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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*:** Genderqueer and nonbinary birthing people's lived experiences are not captured within perinatal mental health literature. Gendered assumptions surround experiences throughout pregnancy, birth, and parenthood. Additionally, psychological distress can have a vast impact on a birthing person. An intersectional approach is vital to support all birthing people during the perinatal period.

***Aims*:** To explore genderqueer and nonbinary birthing people's experiences of perinatal mental health and support in the perinatal period in the UK.

***Method*:** Seven genderqueer nonbinary birthing people's lived experiences of psychological distress in the perinatal period were analyzed 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.

***Discussion*:** Genderqueer and nonbinary birthing people discussed their experiences in relation to a loss and subsequent rebuilding of identity, bodily and social dysphoria, and their felt sense of connection with others. Participants explored how systemic erasure and anti-trans prejudice within services contributed to loneliness, isolation, fear, and distress. Findings encourage the dismantling of traditional gendered notions of pregnancy, birth, and parenthood. They also reinforce the need for transformation in perinatal services to ensure inclusive and safer support for genderqueer and nonbinary birthing people.

KEYWORDS
Identity; perinatal services; pregnancy and birth; social dysphoria; transgender

Introduction

The perinatal period (PNP) is associated with an increased risk of the exacerbation of preexisting mental health conditions (Martini et al., 2015), and the onset of novel experiences of psychological distress for birthing people (Jones et al., 2014). Research indicates that 27% of birthing people (Howard et al., 2018) and 10% of non-gestational partners (Darwin et al., 2020) are affected by diagnosable perinatal mental health (PNMH) conditions in the UK.

Physiological changes in the PNP are vast and can contribute to psychological distress (Blount et al., 2021). The transition to parenthood also involves complex shifts in a person's understanding of their identity (Darvill et al., 2010), societal roles (Shrestha et al., 2019), and the autonomy and power they have (Mauthner, 1999). Feminist perspectives of psychological distress in the PNP highlight how traditional gendered perceptions of parenthood and the pressure to be a 'perfect mother' (Meeussen & Van Laar, 2018) are linked to the felt sense of a loss of a former self and life (Lazarus & Rossouw, 2015; Staneva et al., 2015), a pervasive sense of loneliness and social isolation (Adlington et al., 2023; Taylor et al., 2021), fear of judgment (Young et al., 2022), and increased feelings of guilt and shame (Henderson et al., 2016; McGrath et al., 2013). Unachievable expectations surrounding parenthood can cause increased worry about getting parenting 'right' (McCarthy et al., 2021), reduced sense of self-efficacy (Henderson et al., 2016), and

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increased fatigue (Metzger & Gracia, 2023) and burnout (Meeussen & Van Laar, 2018). For many, a lack of recognition within society of the physical, psychological, and political impact that childbearing can have on a birthing person can create and contribute to distress (Rich, 2021). Social support, however, may buffer these effects (Sufredini et al., 2022).

Despite the greater risk of experiencing PNMH changes for those holding marginalized intersectional identities (Freeman, 2024; Greenfield & Darwin, 2021; Howard & Khalifeh, 2020) most of the research about psychological distress in the PNP represents White, middle class, heterosexual, cisgender women's experiences. For queer birthing people—those who are not exclusively heterosexual and/or cisgender—navigating highly gendered cisheteronormative spaces and societal ideas about parenthood further contributes to feelings of erasure (Darwin et al., 2019), loneliness, and isolation in the PNP (Soled et al., 2023). This is not unwarranted as queer experiences—particularly those of gender diverse people—are underrepresented within perinatal literature, service understanding, and service provision (Darwin et al., 2019; Greenfield & Darwin, 2024).

Research centered on trans and nonbinary (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 can increase uncomfortable feelings of feminization (Falck et al., 2024; Jackson et al., 2024). More often, dysphoria is experienced socially—distress is related to being perceived as woman or mother because of the pregnant body (Greenfield & Darwin, 2021). Increased distress has also been linked to structural barriers, including the lack of medical and psychological information available to support TNB people through pregnancy and birth (Botelle et al., 2021; Coe, 2023; Falck et al., 2024; Jackson et al., 2024; LGBT Foundation, 2022). Experiences of anti-trans prejudice within parenting spaces (Bower-Brown, 2022; Bower-Brown & Zadeh, 2021) and perinatal services (Pezaro et al., 2023; Roosevelt et al., 2021) also increase psychological distress in the PNP, with a lack of gender-affirming perinatal care being associated with increased perinatal anxiety (Pow, 2023).

