not be available, only anonymised excerpts may be included in the write up. Sharing of data with the researchers supervisor and examiner will occur through OneDrive for Business. The data will not be shared with anyone else. Relevant extracts of the data and the findings of the research may be shared during dissemination of the project.
Are any restrictions on data sharing required?	The data that will be shared will all be anonymised. Participants may provide informed consent for their data to be used in the case of publication and would do so by ticking the relevant box on the form.
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Electronic copies of consent forms will be kept until the thesis has been examined and passed. Following this they will be erased. Audio and video files will be deleted directly after they have been transcribed. The files will be deleted from the OneDrive ‘Recycle Bin’.

	The anonymised transcripts, information relating to sample demographics and documents relating to the analysis of data will be retained for 3 years post examination to allow the research to be written up for potential publication. Documents that are not considered of long-term value will be deleted once the thesis has been examined and passed.
What is the long-term preservation plan for the data?	Following examination, the data will be transferred to the supervisors UEL OneDrive to be safely and securely store for three years. After three years of project completion all data apart from the write up of the project will be deleted.
Responsibilities and Resources	
Who will be responsible for data management?	Evelyn Smith (PI) will have primary responsibility for the data. When Evelyn leaves UEL Dr Vicki Collin will take over responsibilities of the data until it is destroyed.
What resources will you require to deliver your plan?	UEL Microsoft 365 suite including OneDrive for Business Microsoft Teams Mobile Phone Laptop or Computer Secure password protected laptop Access to Microsoft Packages which contain word and excel.
Review	
	Please send your plan to researchdata@uel.ac.uk **We will review within 5 working days and request further information or amendments as required before signing**
Date: 12/04/2024	Reviewer name: Leo Watkinson Scholarly Communications Manager

Appendix H: Recruitment Materials – Poster and Alternative Text

RECRUITING GENDERQUEER AND NONBINARY* RESEARCH PARTICIPANTS

Mental Health and Emotional Wellbeing in the Perinatal Period**

What will happen?

A conversation either online or in person London, Stratford
Around 1 hour
Option of being entered into a draw to win 1 of 3 £30 vouchers

You can take part if you:

Do not identify exclusively as man or woman (genderqueer/nonbinary*) and recognised your gender identity this way in the perinatal period**

Experienced changes in your emotional wellbeing/mental health in the perinatal period**

Gave birth in the UK 6+ months ago and are 18+ years

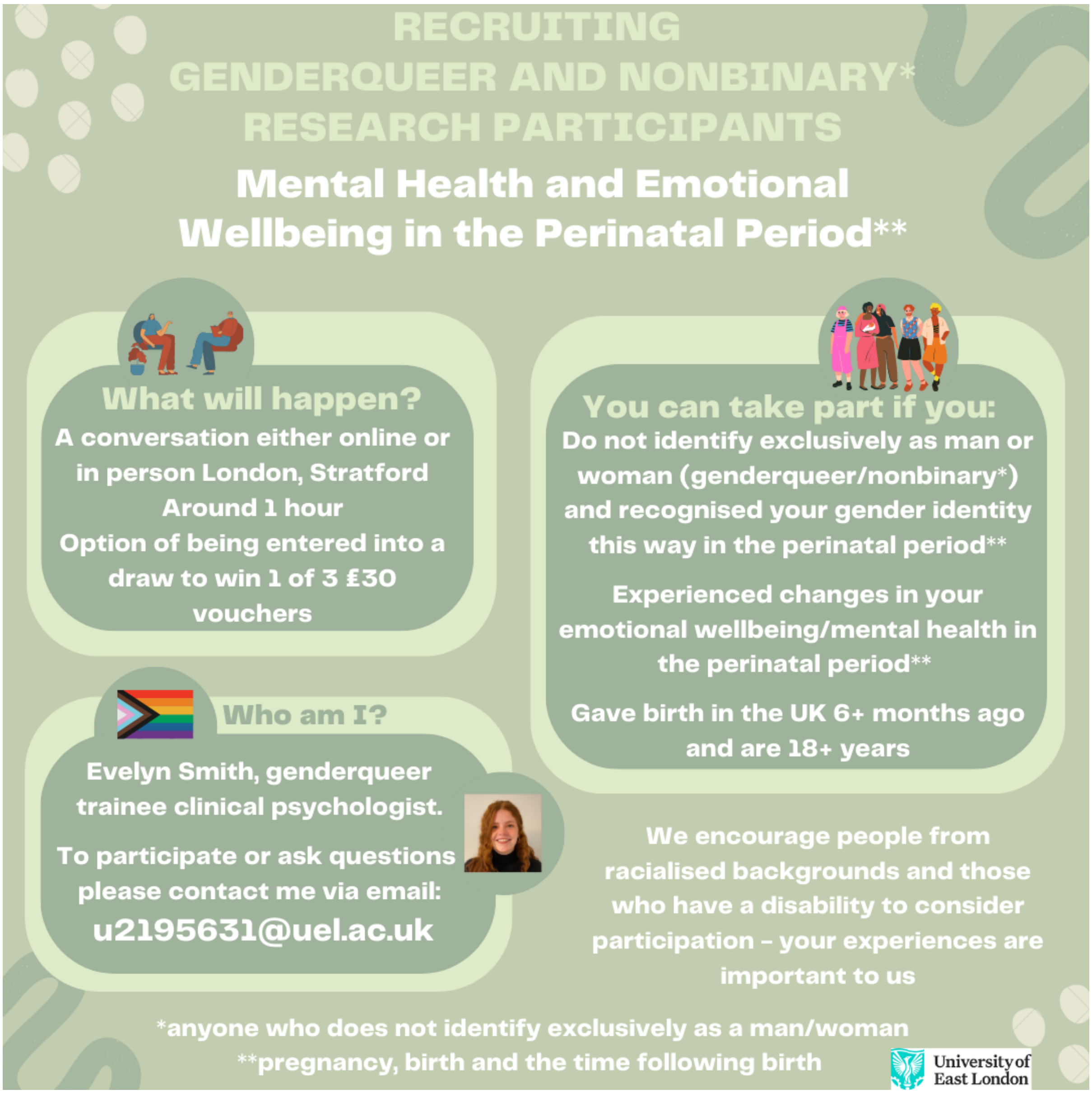
Who am I?

Evelyn Smith, genderqueer, trainee clinical psychologist
To participate or ask questions please contact me via email:
u2195631@uel.ac.uk

We encourage people from racialised backgrounds and those who have a disability to consider participation – your experiences are important to us

*anyone who does not identify exclusively as a man/woman
**pregnancy, birth and the time following birth

University of East London



RECRUITING GENDERQUEER AND NONBINARY* RESEARCH PARTICIPANTS

Mental Health and Emotional Wellbeing in the Perinatal Period**

What will happen?

A conversation either online or in person London, Stratford

Around 1 hour

Option of being entered into a draw to win 1 of 3 £30 vouchers

You can take part if you:

Do not identify exclusively as man or woman (genderqueer/nonbinary*) and recognised your gender identity this way in the perinatal period**

Experienced changes in your emotional wellbeing/mental health in the perinatal period**

Gave birth in the UK 6+ months ago and are 18+ years

Who am I?

Evelyn Smith, genderqueer trainee clinical psychologist.

To participate or ask questions please contact me via email:

u2195631@uel.ac.uk

We encourage people from racialised backgrounds and those who have a disability to consider participation – your experiences are important to us

*anyone who does not identify exclusively as a man/woman

**pregnancy, birth and the time following birth

University of East London

Alternative Text

We are looking for genderqueer and nonbinary birthing parents to participate in a research project.

Alt Text: A green poster with white writing. Three boxes containing text and images.

RECRUITING GENDERQUEER AND NONBINARY* PARTICIPANTS

Mental Health and Emotional Wellbeing in the Perinatal Period**

Box 1: two illustrated people sitting in chairs having a conversation.

What will happen?

A conversation either online or in person London, Stratford

Around 1 hour

Option of being entered into a draw to win 1 of 3 £30 vouchers

Box 2: a group of five illustrated people who are racially diverse wearing bright clothes, one person is holding a baby.

You can take part if you:

- Do not identify exclusively as man or woman (genderqueer/nonbinary*) and recognised your gender identity this way in the perinatal period
- Experienced changes in your emotional wellbeing/mental health in the perinatal period**
- Gave birth in the UK and are 18+ years

Box 3: a picture of the progress pride flag and a picture of the researcher: a white person with long curly ginger hair, smiling.

Who am I?

Evelyn Smith, genderqueer trainee clinical psychologist.

To participate or ask questions please contact me via email: u2195631@uel.ac.uk

We encourage people from racialised backgrounds and those who have a disability to consider participation – your experiences are important to us.

*Anyone who does not identify exclusively as a man or woman

**Perinatal period is defined as pregnancy, birth and the time following birth

Appendix I: Participant Debrief Sheet

Version: 1
Date: 08.04.2023

PARTICIPANT DEBRIEF SHEET

Mental Health and Emotional Wellbeing in the Perinatal Period: The Experiences of Genderqueer and Nonbinary Birthing Parents

Thank you for participating in my research study on genderqueer and nonbinary birthing parents experiences in relation to their mental health and wellbeing in the perinatal period. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository: https://repository.uel.ac.uk. Findings may also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs and on social media. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. Personally identifying information will either be removed or replaced. You will have the option of choosing the pseudonym used for your data.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Hina Dadabhoy for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support.

