"*The Best Revenge is Living a Good Life*":

Queer and Trans Resilience Along the Childbearing Journey

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Abstract

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This dissertation explores multidimensional social support across the perinatal period among sexual and gender-diverse (SGD) childbearing individuals living in the United States. The Social-Ecological Model (SEM) of Health Promotion and resilience theory guided this dissertation. Chapter One provides an overview of emerging health disparities among SGD childbearing people and compelling evidence of their risk for mental health disparities. It also identifies our limited understanding of perinatal social support among this population — an important modifiable risk factor for adverse mental health. Thus, social support was identified as a promising topic for this dissertation that could promote perinatal health and well-being among an understudied childbearing population.

Chapter Two, *Childbearing at the Margins: A Systematic Metasynthesis Review of Sexual and Gender-Diverse Childbearing Experiences,* evaluated and synthesized data from 25 studies on SGD childbearing. Three main themes were identified (1) *Systematic Invisibility: Erasure, Structural Exclusion, Discrimination*; (2) *Creating Personhood Through Parenthood*; and (3) *Resilient Narratives of Childbearing*. We found widespread structural and interpersonal harm and discrimination across the childbearing period while also emerging evidence of positive social experiences and resilience. Gaps in the literature were identified, including data on racially and geographically diverse SGD childbearing populations, perinatal support experiences beyond the healthcare context, and data derived from prospective studies.

Chapter Three, *"Through Our Resiliency We…Find Joy": A Community-Placed Qualitative Study of Social Support Among Sexual And Gender-Diverse Childbearing People,* introduces The Study of Queer and Trans Perinatal Resilience and Experiences of Gestation (PREG). This chapter sought to understand perinatal risk and resilience among SGD childbearing individuals at the inter-and intrapersonal levels of the SEM — namely, coping skills and social support. Four main themes were identified: 1) *Entering a New Season of Life*, 2) *Community is Family*, 3) *The Pain We Bear*, and 4) *Obligatory Resilience*. We found that this new season of life came with unique support needs and sources of support. Support systems were robust and generally diffuse. Family formation signaled a time to heal old wounds among families of origin while simultaneously a time of increased harmful experiences and sacrifices to maintain access to support. Due to a history of stigma and discrimination, SGD individuals had well-developed coping strategies that mitigated harm. They found building a family a profoundly meaningful experience that provided great joy and purpose.

Chapter Four, *"You're Preparing for People to Assess Whether You Can Have Your Own Child": Structural Failures to Support Sexual and Gender-Diverse Childbearing Parents,* explores social support and social needs at the community, organizational, and policy levels of the SEM to understand how structural factors support or fail to support SGD childbearing people. Three main themes were identified: 1) *When Protections Fail to Protect*, 2) *The Burden Is on Our Shoulders*, and 3) *When Privilege Is Protection*. We found that despite advances in legal protection of SGD people, numerous factors undermine the ability to access protections across the childbearing journey. Thus, SGD individuals are faced with impossible choices when building their families and are forced to advocate for themselves, educate others, and pay to

access structural support. Class and racial privilege may play a role in protecting SGD people from these burdens.

Chapter Five summarizes the findings from the three manuscripts in this dissertation, highlighting the strength and weaknesses of the studies, and research, clinical practice, and policy implications. Taken together, the heterocisnormative framework of family formation creates structural stigma and contributes to interpersonal conflict and exclusion that may increase vulnerability to perinatal mental health disparities among SGD childbearing individuals. However, SGD individuals also demonstrated resilience by using well-developed coping strategies and robust social support networks, achieving what was for many a lifelong dream of having a family. This dissertation provides an important contribution to the scientific literature by describing and characterizing perinatal resilience and stigma at each level of the SEM and, in doing so, provides a roadmap to inform clinical practice, policy, and future research in pursuit of promoting perinatal health equity among a marginalized childbearing population.

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Dedication

This dissertation is dedicated to every one of the participants in this study. It was an immense privilege to bear witness to one of the most personal and vulnerable journeys a person can experience. Your stories are a part of me now; they influence how I think about and move through the world and challenge my own stagnant notions of what it means to be held up by community**.** I learned more from you all than I ever fathomed and am forever changed because of it.

This dissertation is a tapestry that weaves together your tears with your laughter, your grief with your joy, your disappointment with your courage, and your anxieties with your hopes. It embraces you in the depths of your vulnerability and cracks open the possibility of imagining new ways of being in relation with one another. My only hope is that this dissertation and forthcoming publications will catalyze justice through the power of your voices and spark a greater conversation about how we can all do better to hold up one another in community. This dissertation is a tribute to your obligatory resilience.

The dissertation is also dedicated to the community of queer and trans doulas, midwives, and other birth workers who tirelessly live and breathe this work. You are the ones cradling and nourishing our community during this tender time. You are the bridge between two worlds and the educators, advocates, and changemakers our community needs. I promise to continue following your leadership, expertise, and wisdom as we work towards creating a better world for queer and trans childbearing people.

Chapter 1: Introduction to the Dissertation

This three-manuscript dissertation reports the findings of an in-depth examination of perinatal experiences — specifically stressors and resilience — among sexual and gender-diverse (SGD) childbearing parents. The overall goal of this dissertation was to describe and characterize the multidimensional aspects of social support experiences across the perinatal period among SGD gestational parents living in the United States (US). The dissertation achieves this goal through three specific aims:

1. Evaluate and synthesize the qualitative literature on SGD childbearing experiences
2. Describe assets of and gaps in social support among SGD childbearing parents at the inter-and intrapersonal levels of the Social-Ecological Model (SEM) across the gestational period
3. Identify facilitators and barriers in SGD gestational parents' accessing structural support at the community, organizational, and policy levels of the SEM across the perinatal period

Chapter One provides the background and significance of the research question, identifies the gaps in current knowledge, and describes the theoretical framework guiding these studies. Chapter Two includes a systematic metasynthesis of SGD childbearing experiences. Chapters Three and Four include original research on perinatal social support among SGD individuals. The final chapter synthesizes the findings across all three studies, identifies gaps in knowledge that our results fill, and articulates this work's research, practice, and policy implications.

1.1 Background and Significance

Perinatal depression and anxiety are among the leading morbidities of childbearing (Creanga et al., 2014; Mathers & Loncar, 2006) and a costly public health issue (Luca et al.,

2019; Sontag-Padilla et al., 2013). The total societal costs of perinatal mood and anxiety disorders (which includes depression) are $14.2 billion, with the most significant costs attributed to productivity losses ($4.7 billion) and health expenditures ($2.9 billion; Luca et al., 2019). Perinatal anxiety and depression not only affect the 9–21% of perinatal individuals who experience these conditions (Gaynes et al., 2005; Woody et al., 2017; Dennis et al., 2017, Fawcett et al., 2019) but also puts the health and development of their 400,000 infants at risk (Earls & Committee on Psychosocial Aspects of Child and Family Health: American Academy of Pediatrics, 2010; Monk et al., 2012; Surkan et al., 2011, 2014). SGD individuals (Table 1.1 for definitions) are a National Institutes of Health (NIH) health disparity population (Perez-Stable, 2016) who experiences health inequalities, including poor mental health outcomes (Crissman et al., 2019; Kidd et al., 2016; Steele et al., 2017). Unfortunately, SGD individuals are underrepresented in perinatal research (Coulter et al., 2014), and relatively little is known about their perinatal health outcomes, particularly their risk for perinatal depression and anxiety.

Table 1.1

Definitions of Sexual Orientation and Gender Identity

Identity	Definition
Sexual Orientation	
Sexual diverse	Those who identify as lesbian, gay, bisexual, queer, or another sexual-diverse identity and/or who have sexual relationships with same-gender partners
Heterosexual	Those who identify as straight and/or have sexual relationships only with different-gender partners
Gender Identity	
Gender diverse	Those whose gender identities exist outside the binary of "male" and "female," including a transgender identity
Cisgender	Those whose gender identity is congruent with their binary sex assigned at birth

SGD Gestational Parents: A Growing Childbearing Population

This dissertation focused on SGD gestational parents: *a gestational or postpartum individual assigned female at birth* who identifies as a sexual-diverse individual (e.g., sexual-diverse woman [a lesbian, bisexual, queer, or pansexual cisgender woman]), a gender-diverse

individual (e.g., a self-identified man, transgender man, or a nonbinary person assigned female at birth), or both (e.g., a gay, transgender man). The population of SGD parents in the US continues to rise (Jones, 2022), including the rate of SGD parents having biological children via gestation or gamete donation (Goldberg & Conron, 2018; Tornello et al., 2019). New growth is expected among SGD families as younger generations (aged 18–35) are having or considering having children at nearly double the rate of older SGD generations (77% versus 44%; Harris & Hopping-Winn, 2019). Despite this growth in SGD family formation, providers are insufficiently prepared to provide reproductive and perinatal care to SGD people (Johansson et al., 2020; Wingo et al., 2018), underscoring the responsibility to include SGD gestational parents in perinatal research to better understand their health and well-being (Lyerly et al., 2017).

Gestational SGD Individuals: An At-Risk Population

What little is known about SGD childbearing individuals' perinatal outcomes has been derived from small, cross-sectional samples of sexual-diverse women primarily outside the US (Chapman et al., 2012; Dahl et al., 2015; Hennekam & Ladge, 2017). These limited data suggest that SGD childbearing people may experience marked mental health and birth disparities. Postpartum depression rates are twice as high (20–31% versus 4–15%) in small samples of Canadian and Australian sexual-diverse women (Flanders et al., 2016; Khajehei et al., 2012; Ross et al., 2012; Yager et al., 2010) versus heterosexual women (Buist et al., 2008; Lanes et al., 2011). Relative to heterosexual women, sexual-diverse women have an increased risk of poor birth outcomes: 185% increased odds of stillbirth, 84% increased odds of very preterm births, and 77% increased odds of miscarriage (Everett et al., 2019). Although prenatal depression may be associated with adverse birth outcomes (Accortt et al., 2015), it is unclear if or how poor mental health impacted these outcomes in sexual-diverse women.

Although only a small number of studies contribute to our current understanding of transmasculine perinatal individuals' mental health during the perinatal period, pervasive loneliness and social isolation (Charter et al., 2018; Ellis et al., 2014; Hoffkling et al., 2017; Light et al., 2014) — known risk factors for depression (Hudson et al., 2016; Wang et al., 2018) — and high rates of miscarriage (Moseson et al., 2020a) have been reported. It might not be unreasonable to assume that the stigma and discrimination SGD individuals experience in other areas of their life (i.e., sexual and gender minority stress; Brooks, 1981; Hendricks & Testa, 2012; Meyer, 2003) — which are known to negatively impact mental health (Hatzenbuehler, 2009; Hughto et al., 2015) — may contribute to the increased risk for perinatal depressive symptoms and poor outcomes seen (Everett et al., 2019; Light et al., 2014; Ross et al., 2007). Importantly, although SGD subgroups vary in their vulnerability to health disparities (e.g., transgender men report higher rates of depression than lesbian, cisgender women; Bockting et al., 2005; Steele et al., 2017), the shared experience of stigma and discrimination makes for a compelling argument to increase the examination of all SGD individual's risks for perinatal depression and anxiety.

Social Support: A Modifiable Risk Factor

High levels of social support in heterosexual, cisgender populations significantly reduces the risk of low birth weight infants (East et al., 2019; Hetherington et al., 2015; Wang et al., 2013), preterm birth (East et al., 2019; Hetherington et al., 2015; Surkan et al., 2019; Wang et al., 2013), and perinatal depression (Alhusen & Alvarez, 2016; East et al., 2019; Kim et al., 2014; Wang et al., 2018), particularly among racially minoritized individuals (Hudson et al., 2016; Pao et al., 2019; Surkan et al., 2006). Specifically, high levels of **familial** (source), **instrumental** (type), and **in-person** (setting) support are protective against perinatal depression risks in

heterosexual and cisgender individuals (Collins et al., 1993; Negron et al., 2013). Yet, SGD individuals have higher rates of estrangement from families of origin (Croghan et al., 2014) and experience discrimination in public, in-person settings (Cherguit et al., 2012). Thus, SGD individuals rely on "**chosen families**" (source) — close friends who share the same identities or levels of marginalization — and **online** (setting) communities for **emotional** (type) support (Alang & Fomotar, 2015; Hunter, 2015; Ruppel et al., 2017) and to buffer against the effects of discrimination (Bockting et al., 2013; Meyer, 2003; Ross et al., 2012).

In Meyer's (2003) minority stress model, coping and social support are the primary mechanisms of resilience in buffering stressful experiences, moderating the relationship between minority stress in SGD populations and mental health. Thus, perceived social support has been studied among general SGD populations due to its moderating effect on minority stress (Meyer, 2003; Hendricks & Testa, 2012). However, the few perinatal studies that examined social support among SGD individuals only addressed sources of support (e.g., partners, parents; Dahl et al., 2013; Ross et al., 2018) and failed to contextualize support within the broader social-ecological context.

1.2 Contributions of this Dissertation

The emerging perinatal health disparities among SGD individuals, combined with our limited understanding of perinatal social support among SGD individuals beyond interpersonal support (e.g., partners, parents, providers), provides an opportunity for investigation. Given the critical role of social support in reducing or preventing adverse health outcomes, formative and prospective qualitative research is warranted to understand the broader social-ecological context of support among SGD gestational parents and their risk for adverse perinatal outcomes.

This dissertation filled this knowledge gap by synthesizing the data on SGD childbearing to date and generating foundational knowledge about social support during the perinatal period that can be used to develop future interventions that can be tested in this health disparity population. Additionally, this dissertation addressed the specific gaps and weaknesses in the prior research by exploring types (i.e., emotional, informational, and instrumental support), sources (e.g., co-parents, extended family, friends), and setting (e.g., workplace, online forums, in the home) of support across the perinatal period, at multiple levels of the SEM, and among both sexual *and* gender-diverse childbearing individuals. We also recruited a sample more racially and geographically diverse (e.g., included rural and Southern areas in the US) than in prior work and used innovative methods to answer these research questions.

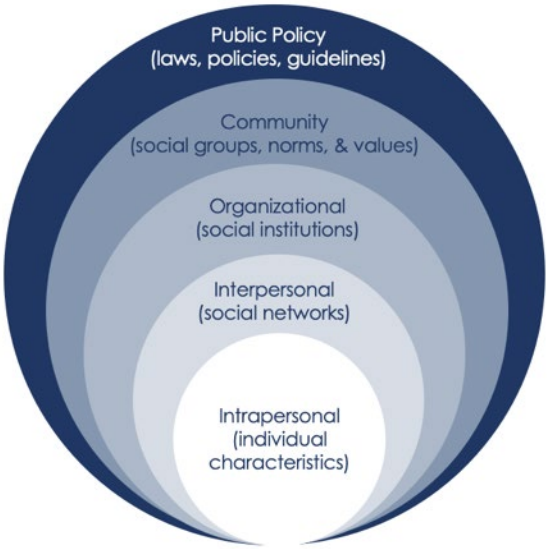
1.3 Theoretical Framework

The SEM for Health Promotion (Figure 1.1; McLeroy et al., 1988) — based on Bronfenbrenner's Ecological Systems Theory (1979) — is the multidimensional and multi-level theoretical framework that guided the conceptualization of social support in this dissertation. While social support in prior research has mainly focused on the unidimensional interpersonal level (i.e., sources of support), the SEM provides a framework for contextualizing how support — in addition to discrimination and stigma — operates at multiple levels of one's environment, impacting the support available to SGD childbearing individuals, and consequently their risk for adverse perinatal health outcomes (Institute of Medicine, 2011; Johns et al., 2018; Sword, 1999; Zimmerman et al., 2015). This framework has been advocated to promote the health and well-being of SGD populations in the National Academies of Sciences, Engineering, and Medicine's (2020b) report *Understand the Well-Being of LGBTQI+ Populations,* as well as is used for the

NIH's 2021 Sexual and Gender Minority Health Disparities Research Framework (Sexual and Gender Minority Research Office, 2021).

Figure 1.1

Social-Ecological Model of Health Promotion



The SEM includes factors at the following five levels: intrapersonal, interpersonal, organizational, community, and public policy. *Intra*personal factors represent individual characteristics (e.g., identities, health history, coping); *inter*personal factors represent social networks and support systems (e.g., family, friends, peers); organizational factors represent social institutions (e.g., work culture around parental leave, health benefits); community factors represent local social groups and norms as well as the SGD community (e.g., social connectedness to other SGD people, inclusive parenting support groups and classes); and public policy represents laws, policies, and guidelines (e.g., parental leave policies, insurance coverage or access to partner's insurance).

Additionally, Fergus and Zimmerman's (2005) resilience framework guided the integration of minority stress theory onto the SEM to identify adversities (i.e., risks) and promotive factors (i.e., essential resilience requirements) at each level of one's environment.

Fergus and Zimmerman posit that resilience is "the process of coping successfully with risk exposure and avoiding negative outcomes associated with risks" (Fergus and Zimmerman, 2005). For our study, risk exposure refers to exposure to minority stressors during the perinatal period, and the key outcome of interest was poor perinatal mental health. Fergus and Zimmerman's framework directed us to not only examine individual assets (i.e., positive traits that reside within an individual) but also resources (i.e., external factors to individuals that help overcome risk) in the broader social environment (e.g., organizational and policy level) that either promote or create obstacles to resilience. This moves beyond minority stress theory by placing resilience in a more ecological context and further explicates how both proximal and distal factors of minority stress are experienced and/or buffered at every level of the SEM.

1.4 Overview of Chapters

The three studies that comprise this dissertation are found in Chapters Two, Three, and Four. Chapter Two is a metasynthesis that accomplished aim 1 — to evaluate and synthesize the qualitative literature on SGD childbearing experiences — using Sandelowski and Barroso's (2006) metasynthesis techniques coupled with Noblit and Hare's (1988) approach to analysis. This review highlighted that SGD individuals face increased and unique discrimination and stigma relative to heterosexual and cisgender parents during the perinatal period, which may increase their risk for adverse perinatal outcomes. Studies rarely examined perinatal resilience — specifically social support and coping — which can buffer the impact of minority stress on adverse health outcomes. This review also highlighted the need to better understand the experiences of SGD childbearing people from rural and Southern areas of the US, with lower socioeconomic and educational backgrounds, and who identify as a racialized person, gender-diverse person, single or actively polyamorous, and differently-abled or neurodivergent. Lastly,

the absence of prospective studies limits the ability to use the data to inform evidence-based clinical guidelines and to advance the science of perinatal health. The target journal for publication of these results is *Birth* (impact factor 3.69).

Chapters Three and Four consist of a community-placed study of perinatal social support called The Study of Queer and Trans Perinatal Resilience and Experiences of Gestation (PREG). This study used a qualitative descriptive methodology and community-placed research methods to guide 24 semi-structured, online interviews of SGD childbearing parents across the perinatal period in the US. A qualitative descriptive methodology was selected to support our exploration of perinatal social support and coping as an SGD childbearing person — understudied topics based on our metasynthesis in Chapter Two. Interviews occurred over six months at three timepoints — the end of the 2nd, 3rd, and 4th trimesters (i.e., three months postpartum) — and included questions addressing each level of the SEM (i.e., intrapersonal, interpersonal, organizational, community, and public policy). Assessments of depression, anxiety, and distress were taken before each visit to quantitative assess mental health. Photos were taken in response to prompts and discussed in the 2nd and 3rd interviews using a modified, virtual photovoice approach. Quantitative assessments and photos provided additional data points onto which we could triangulate our interview data.

Chapter Three focuses on describing and characterizing perinatal social support and social needs at the inter-and intrapersonal levels of the SEM, while Chapter Four focuses on the structural levels of organizational, community, and policy support (Figure 1.2). The dissertation was organized in this manner as the outer levels of the SEM lend better to reducing minority stressors through identifying structural opportunities for systematic change, and the inner levels lend better targets for interventions that will promote coping and support.

Figure 1.2

Dissertation Manuscripts Applied to the SEM of Health Promotion

Community-placed methods were selected to promote engagement among a minoritized and vulnerable (i.e., perinatal) population and allow participants an equal voice in shaping research about their lives (Spears Johnson et al., 2016; Travers et al., 2013). Community-placed methods fall on the spectrum of community-based participatory research with no community involvement on one end and community-driven research on the other (Key et al., 2019). As the key outcome of this study was to advance science through scientific dissemination, our study more appropriately falls under the umbrella of "community-placed" work (Harris et al., 2016).

Community-engaged methods are important when conducting research in communities where distrust is present. SGD people have been historically pathologized and stigmatized by the medical field; thus, overcoming distrust is an important consideration. Interviews were complemented with a modified, virtual photovoice approach which fostered the expression of hard-to-verbalize ideas around perinatal social support, capturing in real-time (versus at three

static time intervals) how support networks and needs may evolve over time. *Social Science and Medicine (impact factor 4.63)* is the target journal for data found in Chapter Three, and *Sexuality Research and Social Policy (impact factor 3.62)* is targeted for the findings reported in Chapter Four. Table 1.2 summarizes each manuscript, dissertation aim, study design and objective, and target journal.

Table 1.2

Summary of Dissertation Manuscripts and Study Methods

Chapter	Aim	Design	Sample	Objective	Target Journal
One				Introduce the dissertation and identify the need to study this topic in this population	
Two	1	Metasynthesis review	*n* =25 peer-reviewed, qualitative studies	Evaluate and synthesize the qualitative literature on SGD childbearing experiences	*Birth*
Three	2	A prospective, mixed-methods, community-placed study	*n* = 24 SGD childbearing parents	Describe assets of and gaps in social support among SGD childbearing parents at the inter- and intrapersonal levels of the SEM across the gestational period	*Social Science & Medicine*
Four	3			Identify facilitators and barriers in SGD gestational parents' accessing structural support at the community, organizational, and policy levels of the SEM across the perinatal period	*Sexuality Research and Social Policy*
Five				Discuss the implications of the findings and propose future directions for research, policy, and clinical practice	

1.5 Study Implications

Our study findings enhance the current understanding of SGD gestational parents in the US by describing and characterizing the multidimensional aspects of support experiences across the perinatal period at every level of the SEM. Doing so provides preliminary insight into factors that should be explored in future studies that may influence this population's perinatal health and well-being. Our findings offer knowledge to potentially inform the future development of social support instruments tailored to SGD childbearing individuals, culturally congruent and community-based social support interventions, inclusive healthcare practice, and equitable policies and laws. This study also served as the first step in a program of research focused on

reducing perinatal health disparities among an underrepresented and minoritized childbearing population.

Chapter 2: Childbearing at the Margins: A Systematic Metasynthesis Review of Sexual and Gender-Diverse Childbearing Experiences

Target journal: *Birth*

Abstract

Background

The reproductive and perinatal health of sexual and gender-diverse (SGD) individuals is a research priority area. Over the past decade, this childbearing population has been the focus of several qualitative studies providing the opportunity to evaluate and synthesize the qualitative literature on SGD childbearing experiences in a metasynthesis.

Methods

We conducted a literature search of four databases to identify original research published from January 2011 through June 2021. These results were augmented by forward and backward searching strategies. Two authors independently screened studies. All qualitative studies of the childbearing experience were eligible. Data were abstracted and inductively coded using conventional content analysis, and studies underwent a quality appraisal by two authors.

Results

From 2,396 articles, 127 full-text articles were screened, and 25 were included in this synthesis. Three overarching themes were identified: (1) *Systematic Invisibility: Erasure, Structural Exclusion, Discrimination*; (2) *Creating Personhood Through Parenthood*; and (3) *Resilient Narratives of Childbearing*.

Conclusion

Relative to heterosexual and cisgender parents, SGD childbearing parents experience unique structural and interpersonal challenges and employ critically important resilience

strategies and coping techniques to manage an overwhelming heterocisnormative experience. These findings provide an important target for healthcare organizations and professionals to improve SGD perinatal health. In addition, this metasynthesis identified persistent gaps in our understanding of this marginalized childbearing population which have important implications for reducing health disparities that SGD parents experience.

2.1 Background

Sexual-diverse (those whose sexual identity or behavior is not strictly heterosexual) and gender-diverse (those whose gender identity differs from the sex assigned at birth) individuals represent approximately 7.1% of the United States (US) population (Jones, 2022). There are an estimated 8.7 million sexual and gender-diverse (SGD) parents who gestated their child in the US, representing a small but growing population (Goldberg et al., 2014; James et al., 2016). The number of SGD parents is projected to continue to increase due to changing social attitudes and advances in legal rights and reproductive health technologies that have facilitated the formation of families through biological pathways (Goldberg & Conron, 2018; Harris & Hopping-Winn, 2019). This likely contributes to younger generations of SGD parents expanding or contemplating expanding their families at nearly double the rate of older cohorts (77% versus 44%; Goldberg & Conron, 2018; Harris & Hopping-Winn, 2019). Of the 6.8 million SGD millennials planning families, over 40% plan to use assisted reproductive technologies — an 8-fold increase from previous generations — and 38% intercourse, suggesting a desire for biological family formation compared to fostering or adoption (Harris & Hopping-Winn, 2019). Unfortunately, SGD people experience worse outcomes during the perinatal period — defined as the period from conception through 12 months postpartum — relative to heterosexual and cisgender women or those whose gender identity is congruent with their sex assigned at birth. These include higher rates of infant loss, very preterm birth, and adverse postpartum mental health outcomes (Everett et al., 2019; Moseson et al., 2020a; Ross et al., 2007).

Prior qualitative literature reviews on SGD childbearing (see Appendix A) have predominantly focused on childbearing experiences in healthcare settings (Agénor et al., 2021; Besse et al., 2020; Brandt et al., 2019; Dahl et al., 2013; de Castro-Peraza et al., 2019; García-

Acosta et al., 2019; Greenfield & Darwin, 2021; Gregg, 2018; Hammond, 2014; MacLean, 2021; McManus et al., 2006; Porter, 2005; Wells & Lang, 2016). This metasynthesis adds to our understanding of SGD childbearing experiences by including recent studies and extending our understanding of childbearing outside of healthcare settings (e.g., experiences in the context of families, communities, workplaces, and society).

2.2 Methods

Qualitative Metasynthesis

A qualitative metasynthesis is an interpretive synthesis of findings from individual qualitative studies to describe a phenomenon conceptually (Sandelowski & Barroso, 2006). It offers novel interpretations and insights on the evolving compendium of knowledge about a phenomenon through deconstructive and interpretive transformations of researchers' findings (Sandelowski & Barroso, 2006; Thorne, 2017). We used all but one of Sandelowski and Barroso's (2006) 6-step metasynthesis techniques for this analysis: step 5 (meta-summary of effect sizes and frequency of codes and categories) was omitted as a meta-summary may be misconstrued as important findings in qualitative syntheses (Thorne, 2017).

Step 1. Conceiving the Synthesis

Our research sought to update and comprehensively document SGD childbearing experiences since the last comprehensive review (Dahl et al., 2013), which included studies published through 2011.

Step 2: Search Strategy

A broad, systematic search strategy (see Appendix B for details on the search strategy) was conducted in four electronic databases (CINAHL, PsychInfo, PubMed, and Embase) using keywords representing "*sexual and gender minorities"* and the "*perinatal period."* Additional

relevant research studies were identified using forward and backward citation searching. In forward-searching, Google Scholar was used to identify all studies that cited the studies we retained for synthesis. In backward searching, reference lists of included studies and previous reviews were hand-searched. The search was initially conducted in November 2019 and then updated on June 7th, 2021. Two reviewers (KS & EM) independently screened each identified study; Covidence was used to manage citation screening.

Study Selection.

Inclusion Criteria.

Peer-reviewed qualitative studies and dissertations published after 2011 were eligible for inclusion. Studies published in 2011 were compared to those included in Dahl et al. (2013) and were excluded from our review if included in their review. Studies documenting the experiences of co-parents were included as it is not uncommon for SGD co-parents to have been a gestational parent to another child (Malmquist et al., 2019).

Exclusion Criteria.

We excluded: (1) non-original research studies (e.g., expert opinion, clinical guidelines); (2) non-human research; (3) mixed-method studies that lacked qualitative depth (e.g., open-ended survey questions); (4) studies that focused on elective abortions, experiences before gestation or after 12 months postpartum, and (5) studies that did not distinguish SGD people from non-SGD participants or the perinatal period from pre-or post-natal time points.

Data Extraction

Systematic review standards guided two reviewers (KS & MD) to extract sample and study characteristics independently (Lockwood et al., 2020). Sample characteristics included sample size, racial/ethnocultural background, age, education, relationship status, sexual

orientation, and gender identity of gestational and/or co-parents. Study characteristics included geographic location, recruitment site, guiding methodology, study aim, data collection, and analytic methods.