Increased rates of psychological distress (Jones et al., 2019; Newson et al., 2021) and experiences of trauma (Mizock & Lewis, 2008), discrimination, and prejudice (Stonewall, 2018) in TNB communities contribute to a higher risk of experiencing psychological distress in the PNP (Gedzyk-Nieman & McMillian-Bohler, 2022). Stigma within perinatal healthcare systems (Pezaro et al., 2023), and eugenicist ideologies about trans pregnancy (Lowik, 2018) may increase the likelihood of birth trauma (Pow, 2023; Svanberg, 2019). Structural inequalities, the rising societal and governmental anti-trans prejudice in the UK (Home Office, 2021; House of Commons Library, 2023), and the lack of understanding, knowledge, and resources related to TNB birthing people's experiences within services and society, mean that many UK perinatal services do not meet the physical and psychological needs of marginalized birthing people (Botelle et al., 2021; LGBT Foundation, 2022; Pezaro et al., 2023).

The limited literature that focuses on noncisgender experiences tends to homogenize gender identities under the trans umbrella. Although there may be some similarities in experience, research suggests an increased risk of poorer physical health (Scandurra et al., 2019) and MH (Jones et al., 2019) outcomes for genderqueer and nonbinary (GQNB) people. Additionally, experiences of parenting (Bower-Brown, 2022), psychological distress (Stanton et al., 2021) and iatrogenic harm from healthcare systems (Fiani & Han, 2020) can differ for binary trans people and GQNB people. GQNB may also experience invalidation and erasure of their gender by cisgender people and binary trans people (Johnson et al., 2020).

The lack of literature that prioritizes the exploration of GQNB PNMH experiences in the UK restricts the nuanced and multifaceted understanding that is required for services to provide safe and effective gender-affirming physical and MH care in the PNP (Greenfield & Darwin, 2021; Riggs & Bartholomaeus, 2018). As the impact of experiencing psychological distress in the PNP is vast (Runkle et al., 2023) and can be grave for some (MBRRACE-UK, 2023), this lack of appropriate care increases GQNB birthing people's vulnerability at a critical time. This research therefore aims to explore GQNB birthing people's

experiences of psychological distress and support in the PNP to support the delivery of tailored and inclusive perinatal care.

Method

Design

A cross-sectional qualitative methodology was selected (Robson, 2002). Semi-structured interviews were used to generate depth and richness when exploring the participants nuanced, multifaceted experiences of psychological distress in the PNP.

Interpretive Phenomenological Analysis (IPA) was used as it has a primary aim of developing a detailed understanding of an experience as it is lived (Smith & Fieldsend, 2021). Eliciting information about how a person perceives and makes sense of their subjective experience (Pietkiewicz & Smith, 2014), and interpreting their narrative of phenomena through their social, political, and cultural histories can bring to light new understandings of intersectional experiences (Neubauer et al., 2019). Exploring complex idiographic 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).

Meaning is created not only through the subject's individual interpretation but also through the researcher's interpretation of their experiences (Gadamer, 1976; Laverty, 2003). The analytical process is therefore a dynamic double hermeneutic (Smith & Osborn, 2008).

Ethics

Ethical approval was provided *via* the Research Ethics Committee at the University of East London, School of Psychology. Informed consent was obtained from all individual participants.

Consultation

Two GQNB people were consulted with during interview schedule development. An additional demographic question regarding sex was added. The structure of the exploratory questions was altered to increase chronology.

Recruitment

Participants were recruited using purposive sampling. Advertisements were shared on social media and with relevant groups, community spaces, charities, organizations, and birthing workers that support queer and GQNB birthing people. Participants had the option to enter a draw to win one of three £30 vouchers. Inclusion criteria: not identifying as a man or woman; gave birth in the UK 6+ months ago; experienced mental health changes in the PNP; aged 18+; speaks English.

Data collection

Individual interviews were used to collect the data, with optional demographic questions being asked at the beginning of the interview to contextualize participants' experiences within their intersectional identities. Open questions were used 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. The interview schedule was used flexibly to support the generation of rich and detailed accounts, creating space for unexpected avenues to be explored (Fusch & Ness, 2015).

