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Lauren Ambrosini
“The Most Badass Thing I’ve Ever Done”:
Experiences of Transgender and
Gender Non-conforming Birth Parents

ABSTRACT

To most people, the ability to carry and bear children is one that is inextricably linked with femininity and womanhood. However, some individuals who gestate and give birth to a child do not identify as women or as feminine. At the forefront of disentangling these two concepts from pregnancy and birth are gender non-conforming individuals, including masculine-identified women, transgender men, and folks who identify as outside the gender binary of man/woman, who have chosen to carry and bear children. Beyond the narratives of a few well-known transmen (e.g., Thomas Beatie) and masculine-of-center lesbians (e.g., A.K. Summers) who have given birth, there is precious little empirical information about the pregnancy and birth experiences of gender non-conforming individuals. In order to better understand and serve this population, I conducted semi-structured interviews with transgender and gender non-conforming individuals who had given birth at least once within the past ten years or who were currently in the second or third trimester of pregnancy, surveying their experiences of conception, pregnancy, birth, and the postpartum period, with particular focus on interactions with healthcare and social work professionals. Preliminary results of the interviews showed that the conception, pregnancy, birth, and postpartum experiences of transgender and gender non-conforming birth parents were diverse and in many ways were similar to the experiences of cisgender individuals, though also included experiences of dysphoria, stigmatization, fear of discrimination, and incredible resilience. More empirical research, both qualitative and quantitative, into the experiences of transgender and gender non-conforming birth parents is needed in order for healthcare and social work professionals to better serve individuals in this community.

**“THE MOST BADASS THING I’VE EVER DONE”: EXPERIENCES OF
TRANSGENDER AND GENDER NON-CONFORMING BIRTH PARENTS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2015

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CHAPTER I

Introduction

In the trailer for the upcoming film *Ma/ddy*, the main character, Skylar, is shown clipping their sideburns and putting gel in their short hair, lighting a candle by a picture of themselves and their wife, Katie, who recently died in an accident (Kirkpatrick, forthcoming 2015). Skylar then walks into the closet and pulls on a binder over their head, giving their chest a more masculine contour. During this beginning scene, we only see Skylar from the chest-up and from behind. However, as Skylar shrugs on a short-sleeve button-down shirt, the camera pans down, and they turn to face the audience, their pregnant belly plainly visible.

Skylar is not only a portrayal of a lesbian, a status that has historically been viewed by Americans unfit for parenting (DiLapi, 1989); Skylar is masculine presenting and pregnant. Many viewers might find this unexpected because pregnancy is associated with the feminine; in other words, pregnancy is seen as the antithesis of the masculine (Ryan, 2013). The film *Ma/ddy* is unique because there are remarkably few representations of gender non-conforming and transgender parents, birth parents in particular, in the media. This is a reflection of American society's lack of understanding of the experiences of members of this community. This scarcity of representation is also illustrative of the dearth of scientific inquiry into the needs and experiences of these individuals.

Overall, societal acceptance for individuals who identify as transgender has increased in recent years; however, individuals who identify as transgender or gender non-conforming still represent an at-risk population and often experience immense social stigma, discrimination,

threat of physical violence, and inadequate access to quality healthcare services (Light, Obedin-Maliver, Sevelius, & Kerns, 2014; Bradford, Reisner, Honnold, & Xavier, 2013). In particular, the scientific literature on the experiences and needs of transgender and gender non-conforming birth parents, which would be used to inform and improve the nature and methods behind services provided to this community, has lagged (Light et al.).

Before broaching a deeper discussion of transgender and gender non-conforming birth parents, distinguishing from one another the concepts of sex, gender, and sexual orientation is crucial. Sex refers to a complex combination of hormones, physiology, and chromosomes that interact to determine a person's sex, which may be female, male, or intersex (West & Zimmerman, 1987). Gender, on the other hand, is socially constructed, something that is continually enacted through the use of clothing, hairstyle, accessories, mannerisms, and interactions with others, often woman or man, but also transgender, genderqueer, two-spirit, bi-gender, gender fluid, and many other related terms (West & Zimmerman). Sex was once thought to determine one's gender identity and expression; however, in the last few decades, the relationship between sex and gender has been increasingly decoupled (West & Zimmerman). Sexual orientation is the relationship between one's own sex or gender identity and that of one's romantic and sexual partners (or desired partners). Neither sex nor gender determines sexual orientation.

Through the use of semi-structured interviews, I sought out to add to the empirical literature about transgender and gender non-conforming birth parents. Specifically, I wanted to learn more about the conception, pregnancy, birth, and postpartum experiences of members of this community. Though their experiences were varied, there were parallel threads woven through many of their narratives, including similarities to cisgender parents' experiences, facing

stigma from medical and mental health professionals, as well as from the broader community, and being misgendered by others. My intention is to provide empirical knowledge about the needs and experiences of transgender and gender non-conforming birth parents that will be used by medical and mental health professionals, as well as to improve social work education, in order to provide the highest quality care to individuals who belong to this growing community.

CHAPTER II

Literature Review

Background

Many transgender and gender non-conforming individuals have children or desire to at some point in their lives (Epstein, 2002; More, 1998; De Sutter, 2009; Light, Obedin-Maliver, Sevelius, & Kerns, 2014). As for the broader population, there are several different potential paths to parenthood for transgender and gender non-conforming people, including biological parenthood, adoption, gestation by a partner, and surrogacy. Adoption and surrogacy are often cost-prohibitive and logistically difficult (Boggis, 2001). For many transgender men and gender non-conforming people who were assigned female at birth, the most feasible or desired way to become a parent is through pregnancy (Light et al.). Pregnancy is conventionally considered a feminine or womanly endeavor, and there was little awareness of the existence of transgender individuals who had experienced pregnancy before Thomas Beatie became a household name (Riggs, 2013). In 2008, Beatie, a trans man, went public about his pregnancy and became an object of mainstream media attention. Despite the widespread societal recognition of Beatie's pregnancy, the empirical information about transgender birth parents remains sparse (Downing, 2013).

The literature on pregnancy can most easily be divided into conception, pregnancy, birth, and the postpartum period, which are outlined below.

Conception

In the literature on conception, there is vast information about influences that could potentially make conception challenging. Various factors, including age, weight, and smoking cigarettes, have been found to negatively impact reproductive capability (Homan, Davies, & Norman, 2007). Research has shown that infertility causes psychological stress, experience of stigma, and potential financial issues related to the cost of assisted reproductive technologies, such as in vitro fertilization (IVF), which may be offer hope for conception (Cousineau & Domar, 2006). A meta-analysis of how gender figures into how heterosexual couples with infertility found that women tended to seek out social support, reframe the situation in a positive light, and utilize more problem-solving and planning techniques than did their partners (Jordan & Revenson, 1999).

Pregnancy

For any person regardless of gender identity, pregnancy is a time that signifies the transition to new parenthood. The scientific literature on pregnancy roughly mirrors *What to Expect When You're Expecting*, a book that is widely read by expectant parents (Murkoff & Mazel, 2008). Much literature is focused on how to be healthy during pregnancy and how to maximize the health of the baby (Gaston & Cramp, 2011; Blumfield et al., 2012; Homan et al., 2007). Conversely, there are many studies that focus on complications and other factors that could potentially impact the health of the fetus, for example, smoking cigarettes, or taking antidepressant medications during pregnancy (Boomsma et al., 2006; Jackson, Gibson, Wu, & Croughan, 2004; Kramer, 1987). Also in the pregnancy literature are descriptions of expectant parents anxieties, expectations, and complex feelings toward their pregnancies (Staneva, Bogossian, & Wittkowski, 2015).

Childbirth

In the literature on birth experiences, research on both medical and psychological aspects of childbirth abounds. A major area of focus is cesarean births, which account for approximately one-third of all births per year in the United States (Morris, 2014). A C-section birth not only increases the risk of medical complications but also can have negative psychosocial consequences for the person giving birth (DiMatteo et al., 1996). In part because of this and due to an increasing preference for fewer unnecessary medical interventions, a growing number of women are opting to give birth at home rather than in the hospital (Olsen & Clausen, 2012). Research shows that social and emotional support during labor, sometimes provided by a birth doula, promotes more positive birth experiences for women (Scott, Berkowitz, & Klaus, 1999). Conversely, a traumatic birth experience can lead to difficulties during the postpartum period, often related to mental health (Grekin & O'Hara, 2014). For some women, the experience of birth is traumatic for a variety of reasons, including protracted labor, emergency C-section, perception of loss of control, lack of social and emotional support, intense pain, or triggering of memories or feelings associated with sexual abuse (Elmir, Schmied, Wilkes, & Jackson, 2010).

Postpartum Period

In the literature on the postpartum period, much of the research focuses on postpartum mental health of the birth parent and the transition to parenthood. Many women experience depression, posttraumatic stress, anxiety, or obsessive-compulsive symptoms in the months following childbirth (Patel et al., 2012; Grekin & O'Hara; Zambaldi et al., 2009; Paul, Downs, Schaefer, Beiler, & Weisman, 2013). Maternal mental health difficulties have the potential to interfere with parent-infant bonding (Muzik et al., 2013). In addition, the transition to parenthood can present new challenges. When parenthood occurs within the context of a couple relationship,

the transition to parenthood can put great strain on relationships due to increased responsibilities and lack of physical, emotional, and social resources (Mitnick, Heyman, & Slep, 2009; Trillingsgaard, Baucom, & Heyman, 2014). Furthermore, the decision to breast- or bottle-feed is one that new mothers must make, and research shows that women often feel pressured to exclusively breastfeed their children even if they do not want to or experience difficulties doing so (Nelson, 2012; Ladores & Aroian, 2015).

The overwhelming majority of the research on conception, pregnancy, birth, and the postpartum period has been conducted using participants who are identified as ‘women’ who are presumably heterosexual. The extent to which these findings apply to birth parents who identify as transgender or gender non-conforming is unknown.