Step 3: Quality Appraisal

We used Guba's (1981) evaluative criteria for appraising the quality of the included studies. As shown in Table 2.1, quality was assessed by identifying reported strategies to enhance the trustworthiness of the study's findings, differentiating those that Guba deemed essential strategies (from those considered optional; Guba, 1981). Codebooks and team coding have more recently been considered an important component of qualitative rigor; thus, we operationalized Guba's strategy of *stepwise replication* to reflect this, characterizing this strategy as essential rather than elective (Reyes et al., 2021). Quality appraisals were performed independently by two team members (KS & MG) and reconciled by consensus in team meetings.

Step 4: Classifying

A research team with interdisciplinary backgrounds in clinical and academic nursing, midwifery, and public health, expertise areas in marginalized populations and perinatal health, and varied SGD identities was intentionally recruited to triangulate a variety of emic (i.e., from within the social group) and etic (i.e., from outside the social group) perspectives and minimize avoidable bias. Using an iterative codebook, two reviewers (KS & MN) coded the researchers' interpretations of the findings (i.e., second-order constructs), which included concepts, themes, and findings drawn from each study's results and discussion sections. The coding process was audited by a third team member (MG) as part of peer debriefing activities. An audit trail was maintained of study procedures through a series of tabular displays, memos, and reflexive

Table 2.1

Guba's Rigor Criteria and Indicators

Rigor criterion	Question	Possible indicators of some details	Possible indicators of in-depth details
Credibility (i.e., the truth value of the findings)			
Prolonged engagement	Did the researcher spend sufficient time with participants until there was no longer a researcher effect?	The appraiser feels there are enough details about the researchers spending sufficient time with participants to deeply learn about the topics of interest	The researcher discusses gaining participants' trust and/or participants being vulnerable to disclose sensitive information or discuss taboo topics OR the appraiser feels there are enough details in the results/discussion section that participants felt comfortable disclosing deeper levels of their experience with the researcher
Persistent observation	Did the researcher spend sufficient time at the research site/with participants to differentiate important from unimportant findings?	The researcher conducted >1 interview with each participant. Interviews lasted at least 1 hour, focus groups lasted at least 90 minutes, or the study met the criteria for prolonged engagement	The researcher states the time spent with participants was sufficient for in-depth depth understanding of the phenomenon, OR the appraiser feels there are enough details in the results/discussion section that the researchers spent enough time with participants
Peer debriefing	Did the researcher review or discuss their work with a peer or supervisor?	The researcher worked with a coding team, including a description of 2+ coders	The researcher states "peer debriefing" AND describes the process as having analysis/findings reviewed by an outside professional (e.g., an auditor, jury of peers, supervisor or dissertation committee) AND results are tested against raw materials (i.e., codebook)
Triangulation (Study design)	Were multiple methods, theories, researchers or data sources intentionally included in the study design for the purpose of examining the phenomenon comprehensively?	Intentionally used multiple researchers (particularly from different disciplines), theories, methods, or data from different time points (i.e., longitudinal), locations (i.e., rural and urban), or perspectives (i.e., gestational and co-parent) to view the phenomenon from multiple vantage points	Any of the above, AND direct evidence that the data sources/perspectives were integrated into the study design
Member Checks (Data collection)	Were emerging themes from prior interviews reviewed in new interviews?	The researcher states "member checking" was conducted throughout the interview process	The researcher describes the member checking process (i.e., data and interpretations were continuously tested with participants), AND the researcher states the inquiry or interview guide was altered as a result of emerging themes
Member Checks (Data analysis)	Were the results of the analysis returned to a subpopulation of participants or a similar group after analysis was complete?	The researcher states the analysis was returned to the participants or a similar group after analysis	The researcher states details about returning the final analysis to participants or a similar group, AND the researcher states the analysis was altered (emerged or unfolded) as a result of feedback
Structural Coherence or Corroboration	Do the exemplars support the themes, and do the themes "hang together"?	Themes are determined a priori/are not well developed, OR exemplars are present but too 'thin' to support the theme	The overall report exhibits coherence; that is, consistency, synchronism, logic, and being "all of a piece" AND exemplars provide thick descriptions of the experience AND themes are highly abstracted and interpretive
Referential Adequacy	Was a transcript created, or were other materials from the data collection process saved (i.e., audio/video recordings) as appropriate?	A transcript was created, or qualitative software was used to facilitate the coding process	A transcript was created by a professional transcriptionist and was cleaned, or qualitative software was used to facilitate the coding process
Transferability (i.e., the applicability of the findings)			
Theoretical/Purposive Sampling	Theoretical: Were participants selected to confirm and disconfirm cases and build a theory (e.g., grounded theory)?	Purposive: Participants met minimum inclusion criteria to answer the research question (e.g., allowed the first participants that fit the inclusion criteria to enroll in the study)	Purposive: The researcher states the sample they selected maximized diversity (e.g., selected participants based on race, educational background, partnership configuration, etc.) ABOVE

	Purposive: Were participants selected to maximize the breadth of experiences under the phenomenon of interest?	Theoretical: see in-depth details	the minimum inclusion criteria. Purposively sampling from a convenience sample was acceptable. Theoretical: Sampled to recruit a negative (disconfirming) case AND to build theory
"Thick" Descriptions (Data collection)	Were the methods and data collection procedures described in adequate detail?	The researcher described data collection procedures in some detail (e.g., included the type, place, and length of interviews OR included sample interview guide OR discussed collection of demographic information)	The researcher described data collection procedures in enough detail to replicate the study procedures AND the researchers included the interview guide
"Thick" Descriptions (Data analysis)	Was the data reported in adequate detail?	The researcher described the sample in some detail OR exemplar quotes were attributed with a single characteristic (e.g., participant pseudonym) OR exemplar quotes are thin/lacking context to understand themes OR participant exemplars aren't representative of the sample, especially in small samples (e.g., <50% of participants are represented in exemplars)	The researcher provides enough information about the sample to test the degree of fittingness to another sample (e.g., Table 1 of participant characteristics) AND exemplar quotes were attributed with participant characteristics relevant to the phenomenon of interest AND "thick" exemplar quotes provide sufficient detail about a participants' experience/thoughts AND included a representative sample of exemplars from participants, especially in small samples (e.g., majority of participants are attributed in quotes)
Dependability (i.e., the consistency of the findings)			
Overlap Methods	Were two or more methods used?	The researcher named and described multiple methods (e.g., interviews and document analysis)	The researcher named multiple methods and indicated they were selected because they were complementary AND were integrated to address the same phenomenon
Stepwise Replication	Was the coding split between multiple researchers?	The researcher mentioned a codebook AND team coding (i.e., two or more coders worked independently to code transcripts)	Possible indicators of some details AND the researcher mentioned team coding was interdisciplinary AND the team met regularly to revise the codebook until consensus was reached
Audit trail	Were records kept that described all data collection, analysis, and study procedures?	The researcher mentioned a journal or audit trail which documented a running account of the process of the research	Possible indicators of some details AND the researcher stated their journal and/or research activities indicated a timely redirection of the inquiry consistent with critiques obtained during peer debriefings (e.g., iterative interview guide, method changes)
Dependability Audit	Did an external auditor examine the research ***process***?	See in-depth details	The researcher mentioned an external audit was conducted on the process of the inquiry (e.g., a dissertation proposal reviewed by a committee; a grant proposal reviewed by peers)
Confirmability (i.e., strategies to reduce researcher bias)			
Triangulation (Study findings)	Were multiple methods, researchers or data sources utilized to inform the findings and reduce bias?	The researcher integrates more than one theory, method, data source (time, person or space), or investigator perspective into the results or analysis	Possible indicators of some details are done in a way that increases the appraisers' confidence in the findings AND in the effort to reduce bias
Reflexivity	Was there a description of a critical appraisal of how the researcher's biases affected the research?	The researcher mentioned keeping a reflexive journal (e.g., introspections recorded daily to critically examine how the researcher as instrument is a source of subjectivity) OR engaging in reflexive practices (e.g., reflexive bracketing) OR the researcher stated introspections were tested during peer debriefings	Possible indicators of some details described in detail AND stated how the results were influenced by their orientation
Confirmability Audit	Did an external auditor examine the research ***products***?	The paper has been published in a peer-reviewed journal	The researcher mentioned an audit was conducted on the products of inquiry (e.g., a dissertation advisor, external peer), verifying that the interpretations are consistent (e.g., data supports every interpretation)

Note. Each rigor criterion was assigned 'in-depth details,' 'some details,' reported, no details,' and 'not reported."
Shading indicates what Guba (1981) states are essential criteria to support qualitative with the addition of stepwise replication, which we added as an essential strategy to reflect the current day importance of a codebook.

journaling to bracket potential biases, increase the results' dependability, and reduce the risk that investigator bias was introduced. Lastly, a saturation table — a measure of data adequacy (Saunders et al., 2018) — was created to determine the breath (diversity) of content (Kerr et al., 2014). Atlas.ti (Version 8.4.4) was used for data management.

Step 6: Synthesis

As per Sandelowski and Barroso (2006) recommendations, we elected to synthesize our findings "in vivo" using Noblit and Hare's (1988) reciprocal and refutational translation of key concepts. Reciprocal translation determines how the studies were comparable and refutational translation accounts for contradictions. First, codes were exported into Excel (Version 16.32) and organized thematically by grouping concepts with similar meaning into categories, then themes. Next, studies' relationality and oppositions were explored by comparing concepts report-by-report to determine the continuum or breadth of each concept to identify differences among subgroups (e.g., cisgender vs gender-diverse experiences). Translations were then synthesized.

2.3 Results

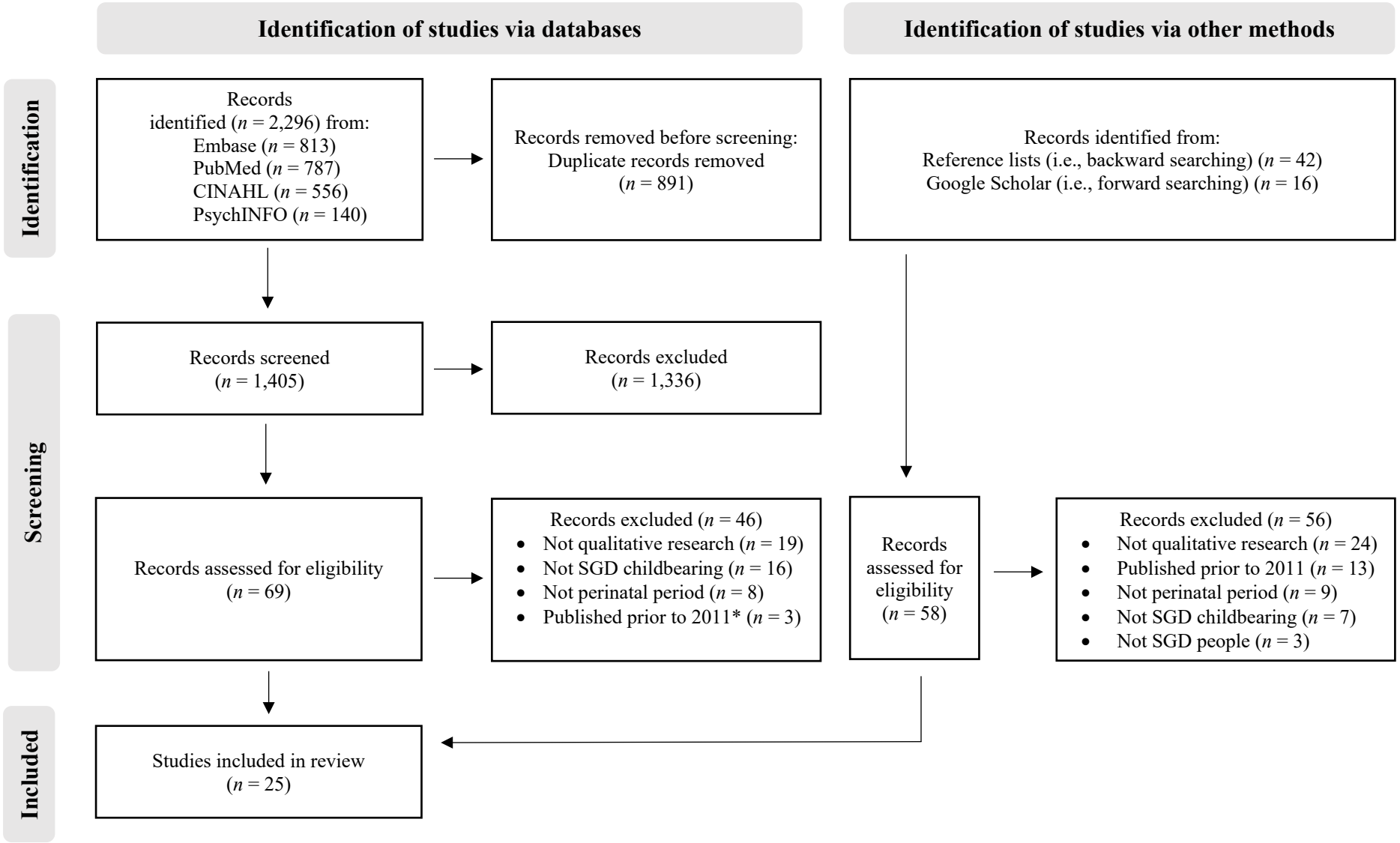
After removing duplicates, 1,405 studies underwent title and abstract screening by two team members (KS & EM) working independently, from which 69 were selected for full-text review. Backward- and forward-citation searching conducted by KS identified an additional 58 studies. As seen in Figure 2.1, this resulted in a total of 25 studies included in the final synthesis. Rationales for excluding the 43 papers that underwent full-text review can be found in Appendix C.

2.3.1 Study Characteristics

Sample sizes ranged from 5 to 28 (M = 14.1) participants, with a total sample size of 297 across the 25 included studies. Most participants were gestational parents (*n* = 13; Burrow et al.,

Figure 2.1

PRISMA Flow Diagram of the Article Search and Selection Process



2018; Charlton et al., 2021; Charter et al., 2018; Ellis et al., 2014; Falck et al., 2021; Fischer, 2021; Hoffkling et al., 2017; Juntereal & Spatz, 2020; MacDonald et al., 2016; MacDonald et al., 2021; Riggs et al., 2020; Rogers, 2020; Searle et al., 2017), co-parents (*n* = 6; Abelsohn et al., 2013; Brennan & Sell, 2014; Cherguit et al., 2012; Dahl et al., 2015; McKelvey, 2014; Wojnar & Katzenmeyer, 2013), or a combination of both gestational and co-parents (*n* = 6; Hennekam & Ladge, 2017; Kazyak & Finken, 2020; Malmquist et al., 2019, 2021; Malmquist & Nieminen, 2021; Rippey & Falconi, 2017). Samples were predominantly White (≥75%), highly educated (≥59% had at least a college degree) and partnered. Eleven samples were majority lesbian or queer cisgender women (Brennan & Sell, 2014; Burrow et al., 2018; Cherguit et al., 2012; Dahl & Malterud, 2015; Hennekam & Ladge, 2017; Juntereal & Spatz, 2020; Kazyak & Finken, 2020; McKelvey, 2014; Rippey & Falconi, 2017; Rogers, 2020; Searle et al., 2017; Wojnar & Katzenmeyer, 2013), eight transmasculine individuals with mixed or unreported sexual orientations (Charlton et al., 2021; Charter et al., 2018; Ellis et al., 2014; Falck et al., 2021; Fischer, 2021; Hoffkling et al., 2017; MacDonald et al., 2016; MacDonald et al., 2021; Riggs et al., 2020) and two included mixed SGD identities (Abelsohn et al., 2013; Malmquist et al., 2019, 2021; Malmquist & Nieminen, 2021). These numbers do not equal 25 because seven manuscripts used the same three samples (Burrow et al., 2018; MacDonald et al., 2016; MacDonald et al., 2021; Malmquist et al., 2019, 2021; Malmquist & Nieminen, 2021; Searle et al., 2017). The majority of co-parents were cisgender women. Further details of sample characteristics can be found in Table 2.2.

Studies included childbearing experiences in the US (*n* = 9; Brennan & Sell, 2014; Charlton et al., 2021; Ellis et al., 2014; Hennekam & Ladge, 2017; Juntereal & Spatz, 2020;

Table 2.2

Characteristics of Samples in the Included Metasynthesis Studies

First author, year	Participants interviewed	Population	Racial/Ethnocultural background	Age, *years*	Education	Relationship status	Sexual orientation [h]	Gender identity/expression, *used by authors* [h]
Abelsohn, 2013	8	Co-parents	12.5% Multiracial 12.5% Persons of color 75% White	26 – 45	12.5% < Bachelor's degree 50% Bachelor's degree 37.5% Graduate degree	100% Partnered	62.5% Lesbian/gay 37.5% Queer	87.5% (Cis) women 12.5% Genderqueer
Brennan, 2014	20	Co-parents	95% White	27 – 44 M = 34	95% ≥ Bachelor's degree 45% Graduate degree	100% Partnered	90% Lesbian 10% Queer	100% (Cis) women
Burrow, 2018	13	Gestational parents	8% First Nations 15% Multiracial 77% White	18 – 42	High school degree (GED status) to Ph.D. preparation	Variety of relationships	LGBTQ2S	Mainly (Cis) women
Charlton, 2021	10	Gestational parents	10% Black 90% White	21 – 53 M = 34.3	*	*	*	100% Transmasculine [a, b]
Charter, 2018	16 / 25[c]	Gestational parents	64% Australian [c] 8% British [c] 4% German [c] 4% Malay-Chinese [c] 8% Missing [c] 12% New Zealand [c]	24 – 46 M = 35.6	24% < Bachelor's degree [c] 68% ≥ Bachelor's degree [c]	52% Partnered [c] 32% Other [c] 16% Missing [c]	30% Heterosexual [c] 61% LGBTQ+ [c] 9% Not sure [c, d]	100% Trans men
Cherguit, 2012	10	Co-parents	10% Anglo Indian 10% British 10% Welsh 70% White	33 – 51 M = 41.5	*	100% Partnered	100% Lesbian	100% (Cis) women
Dahl, 2015	11	Co-parents	*	30 – 52	*	100% Partnered	100% Lesbian	100% (Cis) women
Ellis, 2014	8	Gestational parents	100% White	29 – 41 M = 33	25% < Bachelor's degree 50% Bachelor's degree 25% Graduate degree	87.5% Partnered 12.5% Single	75% Gay 12.5% Bisexual *12.5% Missing*	25% Trans men 75% >1 gender identity

Falck, 2021	12	Gestational parent	*	*	*	50% Partnered 33% Single 17% Multiple partners	*	66% Transmasculine [b, e] 50% Trans men 33% Men 8% Exclusively nonbinary
Fischer, 2021	5	Gestational parent	20% Multiracial 80% White	31 – 44 M = 34.8	100% ≥ Bachelor's degree	80% Partnered 20% Co-parenting with a friend	80% Queer 20% Pansexual	80% Nonbinary 20% >1 gender identity
Hennekam, 2017	28 (14 couples)	Gestational & co-parents	*	28 – 45 M = 35.8	*	100% Partnered	100% Lesbian	100% (Cis) women
Hoffkling, 2017	10 / 41 [c]	Gestational parents	3% Asian [c, f] 3% Multiracial [c, f] 3% Native Hawaiian [c, f] 91% White [c, f]	M = 28 [c, f]	41% < Bachelor's degree [c, f] 36% Bachelor's degree [c, f] 23% Graduate degree [c, f]	*	*	100% Transmasculine [b]
Juntereal, 2020	18 / 68 [c]	Gestational parents	3% Black [c, e] 1% Hispanic/Latino [c, e] 100% Whit e[c, e]	26 – 50 [c] M = 34.5 [c]	*	100% Partnered	100% Currently in a same-sex female relationship	100% (Cis) women
Kazyak, 2020	21 (9 couples)	Gestational & co-parents	5% Multiracial [f] 95% White [f]	29 – 47 [f] M = 37 [f]	19% < Bachelor's degree [f] 33% Bachelor's degree [f] 48% Graduate degree [f]	95% Partnered [f] 5% Single [f]	71% Lesbian [f] 19% Bisexual [f] 10% Gay [f]	100% (Cis) women
MacDonald (2016 & 2021)	22	Gestational parents	9% Black 4.5% Hispanic 41.5% Missing 45% White	24 – 50	100% ≤ Bachelor's degree 59% Graduate degree	68% Partnered	*	100% Transmasculine [b]
Malmquist (2019, 2021, 2021)	17 (4 couples)	Gestational & co-parents	*	25 – 42 M = 34.9	Majority college educated	100% Partnered	76% Lesbian 12% Bisexual 6% Pansexual *6% Missing*	82% (Cis) women 12% Trans men 6% Nonbinary
McKelvey, 2014	10	Co-parents	10% Black 90% White	30 – 61	*	100% Partnered	100% Lesbian	100% (Cis) women

Riggs, 2021	16	Gestational parents	*	23 – 49 M = 35	*	75% Partnered 25% Single or causal partners	31% Queer [e] 31% Bisexual [e] 25% Pansexual [e] 25% Other [e] 19% Gay [e]	44% >1 gender identity 31% Transmasculine 19% Exclusively male 6% Exclusively nonbinary
Rippey, 2017	10 (4 couples)	Gestational & co-parents	10% Hispanic 90% White	27 – 57 M = 37.9	80% ≥ Bachelor's degree 20% Graduate degree	100% Partnered	100% Lesbian	100% (Cis) women
Rogers, 2020	8	Gestational parents	12% Hispanic/White 88% White	27 – 38 M = 33.4	*	100% Partnered	75% Queer [e] 50% Lesbian [e] 25% Bisexual [e] 12.5% Gay [e]	100% (Cis) women
Searle, 2017 [g]	13	Gestational parents	8% First Nations 15% Multiracial 77% White	18 – 42	High school degree (GED status) to Ph.D. preparation	Variety of relationships	LGBTQ2S	Mainly (Cis) women
Wojnar, 2013	24	Co-parents	8% Black 8% Multiracial 84% White	28 – 48 M = 37.2	25% < Bachelor's degree 75% ≥ Bachelor's degree	100% Partnered	100% Lesbian	100% (Cis) women

Note. *Information was not included in the study. [a] Participants could identify as transmasculine either at the time of gestation or data collection. [b] The gender identities or expressions reported under 'transmasculine' included: genderqueer, gender fluid, nonbinary, male, man, female-to-male, transman, trans man, transgender man, on the transmasculine spectrum, or selected more than one gender identity. [c] Indicates data from the parent study sample. [d] Participants reported unsure sexual identity. [e] Does not equal 100% because participants were allowed to select more than one sexual orientation. [f] Information was found in another manuscript of the same study sample. [g] Same sample repeated from Burrow, 2018. GED = general educational development. [h] Definitions for sexual orientations and gender identities can be found in Appendix D.

Kazyak & Finken, 2020; McKelvey, 2014; Rogers, 2020; Wojnar & Katzenmeyer, 2013), Canada (*n* = 3; Abelsohn et al., 2013; Burrow et al., 2018; Fischer, 2021; Searle et al., 2017), Australia (*n* = 1; Charter et al., 2018), European countries (*n* = 5; Cherguit et al., 2012; Dahl & Malterud, 2015; Falck et al., 2021; Hennekam & Ladge, 2017; Malmquist et al., 2019, 2021; Malmquist & Nieminen, 2021), or a combination of these countries (*n* = 3; MacDonald et al., 2016; MacDonald et al., 2021; Riggs et al., 2020; Rippey & Falconi, 2017). Details of report characteristics can be found in Table 2.3.

2.3.2 Quality Appraisal

Among the nine strategies to enhance qualitative rigor that Guba identified as essential, thick descriptions were commonly reported, triangulation was sometimes reported, and member checking (credibility), reflexivity (confirmability), audit trails (dependability), and stepwise replication (dependability; i.e., a codebook) were rarely reported. Full reporting on the rigor of all strategies is in Table 2.4.

2.3.3 Themes

Three overarching themes emerged from this metasynthesis: (1) *Systematic Invisibility: Erasure, Structural Exclusion, Discrimination*; (2) *Creating Personhood Through Parenthood*; and (3) *Resilient Narratives of Childbearing*. Data saturation was met at the categorical level after the fifth report and at the code level after the thirteenth report (Appendix E for saturation table).

Theme I. Systematic Invisibility: Erasure, Structural Exclusion, Discrimination

The first theme, *Systematic Invisibility: Erasure, Structural Exclusion, Discrimination,* consists of three subthemes. This theme describes the pervasiveness of heterocisnormative assumptions around gestational bodies and how biological parenthood resulted in SGD people

Table 2.3

Characteristics of Included Metasynthesis Studies

First Author, year	Country, *city or region where samples were recruited*	Recruitment site	Guiding methodology/ philosophical orientation; Analytic method	Aim	Data collection method *Type, method, & length*
1. Abelsohn, 2013	Canada, *Toronto*	Two midwifery clinics & community networks	Grounded theory Constant comparison inferred	To explore factors affecting mental health and wellness in LBQ nonbirth parents	Semi-structured, *method not reported* interviews (*length not reported*)
2. Brennan, 2014	United States, *large, urban East Coast city*	Local ads & support groups	Interpretive naturalistic approach Constant comparison inferred	To explore how language affects the transition of social (non-gestational) mothers into motherhood	Semi-structured, in-person interviews (45 – 90 minutes)
3. Burrow, 2018	Canada, *rural Nova Scotia*	Healthcare settings, community venues, social media	Feminist and queer phenomenology Feminist, intersectional analysis	To assess queer women's birthing experiences within rural healthcare institutions and explore how they are connected to trauma and vulnerability	Dialogical and semi-structured, telephone and in-person interviews (60 – 90 minutes)
4. Searle, 2017 [a]			Feminist and queer phenomenology Literary analysis	To broaden current understandings of trauma by examining structural marginalization among rural, queer birthing women	Semi-structured, telephone and in-person interviews (60 – 90 minutes)
5. Charlton, 2021	United States, *no further details*	Support networks, community venues, and online methods	Qualitative descriptive inferred* Content analysis	To describe teen and unintended childbearing experiences among trans masculine people	Semi-structured, telephone, video conference or in-person interviews (29 – 87 minutes)
6. Charter, 2018	Australia, *no further details*	Support groups, community networks, social media	* Thematic analysis	To understand the desire for parenthood and childbearing among Australian trans men	Semi-structured, telephone interviews [b] (*length not reported*)
7. Cherguit, 2012	England and Scotland, *rural and urban*	Email to a donor conception charity and snowballing	Interpretive phenomenology methodology and analysis	To explore co-mothers' experiences of maternal healthcare services	Semi-structured video conference and in-person interviews (30 – 150 minutes)
8. Dahl, 2015	Norway, *no further details*	Community organization website and social media	* Systematic text condensation	To explore lesbian co-mothers' maternity care experiences and their implications	*Type and method not reported,* interviews (38 – 78 minutes)
9. Ellis, 2014	United States, *50% rural, 50% urban*	Healthcare and social service providers	Grounded theory Constant comparison	To explore the conception, childbearing, and birth experiences of transgender and gender-variant people	*Type not reported*, video conference interviews (60 – 90 minutes)

10. Falck, 2021	Sweden, *50% smaller city, 50% major city*	Community organizations and health clinic	Minority stress theory Thematic analysis	To investigate how trans masculine people experience gestational and postpartum healthcare encounters	*Type not reported,* in-person interviews (55 – 112 minutes)
11. Fischer, 2021	Canada, *100% urban areas*	Community networks and social media	Narrative inquiry inferred Narrative analysis	To capture the unique reproduction narratives of non-binary people assigned female at birth	Unstructured, video conference and in-person interviews (60 – 90 minutes)
12. Hennekam, 2017	Netherlands, *100% 4 largest urban cities*	Online forums and blogs	Interpretivist epistemology & gender role theory Content analysis	To explore gestational and postpartum experiences of lesbian couples within the workplace	Semi-structured, in-depth, video conference interviews x3 (2-3 hours)
13. Hoffkling, 2017	Majority United States (85% [c]), *no further details*	Online	Grounded theory *	To understand the needs of transgender men who had given birth	Semi-structured, video conference interviews (*length not reported*)
14. Juntereal, 2020	Majority United States (94%) & United Kingdom, *no further details*	Email, social media, community networks	Qualitative descriptive inferred Content analysis	To explore the lactation experience and level of lactation support of lesbian birth mothers	Semi-structured, telephone and in-person interviews [b] (up to 60 minutes)
15. Kazyak, 2020	United States, *Nebraska, Iowa, Missouri ([a]52% urban)*	National and regional LGBTQ organizations, churches, parenting groups and websites, and social media	* Open coding and memoing	To understand how second-parent adoption laws mattered to parents' decision-making processes related to healthcare	Semi-structured telephone, video conference or in-person interviews (*length not reported*)
16. MacDonald, 2016	United States, Canada, Europe, & Australia, *no further details*	Social media, email	Interpretive descriptive Content analysis	To understand the experiences of transmasculine individuals while gestating, birthing, and feeding their newborns	Semi-structured, video conference or telephone interviews (60 – 120 minutes)
17. MacDonald, 2021[d]			Interpretive descriptive Constant comparison analysis	To explore the experiences of transmasculine individuals while gestating and birthing	
18. Malmquist, 2019	Sweden, *60% larger cities, 40% smaller towns*	Social media	Critical realistic epistemology Thematic analysis	To explore experiences of childbearing and childbirth in LBT individuals with an expressed fear of childbirth	Semi-structured, in-person interviews (61 – 180 minutes)
19. Malmquist & Nieminen, 2021[e]				To explore norms concerning maternity, femininity, and cisgender LBT people with an expressed fear of childbirth	
20. Malmquist, 2021[e]				To explore how LBT people negotiate the question of who gives birth when one or both partners have a fear of childbirth	

21. McKelvey, 2014	United States, *nine different states*	Magazine ad and health clinic flyer	Narrative inquiry inferred Thematic narrative analysis	To develop a metastory of nonbiological lesbian mothers' postpartum experiences	Semi-structured, telephone and in-person interviews (45 – 60 minutes)
22. Riggs, 2021	Australia, European Union, and United States, *no further details*	Social media and community networks [b]	* Thematic analysis	To explore experiences of infant loss among a sample of men, trans/masculine, and non-binary people	Semi-structured, video conference or in-person interviews (<60 – >180)
23. Rippey, 2017	Canada (*Ontario and Nova Scotia)* & United States *(NY, IL, AZ/CO)*	Email and network	Feminist theory inferred Thematic analysis	To explore the relationship between breastfeeding and identity in lesbian-identified families	Semi-structured, telephone and in-person interviews (~90 minutes)
24. Rogers, 2020	United States, *no further details*	Social media and network	Grounded theory Constant comparison	To understand the experiences of childbearing for queer, cisgender women who use donor insemination or medically assisted reproductive treatments	Semi-structured, video conference interviews (60 – 90 minutes)
25. Wojnar, 2013	United States, *Pacific Northwest*	Ads in newspapers and websites, posted notices, and participant referrals	Descriptive phenomenology	To describe the experiences of preconception, gestation, and new motherhood among lesbian nonbiological mothers	Semi-structured, in-person interviews (30 – 60 minutes)

Note. * Information was not included in the study. [a] Searle, 2017 shares the same study sample as Burrow, 2018. [b] Mixed-methods study. [c] Information was found in another manuscript of the same study. [d] MacDonald, 202 shares the same study sample as MacDonald, 2016. [e] Malmquist, 2021 and Malmquist & Nieminen, 2021 share the same study sample as Malmquist, 2019. LBQ = lesbian, bisexual, and queer. LBT = lesbian, bisexual, and transgender.