Support Lines:

Mind: https://www.mind.org.uk/ - Mindline Trans+- 0300 330 5468
- https://bristolmind.org.uk/help-and-support/mindline-transplus/

Samaritans: https://www.samaritans.org/
Call (open 24 hours every day): 116 123 Email (response within 24 hours): jo@samaritans.org

Gendered Intelligence Support Line - 0330 355 9678 - https://genderedintelligence.co.uk/projects/supportline.html

Give Us A Shout support line - text SHOUT to 85258 - https://giveusashout.org/

LGBT Foundation Helpline - 0345 330 3030 - https://lgbt.foundation/helpline

Switchboard LGBT+ - 0800 011 9100 - https://switchboard.lgbt/

Support Services:
Gendered Intelligence runs social and support groups in London, Leeds and online. (https://genderedintelligence.co.uk/trans-youth/youth-group.html)

LGBT Foundation offers trans and nonbinary social support groups (https://lgbt.foundation/groups), as well as an advocacy support service (https://lgbt.foundation/how-we-can-help-you/trans-advocacy) They also offer talking therapies (https://lgbt.foundation/talkingtherapies) for individuals located in Greater Manchester.

African Rainbow Family offer social events, signposting and counselling to Black African and racially minoritised LGBTQ+ people (https://africanrainbowfamily.org/).

Spectra hosts regular trans and nonbinary social groups (https://spectra-london.org.uk/trans-services/trans-groups/) both in person and online. They also offer counselling, peer mentoring and advocacy services (https://spectra-london.org.uk/trans-services/)

Black Trans Foundation are a non-profit organisation working to support Black trans people with their mental health and wellbeing (blacktransfoundation@gmail.com).

Please seek support from your GP if you experience difficulties with your mental health and emotional wellbeing that persist over time.

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Evelyn Smith
(Email: u2195631@uel.ac.uk)

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Hina Dadabhoy, School of Psychology, University of East London, Water Lane, London E15 4LZ,
(Email: h.dadabhoy@uel.ac.uk)

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix J: Demographic Questions

I am going to ask you some questions about your identity. These are so that I can know a bit more about who you are and how you would describe yourself, but also so that we know more about who is included in the research sample. If there are any questions you don’t want to answer, just say.

How would you describe your gender?

How would you describe your ethnicity?

How would you describe your social class?

How would you describe your sexual orientation?

How would you describe your sex assigned at birth?

Would you describe yourself as someone who is neurodivergent and/or who has a disability?

What is your age?

How many children do you have?

When did you give birth to your most recent child?

Appendix K: Interview Schedule

I am going to ask you a few questions about your experience of the perinatal period - pregnancy, birth, and the following period. We will be thinking about your mental health at the time. For each question, I would like to know how aspects of your identity influenced how you felt at these different time periods.

Pregnancy

1. Tell me about your experience of pregnancy and how aspects of your identity influenced how you felt about pregnancy. (What was pregnancy like for you?)

2. I would be interested to know more about your mental health and wellbeing – what was your mental health and wellbeing like prior to pregnancy?

3. Did you notice any changes in your mental health and wellbeing when you became pregnant or through your pregnancy?

4. What do you think impacted your mental health and wellbeing during pregnancy?
    a. How do you think your identity impacted how you felt or how you were treated during this period?

Birth

1. Tell me about your experience of giving birth and how aspects of your identity influenced how you felt about birth. (What was birth like for you?)

2. Did you notice any changes in your mental health and wellbeing during or immediately after giving birth?

3. What do you think impacted your mental health and wellbeing during this period?
    a. How do you think your identity impacted how you felt or how you were treated during this period?

The following two years

1. The perinatal period covers the following two years after birth - tell me about your experience of this time or the time of it you have had so far and how aspects of your identity influenced how you felt. (What was the following two years like for you?)
    a. How did you find the transition to parenthood?
    b. What was it like choosing how to raise your child?

2. Did you notice any changes in your mental health and wellbeing over these two years?

3. What do you think impacted your mental health and wellbeing during that time?

   a. How do you think your identity impacted how you felt or how you were treated during this period?

Support

I would be interested to know a bit more about your support system during the perinatal period.

1. Did you receive a mental health diagnosis at any point (Postpartum Anxiety Depression Psychosis)

2. Did you receive support for your mental health?
   a. Where from and what was this like?
      i. Mentions formal support from NHS/organisation: did you receive any support from the people or community around you? What was this like?
      ii. Mentions support from community/surrounding people: did you receive any formal support from the NHS or an organisation? What was this like?
      iii. Were you able to connect with other GQNB people?
      iv. How did you navigate this time as a GQNB person?

   b. Is there anything that got in the way of accessing formal and informal support for your mental health?

3. What helped you get through this period?

4. Are there any changes to perinatal mental health and antenatal services or changes in the community that you think would be supportive for providing gender affirming and effective care to GQNB people?

Prompts:

Please could you tell me more about X?

1. Is there anything that we haven't spoken about today that you think would be important to share?

Appendix L: Interview Checklist

Checklist

- ☐ Date:
- ☐ Has read participant information sheet:
- ○ Questions?
- ☐ Has signed consent form:
- ○ Remind right to withdraw at any time in the interview and if need to take breaks let me know
- ○ Confidentiality
- ☐ Confirm that:
- ○ Gender not man or woman
- ○ Had a baby in the UK over 6m ago
- ○ Experienced changes in mental health in the perinatal period
- ☐ Consent to take a telephone number, in case of loss of connection:
- ☐ Happy to proceed as discussed – recording and captions:
- ☐ Has the person requested a copy of the findings? If yes, contact details:
- ☐ Name referred to in write up:
- ☐ Questions?:

Starting

- ☐ Start **recording**
- ☐ Start **transcription**
- ☐ Check Recording and transcribing
- ☐ Start interview
- ○ Demographics
- ○ Interview Q's

Ending

- Stop recording
- Questions?
- Concerns?
- Debriefing sheet
- Any other people who you know who might like to do the interview?

Appendix M: Transcription Guidelines

<u>Transcription document:</u>

- Wide margins
- Numbered lines
- Different line for each turn in conversation

<u>Anonymising personal data</u>

- Use of pseudonym
- Change all identifying details
    - Other’s names ***
    - Location *