Lesbian Birth Parents

A group whose experiences are in ways similar to transgender and gender non-conforming birth parents is lesbian birth parents. Studies have shown that between 49% of lesbian women and 60% of lesbian and bisexual women who were not currently parents desired to become parents in the future (Kaiser Family Foundation, 2001; Bos, 2013). In the past, the options for lesbian couples to have children were limited, and many lesbians who were parents had given birth to children within the context of a previous heterosexual relationship. Beginning in the 1980s, lesbians with financial means were able to utilize assisted reproductive technologies, such as frozen sperm at cryobanks, in order to have children (Bos). When making the decision of which partner will attempt to conceive, Goldberg (2006) found that lesbian couples take into account each partner’s desire to become pregnant and give birth, biological connection to the child, age, and job flexibility. While research has shown that lesbian mothers experience a similar level of stress related to parenting as heterosexual parents, lesbian mothers

have reported experiencing stigma based on homophobia and heterosexism (Bos, van Balen, van den Boom, & Sandfort, 2004).

Notably, the relatively little information about the influence of gender identity for self-identified lesbians on the wish to become pregnant and give birth suggests that lesbians with a masculine gender presentation or identity are less likely to express a desire to become pregnant, perhaps in part due to community norms associating pregnancy with femininity (Ryan, 2013; Reed, Miller, Valenti, & Timm, 2011).

Transgender and Gender Non-conforming Birth Parents

The fact that there is little information about gender identity and pregnancy has implications for the many transgender and gender non-conforming individuals who were assigned female at birth and are either birth parents or want to become parents through pregnancy and birth (Light et al., 2014). For many individuals who were assigned female at birth, conceiving and gestating a biological child is a possibility (More, 1998).

However, there are barriers to and challenges associated with the process of procreation for transgender and gender non-conforming birth parents, including access to appropriate medical services, transgender-friendly care providers, and, if needed, assisted reproductive technologies (ARTs) (Downing, 2013; Light et al., 2014). The specific reproductive needs of an individual trans person depends in part on whether the person has undergone any medical procedures, including testosterone therapy or gender affirming surgeries, as part of their transition. Regardless of medical transition status, from a social perspective, transgender and gender non-conforming birth parents face challenges related to stigmatization and discrimination, as well as dysphoria related to the physical changes of pregnancy and the ways in

which others interact with them related to the intersection of their gender identity with their pregnancy (Haines, Ajayi, & Boyd, 2014).

To my knowledge, only one published empirical study to date has focused on the experiences of transgender-identified birth parents (Light et al., 2014). The study surveyed 41 self-identified transgender individuals who had given birth and found that most of the participants conceived using the sperm of their partner. Among participants in that sample, only 15% received medical consultation during the conception process, 7% used fertility drugs, and 12% utilized assisted reproductive technologies. This suggests that the process of becoming a becoming pregnant for a trans man or gender non-conforming person who has not had any medical transition and has a partner who produces sperm may be, from a medical perspective, quite similar to the experiences of cisgender females (people who were assigned female at birth and identify as women). Comparatively, couples in which both or all partners were assigned female at birth (i.e., transgender men, lesbians, gender non-conforming people, etc.) require at a minimum, sperm donation from an outside party, commonly in the form of artificial insemination.

Medical and Mental Healthcare Access

As has been well documented in the literature, transgender individuals face barriers in obtaining adequate healthcare, including transphobia and pathologization (Downing, 2013). One manifestation of these challenges is the lower rate of pap smears among trans men as compared to cisgender women (Peitzmeier, Khullar, Reisner, & Potter, 2014). This, along with anecdotal evidence, suggests that trans men access gynecological services in lower proportions than do ciswomen, which is concerning given that gynecological exams are important in diagnosing cancers of the female reproductive organs (Peitzmeier et al.). Moreover, others have noted that

transgender birth parents can have difficulty accessing mental healthcare due to a lack of providers who are knowledgeable about trans issues and accepting of trans and gender non-conforming people (Bockting, Knudson, & Goldberg, 2006).

Dysphoria

Gender dysphoria occurs when a person's internal sense of their own gender misaligns with the way the person's gender is perceived by others (Bockting, 2014). Gender-related dysphoria is a central experience that leads one to recognize a transgender or gender non-conforming identity (Bockting). Related to their transgender identities, trans men often have varied and complicated relationships to their bodies and pregnancies. While pregnant, some transgender and gender non-conforming people have noted an increase in dysphoria, while others have experienced a decrease (Light et al., 2014). Light et al. also found that transgender men thought about their pregnancies in various ways which could mediate their experiences of dysphoria: many did not ascribe a gender to their experience of pregnancy or described their pregnancies as a means to end; others experienced their pregnancies as masculine.

Stigma, Discrimination, and Violence

In the United States and worldwide, transgender and gender non-conforming people are at risk for violence and discrimination on the basis of their gender identities (Bockting, Miner, Romine, Hamilton, & Coleman, 2013). In addition to violence and the threat of violence, transgender individuals face institutionalized discrimination, which includes laws that are unfair to transgender people and their families, such as not being covered by employment nondiscrimination, as well as insurance plans that do not cover hormone therapy or surgical procedures desired by a trans person as part of their transition (Downing, 2013; Currah, 2008).

In addition to violence and discrimination, transgender and gender non-conforming people face societal stigma because of their gender identities (Bockting et al., 2013). In a study of birth parents in the Black lesbian community, Reed et al. (2011) interviewed five individuals who identified as ‘femmes,’ who present as feminine; five who identified as ‘studs,’ who present as masculine; and four who identified as ‘stemmes,’ a term specific to this community which describes a person whose “gender presentation fluctuates” between masculine and feminine. Of the sample, seven individuals had been pregnant at least once, four of whom identified as femmes, one as a stemme, and two as studs. The study found that femmes who planned pregnancies within the context of a lesbian relationship were considered “‘good gay females’ and appropriate mothers,” while studs were regarded as “inappropriate mothers.” The appropriateness of a stemme mother depended on gender presentation at any particular point. Reed et al. further found that participants had a difficult time reconciling a person’s stud identity with the desire to become pregnant, believing that if a stud had given birth to a child that the pregnancy must have occurred prior to identifying as a stud. These findings show the degree of stigma experienced from within the queer community by transgender and gender non-conforming birth parents as a result of transgressing societally prescribed gender roles.

Resilience and Coping Strategies

In the face of these various challenges, transgender and gender non-conforming people often show tremendous resilience in their mindsets and coping strategies (Bockting et al. , 2013). One of the most important coping strategies transgender people, as well as LGBTQ people, have used is to become well integrated into the LGBTQ community, thereby increasing senses of inclusion and validation (Bockting et al.). Another strategy of validating their identities employed by transgender birth parents is to use language that reflects their gender identities,

including being called “daddy” or “papa” by their children, using “chestfeeding” rather than “breastfeeding” if they are nursing their children, and referring to themselves as a “gestational parent” or “carrier” of their children (Light et al., 2014).

Limitations in the Literature

While there have been studies on transgender birth parents, most have been theoretical or clinically-informed. To my knowledge, only one other empirical study has been conducted with transgender-identified birth parents (Light et al., 2014). This study utilized an online survey to collect data and required participants to have self-identified as transgender prior to becoming pregnant; the study did not specifically include individuals who identified as gender non-conforming.

Other studies have focused on transgender men who are parents. Ryan (2009) conducted a study with ten female-to-male (FTM) transgender individuals, some of whom were currently parenting and were either birth parents or psychological parents, and others of whom were planning families at the time of the study. Because this study had a small number of participants and was not specific to trans birth parents, the applicability to the broader community of transgender and gender non-conforming birth parents is limited.

Conclusion

The empirical literature on transgender and gender non-conforming birth parents is nascent and as such incomplete. Because these individuals transgress norms of gender expression with their pregnancies, they can experience stigma, discrimination, isolation, and violence. Transgender and gender non-conforming individuals use various coping skills and demonstrate many resiliencies in managing the challenges that they are faced with because of the intersections between their gender identities and birth parent status. The literature has notable

gaps, including holes that this study aims to fill, by employing qualitative interviews to explore the experiences of transgender and gender non-conforming birth parents.

CHAPTER III

Methodology

The study uses a qualitative, exploratory approach to answer the following research question: *What are the experiences of transgender and gender non-conforming individuals of conception, pregnancy, birth, and the postpartum period?* By taking a qualitative, exploratory approach, I seek to add to the scientific knowledge while keeping central the voices of transgender and gender non-conforming birth parents. To survey the breadth of experiences within this understudied population, this study utilizes semi-structured interviews to examine the range of participants' experiences. From the knowledge obtained from this study, I hope to increase understanding of transgender and gender non-conforming people who are pregnant and parenting and increase awareness of social service and healthcare needs of this growing community.

Sample

Inclusion and Exclusion Criteria

To be eligible for participation, an individual needed to meet three criteria for inclusion. First, the potential participant had to self-identify as gender non-conforming, which for the purposes of this study is defined as either identifying outside of the gender binary of man/woman or identifying as a gender or sex other than the one assigned to the person at birth. Participants could identify with such terms as transgender, butch, masculine of center, genderqueer, two-spirit, bi-gender, gender fluid, stemme, stud, (tom)boi, gender variant, or any other term that indicated non-binary gender identity. Because gender is complex and unique to the individual, I

have intentionally kept the definition of gender non-conforming broad so as to recruit participants of diverse gender identities.

Second, the individual had to have given birth at least once during the past ten years or be in the second or third trimester of pregnancy at the time of the screening phone call. Due to vast changes in the visibility and understanding of transgender and gender non-conforming people within the past decade, this study only includes participants who gave birth within the past ten years because of these changes in the sociopolitical climate of the United States (Andersen & Fetner, 2008). If an individual is currently pregnant, the pregnancy must be in the second or third trimester. The reason for this is that a person increase the odds that the participant is read as pregnant at least some of the time, which is more likely to occur after the conclusion of the first trimester of pregnancy.