The participant information sheet, outlining the studies purpose, potential benefits and risks of participating, and confidentiality procedures was emailed to prospective participants upon expression of interest. The consent form was reviewed at the beginning of the interviews. Interviews lasted 60-90 min and were conducted and recorded on Microsoft Teams. Participants were reminded of their right to withdraw during a verbal debrief. Following termination of the interview, participants were sent a debrief sheet detailing sources of support. Individual interviews were transcribed verbatim. Pseudonyms were used and potentially identifiable information was removed from the transcript to enhance anonymity.

Data analysis

Smith et al.'s (2021) guidelines outlining the iterative and inductive process of IPA were followed.

Transcripts were listened to and read multiple times prior to commencing exploratory noting. Layers of interpretation occurred as the researcher focused on linguistic and conceptual features of the data, the context of the participant, and the participant and researchers meaning making processes. Following this, experiential statements were generated, summarizing interpretations within the exploratory notes. These were printed and manually arranged to search for connections across the experiential statements, exploring areas of divergence and convergence. Personal Experiential Themes (PETs) were generated for clusters of experiential statements. This was repeated for all transcripts before exploring patterns across all participants PETs to develop Group Experiential Themes (GETs).

Reflexivity

The lead researcher (ES): a White British, childless, genderqueer, queer, neurodivergent, middle-class person with experience of psychological distress conducted the interviews and led the analysis, which was discussed and finalized with VC - White British, middle-class, cisgender, heterosexual person, with children and lived experience of changes in PNMH.

Analysis is not an objective process. Researchers' experiences, context, beliefs, and assumptions shape how they make sense of phenomena and interpret data to cocreate knowledge (Smith et al., 2021). The lead researcher holds both 'insider' and 'outsider' positions. This will have affected the interviews, analysis, and results. Lived experience of the GQNB identity will have contributed to a critical exploration of the topic due to an awareness and interest in the social and political climate surrounding gender. Moreover, this shared identity may have fostered a stronger sense of understanding and recognition within the interview process. Conversely, an implicit understanding of pregnancy, birth, and parenthood will have been limited due to a lack of lived experience.

This was explored in a reflective diary and in discussion between the researchers, to explore potential areas of bias and consider how the lead researcher's social location, personal experiences, and responses to the material shaped their sense-making. Staying close to the participants experience by maintaining the integrity of their narratives throughout the analysis and results was vital in minimizing researcher bias.

Results

Participants

Seven people volunteered to participate. All lived 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 ($m = 32.86$). Further demographic information can be found in Table 1.

The idiographic nature of IPA justifies a small sample size as it allows for depth of individual analysis whilst retaining capacity for meaningful comparison of group data (Smith et al., 2021). A level of conceptual depth as appropriate for IPA was reached. The rich data and detailed analysis led to a complex network of themes that are present within each participant's account, contributing to a nuanced and detailed understanding of the phenomena being explored.

Overview of analysis

The analysis resulted in four overarching GETs, each containing subordinate themes that illustrate

Table 1. Participant demographics.

Participant demographics						
Pseudonym	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	Pansexual	Middle-class	White British	Yes	35–39
Theo	Nonbinary	Queer	Working/Middle-class	White European	Yes	30–34
Sam	Nonbinary trans masc	Pansexual	Middle/Working-class	White British	Yes	40–44

participants' idiographic experience and sense-making (Table 2). The researchers attempt at meaning making is one possible interpretation of the data (Pietkiewicz & Smith, 2014). The readers understanding will be influenced by their own sense-making of the researcher's interpretation as they draw on their own experiences (Smith et al., 2021).

Navigating shame and the emotional tides of distress

Distress as destabilizing. Participants highlighted the emotional fluctuations and loss of control 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)*, 'Devastatingly' and 'spiral' suggest an overwhelming sense of hopelessness within intense emotional experiences. Cyclical descriptions indicate the difficulty in finding stability and coping with the distress.

Others conveyed a sense of powerlessness as their typical routine and capacity to experience emotion was suddenly disrupted "*like the day I stopped [pumping], I couldn't get out of bed. I like, it was like I got hit by a truck…I couldn't like feel anything*" *(Lora)*.

For some, this sudden change impacted their ability to care for themself and their baby.

> *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 (Theo)*

Table 2. Themes.