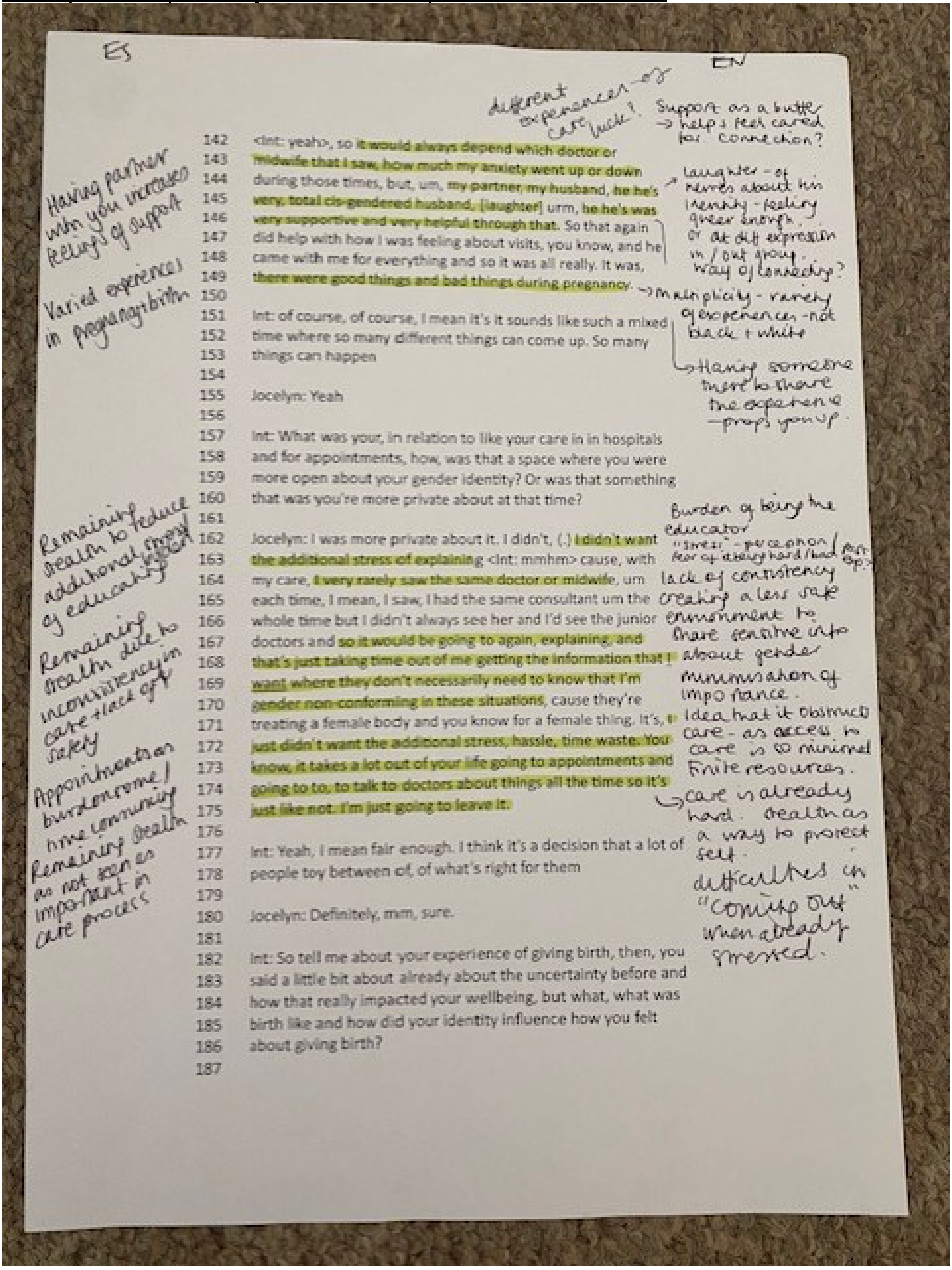
<u>Content of Transcription</u>

- (.) pause
- (2) 2 second pause
- [inaudible]
- <u>Emphasis</u>
- [laughter]
- Brief Interruptions <>
  (e.g. yes they said that it was bad <int: yeah> and so I…)
- Other interruptions or overlapping talking /

(e.g. Int: What do you think made you so/
Participant: I just felt so out of control)

Appendix N: Interpretative Phenomenological Analysis Process

Example of Exploratory Notes and Experiential Statements



ES

Having partner with you increased feelings of support

Varied experiences in pregnancy/birth

Remaining stealth to reduce additional stress/ burden of educating

Remaining stealth due to inconsistency in care + lack of safety

Appointments as burdensome / time consuming

Remaining stealth as not seen as important in care process

<Int: yeah>, so it would always depend which doctor or midwife that I saw, how much my anxiety went up or down during those times, but, um, my partner, my husband, he he's very, total cis-gendered husband, [laughter] urm, he he's was very supportive and very helpful through that. So that again did help with how I was feeling about visits, you know, and he came with me for everything and so it was all really. It was, there were good things and bad things during pregnancy.

Int: of course, of course, I mean it's it sounds like such a mixed time where so many different things can come up. So many things can happen

Jocelyn: Yeah

Int: What was your, in relation to like your care in in hospitals and for appointments, how, was that a space where you were more open about your gender identity? Or was that something that was you're more private about at that time?

Jocelyn: I was more private about it. I didn't, (.) I didn't want the additional stress of explaining <Int: mmhm> cause, with my care, I very rarely saw the same doctor or midwife, um each time, I mean, I saw, I had the same consultant um the whole time but I didn't always see her and I'd see the junior doctors and so it would be going to again, explaining, and that's just taking time out of me getting the information that I want where they don't necessarily need to know that I'm gender non-conforming in these situations, cause they're treating a female body and you know for a female thing. It's, I just didn't want the additional stress, hassle, time waste. You know, it takes a lot out of your life going to appointments and going to to, to talk to doctors about things all the time so it's just like not. I'm just going to leave it.

Int: Yeah, I mean fair enough. I think it's a decision that a lot of people toy between of, of what's right for them

Jocelyn: Definitely, mm, sure.

Int: So tell me about your experience of giving birth, then, you said a little bit about already about the uncertainty before and how that really impacted your wellbeing, but what, what was birth like and how did your identity influence how you felt about giving birth?

EN

different experiences - of care luck!

Support as a buffer → helps feel cared for. connection?

laughter - of nerves about his identity - feeling queer enough. or at diff expression in / out group. way of connecting?

→ multiplicity - variety of experiences - not black + white

→ Having someone there to share the experience - props you up.

Burden of being the educator

"stress" - perception / fear of it being hard / hard [illegible]

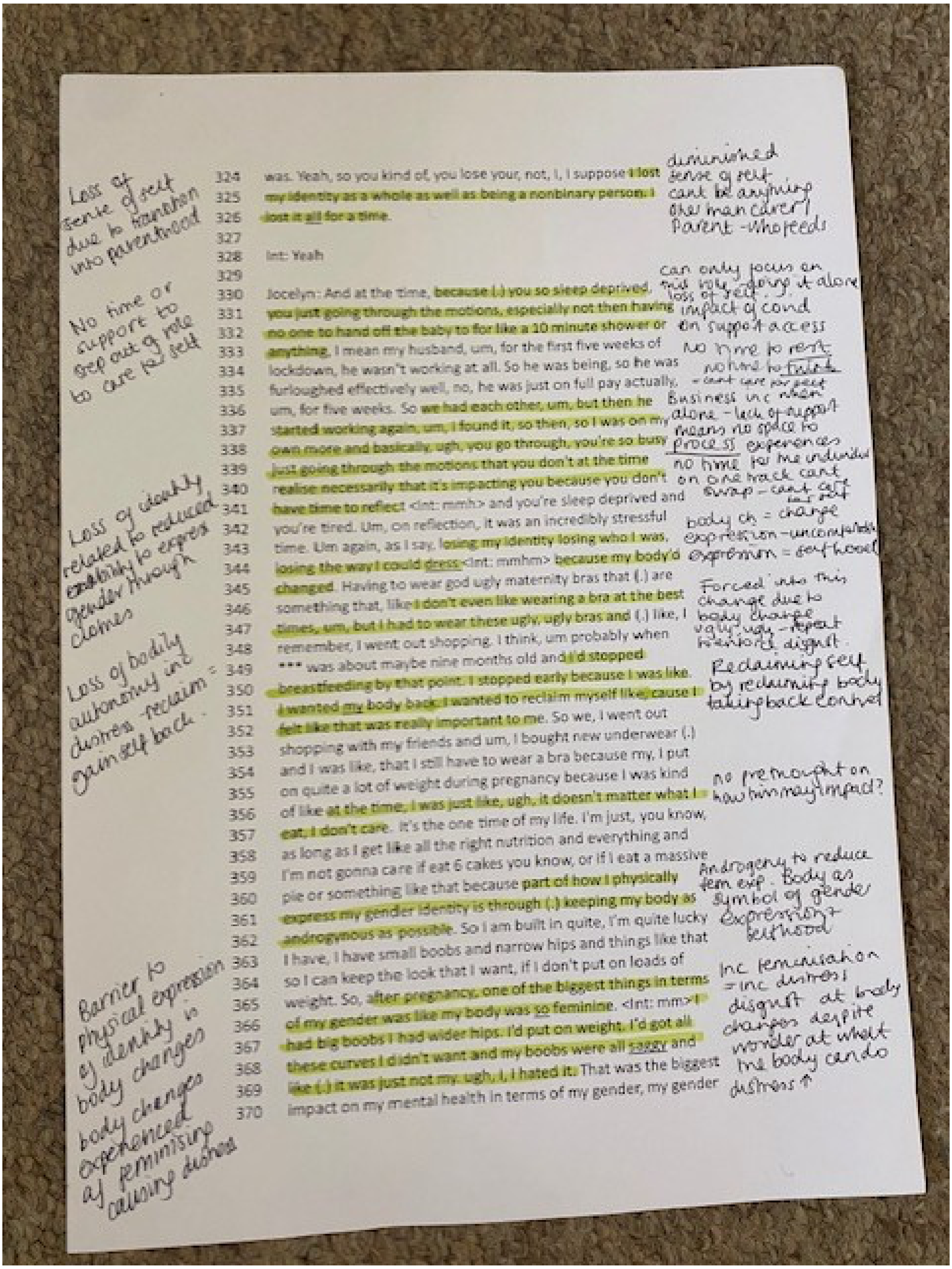
lack of consistency creating a less safe environment to share sensitive info about gender

minimisation of importance.

Idea that it obstructs care - as access to care is so minimal finite resources.

→ care is already hard. stealth as a way to protect self.

difficulties in "coming out" when already stressed.



was. Yeah, so you kind of, you lose your, not, I, I suppose I lost my identity as a whole as well as being a nonbinary person. I lost it all for a time.