Table 2.4

Summary of Quality Appraisal of Included Metasynthesis Studies

First author, year	Credibility								Transferability			Dependability				Confirmability		
	Data collection (C)				Data analysis (A)			C&A	C		A	C		A	C&A	C&A		A
	Prolonged engagement	Persistent observation	Triangulation	Member checks	Member checks	Structural corroboration	Referential adequacy	Peer debriefing	Sampling	Thick description	Thick description	Overlap methods	Dependability audit	[a]Stepwise replication	Audit trail	Reflexivity	Triangulation	Confirmability audit
Abelsohn et al., 2013	✗	✗	✓	✓	✗	★	★	✓	★	✓	✓	✗	✗	✓	✗	✗	✓	✗
Brennan & Sell, 2014	✗	✓	✗	✓	✗	✓	✓	★	✓	✓	✓	✗	✗	✓	✗	✗	✓	✗
Burrow et al., 2018	✗	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	✗	✓	✗
Charlton et al., 2021	✓	✓	✓	✗	✗	★	★	★	✓	✓	✓	✗	✗	✗	✓	✓	★	✓
Charter et al., 2018	?	✗	✓	✗	✗	★	★	✗	✓	✓	★	✗	✗	✓	✗	✓	✓	✓
Cherguit et al., 2012	✓	✓	✗	✗	✗	✓	✓	✓	✓	✓	✓	✗	✗	✗	✓	✓	✗	★
Dahl & Malterud, 2015	✓	✓	✓	✗	✗	★	✓	✓	✗	✓	✓	✗	✗	?	✗	✗	✓	✓
Ellis et al., 2014	✓	✓	✗	✗	★	✓	✓	✓	✓	✓	✓	✗	✗	?	✗	✗	✗	✓
Falck et al., 2021	✓	✓	✗	✓	✗	✓	✓	✓	✓	✓	★	✗	✗	✗	✗	✓	✓	✓
Fischer, 2021	✓	★	✗	✗	✓	★	✓	✗	✓	✓	★	✗	?	✗	✗	✓	✗	✓
Hennekam & Ladge, 2017	★	★	★	✗	✗	★	✓	★	✓	✓	★	✗	✗	★	✗	?	✓	✓
Hoffkling et al., 2017	✓	✗	✗	✗	✗	✓	★	✓	✓	✓	?	✗	✗	✓	✗	✗	✗	✓
Juntereal & Spatz, 2020	✗	✗	✗	✗	✓	✓	★	✓	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Kazyak & Finken, 2020	✓	✗	✗	✗	✗	✓	★	✗	★	✓	?	✗	✗	✗	✗	✗	✗	✓
MacDonald et al., 2016	★	★	✓	✗	✗	✓	★	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓	✓
MacDonald et al., 2021	★	★	✓	✗	✗	✓	★	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓	✓
Malmquist et al., 2019	✓	✓	★	✗	✗	✓	★	✓	✓	✓	✓	✗	✗	★	✗	✗	✓	✓
Malmquist & Nieminen, 2021	✓	✓	✓	✗	✗	✓	★	✓	✓	✓	✓	✗	✗	✗	✗	✗	✓	✓
Malmquist et al., 2021	✓	✓	★	✗	✗	✓	★	✗	✓	✓	✓	✗	✗	✗	✗	✗	★	✓
McKelvey, 2014	✓	✓	✗	✗	✓	✓	✓	?	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Riggs et al., 2021	✓	★	✓	✗	✗	✓	★	✗	✓	✓	✓	✗	✗	✗	✗	✓	✗	✓
Rippey & Falconi, 2017	✓	★	✓	✗	✗	✓	✓	✓	✓	✓	★	?	✗	✓	✗	✗	✗	✓
Rogers, 2020	★	★	✗	★	★	✓	★	✗	✓	★	★	✗	?	✗	✓	★	✗	?
Searle et al., 2017	✗	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	✗	✓	✗
Wojnar & Katzenmeyer, 2013	?	?	✗	✓	?	★	?	✗	✓	✓	✓	✗	✓	✗	✗	✓	✗	✓

Note. ✗ = Not reported; ? = Reported, no details; ✓ = Some details; ★ = In-depth details.
Shading indicates what Guba (1981) states are essential criteria to support qualitative rigor and minimize bias
[a] Stepwise replication was not originally in Guba's essential criteria, but we opted to include it to reflect the current day importance of a codebook

experiencing chronic and persistent *Erasure*, *Structural Exclusion*, and *Discrimination* across the perinatal period, creating systematic invisibility among SGD childbearing people.

Theme 1. Systematic Invisibility: Erasure, Structural Exclusion, Discrimination

The first theme, *Systematic Invisibility: Erasure, Structural Exclusion, Discrimination,* consists of three subthemes. This theme describes the pervasiveness of heterocisnormative assumptions around gestational bodies and how biological parenthood resulted in SGD people experiencing chronic and persistent *Erasure*, *Structural Exclusion*, and *Discrimination* across the perinatal period, creating systematic invisibility among SGD childbearing people.

Erasure

Erasure — that is social norms that reinforce heterocisnormativity (the assumption that heterosexual and cisgender people are the norm) and make SGD people feel invisible — is the first subtheme. Erasure was facilitated by a lack of appropriate information and resources such as books that captured the questions, concerns, and stories of SGD childbearing people (Brennan & Sell, 2014; Charter et al., 2018; Ellis et al., 2014; Falck et al., 2021; Fischer, 2021; Hoffkling et al., 2017; Juntereal & Spatz, 2020; McKelvey, 2014; Riggs et al., 2020; Rogers, 2020; Wojnar & Katzenmeyer, 2013). SGD parents felt like outsiders when accessing parenting resources, support groups, or peer support (Abelsohn et al., 2013; Ellis et al., 2014; Fischer, 2021; Hennekam & Ladge, 2017; Hoffkling et al., 2017; Rippey & Falconi, 2017). This lack of representation perpetuated feelings of isolation, loneliness, abandonment, disempowerment, and depression (Charter et al., 2018; Fischer, 2021; Hoffkling et al., 2017), and parents longed for positive, well-integrated models of diverse parental roles and identities as well as signs of acceptance in healthcare settings (e.g., decoration, flags, pamphlets; Burrow et al., 2018; Charter et al., 2018; Cherguit et al., 2012; Ellis et al., 2014; Hoffkling et al., 2017; Wojnar & Katzenmeyer, 2013).

In healthcare encounters, SGD people felt unseen as a result of being asked invasive and stigmatizing questions (Fischer, 2021; Hoffkling et al, 2017; Malmquist et al., 2019), having their gender identity questioned (Falck et al., 2021; Fischer, 2021; MacDonald et al, 2021), and having their body parts, pronouns, and parental names misgendered (Charter et al., 2018; Ellis et al., 2014; Falck et al., 2021; Fischer, 2021; Hoffkling et al., 2017; MacDonald et al., 2016). Experiences were exoticized and tokenized (Falck et al., 2021) such as participants being told they were 'amazing' for childbearing or 'should be on Oprah' (Hoffking et al., 2017), partnerships were 'straightened' such as assuming a partner to be a sister (Brennan & Sell, 2014; Fischer, 2021; Malmquist et al., 2019, Rogers, 2020), and co-parents were ignored and not recognized by providers and staff for their parental role (Brennan & Sell, 2014; McKelvey, 2014; Wojnar & Katzenmeyer, 2013).

Structural Exclusion

The second subtheme describes how *Structural Exclusion* — systematic processes designed to, both intentionally and unintentionally, omit SGD parents — shaped childbearing experiences. Information systems (e.g., electronic health record [EHR]) were designed to limit access to care to patients with a female sex marker. For example, EHRs were unable to accept a female's social security number in the "father's" place (Dahl & Malterud, 2015), allow for electronic fetal monitoring (MacDonald et al., 2021) or the creation of a patient file (Falck, 2021) for patients with a male gender marker, or differentiate between a patient's legal name and the name they should be called (Hoffkling et al., 2017). Even physical environments structurally excluded participants (e.g., only having a women's restroom in healthcare clinics; Hoffkling et al., 2017).

Standard language on medical forms, educational resources, and birth certificates were also common sites of exclusion in healthcare. For example, marriages were nullified by forcing the gestational partner to identify as single (Brennan & Sell, 2014; Kazyak & Finken, 2020), and gestational fathers' names were not allowed to be listed on birth certificates (Hoffkling et al., 2017). Co-parents were particularly vulnerable to exclusion and being denied their parental status. Their parental role was not included on birth certificates (Abelsohn et al., 2013; Brennan & Sell, 2014; Kazyak & Finken, 2020), medical forms (Brennan & Sell, 2014; Cherguit et al., 2012; Dahl & Malterud, 2015; Wojnar & Katzenmeyer, 2013), educational materials (Cherguit et al., 2012; Kazyak & Finken, 2020), and in child birthing classes (Cherguit et al., 2012). In addition, coverage was not provided for mental health treatment of co-parents after fetal/infant loss (Malmquist & Nieminen, 2021).

Co-parents and transgender gestational parents were also at risk of not being able to obtain and execute their parental rights (Abelsohn et al., 2013; Hoffkling et al., 2017; Kazyak & Finken, 2020; MacDonald et al., 2016; MacDonald et al., 2021; McKelvey, 2014; Wojnar & Katzenmeyer, 2013). The financial costs of legal fees (e.g., donor contracts, second-parent adoptions) were out of reach for many and legal processes, such as second-parent adoption, are not available in all fifty states (Kazyak & Finken, 2020; McKelvey, 2014; Rogers, 2020). To ensure both partners' parental rights, SGD people contemplated giving birth in states with better parental rights (Kazyak & Finken, 2020) or using a sperm bank that legally terminated the donor's rights (Wojnar & Katzenmeyer, 2013). Taken together, accessing parental rights was described as a humiliating experience (McKelvey, 2014), and the ability to protect and even form one's family was controlled by the ability to navigate these systems (Cherguit et al., 2012).

Lastly, a lack of knowledge and cultural competency among providers threatened receipt of quality care and forced SGD individuals to be responsible for educating their providers. Providers lacked adequate knowledge about SGD family-building options or the process of becoming pregnant (Rogers, 2020), lactation-specific needs such as co-nursing or potential lactation issues after chest masculinization surgery (Dahl & Malterud, 2015; Falck et al., 2021; Juntereal & Spatz, 2020; MacDonald et al., 2016), or even that a man could bear a child. The latter was particularly concerning in that it delayed care in a case of premature labor (Falck et al., 2021).

Discrimination

The last subtheme describes the unjust or prejudicial treatment SGD childbearing people experienced due to their sexual orientation or gender identity. This *Discrimination* began before gestation with expectations of being denied access to surrogacy or adoption (Ellis et al., 2014; Malmquist & Nieminen, 2021), as well as actual denial of fertility services due to a transgender identity or heterosexually-based insurance restrictions (Charter et al., 2018; Hoffkling et al., 2017; Rogers, 2020). Those who accessed gender-affirming care before gestation were questioned, shamed, and pressured to be sterilized by healthcare staff (Falck et al., 2021; Malmquist et al., 2021). Staff continued to ask hurtful questions, use hostile tones, and ignore patients in childbearing settings throughout the perinatal period (Burrow et al., 2018; Juntereal & Spatz, 2020). Some described trauma or posttraumatic stress disorder from interactions during labor and delivery (Burrow et al., 2018; MacDonald et al., 2021; Malmquist et al., 2019). Disclosure of SGD identities was repeatedly required to access medical care — including during staff shift changes in the labor and delivery setting — fueling anxiety that the incoming care team would mistreat them (Ellis et al., 2014; Falck et al., 2021; Kazyak & Finken, 2020; Riggs et

al., 2020; Rogers, 2020). Importantly, both anticipated and enacted mistreatment restricted access to information, resources, support, and medical care and often led to hypervigilance and mistrust. Unfortunately, positive relationships and experiences with providers did not attenuate the effects of other harmful healthcare encounters (Fischer, 2021; Hoffkling et al., 2017; Kazyak & Finken, 2020; Malmquist et al., 2019; McKelvey, 2014).

Discrimination extended to other aspects of SGD peoples' lives, too. They anticipated that other parents would reject them in social groups or the workplace (Fischer, 2021; Hennekam & Ladge, 2017), healthcare professionals would deny their parental rights (Abelsohn et al., 2013; Kazyak & Finken, 2020; MacDonald et al., 2016; Wojnar & Katzenmeyer, 2013), or social services would restrict resources such as accessing milk donation (MacDonald et al., 2016). At times, this anticipated discrimination was realized, such as when SGD individuals were denied care and laughed at by healthcare professionals (Hoffkling et al., 2017; Kazyak & Finken, 2020), had difficulty enrolling their child in daycare (Brennan & Sell, 2014), and were placed under surveillance or threatened by social services for no other reason than their gender-diverse status (MacDonald et al., 2021).

Those without the time and resources to advocate and navigate healthcare and insurance were most vulnerable to enduring harm in an attempt to keep themselves and their baby safe (Falck et al., 2021; Fischer, 2021). For example, those who embodied more than one marginalized identity alongside their SGD position — such as being a racialized person, an immigrant, non-Christian, differently-abled, and/or living with limited socioeconomic resources — experienced stigma and increased barriers to accessing resources (Abelsohn et al., 2013; Burrow et al., 2018; Charlton et al., 2021; Falck et al., 2021; Hennekam & Ladge, 2017; MacDonald et al., 2016; MacDonald et al., 2021; Malmquist & Nieminen, 2021; Rogers, 2020).

Multiple intersecting identities additionally fueled feelings of isolation and exclusion (Abelsohn et al., 2013; Burrow et al., 2018; Charlton et al., 2021; Falck et al., 2021; Hennekam & Ladge, 2017; MacDonald et al., 2016; MacDonald et al., 2021; Malmquist & Nieminen, 2021; Rogers, 2020).

Erasure, Structural Exclusion, and *Discrimination* created *Systemic Invisibility* that was isolating, exasperating, and distressing. This was amplified by additional intra- and interpersonal challenges SGD individuals faced during this transition as described in the second theme, *Creating Personhood Through Parenthood*.

Theme 2. Creating Personhood Through Parenthood

The second theme, *Creating Personhood Through Parenthood,* details how SGD people had shared and uniquely different perinatal experiences relative to heterosexual and cisgender parents, especially when navigating their parental identity. The four subthemes include: *Journey to Parenthood, Grappling with Gender, When Creating is Losing,* and *Climbing Mental Mountains*.

Journey to Parenthood

The first subtheme, *Journey to Parenthood*, demonstrates how SGD identities restricted parental identity development on the journey to parenthood for some and facilitated it for others. For example, claiming a new identity as a gestational or chestfeeding (i.e., feeding a baby from the chest) parent granted SGD people who fulfilled gender role expectations of cisgender women access to support and validation from some parent communities (Hennekam & Ladge, 2017; Rippey & Falconi, 2017). However, claiming a parental identity was more challenging for those who violated gender role expectations or those that did not fit neatly into "motherhood" and "fatherhood" norms (e.g., co-parents that are cisgender women; Brennan & Sell, 2014; Cherguit

et al., 2012; Dahl & Malterud, 2015; Hennekam & Ladge, 2017; McKelvey, 2014; Wojnar & Katzenmeyer, 2013). The narrow construction of gender roles associated with parenthood (i.e., mothers are women and co-parents are men/fathers) was stigmatizing. Consequently, gestational and co-parents sometimes concealed an expected baby, which prevented them from claiming their role as parents (Abelsohn et al., 2013; Ellis et al., 2014; Hennekam & Ladge, 2017; Hoffkling et al., 2017).

Additionally, the journey to parenthood was challenging, particularly for non-gestational parents, when their identity as a parent was ignored. In addition to struggling for the inclusion of their role and identity as a parent in healthcare and legal documents, co-parents were left out of parenting rituals such as baby showers (Abelsohn et al., 2013) and feared they would be denied (or, in fact, were denied) acceptance as a 'real' parent by family (Abelsohn et al., 2013; McKelvey, 2014; Wojnar & Katzenmeyer, 2013), friends (Abelsohn et al., 2013; McKelvey, 2014), and colleagues (Hennekam & Ladge, 2017). The absence of terminology to describe their role resulted in feeling "less than" the gestational parent (Brennan & Sell, 2014; Cherguit et al., 2012; Dahl et al., 2015; Hennekam & Ladge, 2017; McKelvey, 2014; Rippey & Falconi, 2017; Wojnar & Katzenmeyer, 2013). The societal importance of a genetic relationship between a parent and child further fostered feelings of self-doubt and hindered attachment (Abelsohn et al., 2013; Brennan & Sell, 2014; Cherguit et al., 2012; Hennekam & Ladge, 2017; McKelvey, 2014; Wojnar & Katzenmeyer, 2013). Even prior gestational parents struggled to find new ways to parent beyond giving birth (Dahl & Malterud, 2015), and not being a gestational parent or nursing delayed bonding (Cherguit et al., 2012; Hennekam & Ladge, 2017; McKelvey, 2014; Rippey & Falconi, 2017; Wojnar & Katzenmeyer, 2013). Resisting the heterocisnormative assumptions of traditional, gendered parental roles required effort and contributed to feelings of

loneliness, isolation, grief, and disconnection during the journey to parenthood (Ellis et al., 2014; Fischer, 2021; MacDonald et al., 2016; MacDonald et al., 2021; McKelvey, 2014; Rippey & Falconi, 2017; Wojnar & Katzenmeyer, 2013).

Grappling with Gender

The next subtheme, *Grappling with Gender,* highlights how nearly all gender-diverse parents reported gender dysphoria, which is significant distress caused by gender incongruence. Dysphoria was triggered by misgendering, such as incorrect use of pronouns (Charlton et al., 2021; Charter et al., 2018; Falck et al., 2021; Fischer, 2021; MacDonald et al., 2016), parental names (Fischer, 2021), partnership status (Fischer, 2021), and parenting configurations (Fischer, 2021). Dysphoria was also perpetuated by a lack of perinatal clothing options that matched one's gender expression (Malmquist et al., 2021; Rogers, 2020). Interestingly, some physical changes, such as an enlarged abdomen among transgender men, were perceived as a fat, male belly which affirmed their gender as male (Charlton et al., 2021; MacDonald et al., 2016). Enlarged chest tissue, however, was perceived as feminine and resulted in misgendering and dysphoria (Charlton et al., 2021; Charter et al., 2018; MacDonald et al., 2016; Malmquist et al., 2021).

Other physical factors contributing to distress included the impact of testosterone tapering — such as loss of muscle and masculine features and increased feelings of depression (Charter et al., 2018; Ellis et al., 2014; Hoffkling et al., 2017) — and gestational changes including weight gain, enlarged abdomen, widening hips, and chest tenderness (Charlton et al., 2021 Charter et al., 2018; Fischer, 2021; MacDonald et al., 2016; MacDonald et al., 2021; Malmquist et al., 2021). Some described physical and emotional changes as feminine or incompatible with masculinity (Charter et al., 2018; Ellis et al., 2014; MacDonald et al., 2021; Rippey & Falconi, 2017; Rogers, 2020), while others described gestating or chestfeeding as not

inherently feminine or belonging to any gender (Ellis et al., 2014; Fischer, 2021; MacDonald et al., 2016; MacDonald et al., 2021).

Prior coping techniques such as chest binding were often not possible while gestating or nursing, increasing feelings of distress (Charter et al., 2018; Hoffkling et al., 2017; MacDonald et al., 2016; MacDonald et al., 2021). However, the impact of nursing varied. Some found meaning and purpose in the experience, some discontinued chestfeeding due to overwhelming dysphoria, and others only experienced dysphoria after weaning (Charter et al., 2018; Fischer, 2021; MacDonald et al., 2016).

When Creating is Losing

The third sub-theme identified in *Creating Personhood Through Parenthood* is *When Creating is Losing*. In this sub-theme creating life was filled with losses: loss of autonomy, privacy, relationships, and baby.

Loss of autonomy began in the preconception period and continued through childbirth. In-vitro fertilization (IVF) initiated an expensive and lengthy treatment process with uncertain outcomes and adverse physical effects on the body from IVF medications (Rogers, 2020). Discontinuing testosterone prior to conception (Charlton et al., 2021; Ellis et al., 2014; Hoffkling et al., 2017) also resulted in a lost ability to shape gender expression and consequently feeling less affirmed (Charlton et al., 2021; MacDonald et al., 2021). Insurances restricted choice of provider services (Rogers, 2020), providers denied choices and requests during childbirth (Burrow et al., 2018; MacDonald et al., 2021; Malmquist et al., 2019; Malmquist & Nieminen, 2021), and failed to discuss feeding options, placing the individual at risk of missing out on nursing opportunities and developing mastitis (Falck et al., 2021; Juntereal & Spatz, 2020; MacDonald et al., 2016).

Loss of privacy occurred when intimate body parts were callously exposed during pelvic exams and childbirth (MacDonald et al., 2021; Malmquist et al., 2019, 2021) and when individuals were repeatedly compelled to "come out" to healthcare staff (Falck et al., 2021) or strangers when asked about the "father" of the baby (Rogers, 2020). Coming out was frequent, uncomfortable, and exhausting, often requiring explanation and education around their identity or SGD family formation. Yet, coming out was necessary to access support (Hennekam & Ladge, 2017), increase visibility of SGD parents (Rippey & Falconi, 2017), and demonstrate that they weren't ashamed of their family (McKelvey, 2014). Childbearing frequently resulted in loss of anonymity of sexual orientation and gender identity in every aspect of their lives, including with colleagues, supervisors, and partners' family members (Ellis et al., 2014).

Other types of salient loss included a loss of connection with their partner (McKelvey, 2014; Rippey & Falconi, 2017; Wojnar & Katzenmeyer, 2013) and the loss of relationships among the SGD community (Ellis et al., 2014; Wojnar & Katzenmeyer, 2013) and families of origin (Wojnar & Katzenmeyer, 2013). Loss was characterized by increased physical and emotional distancing and isolation (Ellis et al., 2014; Hoffkling et al., 2017) as well as severed ties (Wojnar & Katzenmeyer, 2013). Studies also detailed the impact of fetal loss (Ellis et al., 2014; Hennekam & Ladge, 2017; McKelvey, 2014; Riggs et al., 2020; Rogers, 2020). With little to no formal support, decreased social support, increased emotional and financial investment during conception for those needing assistance, and constant interaction with heterocisnormative systems, fetal loss was a uniquely isolating and traumatizing experience (Ellis et al., 2014; Hennekam & Ladge, 2017; McKelvey, 2014; Riggs et al., 2020; Rogers, 2020).

Climbing Mental Mountains

The last subtheme in this section, *Climbing Mental Mountains,* documents the mental health deterioration across SGD family formation. Similar to loss, deterioration began during preconception with assisted reproduction-related mental health challenges among cisgender women (Cherguit et al., 2012; Malmquist & Nieminen, 2021; Rogers, 2020; Wojnar & Katzenmeyer, 2013), and testosterone cessation-related challenges among gender-diverse people (Ellis et al., 2014; Hoffkling et al., 2017). These challenges resulted in an emotional rollercoaster of exhaustion, anger, sadness, stress, anxiety, distress, and disappointment (Cherguit et al., 2012; Ellis et al., 2014; Hoffkling et al., 2017; Malmquist & Nieminen, 2021; Rogers, 2020; Wojnar & Katzenmeyer, 2013).

The emotional toll was carried into childbearing and — in combination with navigating the structural challenges and harm previously described — led to isolation (Charter et al., 2018; Fischer, 2021; Hoffkling et al., 2017; Juntereal & Spatz, 2020; Rogers, 2020; Wojnar & Katzenmeyer, 2013), loneliness (Charter et al., 2018; Ellis et al., 2014; Fischer, 2021, Rogers, 2020) and self-reported depression (Charter et al., 2018; Rogers, 2020; Wojnar & Katzenmeyer, 2013). Postpartum mental health was rarely discussed but included unexpected exhaustion, anxiety, and stress (McKelvey, 2014; Rippey & Falconi, 2017). Co-parents also experienced stressful interactions during their child's birth (Malmquist et al., 2019; Malmquist & Nieminen, 2021), postpartum depression themselves (McKelvey, 2014; Wojnar & Katzenmeyer, 2013), and emotional turmoil around the loss of their baby (Malmquist & Nieminen, 2021; McKelvey, 2014).

Although parental identity development, distressing body changes, fetal loss, changing relationships, and mental health challenges are shared experiences among heterosexual and cisgender childbearing individuals, societal stigma surrounding sexual orientation and/or gender

identity make these challenges uniquely different to the SGD community. Despite these hardships, studies also included resilient narratives of SGD childbearing.

Theme 3. Resilient Narratives of Childbearing

The final theme, *Resilient Narrative of Childbearing,* highlights elasticity in the face of childbearing challenges. The four subthemes include: *Strategies for Emotional and Social Safety*, *Communities of Support, From the Margins to the Center,* and *Queering Childbearing Narratives.*

Strategies for Emotional and Social Safety

This first subtheme, *Strategies for Emotional and Social Safety,* encompasses self-preservation and self-protection strategies. Active nondisclosure (e.g., keeping the baby a secret, retaining a female gender marker), passive nondisclosure (e.g., not correcting assumptions), and selective disclosure (e.g., disclosing a gay but not transgender identity) were frequently employed to avoid mistreatment and harm (Ellis et al., 2014; Hoffkling et al., 2017) from healthcare professionals (Falck et al., 2021; Fischer, 2021; MacDonald et al., 2021), co-workers (Hennekam & Ladge, 2017), families of origin (Wojnar & Katzenmeyer, 2013), and strangers (MacDonald et al., 2016; Malmquist et al., 2019).

Active disclosure (e.g., announcing childbearing status, disclosing identity) allowed co-parents to be recognized as expecting parents early on (Hennekam & Ladge, 2017), and led gender-diverse parents to feel affirmed in their gender identity (Ellis et al., 2014; Hoffkling et al., 2017). Strategies that protected gender expression while minimizing gender dysphoria included affirming clothing solutions such as wearing larger sizes and layering clothing while nursing (Ellis et al., 2014; Fischer, 2021; MacDonald et al., 2016), growing beards (Ellis et al., 2014), limiting weight gain (Ellis et al., 2014), self-isolating (Charter et al., 2018), disconnecting

childbearing from sense of identity (i.e., dissociating; Charter et al., 2018), chest binding, using medically-supervised testosterone while chestfeeding (MacDonald et al., 2016), and medically transitioning before conceiving (MacDonald et al., 2016; MacDonald et al., 2021).