Themes	
Group experiential theme	Subordinate themes
Navigating shame and the emotional tides of distress	Distress as destabilizing
	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

A sense of detachment and disconnection from life prevented them from being able to step into their parental role.

Some participants described unsettling intrusive thoughts of suicide. "*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*" *(Ari)*. Arguably, suicidal ideation manifested due to Ari's desire for the distress to relent rather than wanting their life to end. Alternatively, stigma surrounding suicidal ideation may have influenced how they conveyed the distress they experienced.

Distress as shameful. 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)*. Stigmatization was silencing as they felt others could not tolerate their distress.

Others experienced the silencing effect of stigmatization within services. "*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)*. The smiley face is a sinister mirror of the mask that Alex had to wear when accessing support due to structural stigmatization. Distress was also deemed something to hide due to the punitive and authoritarian feel of helping services. "*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], "immediately it's like abuse and your kids are gonna get taken off you*" *(Theo)*. Instead of being able to be honest, Theo was silenced by fear of judgment and loss.

Others experienced stigma within their family context. "*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)*. The performance of wellness as a neurodivergent birthing person was considered protective as it prevented rejection. Arguably, this acceptance

hinged on stigmatizing views of distress, neurodivergence, and disability, further silencing their true emotional experience.

For some this shame was internalized as they questioned their capacity to meet the expectations of parenthood. "*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)*. Shame, therefore, perpetuated distress as it generated additional fear.

Rebuilding identity under the heavy burden of the cishet gaze

'I Literally couldn't be anything else': a disrupted sense of self. Participants described the early parenting role engulfing their identity and restricting what they could do. "*You turn into a bit of a robot… you're just doing it to sort of um, you know, survive and keep your baby healthy*" *(Ari)*.

Feeling reduced to a provider not only erased their sense of personhood but also created disconnection from their gender identity. Sam highlights the intersectional nature of this loss of sense of self. "*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)*. The societal narrative that the main role of a pregnant person is to grow another, rather than to be and connect with who you are contributed to feelings of oppression. The use of 'doubly not seen' highlights an additional loss of identity for GQNB birthing people as cisheteronormative assumptions throughout society equate pregnancy with womanhood.

To perceive and be perceived: the experience of dysphoria. The nature of dysphoria was linked to feminizing body changes that created a sense of unease and incoherence. "*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*" *(Jocelyn)*. Changes to the body during pregnancy caused dissociation and a disconnect from the experience of pregnancy "*it was really strange because it kind of felt like an out of body experience*" *(Alex)*. A felt sense of misalignment made pregnancy felt surreal.

Participants described how 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 me… maternity clothes are quite like floral and like pretty and feminine. And that's not like how I want to present*" *(Lora)*. Society's binary perception of gender and pregnancy limited participants self-expression.

For others, a sense of security and comfort within their bodies pre-pregnancy protected them from body related gender dysphoria. "*My body had masculinized 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 varying ways GQNB people can relate to their bodies and find gender euphoria.

Participants experienced discomfort in how they were perceived due to societal assumptions about who can and who should become pregnant. The lack of acknowledgement of participants birthing role due to perceptions of their gender invalidated 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)*

A lack of language around GQNB birthing experiences made it harder for participants to communicate their experience and be understood by those around them, creating a deep sense of invisibility, isolation, and rejection.

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. "*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. This involved prioritizing bodily autonomy "*I stopped [breastfeeding] early because I was like. I wanted my body back. I wanted to reclaim myself" (Jocelyn)* and spending time on activities they were interested in "*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)*. Some participants described how working was vital in rebuilding their self-esteem and individuality. This cultivated feeling grounded and present in their parenting role.

> *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 some, psychological distress was reduced through fostering a stronger connection to their parental identity. With the support of services, Theo was able to bond with their child and 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)*. Others 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)*. Familiarity with their child and confidence in managing their role fostered stability as participants were able to cope with the everyday stressors that come with parenting.

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. Participants described security in their bodies capacity to sustain new life. "*It felt um, like yeah, like a thing my body was designed to do" (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.

Others combated cisheteronormative narratives through connecting to ideas of lifelong resistance to conformity "*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)*.