Int: Yeah

Jocelyn: And at the time, because (.) you so sleep deprived, you just going through the motions, especially not then having no one to hand off the baby to for like a 10 minute shower or anything. I mean my husband, um, for the first five weeks of lockdown, he wasn't working at all. So he was being, so he was furloughed effectively well, no, he was just on full pay actually, um, for five weeks. So we had each other, um, but then he started working again, um, I found it, so then, so I was on my own more and basically, ugh, you go through, you're so busy just going through the motions that you don't at the time realise necessarily that it's impacting you because you don't have time to reflect <Int: mmh> and you're sleep deprived and you're tired. Um, on reflection, it was an incredibly stressful time. Um again, as I say, losing my identity losing who I was, losing the way I could dress<Int: mmhm> because my body'd changed. Having to wear god ugly maternity bras that (.) are something that, like I don't even like wearing a bra at the best times, um, but I had to wear these ugly, ugly bras and (.) like, I remember, I went out shopping. I think, um probably when *** was about maybe nine months old and I'd stopped breastfeeding by that point. I stopped early because I was like. I wanted my body back. I wanted to reclaim myself like, cause I felt like that was really important to me. So we, I went out shopping with my friends and um, I bought new underwear (.) and I was like, that I still have to wear a bra because my, I put on quite a lot of weight during pregnancy because I was kind of like at the time, I was just like, ugh, it doesn't matter what I eat, I don't care. It's the one time of my life. I'm just, you know, as long as I get like all the right nutrition and everything and I'm not gonna care if eat 6 cakes you know, or if I eat a massive pie or something like that because part of how I physically express my gender identity is through (.) keeping my body as androgynous as possible. So I am built in quite, I'm quite lucky I have, I have small boobs and narrow hips and things like that so I can keep the look that I want, if I don't put on loads of weight. So, after pregnancy, one of the biggest things in terms of my gender was like my body was so feminine. <Int: mm> I had big boobs I had wider hips. I'd put on weight. I'd got all these curves I didn't want and my boobs were all saggy and like (.) it was just not my. ugh, I, I hated it. That was the biggest impact on my mental health in terms of my gender, my gender

Loss of sense of self due to transition into parenthood

No time or support to step out of role to care for self

Loss of identity related to reduced ability to express gender through clothes

Loss of bodily autonomy inc distress - reclaim = gain self back.

Barrier to physical expression of identity in body changes

body changes experienced as feminising causing distress

diminished sense of self can't be anything other than carer / Parent - who feeds

can only focus on this role - doing it alone loss of self. impact of cond on support access

No time to rest no time to reflect - can't care for self

Business inc when alone - lack of support means no space to process experiences

no time for the individual on one track can't swap - can't self care

body ch = change expression - uncomfortable expression = self hood

Forced into this change due to body change ugly ugly - repeat reinforce disgust.

Reclaiming self by reclaiming body taking back control

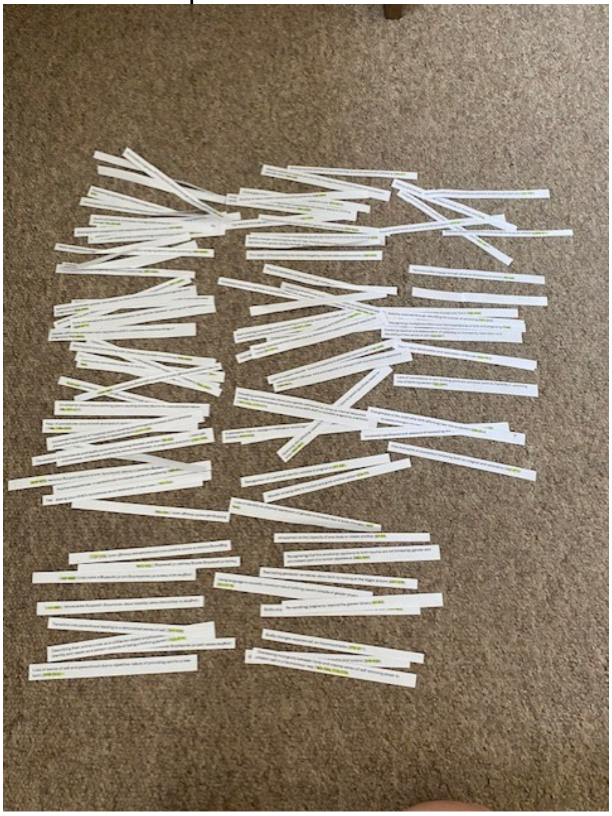
no prethought on how this may impact?

Androgyny to reduce fem exp. Body as symbol of gender expression? selfhood

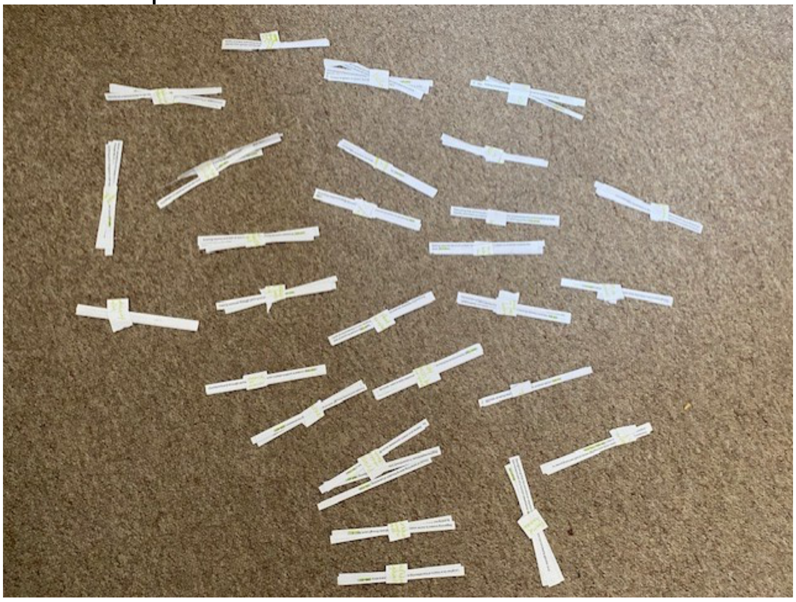
inc feminisation = inc distress / disgust at body changes despite wonder at what the body can do distress ↑

Example of Participants Personal Experiential Themes Sorting Process

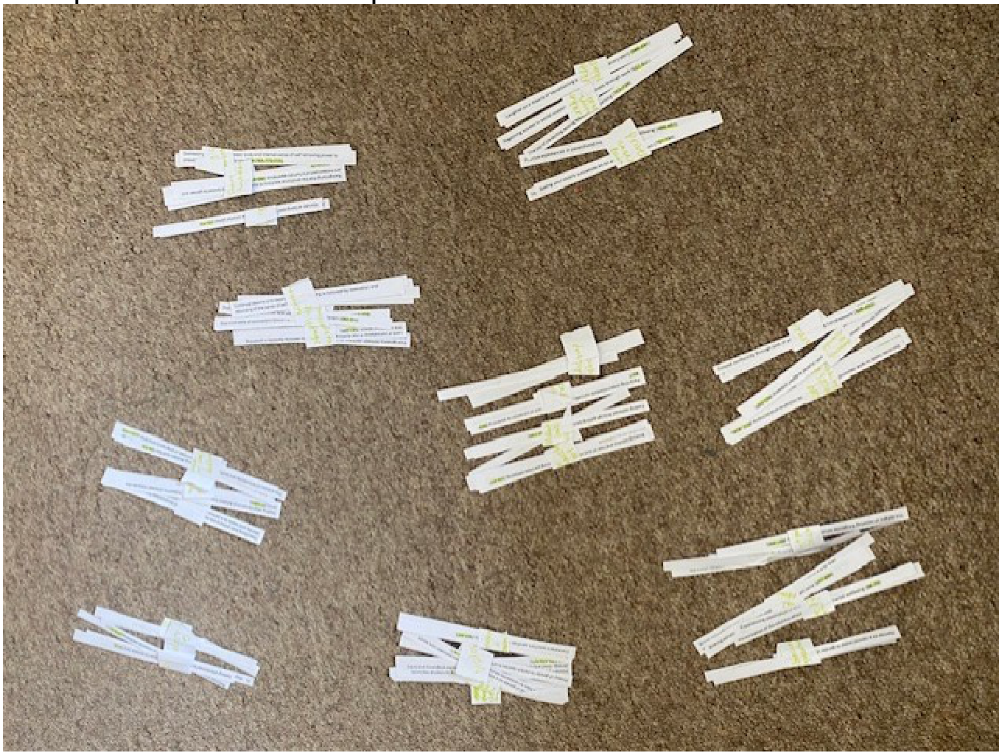
Gather all Experiential Statements for Participant