Third, the individual had to be at least eighteen years old. This is primarily because gender non-conforming teens who are pregnant and parenting are particularly vulnerable to discrimination and exploitation. Additionally, the in-depth interview guide may have been experienced as more triggering for the average teenager than for most adults. A study specifically designed to explore the experiences of pregnant and parenting gender non-conforming teens is warranted but outside of the scope of the current study.

Sampling Method and Strategy

Since the population of transgender and gender non-conforming birth parents is presumably fairly small in number, and there are no centralized records of individuals who identify within this community, random selection of participants was impossible. Alternately, the participant pool was identified through the use of targeted recruitment, as well as convenience and snowball sampling. In sum, seventeen participants were interviewed for this study.

To begin, I conducted targeted recruitment through organizations and online communities that serve the LGBTQ community. Because the various organizations and online communities served more diverse communities than I would have been able to reach using my personal networks, I strived to make this method my primary means of recruitment. Organizations from socioeconomically diverse neighborhoods of urban centers, as well as those located in suburban and rural settings, were targeted for recruitment efforts. The organizations selected were intentionally chosen to increase participation from low-income communities and communities of color, which are traditionally underrepresented in LGBTQ research (Harper, Jernewall, & Zea, 2004).

Simultaneously, I used convenience and snowball sampling methods, beginning with colleagues, friends, and acquaintances of mine who identify as transgender or gender non-conforming or work with members of the LGBTQ community to help identify others who qualified for participation. I recognized that recruitment through convenience and snowball sampling was likely to yield a skewed and constricted sample that would reflect my personal social network (Meyer & Wilson, 2009). This is noteworthy in that a majority of individuals within this network are highly educated and of middle and upper-middle class status. Because of this, I made concerted efforts to reach out to individuals within my network whose social networks were more racially and socioeconomically diverse than my own.

Sampling Plan

The first step in recruiting participants was to compile a list of organizations serving the LGBTQ community and online communities for transgender and gender non-conforming parents. After this list was gathered, initial contact with organizations was made via email, asking to have the email forwarded along with the researcher's contact information to anyone

who might meet be interested in and meet criteria for participation. For online communities, I made contact with a group administrator to ask permission to post a recruitment advertisement in the group's forum.

Concurrently, I began making contact via email and social media with colleagues, friends, and acquaintances who worked with the LGBTQ community or who identified as LGBTQ, with particular efforts to reach individuals who identified as transgender, gender non-conforming, of color, and of low-income background. In order to reduce familiarity bias, I did not interview friends, acquaintances, or anyone with whom I had a current or past personal or professional relationship for this study.

Once a potential participant learned of the study, they were asked to contact the researcher by email for more information. After receiving an email indicating interest, I sent an email back to the potential participant to schedule a screening phone call of around ten minutes to ensure eligibility for participation (see Inclusion and Exclusion Criteria), as well as to confirm that the individual was willing to participate in an interview, either in person or by phone, of around sixty minutes in length.

During the screening phone call, most participants were able to schedule interviews with the researcher, and the remaining participants scheduled interviews via email. As soon as possible after eligibility was confirmed, an Informed Consent Agreement (see Appendix A) was sent to the participant via email. The participant was asked to print, sign, and mail the documents to the researcher. The interviews were scheduled to allow time for the informed consent documents to be received via mail prior to the scheduled interview.

Ethics and Safeguards

Confidentiality, Data Analysis, and Storage

All interviews were conducted by phone. Interviews were recorded using a portable digital audio recorder and separately on the researcher's computer. Audio files were subsequently exported and coded using the researcher's password-protected personal computer. The audio recordings were kept on that computer, as well as on an external hard drive, which was also password protected in order to minimize the risk of violating participants' privacy.

To protect confidentiality, participants' names were not connected to the data on any electronic document, and any notes taken on paper during the screening calls or interviews contained only participants' initials. No identifying information (e.g. name, job, specific geographic location, etc.) is reported in this thesis or will be reported in any subsequent publication. Participants had the right to withdraw from the study at any point until April 1, 2015.

All research materials including recordings, transcriptions, analyses and consent/assent documents were stored in a secure location, where they may remain for up to three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data is password protected during the storage period. Additionally, transcribing assistants, who had access to the data, signed a confidentiality agreement and were subject to the standards of confidentiality as detailed here.

Risks and Benefits

The only identified risk of participation in the study was minor emotional discomfort associated with talking about topics that could reactivate past trauma or difficult experiences.

The risk of emotional distress was higher if a participant had experienced trauma related to their gender identity, especially during the conception process, pregnancy, or postpartum period. However, as expected, no participant experienced more than minor emotional distress as a result of this study.

There were two identified benefits of participation to participation. First, participants were able to share their experiences in a private, confidential, and nonjudgmental setting. Second, participants elected to take part in a study that aims to promote understanding and acceptance of transgender and gender non-conforming individuals within the larger community and within the medical and social work professions. For participants, these two factors in conjunction often produced positive feelings associated with participation in the study.

Data Collection

This study takes a qualitative approach to explore the experiences of transgender and gender non-conforming birth parents, employing individual phone interviews with participants using a semi-structured interview guide (Appendix B). A semi-structured approach enabled the researcher to maintain an agenda of topics to explore, while at the same time allowed flexibility to follow each participant's lead and delve into topics not covered in the interview guide.

The interview guide was separated into seven sections: 1) introduction to the study and interview process; 2) demographic information; 3) gender identity and sexual orientation; 4) planning and conception; 5) pregnancy; 6) birth and postpartum period; and 7) closing.

In the introduction section, participants were asked to introduce themselves and talk about why they chose to participate in this study. Participants were additionally presented with an opportunity to ask questions before beginning the interview, as well as reminded about

consent and confidentiality procedures. This section was designed to set a comfortable tone for the interview and ease the participant into the interview process.

In the demographic information section, participants were asked to describe their racial identity, relationship status, highest level of education, and career or occupation. The purpose of this section was to collect data to ascertain the diversity of the sample in order to assess its generalizability.

For the third section, participants were asked about their gender identity and sexual orientation and how both or either may have evolved over time. These questions were purposely made separate from the demographic questions in the second section because focus on gender identity is integral to this study, and while gender identity and sexual orientation are separate attributes of a person's identity, for many individuals, these identities are often related and intertwined. Additionally, in this section, participants were asked about their thoughts about pregnancy and giving birth prior to conceiving. The rationale behind grouping this question together with the questions about gender identity and sexual orientation was to begin to discuss with participants how gender identity and/or sexual orientation might have influenced (or not influenced) their ideas of pregnancy and birth prior to becoming pregnant.

In the fourth section, participants were asked to discuss their experiences related to planning for pregnancy and the conception process. Example questions from this section were: How did you (and your partner) make the decision to have a child? and, What was your experience like with healthcare or other professionals involved in the process of conception? The purpose of this section was to gauge how the participant (and their partner, if applicable) negotiated the process of deciding whether and how to have children.

For the fifth section, participants were asked about their experiences of pregnancy. Example questions from this section included: What was/has been your experience of pregnancy? and, How did/has being pregnant influence(d) or not influence(d) your experience of yourself as a (gender non-conforming/transgender/other gender identity) person? The purpose of this section was to learn about the needs and experiences of participants during pregnancy.

In the sixth section, participants were asked about their experiences of birth and the postpartum period. Questions from this section included: What was your experience of labor and birth? If currently pregnant, what are your hopes and expectations for the birth process? and, How did you decide what your child would call you (and your partner)? If currently pregnant, have you decided what your child will call you (and your partner)? The purpose of this section was to explore the experiences of participants during birth and the postpartum period to better inform social workers and healthcare professionals working with transgender and gender non-conforming individuals during this important time.

In the seventh section, participants were invited to identify any topics that were missed and to add anything they felt was not previously addressed. The purpose of this section was to ensure that participants' experiences were thoroughly explored even when aspects of their experiences were not explicitly addressed in the Interview Guide.

Data were collected between January 18, 2015 and April 10, 2015. Interviews were recorded using a portable digital audio recorder and separately using the program Garageband on the researcher's personal computer. The purpose of recording on two devices was to increase the likelihood of obtaining a high quality recording, as well as to have an extra copy of the data in the event of technological issues. The researcher took notes on paper for all interviews; these notes were shredded following the coding of the data.

Data Analysis

To analyze the data, I listened to each interview once in search of key themes in participants' experiences. I then listened to each interview a second time to code for the themes present and to transcribe key sections of each interview. Through a process called axial coding, the dozens of identified themes were identified as subcategories of a handful of broad themes, within which most experiences of participants were encapsulated (Charmaz, 2006).

CHAPTER IV

Findings

The results of the interviews showed that the conception, pregnancy, birth, and postpartum experiences of transgender and gender non-conforming birth parents are diverse; they are similar in many ways to those of cisgender parents and in other ways different. This section will describe participants' experiences of conception, how they conceptualized their pregnancies, the challenges they encountered and how they managed those situations, and their interactions, both positive and negative, with medical care providers and mental health professionals.

Conception Experiences and Demographic Data

See Tables 1 and 2.

Table 1

Conception Experiences

Pregnancy Characteristic	All (N=20)^
Age at birth of child (y)	32.05 (\pm 6.76)
Planned	19 (95)
Unplanned	1 (5)
Method of conception	
Insemination by cismale partner	8 (40)
Artificial insemination	9 (45)
In vitro fertilization	3 (15)
Use of cryobank services	10 (50)
Sperm donor	12 (60)
Anonymous	7 (35)
Known	5 (25)
Prior pregnancy loss	4 (20)
Doctor/fertility center involvement	11 (55)

^Three participants were multiparous, resulting in 20 pregnancies among 17 participants.