For some, this deconstruction and rescripting of narratives was explored through 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)*. Deconstructing 'mama' disarmed societal assumptions around the word. Deconstructing motherhood was described as a process. "*I knew I could never be, quote unquote mother to my children. I eventually got to a space of recognizing I could still do mothering, provide the nurture, provide the care regardless of what name I use" (Charlie)*. Connecting to roles within childrearing disrupted linguistic erasure of their experiences.

Feeling understood, connected to others

"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. For some, the transition to parenthood was a catalyst for reduced social connection. Their experience of parenthood shifted their priorities, leading to a loss in long-lasting friendships. "*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" (Ari)*. Participants found it hard to meet other GQNB birthing parents, increasing feelings of isolation "*A lot of the spaces I didn't feel like were for me…everything is like so gendered and…other queer people are really surprised to find out that I'm a parent" (Alex)*. Discomfort around gendered perceptions of pregnancy reduced participants ability to relate to birthing women, contributing to feelings of otherness. "*I just didn't connect with anything they were saying and I really felt like I was an impostor" (Alex)*.

Participants desired collective support and compassion "*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" (Charlie). Charlie conveys a deep sense of longing for belonging, reciprocity, and emotional intimacy. Although this is often understood through a gendered lens of motherhood, they reach beyond these notions by deconstructing the individual acts that contribute to building this model of collective care.

Some participants highlighted the impact of class on access to an understanding community. Although they found a queer parenting space, their differences in experience of the world left them feeling isolated and detached from others. "*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" (Sam).* For Sam, middle-class queer spaces conformed to normative family values, exacerbating their sense of loneliness as they felt 'too queer', too different.

(In)consistent (Un)caring experiences of support. Participants had varying experiences of care from services throughout the PNP impacting their sense of connection. Participants felt safe and cared for when professionals took time to listen 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).*

Others describe a lack of collaborative person-centered care within services. Support from services reduced rapidly once participants had given birth, making it harder to reach out for psychological support. "*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).* Moreover, services dismissed care needs, offering unsafe treatment options without a comprehensive care plan "*I'm asking really…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).*

Poor care was described as a systemic issue that intertwines with societal prejudice. The intersections of participants identity increased marginalization and isolation.

> *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 (Sam)*

Services failing to provide appropriate care was one way of maintaining the status quo when participant's did not conform to the norm.

Finding comfort in a valued partner. Some participants described a sense of togetherness and security with their partner. "*It's just the two of us against the world which I don't mind so much" (Theo).* Trust and interdependence within the partnership supported participants psychological wellbeing. For some this manifested through encouragement and nurturing "*My partner kind of like just sort of gently nudged me towards going to the doctors" (Ari).* For others, this manifested through shared parental duties to create stability and containment *"he got regular hours so we got into a regular routine to again…that was really helping pick me up" (Jocelyn).*

Despite their GQNB identity, as the birthing person, some participants were expected to bear all of the domestic responsibilities, creating feelings of isolation and diminishment within the partnered relationship. Achieving an equal split of duties and resisting patriarchal norms required self-advocacy.

> *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)*

Some participants highlighted how their wellbeing was interconnected with their partners. "*When I think of my mental health, we sort of came as a package" (Sam).* Shared experiences of distress indicate the importance of Systemic approaches within PNMH services.

Community as a healing force. Connecting with others who shared similar experiences helped participants feel implicitly understood, accepted for

who they are, and assured in their sense of self "*The one thing I need more than anything else is community. Nobody else gets what it's like to be trans and pregnant" (Charlie),* "*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)*. Community was a healing force, reducing isolation and dysphoria, and helping participants feel valid in their experiences.

Feeling understood and connected to others was experienced through participants relationship with trans staff. Their identity meant that they were able to understand the participant's needs and advocate on their behalf, creating a network of resistance that supported them through difficult experiences with perinatal services. "*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)*.

Creating safety in an unsafe world

Invisible to the system. Participants described their safety in services in relation to their experiences of systemic erasure as GQNB birthing people, highlighting a lack of representation of people who do not fit the cisheteronormative mold. *"Everything says woman, absolutely everything" (Alex),* "*It was always just a mum, a dad and a baby, and there was never anything different" (Ari).* Normative images and understandings of pregnancy and birth meant that participants felt othered and misunderstood when accessing perinatal services *"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 cisgender people. Moreover, restrictive gender stereotyping and poor training meant that staff's attempts at inclusive care left some feeling misunderstood, alienated, and uncomfortable *"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).*

A lack of research and knowledge about GQNB birthing people's experiences meant that participants 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).* Epistemic erasure meant that participants felt unsure about what advice they could trust from professionals *"I didn't have like a whole load of faith in her [laughter] for that to be like research backed or anything" (Lora).* This lack of professional knowledge also restricted access to psychological support *"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).*

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

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),* especially when they had experiences of being dehumanized *"we were sensationalized 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 some participants were tasked with educating throughout their perinatal journey.