Cluster Experiential Statements into Subthemes



Group Subthemes into Superordinate PETs

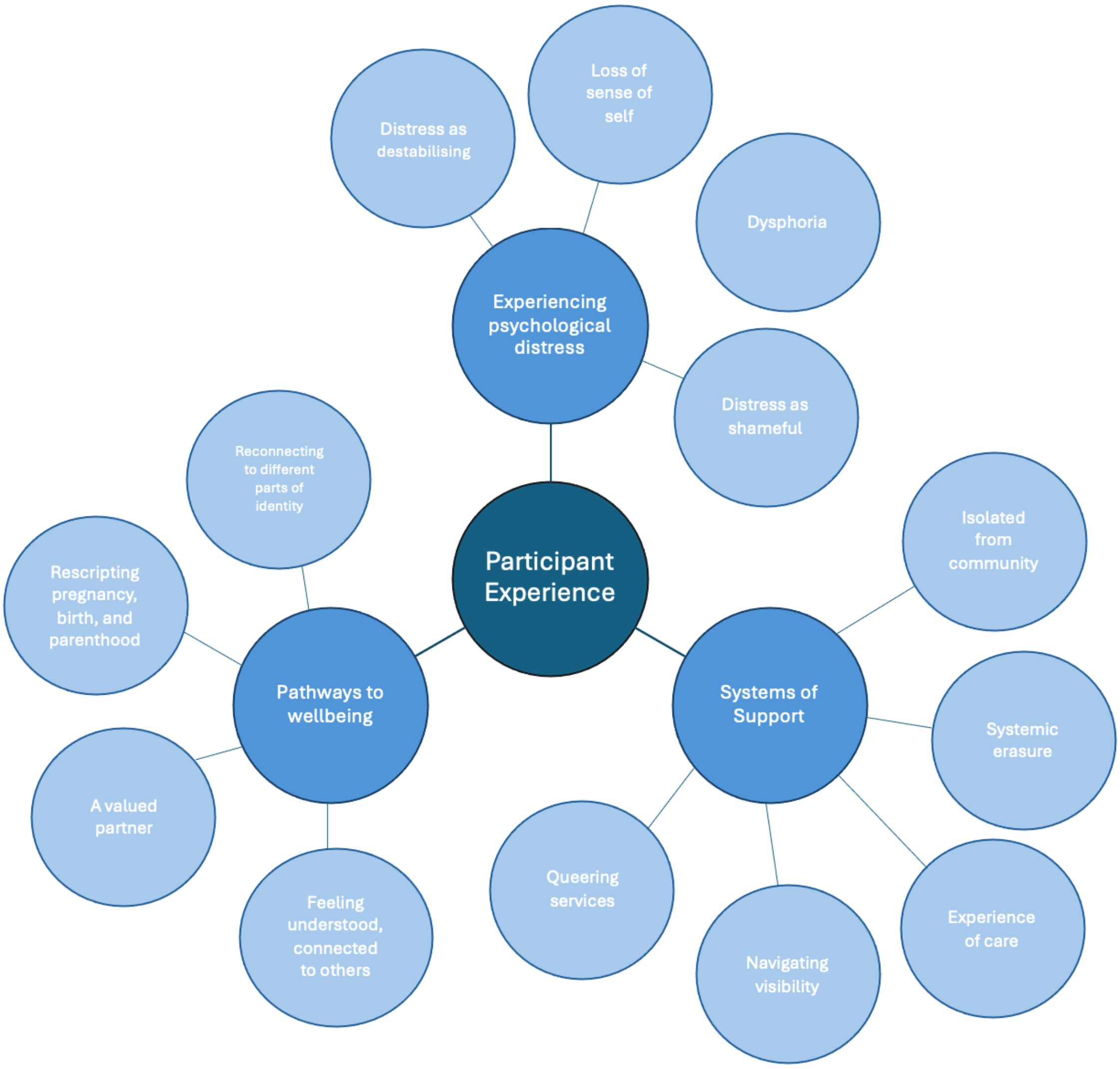


Example of GET Sorting Process (once prior steps have been completed for each participant)

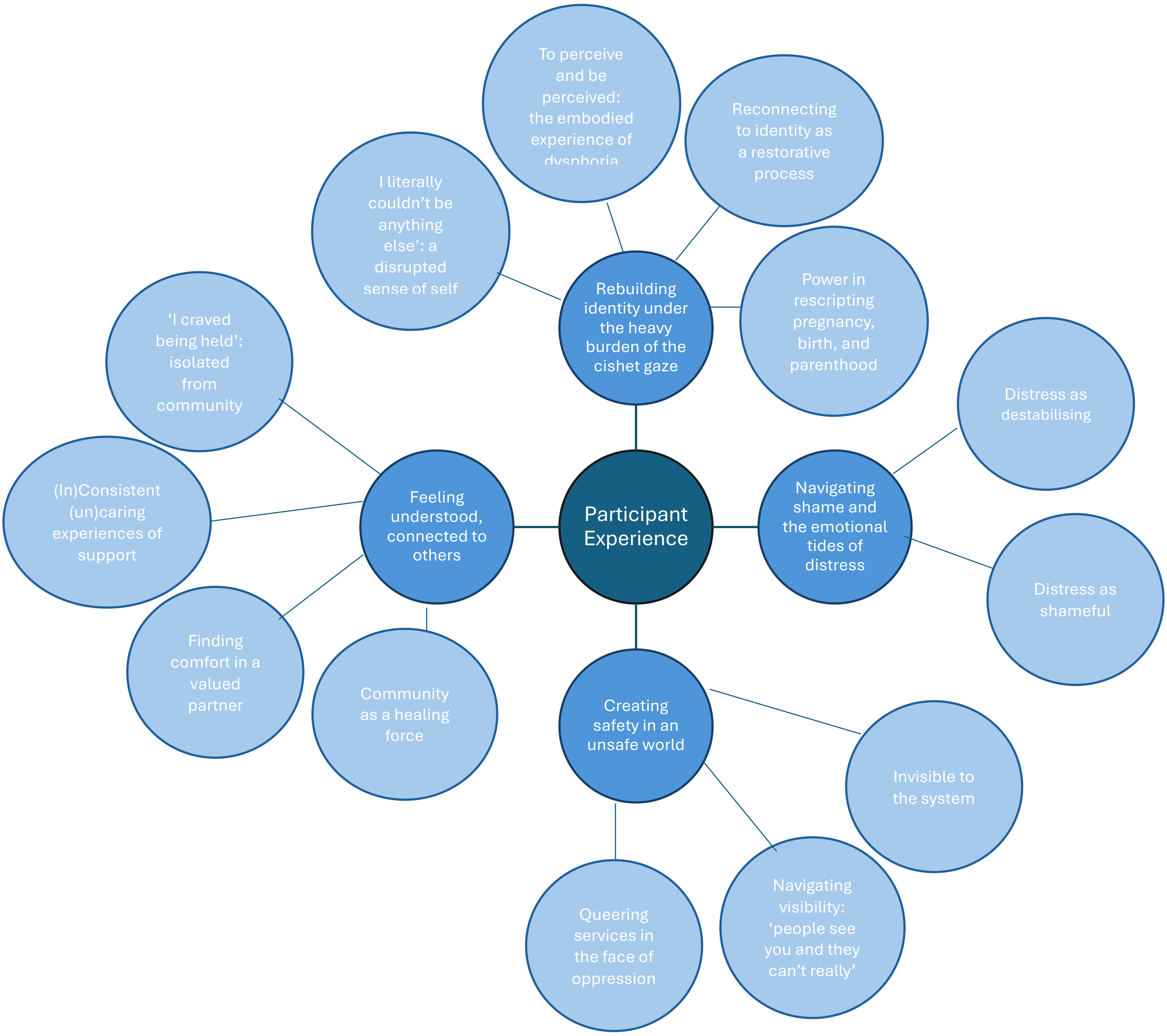
Gather all PETS

Sort PETs into GETs

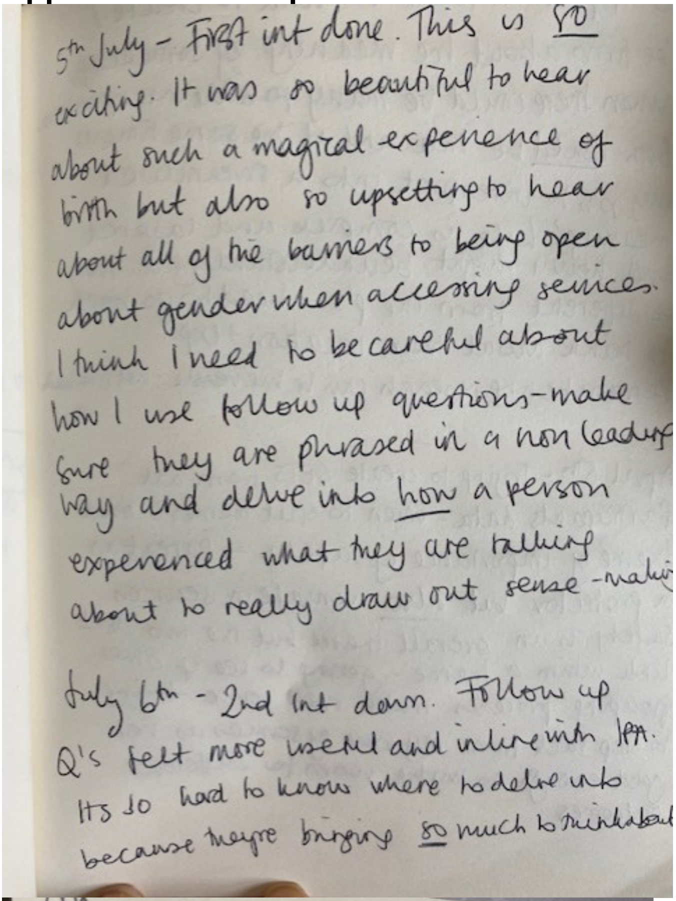
Initial GETs and Subordinate Themes



Final GETs and Subordinate Themes following repeated iterative process and supervision