Parents also actively sought out SGD-friendly providers (Kazyak & Finken, 2020), sometimes specifically seeking midwives (Falck et al., 2021; Fischer, 2021; Rogers, 2020) who were perceived to promote safety in healthcare environments. Others advocated for an elective cesarean section to avoid psychological distress associated with having body parts visible or examined (e.g., during vaginal exams or delivery; Falck et al., 2021; Malmquist & Nieminen, 2021), a homebirth to ensure a safe and supportive environment (Falck et al., 2021; Hoffkling et al., 2017; Malmquist & Nieminen, 2021; Rogers, 2020), or brought friends to appointments or into the delivery room to receive support from an advocate (Falck et al., 2021). Second-parent adoptions (Kazyak & Finken, 2020; McKelvey, 2014), guardianship agreements (McKelvey, 2014), living wills (Kazyak & Finken, 2020; McKelvey, 2014), and designating co-parents as a health proxy (Kazyak & Finken, 2020) were all ways co-parents protected their legal parental rights. Additional strategies included using a shared family surname to give the appearance of a legal connection (McKelvey, 2014) and chestfeeding to reduce the risk of losing custody of their baby (MacDonald et al., 2016).

Communities of Support

Although some relationships were lost, the subtheme *Communities of Support* highlights relationships that were gained, such as an estranged parent embracing their new grandchild (McKelvey, 2014). Support among SGD people provided a unique source of support due to a shared understanding and experience (Charlton et al., 2021; Hoffkling et al., 2017; Kazyak & Finken, 2020; Riggs et al., 2020; Rippey & Falconi, 2017; Rogers, 2020). Gender identity-

specific support was sought through online social media groups like Facebook (Hoffkling et al., 2017; Juntereal & Spatz, 2020; MacDonald et al., 2016; Rogers, 2020). Colleagues offered advice around juggling parenting and work responsibilities (Hennekam & Ladge, 2017; Wojnar & Katzenmeyer, 2013), peers provided support for those living in abusive homes (Charlton et al., 2021), and formal forums like La Leche League welcomed SGD parents into their community (Juntereal & Spatz, 2020; MacDonald et al., 2016). A few studies suggested that social support was key to developing resilience (Hoffkling et al., 2017) and protecting mental health (Rogers, 2020). Emotional support was most widely discussed; informational support — such as recommendations for SGD-competent providers — was mentioned least frequently (Hoffkling et al., 2017; Kazyak & Finken, 2020; Rogers, 2020).

From the Margins to the Center

This third subtheme, *From the Margins to the Center,* embraces the ways SGD childbearing people have become increasingly accepted and integrated into society. Increased visibility of gestational transgender men (Hoffkling et al., 2017), advertising that positively highlights same-sex families (Cherguit et al., 2012), and working within organizations with a positive diversity climate all served as markers of social acceptance (Hennekam & Ladge, 2017). While healthcare interactions were often recounted as sites of exclusion and harm, some found them to be places of acceptance and affirmation. Studies frequently cited positive and affirming experiences among healthcare providers (Dahl & Malterud, 2015; Ellis et al., 2014; Fischer, 2021; Hoffkling et al., 2017; Kazyak & Finken, 2020; McKelvey, 2014; Riggs et al., 2020), encompassing three main facets: knowledge, respect, and accountability.

Providers were highly valued if their care was informed. Competence was measured by knowledge of the SGD family-building process (Rogers, 2020), appropriate language and

questions (Brennan & Sell, 2014; Hoffkling et al., 2017; MacDonald et al., 2016), and knowledge of SGD-specific care needs (Fischer, 2021; Juntereal & Spatz, 2020; Rogers, 2020; MacDonald et al., 2016). These included infant feeding considerations such as co-nursing and inducing lactation (Juntereal & Spatz, 2020), the safe use of testosterone while nursing (MacDonald et al., 2016), and lactation cessation considerations for those with prior chest masculinization surgery (Falck et al., 2021; MacDonald et al., 2016).

Respect fostered feelings of safety and inclusion (Kazyak & Finken, 2020; Riggs et al., 2020; Searle et al., 2017) and was demonstrated by facilitating privacy in healthcare interactions (Hoffkling et al., 2017) and using respectful terminology (e.g., gender-neutral terms, pronouns, and parental names; Brennan & Sell, 2014; Hoffkling et al., 2017). Additionally, equal treatment of co-parents was highly valued. Equality was communicated in several ways: tangibly through involving co-parents in treatment (Rogers, 2020) and the birthing process that included cutting the cord (Cherguit et al., 2012), engaging in first skin-to-skin contact with baby (Dahl & Malterud, 2015), and authorizing medical decisions (McKelvey, 2014). Respect was also fostered by naming both parents on the crib card (McKelvey, 2014), addressing both parents in interactions (Brennan & Sell, 2014; Cherguit et al., 2012; Juntereal & Spatz, 2020; Kazyak & Finken, 2020; McKelvey, 2014), and less tangibly through social interactions, such as eye contact and handshakes (Dahl & Malterud, 2015).

Though rarely described in the studies, accountability was crucial when systemic exclusion was encountered. Accountability included providers educating themselves on SGD perinatal care to prevent exclusion in the future (Hoffkling et al., 2017), having informational technology intervene to override computer systems that prevented entering a miscarriage

diagnosis code for a male patient (Riggs et al., 2020), and revising medical intake forms to include co-parents (Brennan & Sell, 2014).

Queering Childbearing Narratives

The final theme of *Resilient Narratives of Childbearing* celebrates the ways SGD individuals are queering or creating alternative narratives to the heterocisnormative scripts and roles of the traditional family. These alternative narratives were seen as a necessary part of developing a parental identity. Studies documented parents claiming space and performing parenthood by creating a unique childbearing narrative where they could be both a father and a gestational parent to their baby (Ellis et al., 2014), forming family units outside of romantic partnerships, such as co-parenting with a friend (Fischer, 2021), establishing equal divisions of labor in the home (Dahl & Malterud, 2015; Fischer, 2021; Rippey & Falconi, 2017), resisting gendering their children (Fischer, 2021; Rogers, 2020) or categorization of childbearing as a feminine experience (Charter et al., 2018; MacDonald et al., 2021; Rippey & Falconi, 2017), experiencing pride and purpose in their bodies despite societal messaging telling them otherwise (Ellis et al., 2014; Fischer, 2021; Rippey & Falconi, 2017; Rogers, 2020), and inventing nontraditional parenting identities through their parental names (Brennan & Sell, 2014; McKelvey, 2014).

For co-parents, queering their parental role was extremely important in the process of conceptualizing parenthood. Non-gestational parents made purposeful efforts to remain involved in the process by reading books on childbearing or lactation and attending prenatal appointments (Juntereal & Spatz, 2020; Wojnar & Katzenmeyer, 2013). Once the baby was born, co-parents actively defined their role and fostered bonding and attachment to their child through frequent skin-to-skin contact (Juntereal & Spatz, 2020; McKelvey, 2014), active participation in infant

care (e.g., rocking, changing diapers; Wojnar & Katzenmeyer, 2013), serving as the primary caretaker (Rippey & Falconi, 2017; Wojnar & Katzenmeyer, 2013), and engaging in feeding practices (Juntereal & Spatz, 2020; McKelvey, 2014). Feeding practices included co-nursing (Juntereal & Spatz, 2020), non-nutritive comfort feeding (McKelvey, 2014), utilizing at-chest supplementers (i.e., a device that delivers milk to a baby at the chest; MacDonald et al., 2016), and exclusive pumping and bottle feeding to promote equal bonding among parents (McKelvey, 2014).

Additionally, reclaiming childbearing as a queer experience was practiced by investing time and support back into the queer and trans parenting community. This included being active in social media groups to support other families (Rogers, 2020), pursuing a career as an SGD-inclusive support professional (Charlton et al., 2021), and being "out and proud" in the world to increase visibility and positive representation (Cherguit et al., 2012; Hoffkling et al., 2017; MacDonald et al., 2016).

In spite of pervasive systemic invisibility and unique challenges in creating personhood through parenthood, SGD individuals are coping, finding social support, and experiencing increased social acceptance while forming their families. Taken together, SGD individuals are demonstrating resilience along the childbearing journey.

2.4 Discussion

This metasynthesis of 25 qualitative studies identified three themes that encompass the SGD childbearing experience. Erasure, structural exclusion, and discrimination faced by SGD individuals in the workplace, their community, healthcare settings, and society-at-large created systematic invisibility that contributed to adverse mental health and jeopardized physical health. Transition to parenthood was delayed because SGD individuals had to fight to claim the

parenting role and carve out space for childbearing to be something other than a feminine experience. While stigma and loss of autonomy were commonly experienced, SGD childbearing individuals met these challenges with resilience by creating coping strategies and finding new sources of support to buffer harm and exclusion. Compared to findings from previous reviews, social acceptance and affirming healthcare experiences appears to be improving.

Overall, SGD childbearing experiences were generally more similar than different to prior work, particularly regarding pervasive and harmful systematic invisibility within healthcare experiences. For example, prior reviews reported pervasive discrimination, heterocisnormativity, barriers to care, and lack of knowledgeable, culturally competent care as contributing factors in negative perinatal healthcare encounters (Agénor et al., 2021; Besse et al., 2020; Brandt et al., 2019; Dahl et al., 2013; de Castro-Peraza et al., 2019; García-Acosta et al., 2019; Greenfield & Darwin, 2021; Gregg, 2018; Hammond, 2014; MacLean, 2021; McManus et al., 2006; Porter, 2005; Wells & Lang, 2016). Our metasynthesis adds important new data about SGD childbearing experiences outside of the healthcare setting. This included exclusion from parenting resources, support groups, and social services. Despite these findings, research on SGD childbearing experiences remains primarily focused on health care settings. While this is a necessary target for needed health care reform, a greater depth of understanding of childbearing experiences at other levels of the socio-ecological environment is critical to comprehending and remediating all the factors that contribute to adverse perinatal, birth, and infant outcomes.

Our metasynthesis is also the first to include experiences of co-parents during a partners' childbearing experience. Of most importance, co-parents were faced with unique challenges in developing a parental identity compared to gestational parents. Moreover, there was evidence that co-parents experienced emotional distress, too. This is supported by prior quantitative

studies that have shown the presence of anxiety (Goldberg & Smith, 2008) and depression (Maccio & Pangburn, 2012) among co-parents of lesbian childbearing women, beginning with assisted reproductive treatment (Borneskog et al., 2013) and extending throughout the postnatal period (Goldberg & Smith, 2008; Maccio & Pangburn, 2012). As Lee and colleagues (2018) indicate, increased inclusion of heterosexual, cisgender male co-parents in perinatal experiences was essential to improving their identity development, partner relationship quality, and mental health; this will also likely be true for SGD co-parents.

While other researchers have reported on experiences of gender dysphoria among transgender men (Agénor et al., 20201; Besse et al., 2020; Brandt et al., 2019; de Castro-Peraza et al., 2019; García-Acosta et al., 2019; Greenfield & Darwin, 2021; MacLean, 2021), our synthesis includes a description of distressing experiences among cisgender women with diverse gender expressions (Malmquist et al., 2021). This indicates that gendered assumptions around language should not be made based on a patient's gender identity as an individual that identifies as a cisgender woman may prefer the word 'parent' to 'mother' to describe her relationship to her baby. In addition, the use of active nondisclosure, selective disclosure, and passive nondisclosure to avoid harm and mistreatment in healthcare (Ellis et al., 2014; Falck et al., 2021; Fischer, 2021; Hoffkling et al., 2017; MacDonald et al., 2021) could result in underreporting of patients experiencing dysphoria due to misgendering. Taken together, a broader population of childbearing people beyond those who disclose a gender-diverse identity may also be at risk of harm if a feminine childbearing experience is assumed.

It is well documented that sexual-diverse women also experience high rates of poor perinatal mental health (Borneskog et al., 2013; Flanders et al., 2016; Goldberg & Smith, 2008; Khajehei et al., 2012; Maccio & Pangburn, 2012; Ross et al., 2012; Yager et al., 2010).

Moreover, prior reviews commonly reported experiences of dysphoria, isolation, loneliness (Besse et al., 2020; Brandt et al., 2019; García-Acosta et al., 2019; Greenfield & Darwin, 2021; MacLean, 2021), and anticipatory fear (Dahl et al., 2013; McManus et al., 2005; Wells & Lang, 2016). While our current synthesis confirms these findings, we also report a wider range of negative emotional experiences across the perinatal period, such as depression (Charter et al., 2018; McKelvey, 2014; Rogers, 2020; Wojnar & Katzenmeyer, 2013), grief (Ellis et al., 2014; Fischer, 2021; MacDonald et al., 2016; MacDonald et al., 2021; McKelvey, 2014; Rippey & Falconi, 2017; Wojnar & Katzenmeyer, 2013), trauma (Burrow et al., 2018; MacDonald et al., 2021; Malmquist et al., 2019), anxiety (Malmquist & Nieminen, 2021; McKelvey, 2014; Rogers, 2020), and stress/distress (Charter et al., 2018; Cherguit et al., 2012; Ellis et al., 2014; Hennekam & Ladge, 2017; McKelvey, 2014; Rogers, 2020).

Lastly, and most importantly, this review also provides important new understandings of SGD perinatal resilience. Coping and social support are two primary factors that buffer against minority stress, that is, the chronic stress SGD people are exposed to related to societal stigmatization of their identity (Brooks, 1981; Hendricks & Testa, 2012; Meyer, 2003). Thus, understanding how SGD parents cope and construct alternative narratives of childbearing during this period of greater vulnerability and increased risk of harm is essential. In prior work, disassociating, chest binding, and electing for a cesarean section have also been identified as ways to cope with dysphoria (Besse et al., 2020; García-Acosta et al., 2019; MacLean, 2021). Isolating (Greenfield & Darwin, 2021), not disclosing one's childbearing status (de Castro-Peraza et al., 2019), and identifying an accepting care provider (Gregg, 2018) have additionally been cited as ways to avoid stigma and harm in other researchers' findings. This last coping strategy was reported in several of our included studies (Kazyak & Finken, 2020), including

seeking out a specific type of provider (Falck et al., 2021; Fischer, 2021; Rogers, 2020) or location (Falck et al., 2021; Hoffkling et al., 2017; Malmquist & Nieminen, 2021; Rogers, 2020) to promote a safe experience.

The role of social support continues to be understudied. We found that the SGD community-at-large provided a unique source of support (Charlton et al., 2021; Hoffkling et al., 2017; Kazyak & Finken, 2020; Riggs et al., 2020; Rippey & Falconi, 2017; Rogers, 2020), but support was also provided by family members (McKelvey, 2014), colleagues (Hennekam & Ladge, 2017; Wojnar & Katzenmeyer, 2013), peers (Charlton et al., 2021), other heterosexual and cisgender parents (Juntereal & Spatz, 2020; MacDonald et al., 2016), and partners (Juntereal & Spatz, 2020; McKelvey, 2014; Riggs et al., 2020; Rogers, 2020; Wojnar & Katzenmeyer, 2013), supporting the findings in prior work (Manley, Goldberg, et al., 2018; Ross et al., 2018). Yet, sources of support and support needs were less commonly discussed and continue to be poorly understood for SGD populations during the perinatal period.

2.4.1 Limitations

Although we used systematic methods in conducting this review, the search strategy was limited to English-language publications; thus, we may have excluded important non-English studies. We also excluded abstract presentations. Together, these decisions may have introduced some degree of selection bias. In addition, samples were relatively homogenous (i.e., White, highly educated, economically secure individuals from high-income and Westernized countries, and co-parents were nearly all cisgender women). Moreover, studies included childbearing individuals and co-parents whose birthing experiences occurred up to a decade earlier, introducing the risk of recall bias.

While strategies to reduce bias were utilized, it is still possible that researcher bias may have been introduced. We believe that interprofessional perspectives offered by the research team (a practicing midwife [MN], three researchers with expertise in the perinatal period [KS, MN, & EM], two members of the SGD community [KS & MD], and four experienced qualitative researchers [MN, EM, KS, and MG]) may have reduced this risk. Despite these limitations, the metasynthesis is comprehensive, sheds light on experiences of perinatal discrimination outside of the healthcare context and provides new knowledge about SGD perinatal experiences, including both challenges and resilience.

2.4.2 Clinical Practice, Research, and Policy Implications

Our findings indicate that training and clinical education around providing respectful and competent care to SGD people during the perinatal period is essential. A patient-centered and trauma-informed care approach may bolster autonomy while dismantling structural invisibility and heterocisnormativity within healthcare (Rubashkin et al., 2018; Searle et al., 2017) and reducing adverse mental health outcomes (Hall et al., 2021; McNicholas et al., 2021). This approach also promises to repair distrust between the SGD community and the healthcare field generally (Bi et al., 2019) as childbearing serves as a specific time to reestablish regular healthcare services with SGD patients — who often disengage from medical care because of past experiences of discrimination — which could have a positive effect on health outcomes.

Additionally, early and frequent screening for perinatal mood and anxiety disorders could be particularly important in this childbearing community. Our review demonstrates that screening during conception and throughout the perinatal period could be important for SGD individuals given their risk factors (Lancaster et al., 2010) and the frequency in which emotional distress was discussed in our studies. Structural-level changes such as group care models tailored

to SGD communities and access to competent providers are also promising approaches to promoting positive perinatal care experiences, social support, and wellbeing (Foster et al., 2021; Scott et al., 2019). These care models echo previously published recommendations for systemic change and inclusion of SGD people in the perinatal healthcare context (Ellis et al., 2014; Hahn et al., 2019; Moseson, et al., 2020b).

Research must prioritize SGD childbearing people who are not majority White, partnered, well-educated, and from wealthy, Westernized countries. This includes those from settings where SGD rights and safety are restricted (e.g., rural and Southern environments in the US; regions in the Global South including Latin America, Asia, Africa, and Oceania) and with less privileged life experiences (e.g., lower socioeconomic status, lower educational achievement, immigrants, people of color, unpartnered or partnered with more than one person, people with disabilities or neurodivergent), as well as gender-diverse co-parents. A focus on the impact of multiple marginalized identities and how multiple points of marginalization may cumulatively impact childbearing experiences is especially needed.

Research needs to explore positive experiences within healthcare, including the type of provider and the location where care is delivered. Midwifery models of care seem to connote a specific positive meaning and importance among SGD individuals, but increased understanding of motivation behind choice of provider and birth location is needed. There is also a general need to include a greater depth of understanding of childbearing experiences at other levels of the socio-ecological environment to identify all factors that contribute to adverse perinatal, birth, and infant outcomes. Interventions that target mental health among SGD subcommunities are needed to reduce likely disparities in this childbearing population. Further attention to mental health outcomes is also necessary among gender-diverse individuals, individuals with multiple

intersecting identities, and larger, nationally representative samples of all SGD individuals. Social support — particularly from partners and families — may be a promising starting point for future research as it is one of the few modifiable risk factors for perinatal depression in heterosexual and cisgender perinatal populations (Morikawa et al., 2015) and may protect against negative sequelae such as preterm birth (East et al., 2019; Emmanuel et al., 2012; Hetherington et al., 2015; Morikawa et al., 2015).

There are few evidence-based clinical guidelines for perinatal providers, midwives, nurses, doulas, and other birth workers to guide care for gender-diverse individuals (Cronin et al., 2021), or sexual-diverse women (Committee on Health Care for Underserved Women, 2012) during the perinatal period. Healthcare and professional associations need to incorporate and expand perinatal health care topics (e.g., perinatal mental health screening, lactation considerations, co-parent involvement and needs) more intentionally into position statements, clinical guidelines, and policies, including curricula standards and continuing education requirements to promote culturally competent and evidence-based care to this childbearing population.

Findings from this metasynthesis must be interpreted with caution due to concerns about the rigor of the included studies. Of the essential criteria, member checking (credibility), reflexivity (confirmability), audit trails (dependability), and stepwise replication (dependability) were rarely carried out.

2.4.3 Conclusion

This metasynthesis contributes important new understanding of SGD's childbearing experiences within their families, communities, workplaces, and society, specifically highlighting how structural invisibility and pervasive stigma operate in every area of their lives.

It additionally provides insight into ways SGD childbearing parents and co-parents have fostered resilience in the face of this harm and exclusion. Future work must prioritize diverse childbearing samples, examine how resilience influences health outcomes, and identify how culturally competent care can be integrated into the training of perinatal providers and measured to enhance the health and well-being of this vulnerable population.

Chapter 3: "Through Our Resiliency We… Find Joy": A Community-Placed Qualitative Study of Social Support Among Sexual and Gender-Diverse Childbearing People

Target journal: *Social Science & Medicine*

Abstract

Background

Sexual and gender-diverse (SGD) individuals are a rapidly increasing childbearing population that experience marked stigma and discrimination, which contribute, in part, to disparities in mental health outcomes. Social support is a modifiable risk factor for perinatal mood and anxiety disorders, but there is paucity of knowledge about social support among SGD individuals who are childbearing. Thus, the aim of this study is to describe assets of and gaps in social support at the intra- and interpersonal levels of the social-ecological model (SEM) among SGD childbearing individuals.

Methods

This study was guided by a qualitative descriptive methodology and community-placed research methods. It consisted of three semi-structured interviews per participant and a modified, virtual photovoice method completed from the second trimester of childbearing through three months postpartum. Interviews were supplemented with quantitative assessments, surveys, and photovoice prompts. Data were collected from July 2020 through November 2021. A conventional inductive content analysis of data was performed.

Results

Twenty-four childbearing people with a range of sexual, gender, racial, and ethnic identities, ages, co-parenting arrangements, and places of residence participated. Four main

themes were identified: (1) *Entering a New Season of Life;* (2) *Community is Family,* (3) *The Pain We Bear,* and (4) *Obligatory Resilience.*

Conclusion

SGD individuals reported experiencing pervasive stigma and harm specific to childbearing within interpersonal relationships. Sources of support both bolstered and drained intrapersonal resilience and coping may not be sufficient to overcome the adversities faced during this time of heightened vulnerability. Despite adversities, SGD individuals experienced profound joy and meaning in forming their families.

3.1 Background

Perinatal mood and anxiety disorders — such as depression and anxiety — are among the most common complications of childbearing. Perinatal depression and anxiety affect between 9–15% and 15–21% of childbearing people respectively and are associated with adverse perinatal outcomes (Gaynes et al., 2005; Woody et al., 2017; Dennis et al., 2017, Fawcett et al., 2019). Sexual and gender-diverse (SGD) individuals have been identified as a health disparity population by the National Institutes of Health (Perez-Stable, 2016) in that they experience higher rates of poor mental health (National Academies of Sciences, Engineering, and Medicine, 2020b) — a known risk factor for adverse perinatal mental health outcomes such as preterm birth and low birthweight (Simonovich et al., 2021). There is a paucity of data on SGD perinatal outcomes, but emerging evidence indicates that this period may be one in which mental health disparities become manifest (Charter et al., 2018; Flanders et al., 2016; Ross et al., 2007; Ross et al., 2012) which may contribute, in part, to disparities in birth outcomes such as very preterm birth (Everett et al., 2019).

Social support is a protective and modifiable factor associated with a decreased risk of perinatal depression and anxiety (Lancaster et al., 2010; Milgrom et al., 2019). Support is a multidimensional concept that consists of emotional support (expressions of love, care, and empathy), instrumental or tangible support (practical assistance or aid), and informational support (advice, resources, information; House, 1981). Social support and coping (Hatzenbuehler & Pachankis, 2016; Hendricks & Testa, 2012) buffer the negative impact of minority stressors — stressors that stem from the stigma and discrimination associated with a minoritized identity (Brooks, 1981; Hendricks & Testa, 2012; Meyer, 2003) — on mental health (Bockting et al., 2013; Nuttbrock et al., 2015).

In SGD populations, everyday social support (e.g., emotional support, informational advice, tangible help) most often comes from those with similar identities and "chosen families" — individuals that are considered one's family, regardless of blood or marriage, and often also identify within the SGD community (Frost et al., 2016). Yet, among lesbian and bisexual women, major support (e.g., tangible financial support or support when sick) still comes from families of origin (Frost et al., 2016), despite evidence that many (18–41%) experience rejection and hostility by families of origin (Zimmerman et al., 2015). This rejection exacerbates the risk for adverse mental health outcomes among sexual-diverse women (Ryan et al., 2009; Tabaac et al., 2016) and transgender and gender-diverse (TGD) individuals alike (Klein & Golub, 2016). However, the impact of rejection and hostility by families of origin during the perinatal period (when support is often needed at higher levels) is unknown.

Furthermore, there is a paucity of research examining various sources of social support among SGD individuals with the capacity to bear children. This is especially true about the perinatal period — one of the most monumental life events in the human experience. Some recent qualitative work has found anticipated stigma and a lack of community support influenced childbearing experiences and decisions among plurisexual women (i.e., women attracted to more than one gender; Manley, Legge, et al., 2018). Additionally, parenthood may increase motivation to seek SGD community connection (Manley, Goldberg, et al., 2018) and partner support may promote mental health in the transition to parenthood (Ross et al., 2018). Earlier studies also found perceived lack of support and stigma from both parenting and SGD communities among bisexual women (Ross et al., 2012) and that social support was not significantly associated with perinatal depression among sexual-diverse women, despite being an important predictor in

heterosexual women (Ross et al., 2007). This could be due to the mixed support experiences from various support persons that are not captured in support instruments.

Other qualitative studies have limited data about how parenthood drives SGD individuals to reestablish relationships with families of origin (McKelvey, 2014) and the unique nature of support provided by other SGD people during childbearing (Charlton et al., 2021; Hoffkling et al., 2017; Kazyak & Finken, 2020; Riggs et al., 2020; Rippey & Falconi, 2017; Rogers, 2020). A review of childbearing and birth experiences among trans men found some evidence of decreased support and increased social isolation during this time (Besse et al., 2020). Taken together, social support — sources and specific needs — is poorly understood in SGD childbearing people and has been identified as an important area of study to improve perinatal experiences (Charlton et al., 2021). Thus, we sought to describe assets and gaps in intrapersonal (e.g., coping skills) and interpersonal support (e.g., relationships) among SGD childbearing individuals.

3.1.1 Theoretical Framework

We used a social-ecological approach to guide this study which highlights the influence of social risks on an individual's health and wellbeing (Bronfenbrenner 1979; McLeroy et al., 1988). This lens is essential to account for factors beyond an individual's ability to cope (i.e., the effort mounted in response to adversity) or be resilient (i.e., the ability to thrive or have good outcomes in the face of adversity; Fergus and Zimmerman, 2005; Maston, 2001; Meyer, 1995), including structural factors that prevent individuals from having the same opportunity to thrive (Meyer, 2015). This paper focused on the inner levels of the social-ecological model (SEM) framework: 1) intrapersonal factors, which include

individual characteristics such as identities or coping skills, and 2) interpersonal factors, which include social networks and support systems such as family, friends, and peers.