> *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 labor.

Some who disclosed their gender experienced continual misgendering, choosing to preserve their energy by not correcting staff. "*Just easier to not say anything, can just let them assume what they're going to assume, but then and again, that's also tiring" (Theo).* Painful rejections depleted

their energy levels when they were already vulnerable. Participants reflected on how a lack of understanding about the lived experiences and nuance in GQNB people lives results in generalizations, misunderstandings, and stereotypes "*people see you and they can't really*" *(Sam)*.

The pain of misgendering during birth was buffered against through assertive communication.

> *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)*

Lora's experience exemplifies the extent to which GQNB birthing people must go to fight for appropriate care. Language was a powerful tool to protecting their story and experience of birth.

Queering services in the face of oppression. Participants emphasized the necessity of education and training to deconstruct cisheteronormative narratives in services and increase inclusivity. "*I don't know how we can make the changes and space for people if those midwives aren't there learning themselves and feeding that knowledge back to people*" *(Alex)*. Change is seen as an ongoing process with staff as integral to facilitating cultural shifts.

Participants emphasized the importance of consistent, open-minded, understanding staff to create 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)*.

Participants considered how subtle and nuanced understandings of family-making and gender can create services that provide inclusive support using an expansive approach "*I want all those different experiences to be there*" *(Theo)*.

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

> *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. It helps those with lived experience regain control over the narratives of their experience, disrupting the painful isolation that many participants endured.

Discussion

Participants highlight the variety of ways in which they experienced PNMH concerns emphasizing the necessity of understanding of psychological distress beyond diagnostic criteria. Destabilizing experiences of psychological distress in the PNP were related to a rupture of identity. Participants described feeling consumed by their new role. This loss of a sense of self contributed to feelings of dysregulation, isolation, and guilt, emphasizing the destructive impact of patriarchal ideas on all who give birth. For many, their PNMH experiences were amplified by societal stigmatization of psychological distress, impacting help seeking, and feelings of loneliness and shame.

The experiences described have been highlighted in preexisting literature relating to cisgender people's PNMH experiences. Regardless of gender identity, birthing people may have shared experiences relating to the pressure to conform to gender norms (Meeussen & Van Laar, 2018), a felt sense of isolation and disconnection from peers (Adlington et al., 2023) and rebuilding a new sense of self in parenthood (Jewell et al., 2022; Law et al., 2021). Furthermore, distress is experienced in multifaceted ways, with stigma impacting birthing people's access to and experience of mental health care (Adlington et al., 2023; Webb et al., 2023).

For GQNB birthing people within this research, engulfment by the parenting role was compounded by the social and bodily dysphoria they experienced. A lack of language and societal understanding surrounding their embodied experiences of pregnancy and parenthood contributed to a double loss of identity as participants not only lost their sense of self to parenthood, but also experienced a loss of gender identity as their parental role was frequently misunderstood,

questioned, or sensationalized (Greenfield & Darwin, 2021). Although some participants reflected on bodily changes feeling feminizing, this was compounded by a lack of access to gender affirming clothes and care. As reflected in prior research (Bower-Brown, 2022), binary conceptualizations of gender contributed to experiences of erasure as GQNB birthing people did not fit into normative understandings of pregnancy and parenthood. Cisheteronormative conceptualizations of family making therefore exacerbated feelings of isolation, overwhelm, and invisibility for GQNB birthing people (Richardson, 2022).