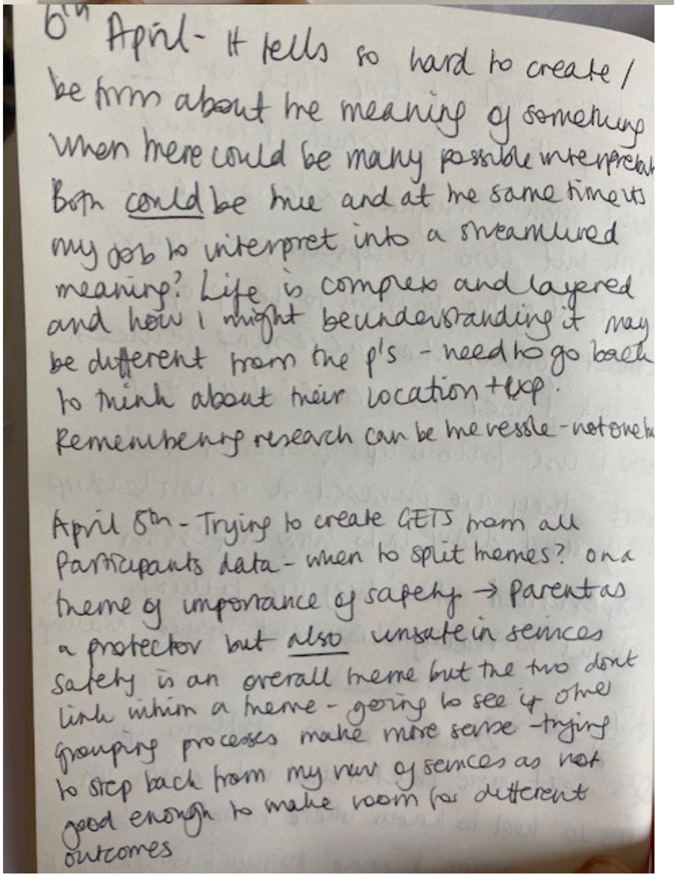


Appendix O: Excerpt of Researchers Reflexive Journal



5th July - First int done. This is so exciting. It was so beautiful to hear about such a magical experience of birth but also so upsetting to hear about all of the barriers to being open about gender when accessing services. I think I need to be careful about how I use follow up questions - make sure they are phrased in a non leading way and delve into how a person experienced what they are talking about to really draw out sense-makin

July 6th - 2nd int down. Follow up Q's felt more useful and inline with IPA. Its so hard to know where to delve into because theyre bringing so much to think about



6th April - It feels so hard to create / be firm about the meaning of something when there could be many possible interpretat Both could be true and at the same time its my job to interpret into a streamlined meaning? Life is complex and layered and how I might be understanding it may be different from the p's - need to go back to think about their location + exp. Remembering research can be messy - not one

April 8th - Trying to create GETS from all participants data - when to split themes? On a theme of importance of safety → parent as a protector but also unsafe in services safety is an overall theme but the two dont link within a theme - going to see if other grouping processes make more sense - trying to step back from my view of services as not good enough to make room for different outcomes

Appendix P: Researchers Positionality: Social GGRRAAACCEEESSS

Appendix Q: Summary of GETS. Recurrence by Participant

Group Experiential Theme	Subordinate Theme	Alex	Ari	Charlie	Jocelyn	Lora	Sam	Theo
Navigating shame and the emotional tides of distress	Distress as destabilising	X	X	X	X	X	X	X
	Distress as shameful	X	X	X		X	X	X
Rebuilding identity under the heavy burden of the cishet gaze	‘I literally couldn’t be anything else’: a disrupted sense of self	X	X		X	X	X	X
	To perceive and be perceived: the embodied experience of dysphoria	X		X	X	X	X	X
	Reconnecting to identity as a restorative process	X	X	X	X	X	X	X
	Power in rescripting pregnancy, birth, and parenthood	X	X	X	X	X	X	X
Feeling understood, connected to others	‘I craved being held’: isolated from community	X	X	X	X	X	X	X
	(In)Consistent (un)caring experiences of support	X	X	X	X	X	X	X
	Finding comfort in a valued partner	X	X	X	X	X	X	X
	Community as a healing force	X	X	X	X	X	X	X
Creating safety in an unsafe world	Invisible to the system	X	X	X		X	X	X
	Navigating visibility: ‘people see you and they can’t really’	X	X	X	X	X	X	X
	Queering services in the face of oppression	X	X	X	X	X	X	X

Appendix R: Summary of GETS with Corresponding PETS

Group Experiential Theme	Subordinate Theme	Participant	Quote	Individual Personal Experiential Theme
Navigating shame and emotional tides of distress	Distress as destabilising	Alex	*you kind of spiral in and out of feeling a little bit better and then, like, really, devastatingly bad again (732-733)*	**The emotional tides of distress**
		Sam	*my mental health was kind of quite up and down in pregnancy quite, I think I was a very, very emotional (26-28)*	**Psychological distress in the perinatal period is not linear**
		Jocelyn	*on reflection, yeah it was [laughter], it was absolutely, (.) it was horrendous in places (709-710)*	**Laughter to defend against pain**
		Theo	*I would still struggle to go out, to remember to feed myself, to remember to feed ***, to remember to change them (.), to remember to just, like, interact with them at all…I went in with an idea of like, 'OK, this is what I'll do' and then it was just completely blown apart by like, the horrific postnatal depression (819-1016)*	**Experiencing psychological distress restricted their parenting choices**
		Lora	*I pumped for, for five months, I think and then as soon as I stopped, like the day I stopped, I couldn't get out of bed. I like, it was like I got hit by a truck… I couldn't (2) like feel anything (385-388)*	**The profound sense of hopelessness within despair**
		Charlie	*I didn't know which way was up, like my whole, the, the room of my head had been flipped upside down and I couldn't work out any directions (110-112)*	**The resurfacing of past trauma in pregnancy**
			had I not had all of the traumatising stuff going on during my pregnancy (2) I would have had a better birth…because we know the birth is better when somebody feels strong and safe and confident (309-314)	**Perinatal distress as a risk factor for birth trauma**
		Ari	*I would kind of (.) get really like angry, but then I would like sh, sort of close down because you can't, it it's hard to sort of feel all those emotions and look after a baby as well, so you tend to kind of shut, like I shut them out (529-533)*	**Creating distance and disconnection to cope with pain**
			suicidal ideation come into your head, even though it, I knew I wasn't gonna do it, it just pops into your head because you're so stressed (.) you don't know what else to think about…I was just completely overwhelmed (575-579)	**The emotional turmoil of unrelenting psychological distress**
	Distress as shameful	Lora	*it's a lot easier to talk about something that like you've overcome or like people I think find it easier to hear that as well, that like I was feeling rubbish and then I found a fix (518-521)*	**Psychological distress experienced as shameful**
		Alex	*I was about to tell her and I looked down and I saw that she already wrote like really good and put a little smiley face in the box and then I just froze (150-153)*	**The stigma of psychological distress**

			I was kind of like almost felt like I was a bad, like a bad parent like feeling like that (695-696)	**The stigma of psychological distress**
		Theo	*it's one of those stories you can only tell after a certain time has elapsed because then you can't get in trouble with CPS [laughter] (785-787)*	**Systemic stigmatisation of psychological distress in the perinatal period**
			immediately it's like abuse and your kids are gonna get taken off you (1579-1580)	**Systemic stigmatisation of psychological distress in the perinatal period**
		Sam	*you're just desperately trying to prove yourself (372)*	**Societal rejection as they don't fit the norms**
		Charlie	*I was like, having the kids and having these meltdowns, trying to hide. I'd like, go into another room and self-harm and then come back out to, like, perform wellness again (702-705)*	**Stigma of psychological distress**
		Ari	*I was scared. Like, am I abandoning her? (543-544)*	**It feels shameful to experience psychological distress**
Rebuilding identity under the heavy burden of the cishet gaze	'I literally couldn't be anything else': a disrupted sense of self	Ari	*you turn into a bit of a robot…you're just doing it to sort of (2) um (.) you know, survive and keep your baby healthy (499-504)*	**Prioritising the babies needs**
		Jocelyn	*she was never off my boobs, you know and like I felt like, like a cow rather than a person…I lost my identity as a whole as well as being a nonbinary person. I lost it all for a time (316-326)*	**Loss of the self within the early parenting role**
		Alex	*I was just stuck being a parent 24/7 because my baby needed to feed 24/7, so I literally couldn't be anything else, so I just felt like I was stuck in that (351-353)*	**No time for an identity outside of parenthood**
		Theo	*I sort of wanted someone to acknowledge that I was like (2) a person outside of being a parent especially with how much I was struggling to parent, I didn't feel like a parent (910-913)*	**Identity as a parent feels crushing**
		Sam	*you just become a vessel to carry and then on top of that if you're trans like it's a whole extra kettle of fish where you're really doubly not seen (697-699)*	**Cisheterosexual narratives of gender and parenthood make your experiences as trans nonbinary parents invisible**
		Lora	*I have a lot of like pain and like back ache and things and that (.) has like, made me feel quite disconnected from my body, whereas pregnancy was something that I, um, like made me feel like my body could do this (25-29)*	**Transformative narratives of the self through pregnancy and birth**
	To perceive and be perceived: the embodied experience of dysphoria	Jocelyn	*my body was so feminine. I had big boobs I had wider hips. I'd put on weight. I'd got all these curves I didn't want…it was just not my. ugh, I, I hated it. (366-369)*	**Social norms surrounding birth, bodies, and parenting reduce control in how you are perceived**
			when people, sort of impose labels on you… it's taking part, bits of me away again (474-479)	**Social norms surrounding birth, bodies, and parenting reduce control in how you are perceived**