3.2 Methods

3.2.1 Study Overview

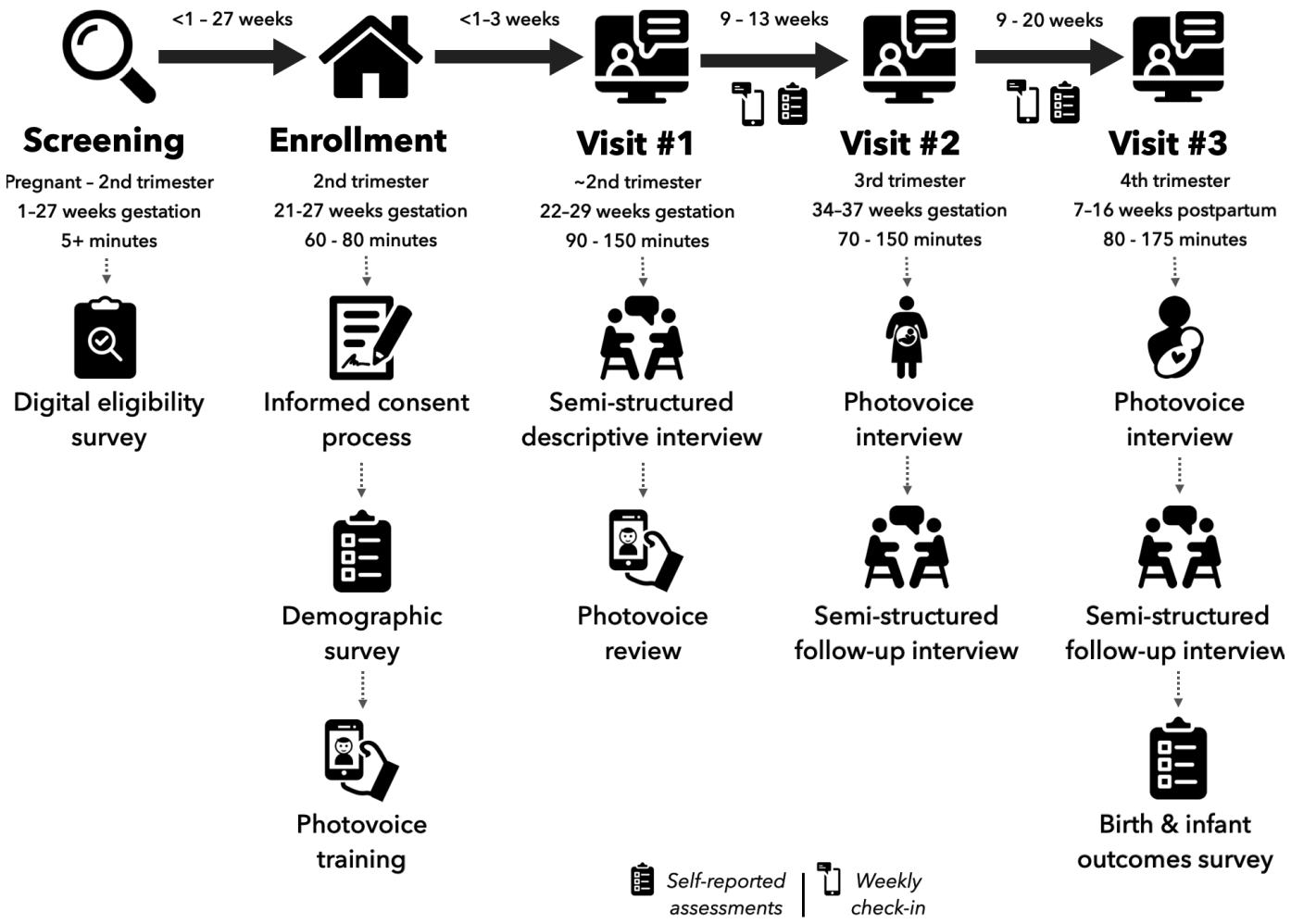
This paper presents an inductive content analysis of inter-and intrapersonal social support among SGD childbearing parents. The Study of Queer and Trans Perinatal Resilience and Experiences of Gestation (PREG) consisted of three semi-structured interviews, three quantitative assessments, two surveys, and twelve photovoice prompts completed across six months or during the 2nd and 3rd trimesters of childbearing and 4th trimester of postpartum (Figure 3.1). The fourth trimester refers to the time period from birth through three months postpartum. Data collection started in July 2020 and concluded in November 2021. Ethical approval was obtained from the Institutional Review Board of Columbia University Irving Medical Center (protocol AAAS7829).

Qualitative descriptive methodology guided this study which employed interview and community-placed research methods. A qualitative descriptive approach supported the development of a focused understanding of an experience that is not adequately understood (Sandelowski, 2000; Willis et al., 2016). This approach guided us to describe social support among SGD childbearing individuals directly from the participants themselves, reducing researcher subjectivity (Bradshaw et al., 2017).

Community-placed research methods fall along the continuum of community-based participatory research (Spears Johnson et al., 2016) and engage community in the research process to generate new knowledge (Harris et al., 2016; Institute of Medicine, 2012). This supplemented our qualitative descriptive approach, which allowed participants an equal voice

Figure 3.1

Data Collection Process



and responsibility in shaping how their experiences were examined. These methods are appropriate when the goal is to reduce the potential harm that can occur when conducting research among a stigmatized and vulnerable community (Scheim et al., 2017; Travers et al., 2013). Community-placed research informed the creation of a community advisory board and the use of a modified, virtual photovoice method.

3.2.2 Community Advisory Board

A community advisory board provides a mechanism for community members to participate in research that is meaningful to them (Newman et al., 2011; Scheim et al., 2017). We strategically selected a small group of informants to represent key experiences of the study sample. Selection criteria included: expertise in the various lived experiences of SGD subcommunities; expertise in childbearing or the perinatal period; and leadership among and connection to the SGD community (Menezes et al., 2012; Newman et al., 2011). Advisors were compensated for their important contributions to the development of the study, recruitment materials, the recruitment process, and interpretation of findings.

3.2.3 Participants

Participants were recruited via a digital flyer and social media posts (Appendix F for study recruitment materials) written in English and sent to the research team's and advisory board's professional and community networks, and posted on social media (i.e., Facebook, Twitter, and Instagram), relevant listservs, and websites. Flyers and posts directed individuals to the study website (www.thepregstudy.com) where more information about the study could be obtained, and an eligibility survey could be taken.

Inclusion criteria included English-speaking SGD adults (≥18 years of age) living in the US and between 22– and 28–weeks' gestation of a child they intend to parent. Participants were

eligible regardless of whether they used their eggs in creating the baby (e.g., in the case of reciprocal in-vitro fertilization) and the nature of conception (i.e., intended or unintended conception). Participants could have a sexual or gender-diverse identity or both, but heterosexual, cisgender women were excluded. See Appendix G for the eligibility screener.

Next, maximum variation sampling was used to select participants representing diverse demographics, locations, and parenting experiences (e.g., race/ethnicity, gender identity, co-parenting arrangements and co-parents' genders, parenting status).

3.2.4 Data Collection Methods

Modified, Virtual Photovoice

Photovoice is a qualitative visual elicitation method that aims to empower individuals by having them share their lived experiences through photography with the goal of inspiring positive social and political change (Catalani & Minkler, 2010; Wang & Burris, 1997). Photovoice was selected to promote participant comfort when discussing sensitive topics (e.g., estranged relationships, discriminatory experiences), record participant support experiences and needs in real-time across the perinatal journey, provide an alternative and complementary way for participants to express themselves (True et al., 2015; Wang & Burris, 1997), and encourage a depth of understanding of the meaning participants ascribe to perinatal social support since images can evoke deeper parts of human consciousness than words (Harper, 2002).

Photovoice methods were modified by using an online and individual (versus in-person and group) format to increase project feasibility and reduce participant burden, address the ethical implications of engaging with a vulnerable population (i.e., gestating people), and minimize outcome bias (i.e., social support; a potential byproduct of group visits). A summary of

modifications can be found in Table 3.1. Twelve prompts were used to solicit information about support at each level of the SEM.

Table 3.1

Strategic Methodological Adaptations of Photovoice with Rationale

Photovoice	Adaptations	Rationale for methodologic adaptations
Eight meetings	Three interviews	Increase feasibility of recruiting participants Decrease participant burden (time requirement)
Group meeting	Individual interviews	Allow dynamic (i.e., continually enrolling) recruitment Decrease bias in the outcome of interest (social support)
In-person	Online, videoconference	Increase feasibility of recruiting a diverse sample Decrease participant burden (childcare/transportation) May increase comfort discussing sensitive topics
Participants drive research and dissemination	Advisory board drives research and dissemination	Decrease participant burden (fewer visits) Allow community members to inform aspects of the research (recruitment, interview guide, etc.) Decrease bias of outcome of interest (social support)
Photos captured on cameras	Photos captured on cell phones	Allow increased ease of taking and uploading photos Decrease participant burden (learning technology)
Weeks between each visit	Months between each visit	Understand social support across the perinatal period Provide enough time for participants to engage with various support types, sources, and locations

3.2.5 Interviews

The development of three iterative semi-structured interview guides (Appendix H for the interview guides) and 12 photo prompts were informed by theory, a review of the literature, and content experts (CAB members). The interview guide was pilot tested (Spring 2020) with individuals who met the eligibility criteria but had given birth in the last year. Interview guides were iterative to include emerging topics and flexible to allow what was most important to each participant to be explored in further depth. If topics were missed, they were followed up in subsequent interviews as an iterative member checking process.

Questions targeted support assets and resources for each level of the SEM, as well as relevant support types (e.g., emotional, tangible, and informational; Collins et al., 1993; House, 1981), sources (e.g., partners, family, friends, peers; Hopkins & Campbell, 2008), and settings (e.g., home, online, phone, community spaces). While the first and second interviews focused on social support while gestating, the third interview focused on postpartum support. Data focused

on postpartum support was excluded from this manuscript due to the overall volume of data collected in the study. Interviews started with a discussion of the participants' photos (Appendix H for photovoice questions within the interview guides), then asked questions that followed up with how support sources, types, and settings changed across the three-time points.

3.2.6 Quantitative Assessments

Three mental health assessments were self-administered at each of the three-time points: the Edinburgh Postpartum Depression Scale (EPDS), State and Trait Anxiety Inventory (STAI), the Revised-Prenatal Distress Questionnaire (Nu-PDQ), and the Common Fund's Patient-Reported Outcome Measurement Information System (PROMIS) measures of Emotional, Instrumental, and Informational Support (Appendix I for quantitative assessment and screening tools).

The EPDS is a 10-item clinical scale ($\alpha = 0.87$) that assesses perinatal depression (McBride et al., 2014). Experts lack consensus on a cutoff score to determine clinical depression using the EPDS, so we included two levels: possible depression cases scored at least nine as this score has a higher specificity and positive predictive value than higher cut off scores (McBride et al., 2014), and clinical depression cases scored at least 11 to maximize sensitivity and specificity levels (Thombs et al., 2015). The STAI ($\alpha = 0.92$) contains two 20-item clinical subscales that assess for state and trait anxiety (Spielberger et al., 1983). A cutoff score of at least 39 was considered a clinical anxiety case (Julian, 2011). The Nu-PDQ contains a 9-item scale used in the 2nd trimester (first interview) and 17-items used in the 3rd and 4th trimesters (second and third interviews) and assesses for perinatal distress ($\alpha = 0.83$-0.86; Lobel et al., 2008; Rosenthal & Lobel, 2018). Distress scores in the third trimester were compared to the Grand Mean total of 11.92 (SD = 6.52) of 37 studies in a review of the Nu-PDQ (Ibrahim & Lobel, 2020). Emotional,

instrumental, and informational support were assessed using PROMIS. Each measure contains an 8-item subscale ($\alpha = 0.99$, 0.96, and 0.95, respectively; Northwestern University, 2015, 2017a, 2017b). Raw scores were converted to t-scores which rescales a raw score into a standardized score with a mean of 50 and standard deviation of 10.

3.2.7 Procedures

Informed consent was obtained in the enrollment meeting. Then participants were trained on a modified, virtual photovoice method (Appendix J for photovoice training outline), and their first interview was scheduled within the following two weeks (Figure 3.1). After the enrollment meeting, participants received a link to a Qualtrics survey to capture additional demographic data beyond the eligibility survey and a practice photo prompt.

The first visit comprised the semi-structured descriptive interview and review of the practice photo prompt. The second and third visits began with screen sharing participants' photographs. Participants were reminded of the photo prompt and then asked to explain the meaning behind the photo (Appendix H for photovoice questions within the interview guide). This was followed by a semi-structured interview. Eleven photo prompts (Appendix K for photovoice prompts) were sent biweekly to participants between the first and third visits. Links to mental health assessments housed on Qualtrics were sent before each of the three visits, and a birth and infant outcomes survey was sent before the final interview.

Participants were compensated with electronic gift cards directly after the enrollment visit and each interview using a graduated incentive approach ($15, $25, $50, and $75) for total compensation of $165. Those who participated in the member checking process received an additional $50. Interviews were conducted in English and audio-recorded using the Zoom

videoconferencing platform, transcribed verbatim using Rev.com (a professional transcription service), and then cleaned.

3.2.8 Data Analysis

Quantitative Analysis

Assessments and surveys were cleaned using MySQL Workbench (Version 8.0.26) and analyzed for descriptive statistics using RStudio (Version 1.4.1103).

Qualitative Analysis

Transcribed interviews were uploaded and analyzed in Atlas.ti (Version 9.1.2) using inductive, conventional content analysis (Hsieh & Shannon, 2005). Photos were linked to corresponding excerpts. Following Hsieh & Shannon's (2005) methods, the author first became immersed in the data by conducting every interview, cleaning, and coding every transcript. Then two coders (KS & MD) independently coded 15 transcripts from diverse participants and each timepoint using memos to record initial impressions, which supported code development (Hsieh & Shannon, 2005). After every few transcripts, the coders met to iteratively consolidate codes and assess for consistency in applying codes to develop a consensus-based, structured codebook (Appendix L for codebook; MacQueen et al., 1998). The first author systematically coded the remaining 49 transcripts, and the second coder was consulted as needed. Throughout the coding process, emerging categories or groupings of the most salient topics were identified by the research team, organized in meaningful clusters, synthesized into broad, overarching themes, and subsequently named. Once the final categories and themes were identified and assessed for coherence across the data, each category was examined for experiential differences by gender, racial identity, and gravida status. Exemplar quotes were selected to illustrate each subtheme.

Next, another team member (MG) audited the findings to confirm that the results could be corroborated. The community advisory board provided ongoing feedback in peer debriefing meetings throughout the data collection and analysis process. Guided by Birt and colleagues' (2016) member checking process (Appendix H for member check interview), findings were revised and then presented to a representative sample of participants (20%) to verify the results. A saturation table was constructed chronologically based on the order transcripts were coded to determine data adequacy (Saunders et al., 2018) and the breath of childbearing experiences (Kerr et al., 2014).

3.2.9 Measures to Enhance Rigor

We used strategies recommended by Guba (1981) to promote the trustworthiness of the results and minimize avoidable bias in qualitative data (Appendix M for Guba's criteria for qualitative rigor applied to Queer and Trans PREG). Trustworthiness includes four elements: credibility, dependability, transferability, and confirmability.

We promoted **credibility** by facilitating an iterative member checking process throughout the data collection and analysis process and triangulating *perspectives*, *methods*, *time*, and *location* in the study design to reduce bias. Our multidisciplinary team (nursing, psychology, public health, midwifery, perinatal health, and primary care) of researchers, clinicians, advisory members, and collaborators (i.e., a brand designer and illustrator) represented a range of positionalities (i.e., gender, sexual, and racial identities; parental and relationship statuses; educational backgrounds) encouraged a breadth of *perspectives,* expertise, and lived experiences throughout the study. "Overlap methods" or complementary data *methods* of quantitative, qualitative, and photographic data were collected prospectively across three-*time* points from participants from varied geographic *locations* to promote the accuracy of the findings.

The **dependability** of our results was supported by two interdisciplinary team members (nursing and public health) independently coding the transcripts, which established the codebook, involving research and advisory team members in the interpretation of findings and keeping a detailed account of all study processes and decisions (i.e., an audit trail). The **transferability** of our results was encouraged through thick descriptions of the study process and participant quotes, as well as a purposive sampling method. **Confirmable** findings were encouraged through reflexive practices outlined in the next section.

3.2.10 Reflexivity

Reflexivity is a process of recognizing and documenting one's own implicit and explicit biases, privileges, and assumptions that influence the research process, including the relationship to participants (Guba & Lincoln, 2005). The first author's positionality as a White, childless, neurotypical, cisgender woman with advanced education and in an interracial, monogamous marriage to a nonbinary person assigned female at birth simultaneously fostered kinship and created a barrier to vulnerability and disclosure in the interviews. Several steps were built into the study process to overcome differences in experiences, develop trust, and gain rich and detailed data. The start of each interview prompted participants to share details about their lives and experiences that showed care and interest in who they were as a person. Intentional self-disclosure by the interviewer and sharing generic similarities to prior participants' experiences cultivated a shared space of vulnerability, relatability, openness, and trust. Care was taken to remember the names of people and important events to evoke a sense of being on the journey together. The interview guide was flexible to share power and responsibility with participants to discuss what was essential to their experience, and the use of photos as data allowed for various ways to express oneself.

A reflexive practice, including bracketing for preconceptions, was initiated during the grant writing process when the study was designed and will continue through the dissemination of manuscripts and community-oriented research findings. After each interview, field notes of participant observations and the process and content of the discussion were documented to reflect on ways to improve interactions, grapple with ways the data may have been influenced, and contemplate the patterns and contradictions arising from the data. Journaling was continued when cleaning transcripts and during coding as a second and third level of reflection. Deeper levels of experience, sensitive information, nonverbals (e.g., joint laughing, participant crying), and sharing they were saying something out loud for the first time were noted to reflect on when and how trust was built as well as when lack of relationality to the participant hindered disclosure. This included when that was due to interviewer discomfort (e.g., apprehension to probe for negative or absent support, especially around co-parents).

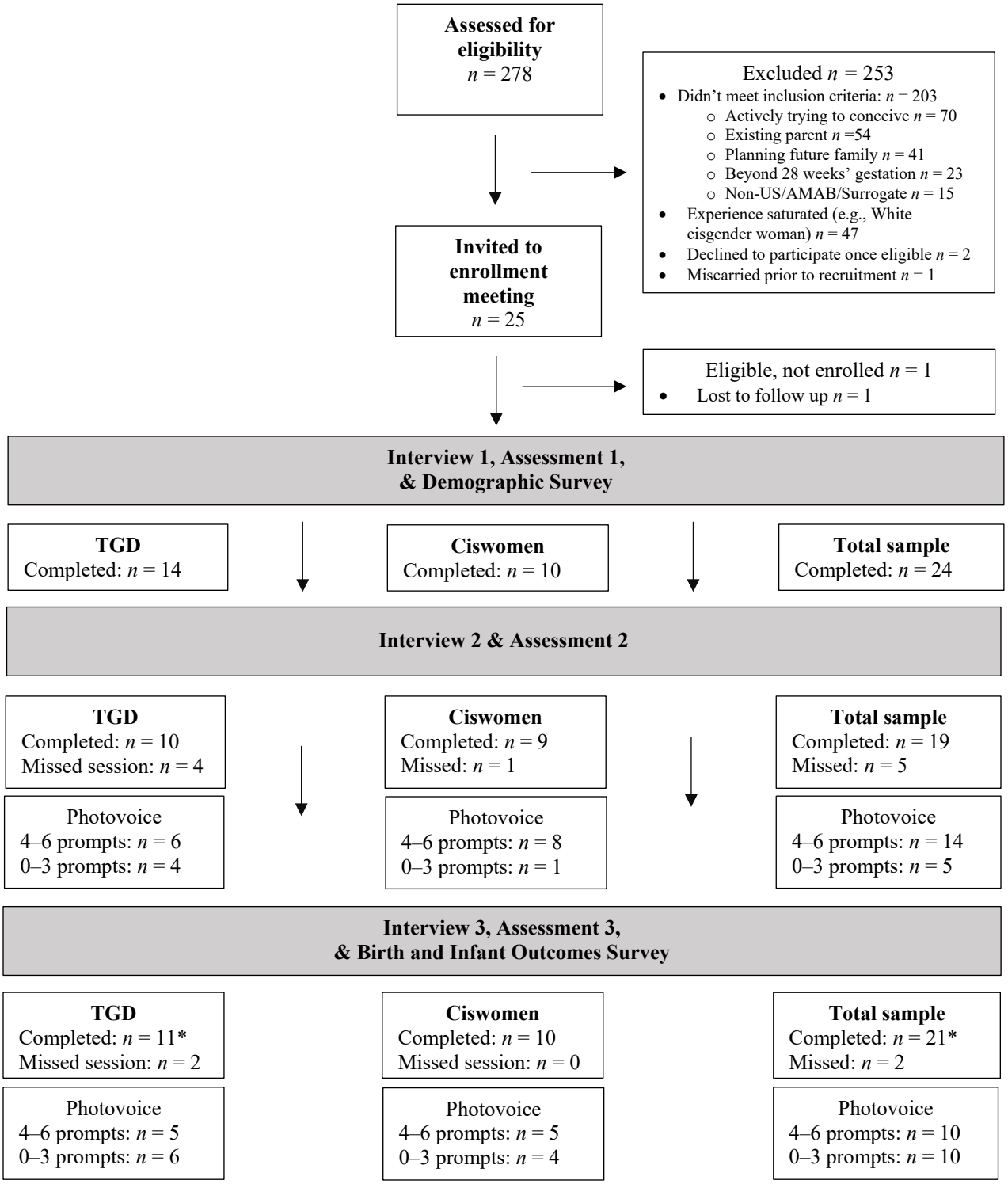
Multiple stakeholders were consulted for continual critical reflection and debriefing of the research process, research products, and interview introspections, including weekly meetings with research team members and biweekly peer debriefing meetings with both a colleague and a qualitative collaborative at Columbia University School of Nursing. Together, attention to these elements enhanced the rigor of this study.

3.3 Results

A total of 278 individuals took the screener, of whom 27 (9.7%) were invited for an enrollment meeting. Twenty-five individuals accepted the invitation, and one was lost to follow-up before any data were collected (Figure 3.2). A total of 24 participants completed 64 interviews (89% completion rate), 65 assessments (90%), 24 demographic surveys (100%), 22 birth and infant outcomes surveys (88%), and submitted 262 photos from 149 prompts (more

Figure 3.2

Consort Diagram of the Recruitment Process, Data Collected and Missing Data



Note. **11 TGD and 21 total interviews and outcomes surveys, 12 TGD and 22 total mental health and social support assessments*

than 50% of participants completed at least 75% of the photo prompts). Each interview lasted between 70 – 175 minutes (M = 116 minutes) and participants submitted 12.7 photos on average. Appendix N for further details of study duration and involvement.

Our attrition rate of 12.5% was relatively low, particularly for a prospective cohort study; however, it is important to acknowledge those who could not continue in the study were all gender-diverse participants, and two of the three participants experienced some of the highest levels of social stressors in the sample. Photovoice participation was more tenuous. Although hundreds of photos were submitted, 41% of the 252 prompts were not completed. However, there was a more significant drop-off during postpartum than during gestation (49% vs 33% not completed), which participants shared had to do with completing a complex task (i.e., thinking metaphorically) during a mentally and physically exhausting time.

3.3.1 Participant Characteristics

Of the 58% of participants who identified as TGD, 71% selected multiple categories (e.g., trans, trans man, and demiguy). Of the 54% who identified as queer, 69% selected multiple sexual identity categories (e.g., bisexual, pansexual, and queer). Participants were between 24 and 39 years old (M = 32.5). The slight majority (58%) identified as a racialized person (i.e., a person ascribed a racial identity that differentiates them from "raceless" White people). Participants were highly educated, but nearly a third (29%) had household incomes less than twice the federal poverty level (i.e., $25,760 – $43,920 depending on household size for 2021). Participants represented every region of the US and Hawaii and lived in diverse settings (i.e., large urban cities to remote rural areas). The majority were married (70%), but, importantly, marriage or romantic status did not define who co-parents were. There were 30 co-parents, of

whom 41% were also genetically related to the baby. Additional demographic characteristics can be found in Table 3.2.

Table 3.2

Queer and Trans PREG Demographic Characteristics

	TGD (N = 14)		Cisgender Women (N= 10)		Total Sample (N = 24)	
	n	*% or mean*	*n*	*% or mean*	*n*	*% or mean*
Age						
Range, *year* (mean)	24 – 39	31.6	24 – 39	33.7	24 – 39	32.5
Sexual identity*						
Lesbian	1	7.1	7	70.0	8	33.3
Queer	11	78.6	2	20.0	13	54.2
Bisexual	2	14.3	1	10.0	3	12.5
Pansexual	4	28.6	1	10.0	5	20.8
Gay	3	21.4	1	10.0	4	16.7
Same-Gender Loving	2	14.3	0	0.0	2	8.3
Gender identity						
Nonbinary/genderqueer	5	35.7	0	0.0	5	20.8
Transgender	3	21.4	0	0.0	3	12.5
Transgender & nonbinary/ genderqueer	6	42.9	0	0.0	6	25.0
Cisgender Women	0	0.0	10	100.0	10	41.7
Race/ethnicity						
Asian	0	0.0	2	20.0	2	8.3
Black	2	14.3	1	10.0	3	12.5
Latinx/Hispanic	3	21.4	2	20.0	5	25.0
Multiracial	2	14.3	1	10.0	3	12.5
Native (Kainai)	1	42.9	0	0.0	1	4.2
White	6	7.1	4	40.0	10	41.7
Education						
High school diploma or G.E.D.	1	7.1	0	0.0	1	4.2
Partial college or associates degree	4	28.6	3	30.0	7	29.2
College graduate	4	28.6	1	10.0	5	20.8
Graduate degree	5	35.7	6	60.0	11	45.8
Occupation						
Employed full time	9	64.3	9	90.0	18	75.0
Student full time	3	21.4	1	10.0	4	16.7
Unemployed/not looking for work	2	14.3	0	0.0	2	8.3
Household income						
<$19,000	2	14.3	0	0.0	2	8.3
$20,000 - $39,999	2	14.3	3	30.0	5	20.8
$40,000 - $59,000	3	21.4	0	0.0	3	12.5
$60,000 - $79,999	1	7.1	0	0.0	1	4.2
$80,000 - $99,999	3	21.4	2	20.0	5	20.8
≥$100,000	3	21.4	5	50.0	8	33.3
Income <2x federal poverty level	4	28.6	3	30.0	7	29.2
Geographic location						
Urban (>50,000)	10	78.6	7	70.0	17	70.8
Urban Cluster (2,500 < x < 50,000)	3	14.3	3	30.0	6	25.0
Rural (<2,500)	1	7.1	0	0.0	1	4.2
Region of country						
West	7	50.0	1	10.0	8	33.3
East	4	28.6	5	50.0	9	37.5
South	2	14.3	2	20.0	4	16.7
Midwest	1	7.1	1	10.0	2	8.3
Hawaii	0	0.0	1	10.0	1	4.2
Relationship status						
Married	8	57.1	9	90.0	17	70.3
Partnered	4	28.6	0	0.0	4	16.7

Single	2	14.3	1	10.0	3	12.5
Current romantic partner(s) gender*						
Ciswoman	2	14.3	9	90.0	11	45.8
Transman/Nonbinary	6	42.9	0	0.0	6	25.0
Cisman	5	35.7	0	0.0	5	20.8
Transwoman/Nonbinary	2	14.3	0	0.0	2	8.3
Current romantic partner(s) race*						
White	9	64.3	7	70.0	16	66.7
Racialized	5	35.7	2	20.0	7	29.2
Not reported	1	7.1	0	0.0	1	4.2
Number of co-parents and partners						
Romantic partner and co-parent	14		9		23	
Non-romantic co-parent	5		2		7	
Romantic partner only	1		0		1	
Current parental status						
Not parenting other children	12	85.7	7	70.0	19	79.2
Currently parenting other children	2	14.3	3	30.0	5	20.8
Gestational carrier	1	7.1	1	10.0	2	8.3
Partner carried	0	0.0	2	20.0	2	8.3
Stepparent	1	7.1	0	0.0	1	4.2

Note. * Select all that apply

The majority of TGD participants reported experiencing depression or anxiety (65% for both depression and anxiety) compared to relatively few cisgender women (10% and 20%, respectively) at some point during early childbearing (sometime before the first visit). Half of the TGD participants had a history of chest masculinization surgery, and just over half (57%) had taken gender-affirming hormone therapy. A quarter had government-funded health insurance; notably, this was exclusively among TGD participants. Half sought out midwifery care or multiple providers (e.g., midwife and OB/GYN), and over half (57%) hired a doula or had another emotional support person at birth (e.g., midwife). A comprehensive description of health history and healthcare characteristics can be found in Table 3.3.

Table 3.3

Queer and Trans PREG Health History and Healthcare Characteristics

	TGD (N = 14)		Cisgender Women (N = 10)		Total Sample (N = 24)	
	n	*% or mean*	*n*	*% or mean*	*n*	*% or mean*
Mental Health Conditions*[a]						
Depression	9	64.3	1	10.0	10	41.7
Anxiety	9	64.3	2	20.0	11	45.8
Other (Autism, PTSD, ADD, OCD)	8	57.1	1	10.0	9	37.5
Currently receiving mental health care	7	50.0	4	40.0	11	45.8
Pre-existing Physical Health Conditions*						
≥1 physical health condition [b]	6	42.9	2	20.0	8	33.3
Gender Affirmation Care*						
Chest surgery	7	50.0	0	0.0	7	29.2

Masculinizing Hormone Therapy	8	57.1	0	0.0	8	
Duration, years	3 – 16					
Counseling/therapy	6	42.9	0	0.0	6	25.0
Insurance						
Private/employer	7	50.0	5	50.0	12	50.0
Private/spouse	1	7.1	4	40.0	5	20.8
Medicaid/government sponsored	6	42.9	0	0.0	6	25.0
Healthcare sharing plan	0	0.0	1	10.0	1	4.2
Insurance coverage to conceive *of those needing assistance*	N = 7		N = 10		N = 17	
No coverage	2	28.6	3	30.0	5	29.4
Partial coverage	4	57.1	7	70.0	11	64.7
Unsure	1	14.3	0	0.0	1	5.8
Place of delivery						
Hospital	7	58.3	9	90.0	16	72.7
Birth center	3	5.0	0	0.0	3	13.6
Transferred to hospital	1	8.3	0	0.0	1	4.5
Homebirth	2	16.7	1	10.0	3	13.6
Healthcare Provider						
Midwife	6	42.9	2	20.0	8	33.3
OB/GYN	7	50.0	5	50.0	12	50.0
Multiple *(*OB, Midwife, and/or NP)	1	7.1	3	30.0	4	16.7
Postpartum support people*						
Birth support	8	57.1	3	30.0	11	45.8
Postpartum doula	4	33.3	1	10.0	5	22.7
Lactation support*	6	50.0	9	90.0	15	68.2
Feeding method*						
Human milk*	6	50.0	9	90.0	15	68.2
At chest	6	50.0	8	80.0	14	63.6
In bottles	3	25.0	6	60.0	9	40.9
Donor	3	25.0	0	0.0	3	13.6
Formula	6	50.0	4	40.0	10	45.4
Partner induced lactation	0	0.0	2	20.0	2	9.5

Note. * Select all that apply

[a] Reported mental health condition anytime during childbearing up until the first interview (2nd trimester)

[b] Baseline physical health conditions included: atypical migraines, cancer, coagulation problems, epilepsy, hypothyroidism, immune disorder, polycystic ovarian syndrome, and respiratory problems

A third (29%) conceived using sexual intercourse — of which more than half (57%) were unplanned conceptions — a third (33%) using in vitro fertilization (IVF), and 38% intrauterine insemination, the majority of which were completed at home (56%). Two participants had given birth prior to this childbearing experience, and two of the participants' partners had given birth. A third (29%) experienced at least one fetal loss prior to this childbearing experience. Deliveries and infant outcomes were generally unremarkable except for an elevated cesarean rate (41% vs 31% national rate) and hemorrhage rate after giving birth (14% vs 3% national rate). Comprehensive data on participants' reproduction, birth, and infant outcomes can be found in Table 3.4.