Table 2

Demographic Data

Characteristic	All (N=17)
Current age (y)	35.18 (\pm 6.79)
Gender identity [^]	
Male/man	4 (23.53)
Transgender/transman/female-to-male/transmasculine	8 (47.06)
Genderqueer, gender-neutral, gender non-conforming, non-binary, androgynous	5 (29.41)
Butch, masculine, masculine of center	4 (23.53)
Female, woman	2 (11.76)
Preferred gender pronouns*	
He	9 (52.94)
They	2 (11.76)
She	4 (23.53)
No preference	3 (17.65)
Race/ethnicity	
White	16 (94.12)
Chinese-American	1 (5.88)
Country	
United States	16 (94.12)
United Kingdom	1 (5.88)
Education level	
High school or some college only	3 (17.65)
College or higher	14 (82.35)
Master's degree or higher	8 (47.06)
Relationship status	
In a relationship	13 (76.47)
Married	9 (69.23)
Domestic partnership	1 (5.88)
Partnered	3 (17.65)
Single	4 (23.53)
Open relationship	1 (5.88)
Polyamorous	1 (5.88)

[^] Participants were allowed to identify with multiple terms.

* One participant noted two different preferred gender pronouns.

Comparison of Experience to Cisgender Parents

In many significant ways, the experiences of transgender and gender non-conforming birth parents were comparable to those of cisgender birth parents of a similar socioeconomic background.

Conception

For participants who did not need to use assisted reproductive technologies (ARTs) to conceive, experiences of the conception process were in general remarkably similar to the conception experiences of straight, cisgender couples who did not use ARTs to become pregnant. Many of these individuals identified the time from beginning trying until conception to be four months or less; some noted that they had gone off birth control to “see what happens” but were not specifically planning or attempting to become pregnant when they did.

For participants who needed ARTs to conceive because of an issue related to fertility (versus needing ARTs because they had no access to sperm within the context of their relationship or were single), the conception experience was often long, stressful, financially costly, and emotionally taxing. In addition, participants noted that navigating the healthcare system and figuring out their insurance coverage were challenging aspects of utilizing ARTs.

Participants who had miscarriages discussed feelings of sadness and loss, as well as an increase in anxiety related to the health of their baby when they became pregnant again. The experiences that participants had during conception outlined here were largely comparable to the conception experiences of cisgender individuals.

Pregnancy

In many ways, the pregnancy experiences of participants were like those of cisgender birth parents. As is the case for virtually all birth parents regardless of gender identity, many

participants talked about wanting to ensure a healthy pregnancy and desired to do all they were able to give birth to a healthy baby. In addition, some participants talked about choosing a midwife, rather than an obstetrician, to deliver their babies due to a wish to avoid unnecessary medical interventions and to exert more control over the labor and birth process. Participants who chose midwives talked about midwives as being more patient-focused, spending more time with patients, and more willing to allow labor and birth to happen naturally without unneeded intervention. The selection of a midwife over an obstetrician is more common among pregnant individuals of a higher socioeconomic status (SES)

Birth

A greater percentage of participants chose home births over hospital births than do so in general population. Participants who chose home births indicated that they desired to have a natural birth and wanted to have more control over their experience than they perceived they would in a hospital. For example, several participants specified that part of the reason for their decision was to avoid having an emergency C-section. Of participants who gave birth in a hospital, a few had C-sections due to what was identified as either stalled labor or the baby in distress. Some participants who gave birth in hospitals talked about feelings of loss of control and disempowerment, not uncommon experiences of cisgender women who give birth in hospitals.

In addition, many participants stated that they had hired doulas for social, emotional, and logistical support during labor and birth. Having a doula is something that is generally not accessible to individuals of lower SES. Hiring a doula for labor support and being more likely to choose a home birth than the general population are both common to people of higher SES.

Postpartum Period

In terms of the transition into parenthood, many of participants' experiences echoed those of any new parent, including lack of sleep and added stress to their relationship. Some participants discussed a multitude of diverse and intense feelings with becoming a parent. Participants also talked about various hopes for their children and families, as well as the love they had for their children.

Overall, the findings outlined in this section are consistent with cisgender parents of high SES and some are consistent with most new parents, regardless of gender identity.

Theoretical Framing of Pregnancy

Means to an End

In discussing with participants how they conceptualized their pregnancies, several main themes emerged. Probably the most common way in which participants talked about their pregnancies was as “means to an end,” with a baby as the outcome. Several participants identified the desire to create a family and raise children as prevailing wishes in their lives and that becoming pregnant was the least expensive and most logistically feasible method of bringing a child into their family. This was particularly true for those who were partnered with cisgender men, none of whom required the use of assisted reproductive technologies to conceive. Others cited the temporary nature of pregnancy as part of what enabled them to conceptualize the experience as a means to the end of building their family. Many emphasized that being biologically related to their children was not an important factor in their decision to become pregnant, instead highlighting that carrying a child was the most straightforward way for them to have a child.

One participant said:

“It was never about, oh I want a biological child. There was just more like what is the easiest way to get a child, you know what I mean.”

Similarly, another participant explained,

“I was interested in being a parent, and I wasn’t particularly—I was sort of intrigued—but didn’t feel that I had to be the person who gave birth to the child I was parenting. It was sort of a means to an end.”

Biology

A few participants identified that having a biological child was important to them. One explained:

“I’m more looking at it from the cold scientific perspective of ‘I need to reproduce so that I can extend my DNA into the next generation. . . . Like, well, I have to be pregnant if I want to make a baby that has my genetic material in it.”

Similarly, some participants cited age as a factor that led them to choose to conceive. One participant explained,

“I don’t want to get to 45 or 50 and regret never trying. I think it’s really this age, you just have this window, and you can’t ever change your mind.”

Superheroes, Battle Wounds, and Sports

While many participants eschewed the idea that pregnancy was an innately female or feminine experience, some described their experience of pregnancy as masculine in nature. One participant explained,

“To me, it was more like an athletic event. . . . It felt like it would never end. And I was going to win at the end, you know, I was going to get a baby.”

Another participant emphasized the inherent strength required to give birth:

“My thoughts about pregnancy have always been kind of ones built around strength and independence, which has fit pretty well with how I express my gender. So I’ve been pretty comfortable with thoughts and ideas around pregnancy.”

That same participant also stated,

“If women talked to each other about childbirth and breastfeeding the way guys talk to each other about a sporting event, like these are just things that come with it, and you should be proud of it. . . . ‘Dude, you delivered a twelve-pound baby; that’s sweet!’ Instead of, ‘Oh, twelve pounds, ouch. . . .’ It’s just an interesting kind of dynamic shift to think about why we don’t talk to each other and congratulate each other about the awesome things that we do, instead of making them into things we should feel sorry about.”

Another participant described his experiences of pregnancy as masculine, even more so than he typically experienced his gender when not pregnant.

“I was surprised at how traditionally masculine a lot of my experiences were while I was pregnant because I’m not a particularly masculine person, but all of a sudden I was feeling very protective, and I was farting a lot and sweating a lot. My libido increased. I was just having . . . kind of like the Homer Simpson version of masculinity was happening.”

Another participant thought of himself as a man with a special superhero-like power to create life.

“One thing that I kind of told myself was—I really like the X-Men, like comic books, movies—and I kind of think of myself like that. Like, I’m a man, and I

have this mutant ability to have kids, and it's different from other people, but it makes me pretty cool, in a way. So I can kind of appreciate that about myself, even though it's still stressful and awkward at times.”

A Non-Gendered Experience

Several participants felt that their bodies were separate from gender identities. One participant explained:

“I tend to kind of think about the body separately from gender. I mean, they're connected, of course, but if you're thinking about reproductive options, you have a certain functional body that you have to work with. So, to me, you know, I was never swept away by cultural constructions of femininity and pregnancy as feminine. . . . I don't think it's masculine or feminine; I think it's just wildly alien to be pregnant, and it's kind of cool.”

Another participant echoed the idea that the experience of pregnancy was not a gendered one:

“I've kind of just always not attached gender to experiences, so it didn't really feel like everything had to be attached to a gender.”

Similarly, another participant stated:

“I think it [giving birth] was the most badass thing I've ever done. It didn't make me feel less manly or anything. I was just doing what I had to do to get my kid out . . . It was like I had this mission I had to accomplish, and I just focused on getting it done and doing what I needed to do, and I did it.”

A fourth added,

“I think it mostly came down to the commitment to each other and to this kid, more so than anything gender-related.”

Miracle of Life

Many participants talked about wanting to become pregnant in order to have the experience creating new life. Others described an intense desire to give birth to a child as a major factor in their decision to become pregnant. One participant described how she had decided that she wanted to become pregnant after her partner had given birth to their first child:

“I wasn’t necessarily ready or sure that I actually wanted to carry a child; I wanted to be a parent. So, she [my partner] went first. And I think from kind of sharing her experience of being pregnant and getting pregnant and birthing a child and having a baby, it kind of changed a lot for me. . . . witnessing it and going through it with somebody, I kind of went 180 on it. . . . I wanted to experience it myself, regardless of how I identified or what relationship I had to my body. . . . The whole idea of creating a person and carrying that person is pretty amazing to me; I think I was pretty detached from it before my partner got pregnant.”

Hoping Femininity Would “Click”

A minority of participants noted feeling that being female would make sense once they had given birth to a child and that femininity would feel right for them. One participant explained:

“I thought it would finally make all the female things that I couldn’t comprehend even, I thought it would all finally click if I became a mother. . . . That was definitely part of my motivation—that things would finally work. . . . I really

thought that I would find joy and peace and purpose in being a mom and that it would complete part of me. . . . And none of that panned out.”

Challenges

Dysphoria

Many participants noted some degree of dysphoria in relation to their bodies or gender identities during conception, pregnancy, birth, or the postpartum period. One participant explained:

“[The physical changes] were pretty uncomfortable for me because I previously would bind my breasts, and so like I had to stop doing that really early on just ‘cause it hurt. . . . I had been binding in some fashion for many, many years, so to sort of wear a . . . bra-type thing was very uncomfortable for me. I was like flying all over the place. I felt that kind of out of control, you know.”

Another discussed discomfort surrounding the accentuation of female body parts that were not normally emphasized:

“It feels wrong and oppressive to be in this female body. Usually I can just ignore it, but being pregnant and giving birth changed that. I could not really ignore my body. Specifically, the female parts which I like to pretend don't exist were front and center every minute of every day.”