		Alex	*I'd like look down at my pregnant self and I'd be like ohh, that's my child and my stomach, but I was like (.) it was really strange because it kind of felt like an out of body experience (118-121)*	**Body dysphoria – this body does not feel like it is mine**
			when I was feeding my baby, it kind of it re- it sounds really strange, it kind of eased a little bit because it felt very u- like utilitarian like I, they had a purpose that I was using it for (317-320)	**Surprise at the nature of dysphoria**
			I felt like I was trying to fit into a box that I just didn't fit in and there was nowhere for me to go (667-668)	**A lack of representation**
			it just felt like I was like, like pretending to be someone in a play (444-445)	**Trapped in cishet narratives of pregnancy and parenting**
		Lora	*I found it really hard to find clothes that felt like me that were like maternity clothes…maternity clothes are quite like floral and like pretty and feminine. And that's not like how I want to present (150-163)*	**Disconnection from self as pregnancy reduces access to self-expression and gender affirming tools**
		Charlie	*my body had masculinized to a degree that I felt very comfortable with (33-34)*	**Surprisingly, body changes were not dysphoric**
			I would go out into the world as somebody who looks very masculine, holding my baby, and people would congratulate my sister…they don't see me as the entire person who's bleeding with lochia, who's got tears from giving birth, who's gone through pregnancy. They don't see that they see 'oh, isn't it nice to see a dad out with the baby' (570-577)	**No one recognises or understands their experience**
		Theo	*I've got a lot of different trauma, but like, my body is not one of them. So I actually quite enjoyed being pregnant (37-39)*	**Gender euphoria and the body**
			I appreciate that you think that I am the dad, but I'm also the person that gave birth to them. I'm also the person that, like, has all those hormones and the emotions and feeling like crap (862-865)	**Erasing nonbinary experiences through gender stereotypes**
		Sam	*lots of women are very much damaged by now being women and mothers it fucks them up… the enforcement of it like and me being enforced to be a mother was just ironic (985-989)*	**Birthing people share similar experiences regardless of gender**
	Reconnecting to identity as a restorative process	Jocelyn	*it was being taken apart brick by brick. But then it was being built back up brick by brick, by brick (753-754)*	**Re-discovering self: the path to wellness following distress**
			I stopped early because I was like. I wanted my body back. I wanted to reclaim myself (350-351)	**Holding on to your sense of self**
		Charlie	*I am gonna go to work. I am gonna do something that isn't to parent…that gives me that space to recover. And so that when I am spending time with them, I'm more of myself (.) rather than an echo, a ghost, a shell (752-758)*	**Rebuilding my sense of self and capacity to care for myself**
		Sam	*straight after the birth, I went to Mandarin lessons…that kind of inspired me to go to back to that uni…despite what people think we should or shouldn't be doing (193-200)*	**Resistance as a way of life**

			there was a chance that I would be OK in my head cause, like, if you're not accepted if you're trans, you're not accepted if you don’t have money (788-791)	**Life is easier when you are accepted by society**
		Alex	*when things go back to normal and I could, like, start doing things that I did, like, before pregnancy, I kind of felt more like myself again (856-858)*	**Regaining autonomy**
		Lora	*I'd kept my placenta…I chopped into small pieces and fried it [laughter], and that worked wonders…the fact that I hadn't felt any joy at all, and it was just like this tiny, like, it was giving me the ability to feel happy again (416-429)*	**The capacity of the body to sustain new life feels extraordinary**
			I think whatever it was like hormonal imbalances sorted itself out (514-515)	**Psychological distress understood through a biomedical lens**
		Theo	*we did some baby massage and like (.) just they would be there while I was looking after *** to sort of (.) if I needed a break, they could just like hold *** for a bit (1150-1153)*	**Perinatal services helped them connect to their parenting role**
		Ari	*I've learned how to sort of (.) deal with you know, think like if, um, if ***’s upset, you know, you kind of like I, I just get, like an instinct (618-620)*	**Parenting as a learning process**
	Power in rescripting pregnancy, birth, and parenthood	Jocelyn	*I felt like, um, a person who was growing another person (31-32)*	**A shared humanity in birth and pregnancy**
			she'll call me things like Mr Mama and I'm like I'm cool with that (442-443)	**Finding joy and power in resistance**
		Lora	*it felt um, like yeah, like a thing my body was designed to do (230-231)*	**The capacity of the body to sustain new life feels extraordinary**
		Charlie	*in many ways it felt like a really natural thing for my body to be doing (30-31)*	**Pregnancy and birth felt natural and empowering**
			I knew I could never be, quote unquote mother to my children. I eventually got to a space of recognising they could still do mothering, provide the nurture, provide the care regardless of what name I use (510-513)	**Linguistic erasure and dysphoria**
		Alex	*I feel a lot more comfortable in like (.) parenthood cause I feel like I, I'm me. I've always done my own, my own thing. And I'm like, I love my child. I look after my child (808-811)*	**Change feels possible**
		Sam	*I was feeding them like loads of times of the day they were lying on me. I was cuddling them in the way I could, do you know what I mean? They were on my chest like, we were doing skin to skin like we were completely active around it all (170-174)*	**Adaptability as a disabled parent – balancing the babies and their own needs**
		Theo	*they started kicking and moving, I found that really like cool. It felt really weird, but like enjoyable weird (70-72)*	**Finding joy in parenting**
		Ari	*to my daughter I'm, I'm mama. Just because you know to me, I like the sound of that word (667-668)*	**Language does not represent who they are**

Feeling understood, connected to others	‘I craved being held’: isolated from community	Jocelyn	*it was so hard…lockdown prevented so much…I couldn't do the usual hand the baby to someone while I take a shower kind of thing (591-595)*	**The impact of covid on access to support**
		Charlie	*I just needed somebody else to look after him (.) for a while (2) while I recovered. I needed someone to look after him but near me (696-698)*	**The intersectional experience of being a disabled parent**
			I craved being held by, by womanhood and by my community of sisters and siblings who have (.) got that vibe…it was about being able to nurture and look after me (514-518)	**A longing for care and community**
		Lora	*nobody cared about me…people like withdrawing because they don't know how to help. Which then (.) doesn't help (484-502)*	**Feeling isolated due to lack of connection with others**
		Ari	*I don't understand how they can (.) how their lives work without a child, but they don't understand how my life works with a child (303-305)*	**The transition into parenthood and the loss of friendship**
			in real life I never knew anybody that was (.) nonbinary and pregnant and for me it was kind of quite isolating (55-57)	**Invisibility of the nonbinary birthing community increases disconnection and isolation in pregnancy**
		Alex	*I just didn't connect with anything they were saying and I really felt like I was an impostor (438-440)*	**Feeling different, feeling othered**
			a lot of the spaces I didn't feel like were for me…everything is like so gendered (2) and…other queer people are really surprised to find out that I'm a parent (528-533)	**Feeling different, feeling othered**
		Theo	*there's a lot of different like experiences…I don't always feel like I kind of fit in there either, but (2) because like I haven’t had top surgery or anything (1381-1389)*	**Coping alone: isolation**
		Sam	*we didn't fit in on any level…like we're too queer for the queers? Like, I don’t know [laughter]. Like, we're not even that queer like, but we're just kinda like, and we don't have money (744-750)*	**The impact of class on their experience of the world**
	(In)Consistent (un)caring experiences of support	Ari	*the level of care is a lot more independent and focused on like the individual person…that helped me get what I needed when I needed it rather than having to sort wait for it (877-882)*	**Well-funded services are needed to create a safe environment to share gender identity**
		Jocelyn	*she monitored me through everything. She, again I saw her like every month we had a chat. It wasn't just a case of here’s your pills, off you go…I got lucky with this particular GP…she was always there (563-574)*	**Consistency and communication create safe perinatal services**
		Theo	*I tried getting that support again for *** but the person that I really like connected with um, they had their own mental health stuff going on so they weren't working (795-799)*	**Perinatal services helped them connect to their parenting role**
		Lora	*if someone had’ve like phoned me to check in…cause, yeah postnatal depression isn't like a weird thing…just, I dunno, book in an appointment just in case (856-860)*	**Towards true person centred care**