Table 3.4

Queer and Trans PREG Reproductive, Birth, and Infant Outcomes

	TGD* (N = 14)		Cisgender Women (N = 10)		Total Sample (N = 24)	
	n	*% or mean*	*n*	*% or mean*	*n*	*% or mean*
Reproductive History						
Infant loss	5	35.7	2	20.0	7	29.2
Abortion	1	7.1	2	20.0	3	12.5
Primiparous (gave birth for the first time)	13	92.9	9	90.0	22	91.7
Multiparous (gave birth > once)	1	7.1	1	10.0	2	8.3
Gravidity (sum of pregnancies), mean (SD)	2.0	1.9	1.5	0.7	1.8	1.5
Parity (birth to ≥24-week fetus), mean (SD)	0.1	0.3	0.1	0.3	0.1	0.3
Conception Method						
In vitro fertilization	2	14.3	6	60.0	8	33.3
Intrauterine or intratubal insemination	5	35.7	4	40.0	9	37.5
At home	3	21.4	2	20.0	5	20.8
At a clinic	2	14.3	2	20.0	4	16.7
Sexual intercourse	7	50.0	0	0.0	7	29.2
Planned conception	3	21.4	0	0.0	3	12.5
Unplanned conception	4	28.6	0	0.0	4	16.7
	(N = 12)		(N = 10)		(N = 22)	
Gestational age at birth, weeks, mean (SD)	39.8	1.6	38.9	2.3	39.4	2.0
Preterm birth (<37 weeks' gestation)	0	0.0	2	20.0	2	9.1
Not preterm birth	12	100.0	8	80.0	20	90.9
Birthweight in grams, mean (SD)	3340.0	446.4	3260.1	696.3	3285.5	576.1
Low birthweight (<2,500 g)	0	0.0	2	20.0	2	9.1
Not low birth weight	12	100.0	8	80.0	20	90.9
Delivery method						
Cesarean section	4	33.3	5	50.0	9	40.9
Emergency	3	25.0	5	50.0	8	36.4
Planned, medically indicated	1	8.3	0	0.0	1	4.5
Vaginal, assisted (induction, vacuum)	3	25.0	2	20.0	5	22.7
Vaginal, unassisted	5	41.7	3	30.0	8	36.4
Birth Complication*						
Hemorrhage	2	16.7	1	10.0	3	13.6
Failure to progress	3	25.0	2	20.0	5	22.7
Perinatal asphyxia	1	8.3	1	10.0	2	9.5
Perineal tearing	3	25.0	4	40.0	7	31.8
Epidural	5	41.7	7	70.0	12	54.5
Other Complications*						
Jaundice	4	33.3	1	10.0	5	22.7
Neonatal intensive care unit	1	8.3	2	20.0	3	13.6
Gestational Physical Complications*						
Group B Streptococcus	4	33.3	1	10.0	5	22.7
Gestational diabetes	1	8.3	0	0.0	1	4.5
Hyper/hypotension	1	8.3	1	10.0	2	9.5
Iron-deficiency amenia	5	41.7	4	40.0	9	40.9
Intrauterine growth restriction	1	8.3	0	0.0	1	4.5
Placenta accrete	1	8.3	0	0.0	1	4.5
Preeclampsia	0	0.0	2	20.0	2	9.5

Note. * = Select all that apply

3.3.2 Clinical Mental Health and Social Support Findings

Participants' emotional, instrumental and informational social support scores were on average higher than national averages of support; however, all three types of support decreased across the course of the study (Table 3.5). Moreover, more TGD participants had lower than average support compared to cisgender women for all three types of support.

Clinical depression and state and trait anxiety scores ranged from 33–73% at every time point, except for depression in the 3rd trimester (21%; Table 3.5). TGD participants had higher levels of depression, distress, and state and trait anxiety at every time point compared to cisgender women, except for depression in the 3rd trimester and anxiety in postpartum.

3.3.3 Qualitative Results

Four themes and thirteen subthemes emerged from the data at the intra- and interpersonal levels of the SEM: (1) *Entering a New Season of Life,* (2) *Community Is Family*, (3) *The Pain We Bear,* and (4) *Obligatory Resilience.* The saturation table (Appendix O for saturation table) signaled that adequate breadth of experiences was captured at the code level after the 12th participant.

Theme 1. Entering a New Season of Life

This first theme contains four subthemes and encompasses how gestating a child represented a new season of life for the majority of participants, and with that came new support needs and sources of support. Our first subtheme, *Layers of Difference,* represents how the intersection of being a gestating person and a queer and/or trans person created challenges in finding support that understood their experience. *Healing Old Wounds* describes how forming a new family healed the trauma and harm experienced during the coming out process — a process of disclosing one's sexual orientation(s) and/or gender identity(ies). *Feeling Let Down* captures

Table 3.5

Queer and Trans PREG Social Support and Mental Health Scores

	TGD (*N* = 14, 10, 12)		Cisgender women (*N* = 10, 9, 10)		Total sample (*N* = 24, 19, 22)	
	Range (mean)	Lower than mean *n (%)*	Range (mean)	Lower than mean *n (%)*	Range (mean)	Lower than mean *n (%)*
Social Support (PROMIS 8A; mean = 50)						
Emotional (range 24.7 – 63.5)						
2nd trimester	40.7 – 63.5 (52.5)	5 (36)	52.1 – 63.5 (58.9)	0 (0)	40.7 – 63.5 (55.1)	5 (21)
3rd trimester	43.9 – 63.5 (51.7)	5 (50)	54.3 – 63.5 (60.7)	0 (0)	43.9 – 63.5 (56.0)	5 (26)
4th trimester	39.9 – 63.5 (51.4)	6 (50)	46.4 – 63.5 (54.3)	2 (20)	39.9 – 63.5 (52.7)	8 (36)
Instrumental (range 27.0 – 65.6)						
2nd trimester	44.3 – 65.6 (54.0)	2 (14)	53.2 – 65.6 (63.5)	0 (0)	44.3 – 65.6 (57.9)	2 (8)
3rd trimester	43.5 – 65.6 (52.7)	2 (20)	53.2 – 65.6 (61.7)	0 (0)	43.5 – 65.6 (57.0)	2 (11)
4th trimester	44.3 – 65.6 (53.9)	1 (8)	45.7 – 65.6 (58.3)	1 (10)	44.3 – 65.6 (55.9)	2 (9)
Informational (range 23.7 – 69.1)						
2nd trimester	39.1 – 64.7 (53.4)	4 (29)	46.6 – 69.1 (61.0)	2 (20)	39.1 – 69.1 (56.5)	6 (25)
3rd trimester	43.3 – 69.1 (53.0)	4 (40)	46.6 – 69.1 (58.9)	1 (11)	43.3 – 69.1 (55.8)	5 (26)
4th trimester	37.0 – 64.7 (52.0)	4 (33)	44.4 – 69.1 (54.3)	2 (20)	37.0 – 69.1 (53.0)	6 (27)
		Clinical cases *n* (%)		Clinical cases *n* (%)		Clinical cases *n* (%)
Depression (EPDS; range 0 – 30)						
2nd trimester						
case: ≥11	5 – 24 (11.1)	6 (43)	1 – 14 (8.2)	3 (30)	1 – 24 (9.9)	9 (38)
possible case: ≥9		10 (71)		5 (50)		15 (63)
3rd trimester						
case: ≥11	6 – 12 (8.9)	2 (20)	4 – 17 (8.8)	2 (22)	4 – 17 (8.8)	4 (21)
possible case: ≥9		5 (30)		4 (44)		9 (47)
4th trimester						
case: ≥11	4 – 19 (10.5)	6 (50)	3 – 18 (10.3)	3 (30)	3 – 19 (10.4)	9 (41)
possible case: ≥9		8 (67)		7 (70)		15 (68)
State Anxiety (STAI; range 20 – 80)						
2nd trimester case: ≥39	24 – 77 (42.3)	8 (57)	21 – 38 (29.4)	0 (0)	21 – 77 (36.9)	8 (33)
3rd trimester case: ≥39	30 – 54 (42.8)	6 (60)	23 – 63 (38.9)	4 (44)	23 – 63 (40.9)	10 (53)
4th trimester case: ≥39	25 – 59 (43.8)	8 (67)	24 – 63 (41.2)	6 (60)	24 – 63 (43.1)	14 (64)
Trait Anxiety (STAI; range 20 – 80)						
2nd trimester case: ≥39	35 – 76 (45.5)	11 (79)	22 – 59 (33.2)	2 (20)	22 – 76 (40.4)	13 (54)
3rd trimester case: ≥39	35 – 48 (42.6)	8 (80)	25 – 49 (33.7)	2 (22)	25 – 49 (38.4)	10 (53)
4th trimester case: ≥39	32 – 73 (46.8)	9 (75)	22 – 57 (42.1)	7 (70)	22 – 73 (45.1)	16 (73)
		Higher than mean *n (%)*		Higher than mean *n (%)*		Higher than mean *n (%)*
Distress (Nu-PDQ; range 0 – 2)	2 – 13 (6.5)		3 – 10 (6.1)		2 – 13 (6.3)	
2nd trimester: no mean comparison	10 – 18 (14.2)	7 (70)	5 – 27 (13.4)	5 (56)	5 – 27 (13.8)	14 (64)
3rd trimester: mean = 11.9	4 – 21 (12.4)	---	3 – 15 (11.3)	---	3 – 21 (11.9)	---
4th trimester: no mean comparison						

how the coronavirus (COVID-19) pandemic centralized support such that there was increased reliance on the nuclear family, as well as the experience of being disappointed by people they expected to provide support (e.g., chosen family). Increased and unexpected emotional support needs during this time is captured in the last subtheme *Emotional Support at the Center of It All.*

Subtheme 1.1 "There's an Inherent Difference Between Us, and That's Unbridgeable": Layers of Difference

For this first subtheme, participants felt at least one, if not several, ways their childbearing experience and needs were profoundly different from other childbearing individuals, regardless of their identities. The overwhelming sentiment was that whom participants did or did not seek support from, and how helpful or not the support was defined these five layers of difference.

The first layer of difference perceived by our participants was how their childbearing experiences and support needs were different from heterosexual, cisgender childbearing people. Negotiating parental titles (e.g., Zaza, Mommy), managing how to feel affirmed in their gestating bodies, and navigating the process of second-parent or stepparent adoption were a few of the ways their experiences and concerns were inherently different. This difference was illustrated by this participant discussing the challenges that come when trying to connect with the White, cisgender, heterosexual women in their life:

> *The whole journey to this has been different from what their journey to parenthood is — even if they had fertility challenges… [The genetic co-parent] and I don't have a sexual relationship, so when we're DYI-ing it, it was a soft cup. "You go in wherever, let me know when you're done [providing a sperm donation], pass it off, I'm going to do the same [inseminate myself with the sperm using a soft cup]." And then, "What? Are we going to get tacos later?"…To explain that to straight people, period is just wild… their discomfort is so palpable that you're just like, "Yeah, and this is why I don't want to talk to you about these things."… There's an effort. There's not a flow,*

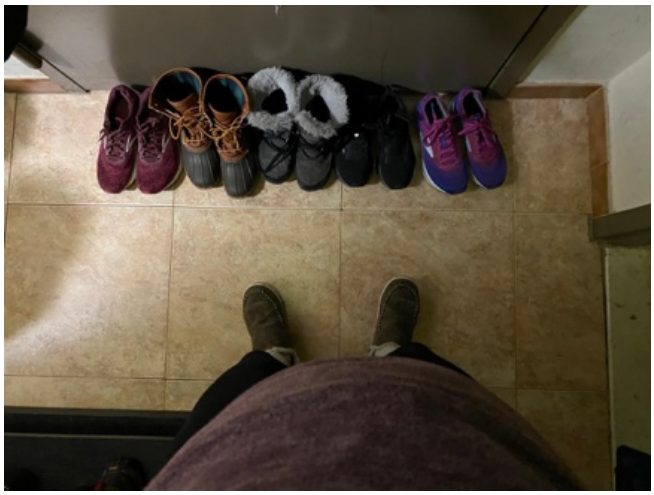
> *and there's not a — it doesn't feel nourishing in the same ways. (Hispanic, queer, genderqueer person)*

The second layer of difference was between racialized and White participants. Racialized participants felt alienated in SGD perinatal support spaces as the majority consisted predominantly of White individuals, since "*they are usually the only people who can afford to go and do what they need to do to have children" (Black, same gender loving, nonbinary person).* Yet, there was double isolation for these participants since they also felt alienated in parenting spaces with other racialized people who were majority heterosexual individuals, as this participant explains:

> *[The photo is] me versus hetero pregnant people. I wanted to show I didn't really have people on my side…. We aren't in even similar shoes. There is no connection or support I feel coming from them. I'm isolated on my side without any other shoes around me while they all have each other. They aren't walking in my shoes… I always still feel this rarity. Or on that listserv, I told you about our queer parents' listserv. It's mainly White, so I always feel a little outsider there. It's like, wherever we're going, I always feel I'm on my own island, except at the hospital. There's a lot of women of color at the hospital. I mean, when I go to my OB appointments, so I feel good there. Or I feel surrounded there, but of course, again, the majority are hetero people. It's a double isolation, in a way. (Asian, queer, cisgender woman)*

Figure 3.3

On My Own Island: The Layers of Difference Between Us



Note. An expecting person's belly and feet in slippers are on one side and a line of sneakers, boots, and other shoes are across from them. This photo represents the layers of difference this participant experienced between heterosexual gestating people as well as White queer gestating people, perpetuating a feeling that they are always alone.

The third layer of difference was divergent pathways and challenges to parenthood (e.g., multiple IVF attempts vs conceived at home on first attempt), co-parenting arrangements (e.g., romantic vs nonromantic co-parents), birthing choices or experiences, and parenting styles. These different experiences, choices, and values created gaps that often felt too big to overcome. This was true even among queer chosen family members:

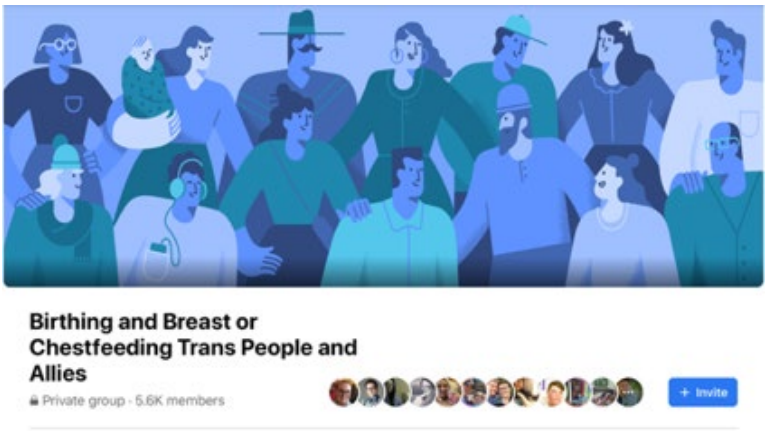
> *My chosen family is queer themselves and also trying for kids themselves. Their approach versus our approach is completely different. They're wanting to go anonymously through a sperm bank and not have a relation. And they're like, "Well, why would you have a relation with the donor? "… They don't understand it. That's what I mean by navigating even my queer family. (Multiracial, queer, and nonbinary person)*

The fourth layer of difference was experienced when participants sought support from SGD individuals who were also gestating or already parents compared to SGD individuals who were not gestating or parents. Individuals who were not gestating or parenting did not know "*the embodied experience*" of childbearing, thus were not able to provide practical advice, guidance, or emotionally connect to their lived experience. Online support groups were a meaningful way in which participants attempted to fill these gaps:

> *All of these [trans] groups are really my support connection to my queer community. Especially during COVID, and because most of the people that are my age that are queer are not in the same — I don't feel like they're in the same stage of life. I'm 26, and I'm having my second kid, and I'm married. Most of the people that I know that are queer are not doing any of those things… I'm finding a lot of these groups are my only connection to one of those pieces fitting. (White, queer, trans and nonbinary person)*

Figure 3.4

My Connection to Queer and Trans Parents: Finding Others Like Me



Note. A screenshot of a Facebook group called "Birthing and Breast or Chestfeeding Trans People and Allies." This photo represents how important online support groups can be to find people who share the intersectional identities of being a queer and/or trans person and gestating and/or parenting as well as a place to see representation of families like their own.

The final layer of difference was between childbearing participants about to parent for the first time and those who were already parenting. Some participants' spouses carried their first child so, despite already being a parent, it was their first childbearing experience. They inherently had different anxieties, questions, and support needs than typical second time parents:

> *I don't even feel like I can relate to [my friends who are expecting their second child] either. I don't really talk to them or ask them about their experience… they've already gone through the fear of anticipating pain and things like that, all the things that I'm anxious about. I feel like there's an inherent difference between us, and that's unbridgeable. (Asian, queer, cisgender woman)*

Subtheme 1.2 "A Lot of Trauma… Has Been Healed Between Us": Healing Old Wounds

Participants commonly recounted painful stories of being disowned and traumatized by their families of origin during the coming out process. Many spoke about relationships that were still distant, yet many had started healing these scars and relationships over time. Although that pain was still raw, family formation became a mechanism for healing those old wounds and rekindling emotionally supportive relationships with families of origin:

> *My mom has stepped up so much… I've intentionally really tried to lean into the relationship with my mom so that she can feel really important, and that's been really healthy for her and for me. I think a lot of like trauma, honestly — small T trauma — has been healed between us… She gave me a gift of this stone, and she was like, "Listen, when your dad and I got married, and you were three years old, we went up to a Hilltop on our wedding day, and we gathered a stone, and it represented the three of us becoming a family. And so today I went up on that same Hilltop, and I gathered a stone for you, [your wife], and the baby to signify the three of you being a family now." That was really, really cool and something I definitely did not anticipate. It felt like an absolute public affirmation of our marriage and our family that I'd never gotten from her before… She just really has identified with the new grandma role that she's in. She's loved it so much that she's enthusiastic about it in ways I did not expect her to be. (White, queer, cisgender woman)*

Figure 3.5

Reconciliation and Recognition by Family of Origin

Note. Four rocks placed on top of a naked, gestating belly. This photo represents the participant's mom affirming her marriage and family and healing the past trauma and harm inflicted upon her by her mom for being queer.

Participants also attributed the change in relationships to parents having a *"door reopened"* that they had previously closed when their child came out to them. The new connection to a shared

lived experience with their child, as well as the prospect of a future grandchild, transformed relationships with many participants' family of origin.

Subtheme 1.3 "I Would've Thought That My Two Best Friends Would Be There": Feeling Let Down

Despite family formation facilitating closeness among families of origin, there were still many instances when participants felt let down and disappointed in the ability of their families of origin to show up in the ways they needed:

> *There's been a number of times where I've been like, "I really wish [my parents] could do something." And it's just, at my big life moments, it doesn't happen. It is what it is. In some ways, I have to say this to myself to protect myself from feeling disappointed when it doesn't happen. (White, lesbian, cisgender woman)*

This was also true among chosen family members, which was perhaps even more disappointing than families of origin, as it was so unexpected: "*Initially, I would've thought that my two best friends would be there. This is my first time really speaking about this out loud, but they haven't been [there]* (*Multiracial, queer, nonbinary person*).

This disappointment was most common among chosen family or friends who were actively trying to conceive and struggling in that process. Yet, many also attributed feeling disappointed to the insularity created by COVID-19. It felt impossible to overcome distance for those that lived far away or receive support from people outside their COVID bubble. Consequently, there was an imbalanced and undesired reliance on the immediate family unit, specifically their partner(s). Several participants described the loss of having co-parents less involved than anticipated due to many living far away. Subsequently, families of origin had a more prominent and increased presence than initially intended:

> *There are these outside forces now that make us more of a nuclear family in a way we didn't want to be. And that feels really s**ty, and it can feel complicated to think of expectations from my family and my partner's family of their involvement with the kid and the roles they'll play. (Hispanic, queer, genderqueer person)*

Subtheme 1.4 "This Is a Pile of Love When I Look at It": Emotional Support Is at the Center of It All

Emotional support was the most desired and appreciated type of support compared to tangible or informational support. However, in addition to the expected hormonal fluctuations of childbearing, participants talked about the additional hormones from assisted reproductive technology medications and hormonal changes from testosterone cessation as setting the stage for needing greater emotional support earlier on and generally feeling less in control of their feelings. Participants emphasized the longing to receive this kind of support from every aspect of their support community, including professional supports, and how affirming it felt was when they did receive it:

> *I would leave that hour-long session with my acupuncturist feeling more affirmed and seen and supported than pretty much any other hour of my life. I think being held in such an intimate way and having holistic care and having someone talk about my physical body and my mind and my emotions, and how they're all completely connected. It really worked for me in a way that I'd never experienced before. (White, queer, cisgender woman)*

Smaller, synchronous support groups were also more beneficial than larger, asynchronous social media groups. They allowed emotionally supportive connections with real humans and an intimate space where they could follow the journeys of other queer and/or trans families and have other families follow their journey. Moreover, personalized acts of service — such as compiling a video with parental advice to celebrate the expecting parents — and handmade gifts

were assigned additional emotional significance. They signified they were understood, loved, and surrounded by their community:

> *This is a pile of some of the handmade things that we have been given. The bottom quilts with the rainbow hearts that's a quilt that our friends put together. Thirteen people all made squares for a quilt, and they each — each square represents something about us, and it's just so cool. And it's for the baby, and we love it… then the purple sweater, a friend knitted for us, and the purple blanket, the same. [My wife's] work friends gifted us the light-colored blanket that's underneath the purple one, and its just — folks have really celebrated this baby. This is a pile of love when I look at it. (White, lesbian, cisgender woman)*

Figure 3.6

A Pile of Handmade Love

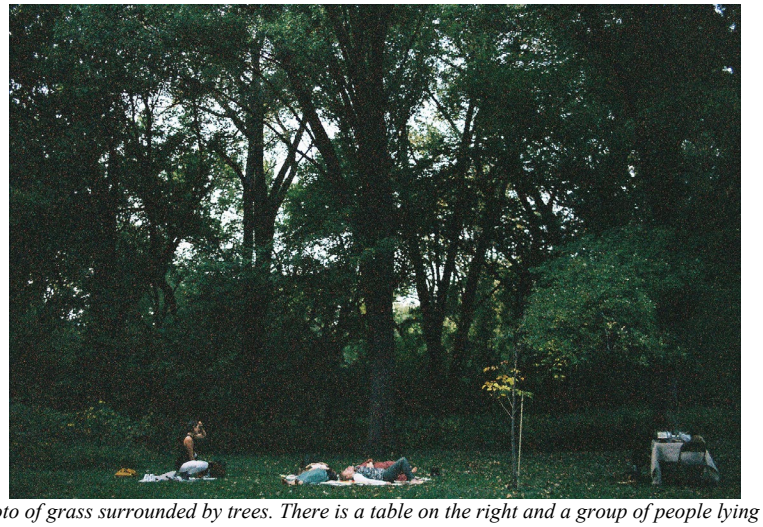
Note. A pile of knitted sweaters, blankets, and a handmade quilt. This photo represents how emotionally supported and loved this participant felt by this pile of handmade gifts for her baby.

Spiritual support was also an essential component of emotional support. Participants sought out or discussed desiring professionals that incorporated a *"spiritual magical component"* into their care. A few participants joined healing circles to invite reverence, ritual, and wisdom into their journey. Beyond emotional support, one participant talked about the transformative opportunity her mother's blessing created between her and her mom:

It was really small and intimate in the woods and ended up being just this really profound experience that I had with my mom. We had a breath worker at the mother's blessing, which was really cool. And we just got to do these mind-body exercises and tie it all into birth and pregnancy, which was really powerful in and of itself. But then I ended up having these moments with my mom — that I'd never had throughout my whole life, let alone in pregnancy — where she was just validating and affirming of my marriage, and my role as a parent and just encouraging with her language in a way that I've just never received before from her… My mom's very evangelical and very religious, and I'm not, but there was this meeting in the middle where it was a very spiritual night, and I think she was able to connect with it in that way…I feel like it was just a really beautiful night to like hold space for everything that is about to happen and is happening and acknowledge that… this moment, this night was really, really special. (White, queer cisgender woman)

Figure 3.7

Spiritual Nourishment: Honoring the Transformation of Parenthood



Note. A faded, dark photo of grass surrounded by trees. There is a table on the right and a group of people lying down on blankets in a circle. Someone who appears to be facilitating the event is sitting upright nearby. This photo represents this participant's spiritually based mother's blessing ceremony and how powerful and profound that night was to recognize and acknowledge her transformation into becoming a parent while also serving as an important moment of reconciliation between her and her mother.

In general, there was a notable increase in emotionally supportive interactions, specifically from female-identified family and extended family members. This included moms, mother-in-law's, sisters, sister-in-law's, cousins, aunts, second moms (chosen family), and other female friends that had previously gestated themselves. However, emotional support was most desired from partners(s), and consequently, they were the primary people responsible for nourishing the emotional wellbeing of participants:

[My partner's] literally the heart of my community right now and has been for a while, especially on this journey. When I look at [these flowers], I'm reminded of how supported I am, how loved I am… [yet] I had expressed to [my partner] how I wasn't feeling supported throughout these pains. I needed more physical touch. I needed more physical support and mental support, and emotional support… I think that has been the most shifting thing of how pregnancy support has really evolved for me… I also recognize and acknowledge the fact that that's a heavy job to be a one-person support for us. (Multiracial, queer, genderqueer person)

Figure 3.8

My Partner: The Heart of My Support Community

Note. Six bundles of roses hanging down with string from a piece of driftwood. This photo represents how their partner is the center of their community and how supported they feel by them. Still, the increased emotional needs during childbearing was more than their partner could provide leaving gaps in emotional support needs.

Pets also served an important role in providing intuitive, emotional comfort to participants. Many sweet and emotionally supportive moments occurred with pets, as well as within participants' religious communities, among neighbors, and colleagues:

I've been only really, really showered in warmth and love from my colleagues and even more from my students. I ended up saving the chat from the zoom day when I told one of my classes only because I felt if I ever felt sad, I could just read that. They were just so extremely celebratory and warm and encouraging and excited. And they continued to be. I had a student a couple of weeks after I shared with her class that I was going to be going on parental leave, who wrote me an email at three o'clock in the morning about how she never had much of a relationship with her father and didn't even feel like she knew what a father was, but she wanted me to know that she thinks what a father is, is

> *exactly me and I'm going to be such an amazing one. And she just really wants me to know how happy she is that I'm going to have a kid in this world. And that's just an example. It was really a lot really, really sweet, really moving. It's just an example that sort of stands in for the level of warmth and celebration that I feel has come my way… A number of students when sharing really warm responses with me have also said, "We're sure you and your partner are going to be such great parents." They make a point of including my partner. They've never met him, of course. They don't know him at all. But I experienced that as an attempt on their part to make sure that I know that they are happy for me, fully and completely. (White, queer, trans person)*

Lastly, doulas — trained professionals who provide various types of support during the perinatal period — were critical to providing emotional support, in addition to informational and tangible support, for participants. They especially helped to meet the emotional needs of participants in the weeks leading up to birth:

> *[My doula's] been the most wonderful decision I think I've made the whole pregnancy. Almost every other week I would say, she puts together like a care basket of foods that she's baked and made, and she'll drop it off. It'll be filled with books of poetry or little gifts for me… She's been such an intuitive guide pretty much anytime I've had a big emotion come up throughout the pregnancy, or just anytime I felt like I didn't want to bother my midwife for an emotional question but needed support. She will just show up in the most tangible way. It's been amazing… she's always checking in on how I'm emotionally feeling. And it's a lot of her sharing her birth stories with me… I feel like I've learned more from hearing her stories than I have from so many of the books I've read. (White, queer, cisgender woman)*

Figure 3.9

My Doula: Intuitive Guide, Masterful Storyteller, Emotional Steward

Note. A person in a cream dress with their arm outstretched and a tattoo of a gestating baby visible on their forearm. This photo represents the importance of the emotional support this participant's doula provided them during their childbearing experience.