Another participant talked about the dysphoria she felt after complications from a C-section:

“I got this horrible rash from the stuff that they put on to do the surgery . . . and I couldn't wear anything besides a skirt; I never wear skirts—I hate skirts. But it was like so uncomfortable—like if I wanted to leave the house not naked, I had to

wear something that didn't touch any of my skin. . . . I remember being totally horrified with that and feeling like it was taking over my identity.”

Another participant described the dysphoria she felt after being told to restrict her activities in a way that did not make sense with her gender identity:

“There was a bit of a discomfort for me in that there were a lot of things that people were telling me that I couldn't do. I tended to kind of push the limit with that. When I was pregnant with [my first child], I got up on the ladder and cleaned the gutters. These are just things I do around the house. With our second [child], I was building a tree house. . . . I kind of felt like, you tell me I can't do all that stuff, like now you've kind of stripped my identity away.”

Of those individuals interviewed who nursed their children, many described experiencing some degree of dysphoria during that process, particularly when feeding their children in public settings. One participant said:

“Nursing was challenging. . . . The first few times I was nursing out in public and feeling very exposed and feeling like vulnerable in some way in terms of my identity.”

Another participant explained his discomfort with nursing his children around friends:

“It was a little bit uncomfortable if we were hanging out with friends and I was going to feed my kids, and I would sort of have to make the choice to take the baby-feeding into the closet from whence it came or I was going to expose parts of my body that I usually make a point of hiding. . . . But if we had friends over or were at a friend's house . . . it would always sort of take me a minute to make that decision.”

Others noted that their experiences of pregnancy and birth had reinforced narratives that they had had about their bodies being “wrong” or “broken.” One participant described his experience:

“It solidified the fact that . . . the chance of being a straight female just wasn’t going to happen. But I didn’t know what else to do; I just thought there was something seriously wrong with me.”

Another participant explained:

“ . . . all of this is sort of feeding this narrative that something’s wrong with my body, you know. Like, why am I not getting pregnant? . . . and then . . . the birth not going very smoothly . . . stalling out sort of fed that narrative . . .”

Locating Resources

Numerous participants described difficulty with finding resources for transgender and gender non-conforming birth parents. Some noted a lack of information from books, medical professionals, childbirth classes, and new parent groups. Speaking of his difficulty finding information, one participant said:

“I was sort of being bombarded with books . . . So the books were telling me that, ‘Women did this and women did that,’ and . . . I was sort of thinking, this isn’t me; this isn’t relevant to what I’m going through.”

Among the many participants consulted their doctors before conceiving, most of those individuals discovered that their doctors had little information about pregnancy specific to transgender and gender non-conforming people. This was in part due to the fact that virtually all medical professionals participants saw had not previously worked with transgender or gender

non-conforming individuals, let alone birth parents. One participant discussed his experience at a clinic with a health department for transgender people:

“I talked to her [clinic’s director] at length about identifying as trans, but wanting to get pregnant and find support around that. . . . She had no idea what I was talking about. . . . She was supportive of my desires, but she had nothing to offer in terms of resources. . . . She didn’t know anybody who was trans and wanted to give birth. . . . It was just really disheartening, and then I just sort of stopped trying to find help there.”

Overwhelmingly, participants reported that birth classes and new parent groups were geared toward straight cisgender women, and many participants reported feeling like outsiders in these settings because of their identities. One participant discussed gaps in the support that she had received while pregnant and as a new parent:

“Yeah, there’s support, but it often feels like you have to let go of parts of yourself to just accept it or be around it. We went to a birthing and childbirth class, and then we joined their new parents group, and it’s really helpful, you know—really, really supportive on the one hand, but then on the other hand, it’s like we’re always different, and people never really understand where we’re coming from.”

Other participants deliberately avoided these groups and classes expressly because they felt that they would not fit in or would have to compromise aspects of their lives and identities in order to receive the support they needed.

“I was a part of a new parent group, but no prenatal classes. . . . I had a long history of never really fitting in with women and socializing with women. . . . If I

were put in the situation, I probably would have felt uncomfortable or like I didn't know what to say or something. So that's probably a big part of the reason why I didn't even look for something like that."

Finding Maternity Wear

A common challenge for participants was finding clothing during pregnancy that was comfortable for them physically and psychologically. One participant stated:

"[Something that was uncomfortable was] the limited clothing that goes along with being butch and being pregnant. So, you're kind of pushed into frilly things or things with different cuts that you would normally not wear, but you have a belly that's expanding beyond normal clothing."

Another participant said:

"I basically wore like sweatpants and my partner's t-shirts the entire time. One of my friends, she took me out to buy maternity clothes . . . I felt bad saying no, that I didn't really want to dress like that. . . ."

Many participants alluded that maternity wear was more feminine than clothes for cisgender women who are not pregnant. One participant said:

"Finding clothing that I liked, that helps me be more me, is just really hard, and it's actually impossible when you're pregnant to find maternity clothing. . . . Finding clothing that I can be comfortable in that's not super, super feminine—because it's all so feminine."

Stigmatization and Discrimination

During the interviews, some participants discussed experiences of discrimination and stigmatization from various sources, including family, friends, community members, strangers, medical and mental health professionals, and insurance companies.

A couple of participants described experiences of being rejected by their parents because of their gender identity. One participant said:

“When I did come out to [my family] as transgender, they basically just think that I’m delusional and that eventually I will realize that I’m actually a woman and that this will be over, but it’s not going to happen, so I’m not sure how long it will take them to realize that or what will happen when they do.”

Another detailed a related experience:

“I sort of like accidentally came out to her [my mother] . . . that was really awful. My mom asked me if I was going to kill the baby . . . She was just like . . . ‘If it’s this hard for you because of your imagined problem or whatever, you’re going to resent the baby . . . you’re not really trans, you’re just upset because you’re pregnant.’ . . . She told my dad, then he called me and called me a selfish bitch and hung up the phone. . . . That was a pretty bad experience.”

Similarly, one participant described how a new friend no longer acknowledged him once he told the friend that he was transgender:

“There was one other dad that was there every time . . . who I hung out with a bunch of times . . . he just stopped talking to me . . . if he and his wife see me, they do not speak a word. . . . I think I just mentioned to him that . . . I’m actually

a man . . . I'm going to go back to transitioning, so you might notice some things.
. . . I didn't realize at the time that he was going to be freaked out."

In more extreme examples, participants were clearly targeted because of their gender identities and/or sexual orientations. The teacher of a participant's child had filed a report with Child Protective Services because the participant was transgender. In another instance, a participant was denied the opportunity to adopt a child through the foster care system because of he identified as transgender, despite the fact that there was no law in the state prohibiting public adoption by transgender individuals.

In addition to these instances, one participant reported experiencing issues with his insurance company related to his gender identity and/or sexual orientation, as he was perceived as a lesbian. Speaking about his experience, he said:

"[The state I was living in] had a mandated insurance coverage [for IVF]. . . but . . . the insurance companies all have this sort of lesbian clause which says that if you have no known exposure to sperm, i.e., you're not in a heterosexual relationship, then you can't possibly be infertile unless you have documented twelve failed consecutive IUIs [intrauterine inseminations] in a doctor's office. So that forced me to do twelve failed IUIs."

Another participant was misinformed by their clinic that their insurance would not cover tests because they were an "unmarried woman," which the participant believed was due to homophobia. They explained:

"Because both of us were in our forties, so we thought it would be a good idea to get some [fertility] tests and stuff, and we were misinformed by a reproductive clinic that said that insurance wouldn't pay for anything for us because we were—

on the insurance paperwork—two unmarried females. And it [the information about the insurance] turned out not to be true . . . so it was kind of a combination of homophobia and internalized homophobia, for assuming they wouldn't pay for it.”

Others acted out of fear of discrimination. The perception of potential discrimination was a powerful motivator for some participants to change their behavior, in attempt to pass or cover. Several participants talked about concealing their true gender identities, preferred gender pronouns, or birth parent status in order to avoid possible issues with others. One participant explained:

“For me, to protect my family—to protect my husband, to protect my baby—I don't want to come out fully and present as masculine while I'm pregnant because I don't want to become . . . a tabloid story . . . I think it's also a lot to ask of my colleagues and friends to start calling me by a new name when I'm super pregnant.”

Still others said that asserting their preferred gender pronouns in a work setting was not important to them. A participant said:

“I don't change the way that I look, but I've never asserted a pronoun onto my coworkers. . . . They always 'she' and 'her' me. . . . But when I came in six months pregnant, it's really hard to ask a staff who doesn't know me to use 'they' and 'them' pronouns . . . I didn't feel like I needed to—it wasn't important to me. All I wanted was to be around people who were loving and kind.”

One participant expressed fear that he would be unable to regain access to testosterone therapy after giving birth due to deviating from a traditional masculine gender role:

“Everything I’m reading online is like, ‘if you sort of deviate from a certain transgender narrative, then you might have a harder time getting hormones.’ . . . Would they say I couldn’t go back on? Or would they put me under scrutiny, or would they make me go to a psychologist to prove I was really transgender? Or would they question my motivations for wanting to do a pregnancy? And I was really scared of that, so I didn’t tell [my medical providers]. . . .”

Experiences of stigmatization and discrimination, as well as the perception of potential discrimination, from doctors and other medical staff were prominent in many participants’ narratives. These are detailed in the section “Challenges, Stigmatization, and Discrimination.”

Others’ Lack of Awareness and Understanding

In addition to the common experiences of dysphoria, locating sufficient information and resources, finding adequate maternity clothing, and discrimination, the majority of participants reported incidents in which they felt misunderstood by other people in their communities, including family, friends, coworkers, and strangers. These were instances in which participants felt that others’ lack of awareness and understanding of the transgender community was primary to their actions, rather than intentional discrimination or malice.

A handful of participants noted that being stared at by another person at least once during their pregnancy or when out in public with their babies. Some of those participants thought that this may have been because others had perceived them as male and wondered about their bellies. One participant discussed an instance in which she had been nursing her young child under a nursing cover and was noticeably misread by a group of people:

“We went for a walk . . . and [the baby] needed to be nursed, so I sat down on this bench in front of a store on the sidewalk and got my little cape out and put her

under there . . . and these three or four twenty-somethings . . . walked by and they were just staring, like they couldn't figure out what I was doing . . . finally I heard one of the women go, 'There's a baby under there! Oh my gosh, it's a woman; she's nursing the baby!' Then they just burst out into hysterics. . . . And I just sat there laughing at them, like, 'You people are so oblivious.'