Similar to existing PNMH literature for cisgender women (Collins et al., 2021; McLeish & Redshaw, 2017), participants reinforced the importance of social connectedness and being able to relate to others who have a similar experience to you to support wellbeing. Psychological distress was exacerbated by how connected GQNB birthing people felt to others, with many finding it difficult to find an understanding and intersectional community, contributing to feelings of loneliness. For GQNB birthing people in this research, prejudice, erasure, and abandonment from services further compounded experiences of distress, shame, and loneliness. Participants continually assessed their safety within services around sharing their identity. In line with theories relating to the 'minority tax' (Rodríguez et al., 2015), when disclosing their gender identity some participants were met with overt prejudice, whilst others were burdened with the task of educating others. Those who did not share contended with the discomfort of not truly being seen or understood by healthcare workers. A lack of inclusive healthcare information, resources, and training for perinatal staff meant that GQNB birthing people were constantly othered and overlooked. As a result, GQNB birthing people were not provided with the physical and mental health care they needed (Pezaro et al., 2023).

Results also highlight variable experiences depending on a person's intersectional identity. Those holding multiply marginalized identities—as related to class and disability within this research—reported experiences of interconnected and mutually reinforcing forms of disadvantage. Understanding the complex ways in which various forms of prejudice and oppression interact is therefore necessary when understanding how gender impacts a person's perinatal experiences.

Within this research, novel ideas around the value of resistance are also captured. For some, this was embodied through political action in transforming perinatal systems and personal action by reclaiming their time or body for activities outside of parenthood to support reconnection to the multifaceted self. For others this involved rescripting, queering, and reimagining narratives of pregnancy, birth, and parenthood. Deconstruction resulted in both utilitarian understandings of the body's capacity—as seen in prior research relating to TNB parents (Jackson et al., 2024)—and pleasure in their experience of pregnancy or parenthood. This, alongside finding and connecting with other GQNB birthing people, increased feelings of visibility and acceptance within a collective identity. Shared experiences and stories bolstered feelings of understanding and self-worth, reducing psychological distress. This was mirrored for those who experienced validation, consistency, and advocacy from healthcare professionals highlighting the importance of being seen for who you are.

Strengths and limitations

This study is the first to explore GQNB birthing people's PNMH experiences in the UK. Nizza et al. (2021) and Yardley's (2000) quality indicators guided the research. The sensitivity to both participant and researcher context, active engagement with the literature, and the consistent and rigorous approach taken supported the construction of rich phenomenological data. Findings highlight socio-cultural, systemic, and political influences on distress, supporting the development of a nuanced understanding of and attendance to GQNB birthing people's experiences in the PNP.

The stories shared provide valuable insight for professionals, individuals, and communities to better understand GQNB birthing people's experiences in the PNP. Participants experiences emphasize practical recommendations for services and communities to improve perinatal care for

GQNB birthing people and their families—e.g. speaking about gender and wellbeing, consistent care, and understanding and being able to identify PNMH concerns related to GQNB birthing people (for further discussion: Botelle et al., 2021; Greenfield & Darwin, 2021; Pezaro et al., 2023; Pezaro et al., 2024). Whilst changes in language, service policy and practice, and education and training are needed, transformation starts with an individual and systemic openness to learning about people's experiences and deconstructing social narratives.

The IPA approach allowed exploration of both individual stories and group experiences. Although generalizations cannot be made, the findings may support increased awareness of what some GQNB birthing people experience. Space for nuanced and idiographic stories exemplifies the diversity of experience.

Although participants form a homogenous sample—a core tenet in IPA (Smith et al., 2021)—they are not representative of 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, 2022; Coe, 2023), all participants were White, and none disclosed experiences of perinatal OCD, eating disorders, or inpatient admissions. Consequently, the results do not capture the intersectional experience of racialized minoritized GQNB birthing people or those with less common PNMH experiences.

Future research

Future research is needed to address the gap in knowledge surrounding the experience of racialized minoritized GQNB birthing people and those who have experienced less common PNMH concerns and/or inpatient and parent-baby units.

This is especially important as racialized minoritized GQNB birthing people will experience the same discrepancy in care that results in devastating outcomes for racialized minoritized birthing women (MBRRACE-UK, 2023). The lived experience of psychological distress is influenced by experiences of marginalization and identity for racialized minoritized people (Beauboeuf-Lafontant, 2007; Hackett et al., 2020). As such, neglecting to understand intersectional experiences—especially when literature may be used to alter service provision and policy—will only serve to perpetuate discrimination and harm.

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 (Greenfield & Darwin, 2021). 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.

Conclusion

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. Attending to the needs of those most marginalized 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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Note

To read a more detailed analysis and discussion please refer to Chapter 3 and 4 in the authors thesis (Smith, 2024).

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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