Notably, in addition to the significant number of participants who hired a doula, many others mentioned they desired a doula, but COVID-19 hospital protocols and affordability were barriers to accessing to this type of support.

Theme 2. Community is Family

This theme contained two subthemes and captured how it was uniquely crucial that participants receive support from a community of people that feels like family — where the quality of support is as nourishing and cozy as *Feeling at Home (When Being Supported)*. In *It Takes a Village,* robust support communities were essential in meeting participants' various support needs, and parenting villages uniquely included nonromantic and/or multiple co-parents.

Subtheme 2.1 "It's Life Giving in a Really Indescribable Way When You're Able to Be Cared for and Seen": Feeling at Home (When Being Supported)

Narratives of stigma and discrimination from heterosexual and cisgender people that could *"take the wind out of your sails"* were frequent. Consequently, participants often only surrounded themselves with people and community who provided comfort, safety, validation, and affirmation — who provided a sense of feeling cozy and at home when enveloped in their

support. Due to the comfort and safety within romantic partnerships, it again made these people the most significant person to seek support from:

> *These are my partner's hands and my belly… He's been the main person giving me support and the person I felt most comfortable asking for support or talking to when I'm feeling down, or I need extra support. He's also been very encouraging and affirming of me being more celebratory or more public or more wanting to share my pregnant self with the world — which is the exposed belly. (White, queer, trans and nonbinary person)*

Figure 3.10

Comforted and Held in Your Arms

Note. A photo of a gestating, exposed belly with two hands holding it from behind. This photo represents the support, love, and comfort this participant received from their partner and their encouragement to share and expose their childbearing experience with more of their community.

However, feeling at home was also a key theme in the support sought from families of origin, chosen family, community, support groups, and even informational resources like birthing classes. Although participants engaged in both queer and trans-specific and general child birthing classes, there were stark differences in how participants described the delivery of information and content in these two settings. Comfort, safety, validation, and affirmation were foundational attributes for participants feeling safe enough to enroll in and benefit from classes. These same reasons were also referenced as reasons heterosexual and cisgender support groups

were not supportive spaces. When it came to the vulnerability surrounding birth, participants needed support that was curated, comfortable, and cozy:

> *The whole birth class was just so f**king great. 'Cause [the doula] is not using mom language. We're talking about how to navigate… strategy around how to f**king delay intervention. And also using affirming f**king language and not making assumptions about what we want to be called or how we want our kid to be talked about or treated. And giving — the examples were of queer people. When [the doula] was like, "Here's what early labor looks like." It's a f**king trans person — you know what I'm saying? All of that just makes such a difference. I don't have to see things that make me feel excluded. I get to see things. And if there are things where the person's using certain specific language, just like you do in your research, [the doula's] like "So some things that might be triggering about this is they use this and this, but this is why I use this. Ultimately, you can skip, literally, you can skip to five minutes and four seconds of this video for like this part." All of it's so carefully thought out and curated and tailored to us in a way that feels so comfortable and good and affirming and amazing. The support group — I mean the same thing [the doula] is great at having it be open to what we need. And then saying, as things come up, being like, "I have an article about that or this documentary was really cool, or I've come across this piece that talks about these people that were parenting in that way, would y'all want me to share it?" Everything is — all the communication is with consent. It's completely mindful about the various ways that we're all experiencing this similarly and differently. You just don't have to f**king explain s**t to this person. You know what I mean? And yeah, it's so nice. It's so cozy. (Hispanic, queer, genderqueer person)*

Importantly, although many birth classes and support groups were held online, participants attributed their ability to access support people and services that were comfortable, safe, and validating to their geographic location.

Regardless of whom support was provided from (e.g., doulas, educators, friends), having shared lived experiences with others was an essential aspect of feeling at home with support; as one participant explained, "*the more different anchors that I have with the person or with people, the more I feel comforted and seen and held, and all the good things" (White, queer, trans person).* Juxtaposed to layers of difference, the more layers of similarity one had, the more at ease and at home they felt in that support:

> *When you're around other queer families who have had babies or who are trying to have babies, you feel this, a relief of just being able to be in their presence and not have to explain the depth of your longing… We don't have to explain anything. We're understood fully, and it just feels like we can kind of relax into that experience. Not that we don't feel safe with some of our hetero friends, but it is life-giving in a really indescribable way when you're able to be cared for and seen by another queer person who just gets it. Without it being something that you have to talk about at all. (White, queer, cisgender woman)*

Subtheme 2.2 "We Want to Have This Baby Be Raised by a Village": It Takes a Village

Compared to the heteronormative, nuclear family, many participants intentionally curated villages to raise their child. Among the 24 participants, there were 30 genetic and non-genetic co-parents who consisted of both romantic partners and non-romantic co-parents. Despite the relationship to the participant or child, co-parents all identified within the LGBTQ+ community and were an essential part of the village they wanted to raise their baby in, "*we all wanted this, and we're all from different cultures, and we all love and care about each other. We want to have this baby be raised by a village"* (*Multiracial, queer, nonbinary person*).

Yet, romantic partners that were also co-parents were the keystones of participants' daily support system; thus, those that had multiple romantic partners ended up having more buffers to meet their support needs, as this next participant describes:

> *I honestly feel like I've lucked out mostly by being poly[amorous] if I'm honest. There's a lot of things that should have impacted me didn't because I had a second partner who's in a more stable place in his life. I mean, a self-employed attorney [boyfriend] has a lot more flexibility and resources than the part-time organizer and the full-time grocer [nesting partner]. (Black, bisexual, trans and nonbinary person)*

Romantic partners also took on the *"burden of preparation"* for parenthood. Participants spoke about their partners lovingly driving them to doctor appointments — despite not being

able to go into the actual clinic due to COVID-19 restrictions — taking over all the household chores, caretaking older children, cooking them nourishing meals, and conducting research on every aspect of their and their baby's needs:

> *One of the major ways that he shows his love is through service. He is doing for us all the time. I'm at my parents' house right now, and my mother said to me, "I have never seen anybody work as hard to get ready for a baby as [your partner] is working right now"… He's gentle and loving towards me in lots of ways, but a lot of his focus is on making sure that I know that I can depend on him for anything. (White, queer, trans person)*

However, villages of support extended beyond partners and co-parents. Chosen family, friends, extended community, neighbors, doulas, and colleagues came together as a community to provide material resource contribution. This included organizing baby showers, purchasing baby gifts, walking pets, babysitting older children, and bringing over meals or ordering delivery:

> *Our community has really stepped up… almost every single day, someone has reached out and been like, "Can I bring you a meal tonight?" We don't even have a baby yet. People are definitely present, and we're on a lot of people's minds, which feels really special. (White, queer, cisgender woman)*

Families of origin and extended family were the most essential sources to provide financial and material support for those who needed it, as well as to provide tangible, in-person support, especially among those who were solo parenting or parenting with non-romantic co-parents.

Theme 3. The Pain We Bear

The third overarching theme captures the pain that was an unavoidable cost of SGD childbearing. This theme consists of three subthemes. *Hostility and Harm From Others* was inflicted through remarks and behaviors, triggering *Hurting on the Inside*. Often participants

were *Sacrificing the Self* or compromising parts of themselves in undesirable ways to maintain support from their community.

Subtheme 3.1 "[My Mom] Didn't Think That Gay People Should Have Kids": Hostility and Harm From Others

Histories of hostile and harmful words and actions, specifically from families of origin, were prevalent. This past trauma set the tone for many encounters during the childbearing period, particularly if reparations or reconciliation never occurred for past harm. *"My wife's sister literally refused to look at us in the eyes. And I would ask her questions, and she would just walk away. I think that's been really painful for my wife, and it's been painful for me" (White, queer, cisgender woman).* Harm was commonly discussed during spontaneous reflections of their coming out process. In these stories, participants were taught and told they weren't deserving of a family:

> *When I first came out to my mom, she told me I couldn't have kids and that she was really sad by that. She felt there was just no way that we'd be able to have kids and didn't think that gay people should have kids, and she thought that I wouldn't be a good mom. That was really hard for me because I, I'm, sorry, [starts to cry] I just really wanted a kid. (White, lesbian cisgender woman)*

However, harm most often occurred when participants announced they were expecting. This announcement sometimes took place before the gestational period, such as during the trying to conceive process. One participant shared with their parents they were interested in IVF and was told, "*that wouldn't be a real grandchild,"* along with other hostile and stigmatizing remarks. Announcements to one's family of origin and friends were characterized by normalizing comments and confusion such as, "*Who's the father*?", "*How did that happen*?", "*Who's baby is that?*" and "*Does this mean you're a woman now?*" Announcing they were expecting a baby resulted in a second anxiety-inducing and painful coming-out process for participants:

> *My paternal grandparents said a lot of things like, "It's unfair to the baby to be raised by two moms. They should definitely have a mother and a father." And "It would be better if you're a single parent" or, you know, "You're going to go to hell because now you're bringing a child into the world. Before, it was just you two making this sinful decision. Now you're bringing a child in the world, and that's even worse." They're kind of on the extreme end of saying, like, "We'll never be able to visit you. We'll never see you." And I want to love this baby, or I want to be excited about this pregnancy, but I just can't, and that's painful for me. (White, queer, cisgender woman)*

Participants of all genders were gendered in distressing and undesired ways throughout the childbearing journey, although many commented on how the isolation of COVID-19 largely protected them from experiencing dysphoria and discomfort related to their gender. Being gendered reinforced feelings of alienation and deepened distrust, such as this next participant who withdrew from relationships that forced a feminine experience upon them and their childbearing experience:

> *I was able to cultivate this, at least androgynous image where people were at least able to kind of scrape me out of the girl category. And it felt like as soon as I told people I was pregnant, four years of a lot of work went down the drain instantly. It was really f**king depressing, actually. Also, I think because people didn't just see pregnancy as a singularly female experience. They wanted me, at least a couple of people, really wanted me to suddenly become a happy woman. Like, "Oh, you're pregnant now. That must mean that not only does your identity [change], but this is an identity that you should be excited about. Because I only know how to be excited for you within this box." (Black, bisexual, trans and nonbinary person)*

Subtheme 3.2 "[I've Been] Feeling Very Isolated, Feeling Very Alone": Hurting on The Inside

Harm from others and harmful societal messages led some participants to question if they would be good parents. Although heterosexual and cisgender parents have similar fears, participants discussed the additional layer of "*the world tells us we shouldn't be parents*" that contributed to this internalized oppression:

> *Someone like me who has a family like mine — is it okay for us to have a baby? The conversation that I had with myself about whether or not — it's internalized homophobia, classic — and just this fear of being different or not having support because I'm different… So it's a lot of things. It's difficult on an incredibly personal level. And then you add in the politics and the news cycle. It's a lot. (White, lesbian, cisgender woman)*

Loneliness and isolation were the most common negative emotional states experienced across the childbearing journey. This was primarily attributed to the COVID-19 pandemic. Despite staying connected with their community via texting, Zoom, and phone calls, being unable to be in the presence of their community was excruciatingly lonely and isolating:

> *When I feel supported, I feel like I can see the bigger world and remember how it feels to feel connected to my community, to be a living being, to be on this earth and the beautiful thing that is this planet. I remember those things, and I can, I feel a part of them. But when I don't feel supported, I feel like they exist, but I can't even see them. I feel locked away from them… The closed window — you can't even tell through the window if there are trees out there… [I've been] feeling very isolated, feeling very alone, feeling not in touch with who I am, or really honestly alive in many ways. That's what that closed window represents for me. (Hispanic, queer, genderqueer person)*

Figure 3.11

The Loneliness of Childbearing in Isolation

Note: Left photo: A fogged window is cracked open from the top, and trees are visible outside through that crack.

Right photo: A fogged window is closed, and nothing can be seen outside the window. This photo represents how the COVID-19 pandemic feels like a closed window. Although this participant has a community of supports, not being in person with them makes them feel like they're not there, perpetuating isolation and feeling alone in the journey.

Furthermore, anxiety and depression were feelings frequently experienced while gestating. Participants commonly cried during interviews or shared stories about a recent breakdown where they needed support. Despite having robust communities of support, supports could not protect against the sheer amount of harm participants endured: *"These vines are supported by the wall and are there but they're also lifeless, and I feel that way. I feel supported, but lifeless at times. I've been struggling with real bad anxiety and depression, to be honest" (Multiracial, queer, nonbinary person).*

Figure 3.12

Lifeless: The Crippling Cost of Enduring Harm

Note. A grey, cement wall with frozen, dead vines outstretched on it. This photo represents that although this participant has a community of support like the structure of the vine, they feel lifeless like the dead vine and are struggling with anxiety and depression.

Subtheme 3.3 "Any Kindness Comes With Stipulations Where I Have to Reduce Myself": Sacrificing the Self

Every participant described ways they sacrificed or compromised their values in order to maintain support. Sacrifices were commonly expected among families of origin and extended family. For example, this next participant's risked losing access to their paternal grandmother

after cutting off their transphobic dad, and endured harm from their maternal grandmother in order to maintain access to their siblings and receive essential material support for their baby:

> *Hopefully, I get to keep [my paternal grandma]. The big thing is with cutting off my dad — I don't know how that's going to work with [my grandma]… My dad was straight up saying he will never call me [my name]. [crying] Just my dead name… because he sees me being trans is me being mentally ill.*
>
> *[I was] asking for gender-neutral stuff and refusing to share the sex of my baby and not finding out for myself. And [my maternal grandma's] like, "Oh, okay." And gets me hyper-gendered stuff… Any offer they make, any kindness comes with stipulations where I have to reduce myself… They will always say they love me, but not support my life choices with that backhanded support. (Multiracial, pansexual, trans and nonbinary person)*

Sacrificing the self also meant enduring being misgendered, having their identity erased, or being indebted to people for their support. The significance and emotional toll of these compromises were profound:

> *[My partners'] entire family, with the exception of his brother and future brother-in-law and some cousins, voted for Trump. For us, that's really hard… What you do, who you support, what you vote for, the things you say is not something I can bifurcate from the ways that you show up as kind and loving to me, right? Because you're only kind and loving to me because you have erased the things that are different about me or patronized them or made them silly and recognized me as in the image of you and in these other ways. Its violent… and [my partner's] mom and stepdad have also bought us a lot of things, and that feels complicated and gross… It feels like I'm enabling their mental gymnastics and cognitive dissonance around what they actually enable in terms of harm against my community and other communities — that I'm letting them off the hook by letting them buy our kids s**t. And that they are going to feel somehow entitled to being involved in our kid's life because they've bought us s**t. So that sucks. (Hispanic, queer, genderqueer person)*

Additionally, participants had to sacrifice their privacy. Gestating inherently put them on display in support groups and childbearing classes and forced them to come out to coworkers and extended family that did not know their sexual orientation(s) and/or gender identity(ies). This

forced outing was also a source of stress in what would otherwise have been a joyful conversation:

> *We held a Zoom town hall with [my partner's] family where all the different cousin families zoomed in. And we did a real educational rundown on gender and sex and pregnancy and sexuality — all the things… The trans stuff gave me a lot of anxiety in the conversation, and though people were very excited for us, it was not — for me — a joyful conversation because I was explaining to a lot of people… what I am. Where what I am was the topic to be inquired upon further. Like we took questions about what I am. That's not joyful for me. (White, queer, trans person)*

On the contrary, some participants avoided telling colleagues or others they were gestating and quickly changed the topic to steer around the sequelae of invasive questions that stem from disclosing a childbearing status (e.g., what's your husband do?). Others avoided spaces where they anticipated harm would be caused or withdrew from spaces and people that made them feel unsafe or different. The cost of these compromises was just another form of erasure and sacrifice — sacrificing being celebrated, having their experience acknowledged and validated, and receiving support and information:

> *[Our birth class] was awkward, for sure awkward. Everyone would mix up our names which we're very used to, but it was these little things. And we ended up actually leaving the group and getting a refund on the class. Not because we didn't feel safe in the group, but it just did not feel like it was our people… We're surrounding ourselves only with people that really don't make us feel different. (White, queer, cisgender woman)*

Theme 4. Obligatory Resilience

The last theme, containing four subthemes, captures the effort and coping required to survive the adversities of childbearing, yet how joyful and important their family was to them. Despite resilience being essential when facing challenging times, the first subtheme highlights the frequency at which participants were forced to be resilient. It was staggering and deeply

exhausting. At every turn, participants were *Laboring for Support (The Effort and Energy to Access Support)* or exerting energy to access support that met their needs. Due to the vulnerability and other unique factors associated with asking for support, asking for help when it was needed was simply *To Ask Too Much* of participants. Thus, participants turned inward to cope with the pain and sacrifice by *Putting the Oxygen Mask on First***.** Yet, this journey also symbolized hope: their experience was able to support and be a source of positive representation for other queer and/or trans people, and their long-desired baby brought joy and meaning to their life, as captured in the final subtheme *Finding Our Joy*.

Subtheme 4.1 "We Have Our Own Research Going on…Which Can Be Frustrating and Exhausting": Laboring for Support (The Effort and Energy to Access Support)

As perinatal support and resources are innately heterocisnormative, it required tremendous effort and additional time and labor to find inclusive resources that centered participants' unique needs, fears, and questions. This was not only described as a lonely and alienating experience, but placed the burden of responsibility on participants to educate others as a condition of receiving support, such as asking for permission to attend a birthing class as a same-sex couple or patching information together on their own:

> *[My partner] and I do our own research. We have our own research going on, and we expect ourselves to accommodate ourselves at this point, which can be frustrating and exhausting… Everything has been morally disappointing as a queer and trans or non-binary birther when it comes to apps and books. (Multiracial, queer, and nonbinary person)*

Additionally, laboring for support demanded participants manage others' emotional responses. Participants had to sensitively manage defensive reactions when attempting to educate others, as well as set boundaries and quell fears about being an SGD childbearing person or having a unique parenting structure. Participants were warned to secure donor contracts and not

share the child's genetic parent out of fear the co-parent would steal their child. They were even questioned if reporters would show up at their house and make a spectacle of them. These experiences within participants' inner circle then informed the amount of labor that went into carefully crafting scripts on how their gestational status or parenting structure was shared in wider circles:

> *I did announce that I'm going to go on parental leave soon. And I spent a lot of time thinking through my language around it. The students haven't asked any invasive questions. I assume that they assume that we're adopting because they know that I'm married to a man, and I'm okay with that. I sort of offered them that as a way of thinking, right? I said, "My husband and I are going to become parents"… I spent some time stressing out about telling the students. Feeling anxious about that… I figured the students would ask me all kinds of questions, and I was really ready with, "I'm going to actually choose not to share that part, but it's okay that you asked. I'm just gonna keep that part private." That was a thing I never had to say, but I practiced saying it a lot of times. (White, queer, trans person)*

The participants' local environment informed the effort required to obtain inclusive and safe resources. Several participants moved to rural, conservative areas during the family building process, which directly impacted how unsafe they felt or how much additional labor was necessary to access support in these places:

> *Politically it's a very conservative town… you'll see Biden, Biden, Biden, Biden [signs], and then you'll hit [our city] sign, and it'll be Trump, Trump, Trump, Trump all the way to our house…. It's a big struggle for us, and so we have — that translates into second thinking going to a group here in [our home city] for pregnancy stuff and running into a bunch of Trump fans, which would be devastating for my wife, so we don't really seek that stuff out in [our home] area. (Mixed race, bisexual, cisgender woman)*

Subtheme 4.2 "It's Harder to Reach Out Than It Is to Just Get Through This Moment": To Ask Is Too Much

Asking for support, versus simply receiving support, was one of the most significant barriers to getting support. Despite robust communities of support, asking for support was a hurdle that asked too much of participants during a tender time:

> *There's just so much happening that you can't even reach out and get the support even if it's right in front of you, like the fence. It's right in front of you, but you are your own barrier to accessing it. There were many, many times where I felt so bad, and then I was just like, "It's maybe not worth it to reach out. It's harder to reach out than it is to just get through this moment." (Asian, queer, cisgender woman)*

Figure 3.13

The Chain Link Fence Between Support and Me

Note. A chain link fence with an industrial environment behind it. This photo represents the barrier or fence of asking for support that prevented this participant from accessing support on the other side.

Some described how the COVID-19 pandemic forced them to ask for support more because there weren't organic opportunities to be in the company of others. Still, for many, it came down to the vulnerability required when asking for support and admitting they needed help. This facilitated smaller circles of support which only included individuals they were most comfortable being vulnerable around:

> *Oh, it was a deluge of hearts and support [in response to my text]… It was immediate, and it was applauded — my vulnerability was applauded by them. [Interviewer asked how that felt] Oh, I cried. I mean, I cried very happy tears. I was like, "Oh yeah, I'm not alone. Duh." Just had to poke them a little bit…*

[But] it was temporary. It lasted for about a week. And then, I felt a little better. But the next low, I didn't feel I could do that again. Actually, I never did that again, and I just have been talking to my partner instead. (Asian, queer, cisgender woman)

Figure 3.14

The Unbearable Vulnerability of Asking for Help

Note. A text message sent to a friend group asking for support. This represents how vulnerable participants felt in asking for support even though they have a community of support.

However, several other reasons arose that are unique to SGD childbearing people. Since many participants were rejected by families of origin during the coming out process, they learned to become self-sufficient:

I've been so independent and by myself in a lot of instances, especially once I came out. My parents kicked me out. I was homeless for a minute. It was just so much going on. I just developed a mentality I can do any and everything by myself. I don't always need — which isn't necessarily true — but I had that "I don't need anybody to help me" mentality. (Black, gay, cisgender woman)

Some felt the pressure to prove they were a responsible and capable parent, while others feared their parental rights would be at risk if they were seen as being in need. This prevented them from asking for help, even when that meant not being able to join in family activities due to financial strain:

> *[My wife's] afraid to ask [her family for money]. I don't think she wants to seem like she can't take care or do something… Even as a woman, and then on top of that, identifying as lesbian that I do feel like I have to, in a way, prove, even to my employer, anytime I'm working or something, that I have to be somewhat better than the average person. I have to prove that any type of stereotype that might be had is incorrect. (Hispanic, lesbian, woman)*

Additional barriers to asking for help included not knowing who or where to ask because of unique needs, challenges to recognizing their needs due to neurodivergence, and not asking for help due to its association with a feminine gender role:

> *I'm a very masc presenting individual. And so oftentimes, I'm used to being the one to carry stuff for friends and build stuff and put things together and show up and support and hold space. And it's been completely the reverse for a lot of people, and it's just — then I think for me [I've had] a hard time to be like, "Yo, can you come over and help me move this box because it's too heavy"… But just really having to like step out of my comfort zone of not asking for help and actually asking for help… Also being neurodivergent — when it comes to my brain, I genuinely just am unable to recognize when I need help. (Multiracial, queer, nonbinary)*

Subtheme 4.3 "You Got to Take a Stand Somewhere, and I Think It Starts With Your Family": Putting the Oxygen Mask on First

Participants had a diverse set of coping tools, which was, in a sense, putting the oxygen mask on themselves first to survive. Dissociating from one's body, avoiding public places where harm was anticipated, withdrawing from relationships, and maintaining low expectations to prevent disappointment were common tactics for self-protection:

> *[A close friend] decided that [the bleeding I experienced in my first trimester] had to do with my acceptance or whatever of my body [as feminine] or something. I didn't have the energy to deal with that c**p. Dealing with that once, I kind of withdrew from that friendship a bit. And experiences like that made me wary of telling more people because that wasn't the only time that happened. (Black, bisexual, trans and nonbinary person)*

When possible, SGD-specific support groups and classes were sought out and used, but these weren't easily located or affordable. Consequently, participants used online and pre-recorded childbirth classes, books, and apps, and one-on-one sessions with doulas to receive childbirth information. These tactics reduced the need to educate others and created a sense of privacy since "*that level of discomfort isn't there when you're reading something or going through an app versus a face-to-face class*" *(Asian, lesbian, cisgender woman).* Despite the already present financial strain of family formation, hiring and relying on professional supports (e.g., doulas, acupuncturist, therapists, nanny's) was an essential way participants coped with meeting their needs. Anticipating future support needs and dangerous situations, and creating buffers helped participants manage challenging times:

> *I was very anxious to have the conversation [about expecting a baby] with a lot of my family. I frequently would plan to have the phone calls within a day or two before therapy so that I would have the support there for whatever the fallout would be. (Multiracial, pansexual, trans and nonbinary person)*

Setting boundaries and advocating for their needs was an important way for participants to maintain access to support while also refusing to compromise their safety or values. This was done either by setting clear expectations of the kind of support they would or would not accept. This was done both publicly on social media and privately within familial relationships:

> *My family doesn't necessarily understand that there are certain members of the family who are maybe ultra-conservative or who support a certain person in the White House. How inviting them to like a baby shower for big gay old me doesn't necessarily feel safe. And I refuse to compromise on that. And it's seen as, it's funny, 'cause it's seen as me being difficult and exclusionary, and yet it's so affecting… You want to be loved by your family and celebrate this really special thing that we tried so hard for so many years to do. And then they're like, "Gotta invite your uncle and aunt, who are the big Trump supporters"… You got to take a stand somewhere, and I think it starts with your family. (White, lesbian, cisgender woman)*

Subtheme 4.4 "Thriving as a Queer Family": Finding Our Joy

Many found power and purpose in giving back to the SGD community and being a visible gestating person. Community mutual aid — solidarity-based support in which there is a reciprocal exchange of resources or services that yields mutual benefit — was an important part of receiving and providing support. For example, loosely connected community members chipped in to buy baby supplies and contributed to GoFundMe campaigns to pay for doulas. Several queer doulas and midwives bartered for services or offered sliding scale or free services to community members. In turn, participants shared advice and anecdotes to help others in the community on their journey to family formation. They served as essential sources of inspiration and visible representation for other queer and trans people:

> *There is so much power in being seen and being visible and feeling that community — to show our families… In these online groups people ask, "Can you share pictures of you pregnant? Because my kids haven't seen any other trans people who are pregnant." I'm gonna cry just thinking about that — that visibility can feel so, so important. (White, queer, trans and nonbinary person)*

In this way, simply existing as a SGD childbearing person symbolized an audacious act of resilience:

> *Defiant — to be a black, trans pregnant person in public — which hasn't happened very often because of the pandemic — but when it does, just being like, "Yep, this is just how it is"… I was embracing the defiance of existing in a way with that photo. (Black, bisexual, trans and nonbinary person)*

Figure 3.15

The Defiance of Existing as a Black, Trans, Pregnant Person

Note. A Birdseye view looking down on a Black gestating belly and their toes peeking out below. This photo represents the innate defiance of simply existing as a SGD childbearing person in a heterocisnormative world.

Although joy was not discussed during childbearing, in retrospect participants discussed overwhelming joy and pride in creating their families in spite of obligatory resilience:

> *Through our resiliency we've been able to find joy. Though we've had these obstacles, they don't define our story. They're just a part of it. We go through them, we overcome them, we figure out a solution. Also, my kid is my world. Regardless of the day-to-day that I experience, whatever that may be while I'm out in the world, my kid is my world. No one's gonna take that from me. That's my joy, my pride, my everything… resiliency equals joy for us in the end. (Multiracial, queer, non-binary person)*

In the end, forming a family provided participants profound purpose and meaning in their life:

> *The joy that my children bring, the joy that my family brings, and thriving as a queer family — it's so much more than just that one year or those two years that I was pregnant… My partner often reflects on his grandparent's favorite saying about someone having wronged you, "the best revenge is living a good life." Reflecting on all the wrongs and hurt and systemic oppression — every time I look at my beautiful children, every time they lovingly call me "Momo," every time my family is together in love — my heart is so full, and I know I am living a good life. (White, queer, trans and nonbinary person)*

3.4 Discussion

This is the first study that we are aware of that examines multidimensional social support among SGD childbearing people across the perinatal period. Our findings demonstrate that SGD

childbearing individuals have robust and multifaceted support networks, with romantic partners and/or co-parents at the center of those support systems. Families of origin, extended family, chosen family, non-romantic co-parents, pets, neighbors, colleagues, peers, religious community, and SGD community — particularly those that shared similar lived experiences and were experiencing similar life phases — are important facets of an extended network we describe as "support villages." SGD childbearing people also have strong and well-developed coping skills, including emotional resilience, boundary-making, advocating, autonomy in self-learning, ability to navigate bureaucracies, resourcefulness, and expertise in developing robust support systems. Despite these skills, repeated exposure to harm, hostility, and heterocisnormativity exacted a high toll on mental health. Yet, the joy and purpose derived from expanding their family made navigating childbearing a worthwhile endeavor.