Of note, numerous participants reported that some semi-culturally acceptable behaviors surrounding pregnancy, including touching the belly of a pregnant person, were especially difficult for them because of their relationships with their bodies and gender identities. One participant explained:

"People would come up and touch my body, and I was already uncomfortable with my body. . . . One woman lifted my shirt to stick her hand on my bare belly . . . I was just like, 'What are you doing?'" And she went, 'Oh, you're having a boy.'" I was like, "I'm having a heart attack because you're touching me."

In general, many individuals interviewed talked about feeling that their friends, families, coworkers, and strangers did not fully understand their gender identities.

Managing Challenges and Interactions

There were many different strategies that participants employed in navigating the variety of challenging and difficult situations they were faced with. One common strategy was "passing," in which individuals who were able to appear cisgender, either as female or male, did so in order to minimize possible threats of discrimination and violence. Several of those who passed as cisfemale while pregnant discussed how that experience put them at a lower risk for discrimination and stigmatization but led to dysphoria. For example, one participant who chose not to come out to their coworkers or medical providers, and passed as female, talked about how

that decision caused dysphoria but also made him feel that he was making a decision that would be safe and not cause difficulties with others.

In describing his experience of passing as cismale while pregnant, another participant said:

“Throughout my pregnancy . . . I still passed. I don’t 100% want to or do pass . . . I just wore big clothes and stuff, and I’m not body dysphoric anyway, and so it felt just more like an interesting journey than something that was at odds with who I was.”

Another common approach was “covering,” which refers to how a member of a marginalized group may downplay certain aspects of themselves, rather than hide their identity altogether. For example, in a setting of heterosexual, cisgender parents, a parent who is openly lesbian might emphasize their commonalities with the other group members and shift focus away from their sexual orientation, despite not hiding their orientation altogether.

Covering was also something that occurred within the broader queer community. One participant described feeling the need to cover during interactions with cisgender lesbians and gay men in order to not accentuate a non-binary gender identity:

“I think there’s some more support [with queer parents] . . . but it is very much you just identify as lesbian or gay [rather than as transgender or non-binary], you know, and that’s sort of like not really how [my partner and I] identify . . .”

Another important coping strategy participants used was surrounding themselves with other people and communities that were accepting and loving. One participant explained:

“Like every society, there is a thread of nastiness that runs through it [my community], but for the most part, the bulk of the people here are very accepting

and very nice. I don't know if that's just because of the area . . . that I live in or because I surround myself with nice people anyway. Like, I didn't have any qualms about coming out to my in-laws. . . . The people at the coffee shop down the road, I would quite happily tell them, the people that work there, that I'm trans."

A couple participants talked about using detachment from their bodies as a mechanism of coping with the psychologically distressing changes that occurred during pregnancy. One participant explained:

"I guess a lot of my coping mechanisms in the world are to remain very detached from my body, so being pregnant was very upsetting because . . . you're very aware of your body, and your body's changing. . . . I've had a lot of posttraumatic stress just from being pregnant and giving birth, and so I have been doing . . . therapy to try to get over it . . . A lot of times I think, oh maybe if I had a better relationship with my body, it [pregnancy and giving birth] would have felt different . . ."

An important way in which participants were able to reconcile their gender identities with how others perceived them was in using alternative language to refer to themselves and to processes such as nursing. For example, rather than using the word "breastfeeding," many participants preferred language including "chestfeeding," "feeding," "nursing," "giving milk," and "eating."

Similarly, many participants chose to refer to themselves using the word parent when talking about their parental status, rather than using gendered language, such as mother or father.

In terms of how their children referred to them, some participants chose gender-neutral names. In talking about his preference a parent name other than mother or father, one participant said:

“I chose ‘baba’ because it means father in Japanese, some African languages, and Chinese . . . and then also, it gives me an out so I don’t have to tell people exactly why [I chose ‘baba’] because also it’s kind of like the noise babies make about bottle . . . It is a way that I can kind of get what I want without explaining to people why I want it.”

Others preferred to use derivatives of father or mother. One participant talked about choosing to be called ‘papa’:

“I go by ‘papa’ and my partner goes by ‘dad’ or ‘daddy.’ We decided that before she was born, and also talked about, you know, at some point, she can come up with her own names for us; that’s fine.”

A participant who preferred “mommy” said:

“I always called my mom ‘mom’ or ‘mommy’ . . . So I remember it was a discussion that we had early on in the relationship before we even started trying. . . I was like . . . if I’m giving birth, I’m going to be ‘mommy.’ That’s my one condition: I get to be called ‘mommy.’”

For many participants, carefully choosing the language that they, their children, and their partners would use was an important strategy for making them feel comfortable in their identities as parents.

Interactions with Healthcare Professionals, Social Workers, and Therapists

Choosing Medical Providers

While many participants utilized the services of doctors for prenatal care and delivery, about half chose to be under the care of midwives, rather than OB/GYNs. As previously discussed, this is consistent with the relatively high socioeconomic status of most participants. However, some participants who chose midwives talked about selecting a midwife rather than a doctor noted that their gender identity was a factor that informed their decision. These individuals noted that they chose midwives because of the common idea that midwives are more patient-focused, nonjudgmental, and flexible than doctors, which they believed would lead a midwife to be more accepting of their gender identity and/or sexual orientation. One participant explained:

“The birth was great. I’m not sure I would have the same experience if I had the baby in the hospital. But at home . . . my midwife stayed in the spare bedroom that we had upstairs, so she just kind of hung out and let me do my thing . . . She just kind of left me alone, which is exactly what I needed.”

Another participant said:

“So the midwives who helped me with my pregnancies were really exceptionally wonderful. They were experienced at working with queer families, but we were their first trans family who they had worked with, but they were trans aware. . . . They were excited to be welcoming.”

A couple participants also noted that their midwives had not done vaginal exams until they were in labor, which was important to them.

“They never even touched my private parts, not once, until I actually gave birth. You know, they didn’t ask about it; they didn’t care about it. They just wanted to hear my belly . . . and the baby’s heartbeat and then just talk about my exercise . . . and what I was eating. . . .”

Regardless of the type of medical professional chosen, several participants went to a handful of different providers before selecting one, in part to ensure that the provider they chose was LGBTQ-friendly, as well as personal compatibility. One participant, in describing the experience of selecting a care provider, reported:

“The hardest part about it was finding support. . . . I had to find healthcare . . . I probably met a dozen doctors and talked to two dozen midwives over the phone to find someone who would help me. . . .”

In addition, many participants’ births were attended by doulas, professionals who provide social and emotional support to the laboring person. Some participants emphasized that the decision to have a doula was in part due to the doula’s ability to act as a liaison between the individual and the medical staff during the birth in order to support the staff in respecting the individual’s preferred name, gender pronouns, and other needs related to their gender identity. A participant explained:

“She had worked with many other queer couples in the area and was trans knowledgeable. . . . Selecting such an accepting doula and having a care provider would was open to conversations about trans issues made a huge difference for us. Since we knew our provider would deliver our child, we were able to control the birth space and have only calm, accepting people in it. I cannot say how important to us this was.”

For many participants, having LGBTQ-friendly medical providers and doulas was essential to making their birth experiences more positive and comfortable.

Social Workers and Therapists

The overwhelming majority of participants did not have interactions with social workers or therapists during the conception process, pregnancy, or postpartum period. Of those who had experiences with social workers or therapists, one participant were required to see a therapist with their partner before beginning use of any assisted reproductive technologies, which the hospital said was standard procedure for all couples who needed those procedures. Another participant was required to see a social worker during the conception process, which he thought might have been because he was perceived as transgender or as a lesbian. Other participants endorsed challenges, depression, and suicidal ideation during pregnancy or the postpartum period for which they now believed they should have sought out therapeutic services but did not for fear of stigmatization or not being understood. At the time of the interview, one participant was receiving EMDR (Eye Movement Desensitization and Reprocessing) treatment for trauma related to being pregnant and giving birth, and at least one other participant was receiving therapeutic services for issues unrelated to pregnancy and giving birth.

Positive Interactions

The majority of participants described their experiences with their medical providers as positive overall. Several reported that they were open with their providers about their gender identities and that the providers were accepting. About the experience of being out to their medical providers, a participant said:

“They hadn’t had any trans clients prior to my working with them, but I knew at least three other queer families who had used them . . . Between the . . . midwives,

there were some who totally got it and didn't need any education, and a few of them maybe needed a little bit more. But they totally welcomed us into their practice; I got excellent care.”

Another described their experience:

“I had a lot of ongoing concerns with, do I tell prenatal care providers that I had been on testosterone in the past, do I tell them that I'm transgender? And I didn't want to because I didn't want them to be mean to me. . . . I didn't tell any of my providers I was eight months pregnant . . . [After I told them,] I think they felt really bad for me . . . they could see in my body language, and they could tell from the time I took to tell them that I was obviously very afraid . . . I expected to be mistreated, but I didn't expect to be accepted. They were like, ‘No, no, it's fine.’”

Some reported that they believed that their positive experience with their providers was due mainly to the fact that they had not disclosed their gender identities or preferred pronouns to their provider. One participant said of his experience:

“My doctors were really good . . . They just saw me as a straight female who was pregnant on purpose, so that's how they treated me.”

Challenges, Stigmatization, and Discrimination

Participants noted negative interactions with medical professionals at various points during their experiences—from before conception to the postpartum period. One participant described an instance in which their doctor recommended that the participant's cisfemale partner attempt to conceive instead:

“The first doctor we went to actually told me that I shouldn’t even try, that my wife should be the one to carry, and he told us that prior to even checking us medically, and I think it was solely based on how we looked . . . she has more of a female presentation, and she looks more fit . . . and then once he checked us, it was like, ‘Oh yeah, you shouldn’t even try . . . you should let her have the baby.’”