		Charlie	*I'm asking really hel, clearly for like space for somebody to sit with me, listen to me and work out a plan, not (.) um, just stick me on a medication that has previously put me in hospital (150-153)*	**Wanting the suffering to end**
			because I can say to somebody, even in the moment 'I am in crisis right now, I am breaking and I want to die' so they're like, 'mmhm, yeah, I hear the words of how big that is', but they're not, they don't get the sense of urgency (824-828)	**Perinatal mental health services inaccessibility – a lack of support offered**
		Sam	*there's violence in society, but you don't feel it until you're on the edge of something and like being trans you're so close to being on the edge and then being pregnant, you're even closer to the edge and you're breaking all these rules of what you shouldn't be doing (218-223)*	**Anti-trans prejudice makes the world unsafe**
			we're like…'you do not understand what could happen and the stress we'll be under like it is just not OK, it's not OK for us, it's not OK for our baby' (727-730)	**Services can't help as they don't understand trans nonbinary experiences**
		Alex	*I feel like my experience with my mental health was actually really negatively affected by not feeling safe to talk about how I was feeling (1049-1051)*	**A lack of safety in services makes it hard to access care**
	Finding comfort in a valued partner	Theo	*It's just the two of us against the world which I don't mind so much (1132-1133)*	**The partner relationship as special**
		Alex	*he's a God send, like I feel so much like I couldn't be a parent without him (880-881)*	**Parenting as a partnership**
		Ari	*my partner kind of (.) like just sort of gently nudged me towards going to the doctors (567-568)*	**The caring role of a partner**
			we sort of work together, um (.) but (.) yeah, because er we, we have like a system as well…the first few months is probably the hardest for a couple which I think it definitely was because we were figuring out that system of like what we both needed at the time (621-629)	**Navigating parenthood with a partner**
		Lora	*massively like in all ways like listening to me and like taking care of me and cooking for me when I wasn't up to doing it myself and that kind of thing. Um, and like, encouraging me to try things as well (673-676)*	**Finding solace in community**
		Jocelyn	*he got regular hours so we got into a regular routine to again, that's another thing towards the end that was really helping pick me up (588-590)*	**Navigating parenting together**
		Charlie	*I had to say to my husband that he needed to step up. So initially he wouldn't have both children at the same time so it then became that I was kind of forcing him to do [laughter] a little bit more and a little bit more (727-730)*	**The protective role of the birthing parent**
		Sam	*when I think of my mental health, we sort of came as a package (685-686)*	**Their wellbeing is linked with their partners wellbeing**
	Community as a healing force	Charlie	*the one thing I need more than anything else is community. Nobody else gets what it's like (.) to be (.) trans (.) and (.) pregnant (402-404)*	**Understanding and acceptance within a nonbinary trans parenting community**

		Alex	*it just felt really (.) like affirming to be surrounded by more queer people and like queer parents, because I didn't even know anyone like me existed…that just made me feel like more comfortable in myself again (962-966)*	**Community as a healing**
		Jocelyn	*they understood like how much it sort of, the body changes and said they were able to then (.) like give me the reassurance that I needed that I was, what I was feeling was (.) normal…we could be there for each other (791-795)*	**Community as restorative**
		Lora	*having like talked to people who have experienced the same thing like does like make you feel like you can do it (800-802)*	**Finding solace in community**
		Ari	*If I meet another parent, it's like oh we both have kids. Like we're not the same as each other, but we both have kids (1016-1017)*	**Mitigating a lack of connection with nonbinary birthing parents by identifying parenthood as the central part of a shared experience**
			it's like the one thing that you know you have to have like other parent friends (824-825)	**A shared experience helps them feel understood within their parenthood role**
		Sam	*This was like an absolute Gods, I think without that, I don't know, it would have been even more hell on earth like [laughter] it was like, and they were brilliant (150-153)*	**The value of a diverse workforce – feeling understood**
		Theo	*Just like helping look after the kids…it actually gives us a nice like just the two of us time (1109-1115)*	**Transition to parenthood involves a shift in priorities**

Creating safety in an unsafe world	Invisible to the system	Alex	*everything says woman, absolutely everything (363-364)*	**A lack of representation**
			I knew it was dysphoria, but I almost couldn't name it as that…I'm like, like naming all the things that were like to do with like my dysphoria and they were like, 'oh no, it's fine' (823-832)	**A lack of resources**
		Ari	*it was always just a mum, a dad and a baby, and there was never anything different (1089-1091)*	**Cisheteronormative values in society contribute to feeling othered**
		Charlie	*I know in hospitals I would be misgendered both by the space and by the people…it didn't feel safe (229-334)*	**Anti-trans prejudice and the NHS**
			I didn't even know if I could get pregnant because I'd been told that taking testosterone would make me infertile (20-22)	**A lack of knowledge about trans and nonbinary reproductive healthcare within the NHS**
			I texted the prenatal mental health team and the reply I got was (.) 'This is a service for pregnant women' (135-137)	**Anti-trans prejudice and the NHS**
		Lora	*she said that the like maternity system couldn't cope with someone not being like female in the system (212-213)*	**Systemic erasure of gender diverse birthing people through adherence to cisnormative ideas of pregnancy and gender in the NHS**
			I didn't have like a whole load of faith in her [laughter] for that to be like research backed or anything (154-156)	**Epistemic erasure of gender diverse birthing people's experiences impacting access to care in NHS**
		Sam	*I just haven't had any hormones in at the right levels for a very long time…I got a very severe skin reaction that made me, it could have made me go blind (487-494)*	**The NHS failure to meet their health care needs as a trans nonbinary person made them ill**
			it turns out I could have a baby, heck and the menopause is something that you should really look into and find out about. Just not telling me I might be going through it (913-915)	**Epistemic erasure complicates their journey as a trans nonbinary birthing person**
		Theo	*they were really like 'Is it OK if we do this like is it really OK? Are you gonna be comfortable? What do you want, like a chaperone?'… and it's like, just like treat me like a normal person (51-56)*	**Staff didn't know how to work with me: feeling othered**
	Navigating visibility: 'people see you and they can't really'	Alex	*I'm not going to add that added uncomfortable feeling of talking about this to these midwives that I've never met before (189-191)*	**It doesn't feel safe to be 'out'**
		Jocelyn	*I didn't want the additional stress of explaining cause, with my care, I very rarely saw the same doctor or midwife… it would be going to again, explaining, and that's just taking time out of me getting the information that I want (162-169)*	**Gender disclosure feels uncontaining**

		Lora	*they assessed me psychologically to make sure that I was like, prepared for being a surrogate… so it felt like something that I couldn't really tell them about (67-76)*	**Privacy as protective**
			I had to like make it really obvious to like whoever turned up, so I had a sign on the door… that was like the most important thing…it was just about how I wanted to be I talked to, talked about (271-281)	**It is a battle to get your needs met**
		Theo	*just easier to not say anything, can just let them assume what they're going to assume (2) but then and again, that's also tiring (1560-1562)*	**The emotional toll of misgendering and educating**
		Sam	*people see you and they can't really (868)*	**Seen as less than**
			we were sensationalised quite a lot…I was trans, seen as a trans man, like and it's the first trans person they'd ever met (54-57)	**Dehumanising care and a lack of understanding**
			I said to all of them, I said 'you will have had a trans person. You would have had a queer person. You've had a nonbinary person. You just wouldn't have known it, no one's gonna be telling you, like, and even if you know it, no one's asking' (635-639)	**Education is part of systemic change – trans people are leading the way**
		Ari	*more of the doctors that I was seeing that were deliberately correcting themselves…it definitely made me feel better. Um (2) like even just to know that there was one person that was that took an interest (344-383)*	**Gender affirmation starts with a conversation**
		Charlie	*I was also terrified of being Britain's first pregnant man again (26-27)*	**The objectification and dehumanisation of trans pregnancy**
			I spent the whole of my pregnancy, my birth, and my postnatal period having to educate every single member of staff I came into contact with… it was also scary because I didn't know if I was gonna receive transphobia (938-945)	**A lack of knowledge about trans and nonbinary reproductive healthcare within the NHS**
			I had the realisation that I could never keep my transness to myself again…my transness wasn't just mine anymore, it was also my child's. Because her narrative of how she came to the world, her story, hinged on my transness (43-48)	**The protective role of the birthing parent**
	Queering services in the face of oppression	Ari	*a lot of doctors in the sort of general medical system, don't tend to really know about sort of trans and nonbinary healthcare (85-87)*	**The silencing effect of epistemic erasure**
		Alex	*I don't know how we can make the changes and space for people (2) if those midwives aren't there learning themselves (.) and feeding that knowledge back to people (1007-1010)*	**Creating safety in services**
			before I didn't really feel as important to be like as representative and I was like, really (.) dismissive of who (.) I was trusted to, you know, to be like myself with. But now I'm kind of getting to the point where I'm like. If we need the world to be better place, I kind of have to get over that uncomfy feeling (575-583)	**Being part of the change**
		Jocelyn	*ask (.) what my gender is, and then talk about the gender. And*	**Perinatal services need to create**

			then it would be on record from the word go (.) and then you wouldn't need to keep explaining (837-839)	**space for gender diversity**
		Theo	*I want all those different experiences to be there (1531-1532)*	**Queering support spaces: the need for expansive spaces**
		Lora	*someone who is aware that people who aren't women can get pregnant [laughter] which is so like, such a, such a low bar, but like not one that we've cleared (828-830)*	**Systemic erasure of gender diverse birthing people through adherence to cisnormative ideas of pregnancy and gender in the NHS**
		Sam	*Things have shifted so much that the medical professional and psychologists are gonna have to (.) sort themselves out like, because it's going to be a massive gap (535-537)*	**Anti-trans prejudice is a systemic issue**
			it's really good to just feel like I'm able to do something like that might help…you're like, just hoping that things will be different for the future (1044-1052)	**Education is part of systemic change – trans people are leading the way**
		Charlie	*I feel it strongly enough that I've set up a business to try and make the change [laughter] (954-955)*	**The self as powerful, capable, resourceful**