Another participant described an experience in which a nurse did not realize they had just given birth, due to their gender presentation:

“They give you an icepacks so that you can put it in your underwear, because I had a small tear and you’re sore, of course. [When I asked the nurse for an icepack,] she was like, ‘What?’ And I’m like, ‘Can I get an icepack?’ And she’s like, ‘What do you need an icepack for?’ And I’m like, ‘I just gave birth’ and . . . she’s like, ‘Oh, you’re a patient?’ . . .”

Some participants covered, passed, or did not assert preferred pronouns or come out in order to avoid potential discrimination or to avoid having to explain their identity. In addition, there were instances of medical professionals misgendering participants after preferred name, gender pronouns, and/or terminology were explicitly stated. A participant described an experience in which their son’s doctor had difficulties remembering their preferred language and that they were not nursing their child:

“My son goes to a local health center. The doctor’s nice. He sees a lot of queer families. I think he’s finally got my parent choice name, hopefully. But he doesn’t get it still, honestly. . . . He made an assumption during one of the appointments that I was breastfeeding, which he should know that I wasn’t doing.”

A few participants described instances in which their child's doctor was visibly uncomfortable around them due to their gender identities and/or sexual orientations. One participant, for example, described a situation in which a nurse would not look him in the eye after she perceived him to be a gay cisman.

Of the participants who saw social workers or therapists, one participant who was required to see a social worker during the conception process said of the social worker:

“When we transferred into the hospital, part of their protocol was that they had you meet with a social worker. . . . We were told it was a routine thing, but we perceived it as a sort of test. You know, ‘Are you a stable couple; are you going to be good parents?’ . . . I think it was intended as a support mechanism because it is extremely stressful to go through fertility treatment for anybody . . . I was struck [that the social worker's] perception of how people should be reacting to infertility and my reality were two different things. . . . it has nothing to do with my identity as a woman or as a mother or whatever because that doesn't even apply to me. . . . I do think that she was kind of shocked when I actually got pregnant.”

Another individual who was also required to see a therapist reported:

“If you weren't a heterosexual married couple, you had to see . . . some form of therapist, for an hour, and you had to pass her test basically—that we were really serious and that we were going to stick together and we were going to do this.

And that just felt really unfair because they weren't making heterosexual married couples go through the same thing, so why were they trying to screen us? . . . So

basically by the end of the hour, . . . we were just kind of saying whatever we thought she wanted to hear, to get through it.”

Other participants explained that they felt they had needed therapeutic services at the time but did not seek out such services due to fear of stigmatization and not wanting to have to explain their gender identities to clinicians.

“As far as postpartum stuff, I probably should have reached out [to a mental health clinician] and didn’t because . . . I just didn’t feel like I wanted to go through the whole explaining [my gender identity and that I’m a birth parent] . . . It probably would have been fine . . . but if someone was going to give me a hard time, I just didn’t think I could handle it.”

Overall, there were many instances in which medical professionals demonstrated a lack of understanding about the needs and experiences of transgender individuals, and there were a few cases in which providers’ prejudice created situations that caused participants to feel stigmatized and discriminated against.

Conclusion

While the experiences of the transgender and gender non-conforming birth parents interviewed were varied, there were parallel threads running through many of their narratives. First, there were extensive similarities to the experiences of cisgender parents, including wanting to have a healthy pregnancy and baby, experiencing a multitude of different emotions during pregnancy, and feeling joy and stress at the transition to parenthood. Despite many comparable experiences to cisgender birth parents, there were some experiences that were unique to transgender and gender non-conforming birth parents. In handling challenges related to dysphoria, a lack of awareness and understanding of others, the threat of discrimination and

stigmatization, and from the ways in which they thought about their pregnancies or birth parent status to the language with which they used to refer to themselves as parents and processes such as nursing, the strengths and resilience of each of the individuals interviewed were clear.

Chapter V

Discussion

The purpose of this study was to broadly survey the experiences of transgender and gender non-conforming birth parents. Because so little literature about this community exists, this study was intentionally exploratory in nature and sought to answer the question: What are the conception, pregnancy, birth, and postpartum experiences of transgender and gender non-conforming birth parents? In this chapter, I will represent key findings and situate them in the broader context of the current scientific literature on transgender and gender non-conforming birth parents, noting both consistent and inconsistent results. Next, I will describe the strengths of the current study, followed by an exploration of its limitations. Finally, I will discuss the implications of this study for social work practice and education.

Summary of Key Findings

In analyzing the results, a significant finding was that the experiences of transgender and gender non-conforming birth parents are in many ways analogous to those of cisgender birth parents, particularly to those of a similar SES. For participants who had access to sperm within the context of their relationships, conception experiences were medically indistinguishable from those of their cisgender peers. In addition, the pregnancy, birth, and postpartum experiences of participants were similar in many ways to those of cisgender women of the same SES background, including choosing midwives over doctors, hiring doulas as labor support, and generally experiencing a combination joy and stress after the arrival of their child.

From the results, there were four major themes that were specific to transgender and gender non-conforming birth parents in the findings. First, participants conceptualized their pregnancies in various ways, many as a ‘means to an end,’ some as a non-gendered experience, and others as a masculine endeavor, speaking of gestating their children as a superhero-like ability and birth as an athletic event, in which a baby was the prize. Second, the transgender and gender non-conforming birth parents who were interviewed faced challenges because of the intersection of their gender identities with their birth parent status, including dysphoria, stigmatization, and discrimination. Third, participants navigated these challenges in different ways, through choosing alternative language, surrounding themselves with accepting and supportive communities, selecting LGBTQ-friendly medical care providers, and sometimes by downplaying or hiding aspects of their gender identities or sexual orientations. Lastly, few participants had interacted with social workers or therapists between beginning the process of conception and the postpartum period, and many, but not all, of those who had seen mental health professionals had had negative experiences of feeling stigmatized or that they were being “tested.” In addition, many participants noted that they now felt that they should have sought therapeutic services during the conception process, pregnancy, or postpartum period but did not because they did not, for fear of stigmatization and the prospect of having to explain their gender identities and birth parent status. While the experiences of participants were varied, the experiences of each of the individuals interviewed included elements from most of the key finding areas detailed in this paragraph.

The Results in Context

Results Consistent with the Literature

Overall, many of the findings of this study echoed the scientific literature. For example, participants experienced issues related to infertility to be challenging, emotionally and financially. Navigating the medical and insurance systems related to infertility and to ARTs, even for those who had no known fertility issues, was often stressful and financially burdensome. Many participants talked about wanting to stay healthy during pregnancy and that this was of utmost importance to them in order to maximize the health of their baby. Several participants discussed having miscarriages, and when they became pregnant again, they worried about the possibility of another pregnancy loss. In addition, many participants pointed out that they wanted to avoid having a C-section or any unnecessary medical interventions. A few participants had emergency C-sections, and some expressed feelings of failure and psychological distress. With the transition into parenthood, participants talked about joy, stress, and mixed emotions. As transgender and gender non-conforming birth parents, participants often experienced misgendering, microaggressions, and discomfort as a result of others' lack of awareness and understanding. Additionally, many participants thought about pregnancy as a non-gendered or masculine experience, which is consistent with the limited literature on transgender and gender non-conforming birth parents.

Results Inconsistent with the Literature

Participants described relatively few instances of overt discrimination, and many of the experiences they related were circumstances in which participants had feared discrimination but had not been discriminated against or had changed their behavior to avoid such a situation and did not know whether they would have experienced discrimination had they not modified their

behavior. Likewise, no participant described an incident in which they had experienced physical violence.

While the data seem to suggest that transgender and gender non-conforming birth parents do not generally experience a high degree of discrimination or violence, I believe that this outcome was greatly influenced by the fact that participants in this study tended to be white, well educated, middle and upper-middle class, and living in areas of the country that are more liberal. In a study of transgender and gender non-conforming birth parents of color or of those living in rural or conservative, I would expect more experiences of overt discrimination on the basis of gender identity, birth parent status, and possibly perceived LGBQ identity.

Strengths of the Study

In terms of strengths, the research question was broad, which allowed me to obtain a vast amount of varied information. In addition, the flexible structure of the interview guide permitted me to ask participants in depth questions about the experiences that they brought up during the interview, which helped the salient aspects of each participant's narrative come to the forefront of their interview. In terms of the sample's diversity, participants identified their gender identities and sexual orientations in various ways, including many as transgender and as non-binary. This is a strength in terms of representing several different non-cisgender identities.

Limitations

In regards to limitations of the current study, one such weakness is that the research question lacked specificity. Likewise, the flexible nature of the semi-structured interview guide made uniformity between interviews impossible, which caused directly comparing and contrasting participants' experiences to be difficult. In addition, the data are mainly retrospective in nature, as most of the interviewing took place on average one to five years post-giving birth,

and only one participant interviewed was currently pregnant. These factors could have posed a recall bias, in that aspects of a participant's experience may seem more or less salient with the passage of time than they may have been experienced when they actually occurred. Third, the fact that most interviews took place via phone rather than in person, which may have limited the quality and quantity of data gleaned from interviews with participants. For example, conducting more in-person interviews might have promoted a more conversational and relaxed atmosphere, thereby encouraging an increase in important information shared.

An important limitation of this study is that the sample was highly skewed toward white, middle-class, and highly educated individuals. Because the sample was restricted, this study is most generalizable within white, middle-class, and well-educated transgender and gender non-conforming communities. Because the utilization of sperm banks and most fertility procedures are only accessible to individuals in the middle and upper classes, who are more likely to be white, the experiences of low-income people of color who are birth parents are likely different in many ways, possibly drastically so, than those outlined here.

Implications

The results of this study can be used to inform social work practice and education, as well as the practice of healthcare professionals, as to the experiences and needs of transgender and gender non-conforming birth parents and those considering pregnancy. This study shows that transgender and gender non-conforming birth parents often have ambivalent and negative experiences with social workers and medical care providers, in part due to actual and feared stigmatization and discrimination. In order to better convey acceptance toward transgender and gender non-conforming birth parents, social workers and medical providers should adhere to the following recommendations.

First, asking for a client's preferred name and gender pronouns, as well as gender identity, on intake forms is important, both for the clinician to know and to signal to the client that the provider is accepting. This information should also be confirmed in person with the client during an appointment. In addition, medical care providers should ask about sexual orientation when deemed medically relevant; social workers, on the other hand, can include sexual orientation on intake paperwork. Important to know is that LGBTQ-identified people may feel uncomfortable disclosing this information upon intake, especially if they do not have a clear idea whether the provider will be accepting. If the provider suspects that a client may identify as transgender or gender non-conforming but has not come out, the provider can indicate their support of LGBTQ-identified individuals, particularly of those who are birth parents. In order to do this, providers can put safe space stickers, rainbow stickers, and other posters indicating a queer-friendly space in their offices and keep pamphlets in their waiting rooms or offices on issues specific to transgender and gender non-conforming individuals, as well as issues affecting LGBTQ-identified individuals.

Finally, practicing social workers and medical providers should continue to educate themselves on issues related to gender identity. There are a multitude of conferences, workshops, and trainings designed for the education of providers about gender identity and sexual orientation for providers with all levels of knowledge about the transgender community.

Future Directions

Qualitative and quantitative research that is specifically targeted to low-income individuals and people of color, as well as to individuals living in rural and conservative areas, is imperative to understanding the needs of birth parents in those communities.

In terms of future research questions and methodology, studies that are able to look at differences between transgender-identified individuals and those who identify as non-binary would be useful, taking into account any elements of physical transition, including hormone therapy and top surgery, that may have been done. The results of such a study might be able to illuminate how any changes to physical appearance alter how the birth parent is perceived and treated by others.

Further research could focus on specific times in birth parents' experiences, including the conception process, pregnancy, birth, and the postpartum period, rather than surveying individuals' experiences of all four points in time simultaneously. This would improve specificity and potentially applicability.

Specific to the field of social work, studies recruiting only transgender and gender non-conforming birth parents who had seen social workers during the time between beginning the conception process and the postpartum period would help to elucidate how social workers can be more supportive to their clients who identify as trans and gender non-conforming birth parents, as well as describe common pitfalls of social workers who interact with members of this community.

Conclusion

Due to a lack of research, the experiences of transgender and gender non-conforming birth parents are not well understood by those outside of the transgender parent community, which includes most professionals in the fields of medicine and social work. By analyzing data from seventeen semi-structured, qualitative interviews, this study found that the experiences of transgender and gender non-conforming birth parents share many aspects with those of cisgender parents, such as the desire to promote the health of their babies while in utero and the experience

of stress and mixed emotions with the transition into parenthood. The findings of this study also suggest that the experiences of transgender and gender non-conforming birth parents are distinctive in various ways, including challenging gender roles and the gender binary, as well as experiencing dysphoria, stigmatization, and discrimination, which stem from the intersection of their birth parent status with their transgender or gender non-conforming identities. This study provides what is likely a broad overview of the experiences of members of this community and requires further, specific inquiry, particularly into the experiences of transgender and gender non-conforming birth parents of color and of low income. With the findings of this study, medical providers and social workers can begin to educate themselves about how to better work with individuals in this community.

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Appendix A

Informed Consent Agreement

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....
**Title of Study: Queering Pregnancy: Transgender and Gender Nonconforming Individuals’
Experiences of Conception, Pregnancy, and the Postpartum Period**

Investigator(s): Lauren Ambrosini, Master of Social Work Candidate, (603) 845-8297
.....

Introduction

- You are being asked to be in a research study of the experiences of conception, pregnancy, and the postpartum period of transgender and gender nonconforming individuals.
- You were selected to participate because you have described yourself as transgender or gender nonconforming and you have given birth to a child within the past ten years or are currently in the second or third trimester of pregnancy. To participate in this study, you must be at least eighteen years of age, identify yourself as transgender or gender nonconforming, and be currently in the second or third trimester of pregnancy or have given birth within the last ten years.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to better understand the experiences of conception, pregnancy, and the postpartum period of transgender and gender nonconforming birth parents. This increased understanding will facilitate the making of recommendations for improving delivery of social services to this community, as well as document the many ways that transgender and gender nonconforming birth parents choose to create and structure their families and how gender influences these processes.
- This study is being conducted as a research requirement for my Master’s in Social Work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: participate in one interview (in person or via phone) of no more than ninety minutes in length. During the interview, you will be asked about your experiences of conception, pregnancy, and (if applicable) the postpartum period and how your gender identity influenced those experiences. Following the interview, you will be asked to take part in a brief phone call of no more than twenty minutes with the researcher in order to ensure that the information you shared about your experiences has been understood accurately.

Risks/Discomforts of Being in this Study

- The study has the following risk: If you have experienced emotional trauma related to your gender identity, especially during the conception process, pregnancy, or postpartum period, you may experience some emotional distress if you choose to recount those experiences. The likelihood of experiencing more than minor emotional distress is minimal.

Benefits of Being in the Study

- The benefits of participation are: (1) To share your experiences in a private and confidential setting, and (2) To be part of a study that aims to promote understanding and acceptance of transgender and gender nonconforming individuals into the larger community.
-
- The benefits to social work/society are: (1) To expose gaps in services for gender non-conforming birth parents and to provide a foundation for recommendations for best practices for working with this population in health or mental health capacities, and (2) Society may benefit from being exposed to alternative ways to structure families and think about gender and parenting.

Confidentiality

- Your participation will be kept confidential, meaning that no information that could be used to identify you will be used in the write-up of the study or in any subsequent publications. Your name and other identifying information will be removed and/or changed.
- Interviews will take place in spaces offering ideal privacy, such as conference rooms and study rooms at public libraries and colleges/universities. Interviews will only take place in a more public location, such as a coffee shop, if the participant prefers that location, and the space is quiet enough for adequate recording quality.
- Interviews will be audio-recorded and coded using the researcher's password-protected iPhone and personal computer. The audio recordings will be kept on this computer, as well as on an external hard drive, which will also be password protected in order to minimize the risk of violating participants' privacy. To protect confidentiality, all names will be erased from the audio files and replaced with randomly generated numbers. An electronic document linking participant's names to assigned numbers will be kept on the researcher's personal computer and external hard drive, both of which will be password protected and kept in secure locations. Following the completion of follow-up phone calls with participants, this document will be permanently deleted.
- The researcher, researcher's adviser, and transcribing assistants may have access to the audio files; all of those individuals are bound by the terms of confidentiality set forth above.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to

withdraw by email or phone by April 1,, 2015. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Lauren Ambrosini at lambrosini@smith.edu or by telephone at (603) 845-8297. If you would like a summary of the study results, please send a request to lambrosini@smith.edu, and a summary of the study will be sent to you following completion of the study. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....
Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....
1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix B

Interview Guide

- I. Opening
 - a. Introduction to the interview—structure, opportunities for questions throughout
 - b. Reminders about consent and confidentiality
- II. Demographic Information
 - a. How would you describe your racial identity?
 - b. How would you describe your relationship status? (e.g. single, partnered, married, polyamorous, etc.)
 - c. What is the highest level of education you have completed?
 - d. How would you describe your career or occupation?
 - e. How old are you?
- III. Gender Identity and Sexual Orientation
 - a. How would you describe your gender identity?
 - b. How would you describe your sexual orientation/identity?
 - c. How has your gender identity (and/or sexual identity) evolved over time?
 - d. Prior to deciding to become pregnant, what were some of your thoughts about pregnancy and/or giving birth?
- IV. Planning and Conception
 - a. When did you first begin to imagine yourself as having children?
 - b. At that point, how did you imagine the children joining your life?
 - i. Did you consider adoption? Who did you imagine you would bear the child? What did you imagine that experience would be like? Did you imagine your partner would carry? Tell me more about that.
 - c. How did you (and your partner) make the decision to have a child?
 - i. How did you (and your partner) determine who would carry?
 - ii. How did this decision fit or not fit with your gender identity? With you personally otherwise?
 - d. What was your experience like with healthcare or other professionals involved in the process of conception?
 - e. When you were in the process of planning and conception, what were some of your hopes and expectations for pregnancy?
- V. Pregnancy
 - a. What was/has been your experience of pregnancy?
 - b. How did/has being pregnant influence(d) or not influence(d) your experience of yourself as a (gender nonconforming/insert identity here) person?
 - i. Maternity clothes; body changes; appearing pregnant/definitively female
 - c. How did/have others respond(ed) to your pregnancy?
 - i. Friends, family, coworkers, LGBT community members, strangers
 - d. What was/has been your experience with healthcare or other professionals involved in your prenatal care?
- VI. Birth and Postpartum
 - a. What was your experience of labor and birth? If currently pregnant, what are your hopes and expectations for the birth process?

- i. For those who have given birth already: Where did you give birth? What was your birth plan? How was this experience compared with your expectations? What was your experience with professionals involved in the labor and birth process? With family and friends involved in the process?
 - b. How did you decide what your child would call you (and your partner)? If currently pregnant, have you decided what your child will call you (and your partner)?
 - c. How did you feed your child? If currently pregnant, have you thought about how you will feed your child? If so, please explain.
 - i. For those who have given birth already: Did you bottle-feed? Breast/chest feed? What was/is that experience like for you? How did your gender identity factor into your decision of how to feed your child?
 - d. If you have already given birth, what was/has been your experience with any healthcare or other professionals involved the postpartum period? If currently pregnant, how have you imagined your experience with healthcare or other professionals involved in the postpartum period?
 - i. Well child visits; sick visits, etc.
- VII. Closing
 - a. Are there any topics you feel were missed or questions that could have been helpful to ask?
 - b. Is there anything that you would like to add?

Appendix C

Human Subjects Review Approval Letter



School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950 F (413) 585-7994

November 25, 2014

Lauren Ambrosini

Dear Lauren,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Hannah Karpman, Research Advisor