This study contributed novel findings to the literature, including identifying the most salient types and sources of perinatal support among SGD individuals and identifying social support that could be simultaneously supportive and harmful. In addition, our findings provide data showing that social support and coping may be insufficient buffers against adverse mental health outcomes among this perinatal population. Data also shows that SGD individuals experience perinatal mental health disparities, with higher perinatal anxiety, depression, and distress levels among TGD compared to cisgender individuals. Prevailing gender norms and childbearing expectations harmed and constrained both TGD and cisgender participants alike, but restricted social interactions due to COVID-19 limited dysphoria and may indicate mental health could be improved by reducing exposure to stigmatizing experiences and heterocisnormativity.

The systematic examination of social support constructs — namely emotional, instrumental, and informational support (House, 1981) — is lacking in SGD childbearing populations. We found that emotional support needs markedly — and for participants unexpectedly — increased over the perinatal period and other types of instrumental support (e.g., being gifted a handmade knitted baby blanket) and informational support (e.g., listening to childbirth stories) were perceived as emotionally supportive. Taken together, receiving emotional support was the most important type of support participants voiced. This is an interesting finding in that it contradicted quantitative support scores. We believe the quantitative assessments may be different because they do not take into account how much a support construct was needed at a given time point.

Partners and co-parents were the most important people to provide emotional support, but at times fell short of meeting needs. This was in part because the majority did not have a shared experience of childbearing and were navigating minority stress and parenthood themselves. This prompted participants to look for emotional support elsewhere, such as in social media groups, reaching out to acquaintances with shared lived experiences, and hiring professionals (e.g., doula, midwife, acupuncturist) as others have reported (Hoffkling et al., 2017; Juntereal & Spatz, 2020; MacDonald et al., 2016; Rogers, 2020). Due to increased emotional needs among participants, support spaces that were synchronous, intimate, and comprised of and led by SGD childbearing people were more supportive spaces than those that were large, asynchronous, and comprised of and led by heterosexual and cisgender childbearing people. Notably, TGD individuals were more likely to have multiple and/or non-romantic co-parents who were helpful in meeting support needs, particularly instrumental support.

Doulas provide crucial emotional support among heterosexual and cisgender perinatal populations, especially among people at risk for poor perinatal outcomes (Kozhimannil et al., 2016; McLeish & Redshaw, 2019). However, doula support within the SGD community has not been previously reported. Doulas reduced the need for our participants to ask for help since it was understood doulas were there to help. They were described as being both emotionally supportive and helpful with practical advice around support needs (i.e., informational support) and concrete tasks (i.e., instrumental support). Notably, over half of this sample reported employing a doula or other emotional support professional (e.g., midwife) compared to a national rate of just 6% (Declercq et al., 2013). Yet, many participants could not afford these services or did not hire a doula because of COVID-19 restrictions, suggesting that this perinatal population has a uniquely high usage of, and need for, this service. However, it should be noted that our participants struggled to find SGD-competent doulas, including doulas with a shared identity (i.e., queer, trans, and/or person of color). Desiring perinatal support from those with a shared identity has been an essential asset of support among other minoritized communities as well (Hardeman & Kozhimannil, 2016). In the US, doulas are mostly White, cisgender, heterosexual women from upper-middle-income households (Lantz et al., 2005) who can afford certifications that allow for insurance reimbursement. Thus, a marked gap exists between the types of doulas desired by SGD parents and those available to them.

It is well known that rejection by families of origin among SGD people — especially those who come out during their youth — is common (Romero et al., 2020). Few studies have examined the support from families of origin during SGD childbearing, but there is some evidence of increased acceptance with the arrival of a baby (McKelvey, 2014; Ross, 2005). Our findings support this: family formation was largely a time of reconciliation with increased

support from families of origin. However, this support could be simultaneously harmful and helpful such as having to tolerate transphobic family members to receive needed material items for their baby. Where close friends and chosen family might have been expected to buffer harm or be unfailingly supportive, their own prejudices — including internalized homo and/or transphobia — also contributed to a mixed experience and prompted many participants to create distance within these relationships. This makes navigating relationships extremely challenging and demands a high level of coping within interpersonal relationships to maintain emotional safety and wellbeing.

In addition to high levels of partner and/or co-parent support and coping, we found high levels of community mutual aid and above-average levels of emotional, instrumental, and informational support. Yet, we also found elevated rates of anxiety, depression, and distress. This is contradictory to evidence that has shown that high levels of partner, emotional, and instrumental support and coping protect against prenatal depression and anxiety (Biaggi et al., 2016; Cheng et al., 2016; Werchan et al., 2021), and that community activism promotes psychological wellbeing in the face of minority stress (Szymanski et al., 2021). Hatzenbuehler and colleagues (2013) postulate that stigmatized individuals who are subjected to chronic minority stress require emotional regulation and resources which are depleted over time, diminishing the ability to cope and negatively impacting mental health. Thus, the intensity and frequency of interpersonal stressors reported across childbearing may have diminished participants' ability to cope using their internal assets. This suggests more effort and attention is needed to understand and reduce stigma surrounding SGD childbearing if psychological distress is to be reduced.

In contrast to what is known about heterosexual and cisgender perinatal individuals, our participants' self-reported distress was distinctly higher in the 3rd trimester (Ibrahim & Lobel, 2020). Rates of self-reported clinical anxiety and depression among our participants were also higher at every time point relative to heterosexual and cisgender perinatal individuals in the US (Gaynes et al., 2005.; Woody et al., 2017; Dennis et al., 2017; Fawcett et al., 2019) — even when accounting for COVID-19 (Werchan et al., 2021). This is also true for sexual-diverse, cisgender women (Flanders et al., 2016; Goldberg & Smith, 2008; Ross et al., 2012; Yager et al., 2010). See Appendix P for comparison tables. Similarly, prior qualitative literature demonstrates that depression, anxiety, and isolation are also common among SGD childbearing people (Besse et al., 2020; Dahl et al., 2013; Gregg, 2018; MacLean, 2021).

There is a growing body of evidence demonstrating greater mental health disparities exist among TGD compared to sexual-diverse individuals (Su et al., 2016). Although qualitatively, experiences of childbearing were largely more similar than different between cisgender and TGD participants, quantitative assessments were markedly different: TGD participants had lower rates of social support and higher rates of anxiety, depression, and distress. Because prior studies of TGD perinatal individuals have not measured mental health using validated anxiety and depression assessments, we do not know if our findings are similar or different. It is worth noting, however, that a higher percentage of our TGD participants reported a history of mental health conditions (at least before the 2nd trimester) which may explain these differences. Conversely, adverse birth outcomes (i.e., preterm birth and low birthweight births) were more common among cisgender than TGD participants, but our sample is too small to make meaningful conclusions about these differences.

COVID-19 may have confounded our mental health findings. There have been substantially elevated rates of self-reported anxiety, depression, and loneliness reported during COVID-19 among perinatal people globally compared to non-perinatal populations (Basu et al., 2021; Kotlar et al., 2020; Werchan et al., 2021). There is also data showing that during the pandemic SGD populations had an increased risk of depression compared to heterosexual and cisgender populations (Veldhuis et al., 2021). However, participants reported myriad ways that the insulation and isolation of COVID-19 protected them from experiencing heightened levels of harm, hostility, and heterocisnormativity, and consequently may have reduced mental distress.

COVID-19 also decreased the number of social interactions participants anticipated would have triggered gender dysphoria, a common experience among TGD perinatal people (Charlton et al., 2021; Charter et al., 2018; Fischer, 2021; MacDonald et al., 2016). However, it is also worth highlighting that cisgender participants reported being gendered in uncomfortable ways and reported experiencing distressing gendered body changes. This demonstrates that even those that identify as cisgender can be constrained and harmed by the prevailing gender norms and expectations of childbearing as a feminine experience — something that has only been described vaguely in one prior study (Malmquist et al., 2021). Taken together, these data suggest that reducing heterocisnormativity and stigma surrounding childbearing could possibly reduce distress among a more diverse group of childbearing individuals than previously considered.

3.4.1 Limitations

Although our participants were a diverse SGD childbearing sample most were highly educated, in monogamous partnerships, and residing in liberal-leaning cities, even when living in conservative states. Solo parents were underrepresented, and first-time parents were overrepresented so these experiences may not fully reflect families with one parent or with

multiple children. In addition, 42.9% of participants identified as both nonbinary and transgender which prevented us from analyzing nonbinary and transgender identities separately. Those who elected to join and complete our study are likely different from those who did not. For example, the burden of study participation (three interviews and multiple photo-taking assignments and assessments), likely introduced self-selection bias. Additionally, many participants reflected that their motivation to participate was rooted in helping others in the SGD community. This may have additionally biased who chose to participate in the study and contributed to the risk of social desirability.

Another limitation was the potential risk of bias on part of the investigator. Although purposive sampling and reflexive practices were used to reduce this risk, it cannot be ruled out. All assessments were self-reported; we also did not collect baseline data prior to gestation or in the first trimester. Moreover, while the study was not designed to be interventional, participation may have been supportive and facilitated coping. As this study took place during the COVID-19 pandemic, unique facets of support and mental health experiences may have come up during this study that would not have otherwise.

Lastly, more missing data from photo prompts occurred in the postnatal period and participants reported that pandemic restrictions limited where photos could be taken. Our analysis of each prompts' completion rate identified that the two most abstract prompts (Appendix K, prompts #6 and #12) had much lower completion rates compared to other prompts, suggesting that conceptual prompts may be less successful in virtual photovoice projects. Despite these limitations, our study used rigorous and multiple methods which produced rich and novel data, allowing us to better understand the breadth and complexity of SGD childbearing experiences.

3.4.2 Implications

There are several research, practice, and policy implications of our findings. First, as it relates to research, we found that partner support, emotional support, and active coping — assets known to be protective in heterosexual and cisgender populations — may be insufficient to overcome stigma and minority stress. Consequently, we suggest that future interventions focus on reducing stigma — a fundamental cause of health inequities (Hatzenbuehler et al., 2013) — and increasing capacity among supports to enable helpful and needed support. Research should continue to explore the types and sources of helpful social support and harmful influences that drain coping capacity among SGD childbearing individuals to understand how this may have functioned differently during non-pandemic times. This may include developing new tools to more accurately measure the unique support needs and networks that encompass SGD individuals. As doula support was so widely utilized and provided all three types of support, this may be a particularly promising mechanism to target. Some SGD community doulas have offered classes that focus on other support people, such as teaching friends how to support perinatal people. This could be extended to family members as well and is an extremely promising way to increase helpful resources and capacities among intrapersonal supports. Community-based knowledge, healing, and mutual support have been suggested as important missing factors in interventions that target individual coping assets (Foster et al., 2021). Thus, education focused on support villages would be an important way to build capacity within communities and promote resilience. Furthermore, examining mental health outcomes in large population datasets during non-pandemic times, and across longer periods of time, is also needed as evidence suggests depression symptoms can increase across the first 12-months postpartum

(Rosander et al., 2021) and linger up to three years postpartum (Jacques et al., 2020; Putnick et al., 2020).

Regarding clinical practice, as more SGD people are forming families and increasingly choosing biological family formation pathways, there is a growing population in need of culturally tailored perinatal care models. Group prenatal care is a model of care that generally has a provider, such as a midwife, share perinatal-related information in a group setting which allows for expanded visit times and access to peer-to-peer social support (McCue et al., 2018). Community-based group care models have been used to reduce stress and promote wellbeing among other stigmatized communities, particularly those historically (and currently) experiencing mistreatment in healthcare settings (National Academies of Sciences, Engineering, and Medicine, 2020a; Vedam et al., 2019). Accessible group care would meet several gaps participants described: bringing spiritual and emotional components into care paradigms, being in a community with more people of shared lived experiences, having a small, intimate, in-person group to create a safe space for being vulnerable and having a group who can follow one another's childbearing journey.

Lastly, in terms of policy implications, diversifying the healthcare workforce is an important aspect of promoting better quality care to underserved populations (Council on Graduate Medical Education, 2016). This extends to promoting diversity among healthcare providers and birth workers alike, including doulas (Hardeman & Kozhimannil, 2016). If doulas could be granted community health worker status, then a reimbursement pathway that supports access to marginalized doulas and birth workers would become available (Ogunwole et al., 2020). To that end, several states have used Medicaid coverage for doula care as a key strategy to improve perinatal health equity (Safon et al., 2021). Moreover, as corporate trainings fall short

of culturally appropriate curricula, SGD community doulas and organizations have been key stakeholders in training the greater community of doulas and other birth professionals (Paynter et al., 2022) through the inclusion of topics specific to marginalized populations such as advocacy and structural discrimination (van Eijk et al., 2022). Culturally competent community-based birth workers — including individuals such as perinatal chiropractors or massage therapists — were sought by our participants, but rarely found. Thus, a greater community of birth workers need to receive training as well. Directing resources that allow community leaders to provide affordable training could allow greater access for more doulas and birth workers to become culturally competent, increasing access to this type of care.

3.4.3 Conclusion

We found high levels of stigma and harm during childbearing, as well as evidence of robust social support networks and coping tactics. Social support and coping may not be sufficient to overcome the mental health impact of stigma and harm SGD people experience during this time. Taken together, these data show this population has unique needs — some that have been discussed in prior research and some that we have been the first to document. Longitudinal, mixed-method approaches can extend this work to further explicate the obstetrical and birth outcomes of this population, identifying their unique health and support needs that could be targeted for enhancement using tailored interventions tested in future trials.

Chapter 4: "You're Preparing for People to Assess Whether You Can Have Your Own Child": Structural Failures to Support Sexual and Gender-Diverse Childbearing Parents

Target journal: *Sexuality Research and Social Policy*

Abstract

Background

Sexual and gender-diverse (SGD) individuals are a growing childbearing population that experience numerous health disparities due to stigma and discrimination. Emerging evidence demonstrates structural stigma is associated with specific adverse reproductive and birth outcomes; however, relatively little is known about the influence of structural stigma among SGD childbearing individuals. Thus, the aim of this study sought to examine multidimensional facilitators and barriers in accessing structural support among communities, organizations, and policies during the childbearing journey of SGD individuals.

Methods

The social-ecological model of health promotion, a qualitative descriptive methodology, and community-placed methods guided The Study of Queer and Trans Perinatal Resilience and Experiences of Gestation. This was a prospective and mixed-methods cohort study that took place from the 2nd trimester of gestation through three months postpartum. It consisted of three interviews, three assessments, two surveys, and twelve photovoice prompts. Data were collected between July 2020 and November 2021 and were analyzed using a directed and deductive content analysis.

Results

Twenty-four SGD childbearing individuals from across the US and that embody a breadth of lived experiences participated in the study. Three main themes emerged: (1) *When*

Protections Fail to Protect, (2) *The Burden Is on Our Shoulders*, and (3) *When Privilege Is Protection*. We identified gaps in and barriers to accessing structural support along the perinatal journey which took a heavy toll on SGD individuals' financial and mental resources.

Conclusion

Findings demonstrate pervasive structural stigma and discrimination against SGD people during an already vulnerable time. Legislation and policies are needed to protect SGD people's rights related to childbearing with particular attention to equal access and non-discriminatory implementation.

4.1 Background

Sexual and gender-diverse (SGD) people are a growing childbearing population. SGD people include individuals who have diverse sexual identities (i.e., identity, orientation, or practices differ from the majority), gender identities (i.e., assigned gender at birth differs from current gender identity), or both. Among the ~18 million SGD people in the United States (US; Jones, 2022), estimates suggest approximately 31% of self-identified lesbian women, 59% of bisexual women (Goldberg et al., 2014), and 10% of transgender men (Moseson et al., 2020a) have given birth.

SGD individuals have benefited from wider social acceptance and advances in legal protections over the last decade that has contributed to a growing population (~8.7 million) of SGD parents with genetically related children (Goldberg et al., 2014; James et al., 2016). For example, Obergefell v. Hodges (2015) extended marriage equality to same-sex couples in 2015, Pavan v. Smith (2017) allowed both members of a same-sex couple to be listed as the parent on a child's birth certificate in 2017, and the 2020 court opinion Bostock v. Clayton County (2020) provided protection against employment discrimination based on sexual orientation or gender identity. However, SGD families remain at-risk of discrimination, stigma, and inequitable legal rights.

For example, some states do not allow second-parent adoptions which is the recommended process for non-genetic parents to secure their parental rights (National Center for Lesbian Rights, 2019). If Obergefell v. Hodges (2015) were to be overturned, SGD parents living in states that only allow stepparent adoptions would be more vulnerable to losing their parental rights because these adoptions are contingent upon marriage, domestic partnerships, or civil unions. Additionally, some states restrict non-genetic parents' rights (Movement Advancement

Project, 2021b) by requiring that families be formed through expensive and medicalized pathways and be limited to married partners, such as Kansas which dictates that assisted insemination be provided by a licensed physician to a married childbearing person to access parental rights (Luetkemeyer & West, 2015). Subsequently, lack of a legal relationship with a child has numerous consequences for SGD parents such as not being eligible for parental leave after the birth of a child (Movement Advancement Project, 2021a), not being able to add their child to insurance policies or make emergency medical decisions for their child, among others (D'Ginto, 2018).

Beyond restricted access to legal rights, SGD people generally face stigma and discrimination in their everyday lives (i.e., sexual and gender minority stress; Brooks, 1981; Hendricks & Testa, 2012; Meyer, 2003), which is known to negatively impact their health outcomes (Hatzenbuehler, 2009; Hughto et al., 2015). Stigma and discrimination may similarly contribute to an increased risk for adverse perinatal outcomes as emerging evidence points to perinatal-specific disparities in their mental health (Charter et al., 2018; Ross et al., 2012) and birth outcomes (Everett et al., 2019; Moseson et al., 2020a). Stigma is pervasive and operates at every level of the social-ecological environment (Hatzenbuehler, 2016; Hughto et al., 2015; Link & Phelan, 2001). Thus, a social-ecological approach (Bronfenbrenner, 1979; McLeroy et al., 1988) guided this study to contextualize how SGD perinatal social support, and consequently health and well-being, is shaped by the complex, reciprocal, and interacting layers of stigma and discrimination at each level of one's environment. This approach has been advocated to understand the etiology of risk and resilience, as well as interventions that support the well-being of SGD people (National Academies of Sciences, Engineering, and Medicine, 2020b; Sexual and Gender Minority Research Office, 2021).

This paper focuses on upper levels of this framework: 1) organizational factors, which are social institutions such as employer-paid parental leave policies or access to competent healthcare professionals, 2) community factors which are local social groups and norms, as well as the broader SGD community such as SGD perinatal support groups and classes, and 3) public policy which includes laws, policies, and guidelines such as state laws around a second or stepparent adoption. Stigma and discriminatory experiences have been thoroughly described in the healthcare context among SGD childbearing people (Besse et al., 2020; Dahl et al., 2013; Gregg, 2018), but relatively little is known about these experiences in other contexts. Thus, for the scope of this manuscript, we focused on experiences outside of healthcare.

These levels comprise structural factors where structural stigma and discrimination may exist. Structural stigma and discrimination refer to societal-level norms and conditions, as well as institutional policies and practices that constrain the opportunities, resources, and well-being of, or result in unintended consequences for, marginalized individuals (Hatzenbuehler et al., 2010; Link & Phelan, 2001). Structural stigma has been associated with health inequities, including mood disorders among SGD people (Hatzenbuehler, 2016; Hatzenbuehler et al., 2010; Hughto et al., 2015), in addition to reproductive health disparities among sexual-diverse adolescents (Charlton et al., 2019) and adverse birth outcomes including preterm birth and lower birthweight among sexual-diverse populations (Everett et al., 2022).

Social support is not only a well-established modifiable risk factor to buffer against minority stress (Brooks, 1981; Hendricks & Testa, 2012; Meyer, 2003) caused by stigma, but it is also a protective factor for heterosexual and cisgender populations against the risk of low birthweight infants (East et al., 2019; Hetherington et al., 2015; Wang et al., 2013), preterm birth (East et al., 2019; Hetherington et al., 2015; Surkan et al., 2019; Wang et al., 2013), and perinatal

depression (Alhusen & Alvarez, 2016; East et al., 2019; Kim et al., 2014; Wang et al., 2018). Thus, the aim of this study was to examine facilitators and barriers in accessing structural support at the community, organizational, and policy levels of the social-ecological model (SEM) to understand how structural factors inform SGD childbearing experiences.

4.2 Methods

This paper presents a directed and deductive content analysis of structural support among SGD childbearing parents. This was part of The Study of Queer and Trans Perinatal Resilience and Experiences of Gestation (PREG), a community-placed research study consisting of semi-structured interviews, quantitative assessments, surveys, and a modified, virtual photovoice method that was completed from the 2nd trimester through the 4th trimester (i.e., the first three months postpartum). In-depth details about this study's methods have previously been described in Chapter Three.

A qualitative descriptive methodology and community-placed methods guided the study. Qualitative descriptive is particularly useful when describing a phenomenon that is not well understood (Sandelowski, 2000). Community-placed research, a method along the community-based participatory research continuum, is used to engage the community under study in the research process (Spears Johnson et al., 2016). This approach informed the development of a community advisory board and use of a modified, virtual photovoice method.

4.2.1 Sample and Sampling Strategy

English-speaking SGD adults in the US who were 18 years of age or older and between 21– and 28–weeks' gestation with a child they intended to parent were invited to take an eligibility survey. Recruitment occurred via social media, professional and community networks, and other listservs or websites relevant to the study participants. Purposive sampling was then

employed to select survey respondents who represented a breadth of experiences (e.g., variation of racial and gender identities, states of residence, number and gender of co-parents, first– or second–time parent). Only 9.7% of those who responded to the survey were invited to participate in the study (see Figure 3.2).

4.2.2 Data Collection

Semi-structured interview guides were pilot tested prior to the study and iterated upon throughout the study (Appendix H for interview guides). Interviews were scheduled in each of the three trimesters of study and took place over a HIPAA- compliant Zoom videoconferencing platform. Interviews were audio-recorded and transcribed verbatim using Rev.com professional transcription services then cleaned and de-identified. Twelve photo prompts (including one practice prompt) were sent biweekly from the first through third interview. Photos from the first six photo prompts were discussed in the 2nd interview (3rd trimester) and photos from the second six photo prompts were discussed in the 3rd interview (4th trimester). Interview questions and photo prompts were developed to represent support assets (i.e., promotive factors) and needs (i.e., adversities) from every level of the SEM. A demographic survey was collected at baseline and a birth and infant outcomes survey before the final interview. Data collection occurred from July 2020 through November 2021. Data adequacy was measured through the creation of a saturation table (Saunders et al., 2018).

4.2.3 Data Analysis

Transcriptions and photos were analyzed using directed and deductive content analysis (Hsieh & Shannon, 2005). KS immersed herself in the data through conducting interviews, cleaning, and coding every transcript. A second-team member (MD) independently coded 15 transcripts and met frequently with KS to agree on names and application of codes which formed

a structured codebook (Appendix Q for codebook; MacQueen et al., 1998). KS coded the remaining transcripts in meaning units and compared codes in an iterative process across transcripts to identify similar and contrasting experiences. Manifest codes (e.g., describing what is on the surface or staying closer to the text) for support constructs (i.e., resources and support that were present and/or absent to promote perinatal resilience) were applied to the interview data representing the organizational, community, and public policy levels of the SEM. Then categories were developed, and crosscutting themes identified in a team process (KS, MD, WB, and MG). Findings were audited (MG) to confirm the results could be corroborated by the data. Atlas.ti (Version 9.1.2) was used to manage interview and photo data.

4.2.4 Rigor and Reflexivity

Guba's (1981) strategies to promote trustworthiness of qualitative research were employed to reduce researcher bias. This included an iterative member checking process throughout data collection and analysis (e.g., data was presented to the advisory board and a subsample of participants; feedback was integrated into these presentations of final findings) and triangulation of perspectives (interdisciplinary research team), methods (interviews, photos, and assessments), time (three trimesters), and location (across the US, rural and urban environments). Team coding, an audit trail documenting study processes and decisions, and a reflexive journal were used to enhance confirmability of findings.

4.2.5 Ethics

Approval for this study was provided by the Institutional Review Board of Columbia University Irving Medical Center (protocol AAAS7829). Participants were compensated with electronic gift cards after the enrollment visit ($15) and after each interview using a graduated incentive structure ($25 for the 1st interview, $50 for the 2nd, and $75 for the 3rd) for a total

potential compensation of $165. Those who participated in post-analysis member checks received an additional $50.

4.3 Results

4.3.1 Participant Characteristics

Twenty-four SGD childbearing individuals participated in 64 interviews (range 70–175 minutes; M=115 minutes) and submitted 262 photos across the course of the study. The majority of participants identified as queer (54%), transgender or gender-diverse (58%), a race other than White (58%), and had a mean age of 32.5 years. Participants were highly educated (67% college graduates or higher) but had a range of household incomes: a third (29%) had household incomes less than twice the federal poverty level (i.e., $25,760–$43,920 depending on household size for 2021) and a quarter (25%) had Medicaid insurance. While the majority lived in urban areas, nearly a third lived in smaller towns or rural areas and they represented every region of the continental US and Hawaii. The majority were married (70%); regardless of marital status, many additional partners (24 total romantic partners) and co-parents (31 romantic and non-romantic co-parents) were involved in raising the baby, of whom less than half (41%) were a genetic parent of the baby. A third of the sample conceived using sexual intercourse (29%), a third intrauterine insemination (38%), and a third in vitro insemination (33%). Additional characteristics of the sample can be found in Tables 3.2 and 3.3.

4.3.2 Themes

Three crosscutting themes (and nine subthemes) were identified: (1) *When Protections Fail to Protect,* (2) *The Burden Is on Our Shoulders,* and (3) *When Privilege Is Protection.* To maintain confidentiality of a vulnerable childbearing population, participant quotes have been ascribed a single gender identity, sexual identity, racial identity, and were categorized by their

place of residence as a high, medium, low, or negative equality state (Movement Advancement Project, 2021c). A saturation table (Appendix R for saturation table) was constructed chronologically based on the order transcripts were coded. It signaled that adequate breadth of experiences was captured at the code level after the 9th participant, then the following 15 participants allowed us to saturate the depth of experiences.

Theme 1. When Protections Fail to Protect

In this theme, SGD childbearing people described harm experienced, increased anxiety, and barriers to accessing support during the perinatal period, despite increased legal protections at a federal level. These experiences were caused by national-level social and political events, employment policies (or lack thereof), individual state laws, insurance policies, and other individuals who worked in these settings. This theme highlights the ways that anti-discrimination laws, as well as laws with inclusive language, still failed to protect these families. It is composed of four subthemes.

Subtheme 1.1: "Things Still Feel Scary — Even Though I Live in a Really Liberal Bubble": Legal Rights Can't Shelter From a Hostile Social Climate

Participants discussed how the 2020 presidential election and the January 6th, 2021, attack on the US Capitol highlighted hatred and hostility in a new, public way. These events heightened fear and anxiety about being an SGD person, particularly a childbearing SGD person who was bringing new life into this "*dumpster fire around us*":

> *I think of the significance of being two women and bringing this new life into the world right around the [presidential] election felt very pivotal… Our family is different and could be really impacted if the election had gone a different way. It was just interesting at that time to reflect on that — us having a family is something that's different and we can't take it for granted, even though a lot of the time we do, and we are lucky that we can take it for granted. But we might not necessarily be in that position always… I think the election was a reminder of, even though we live in this bubble there are these*

national forces at play and there are people who would see us as being wrong in terms of our family structure and something that should be avoided or changed. (White, cisgender lesbian, high-equality state)

Figure 4.1

Queer Family Formation: We Can't Take It for Granted

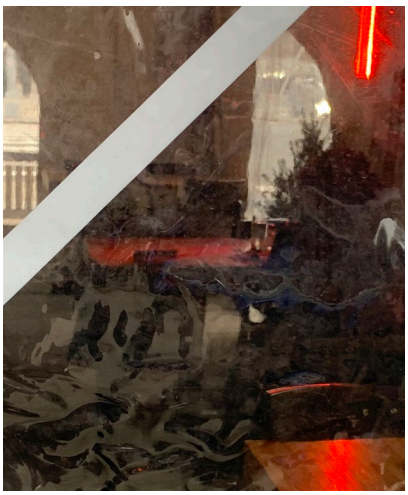
Note. The participant and her wife are sitting next to one another holding hands with 'I voted' stickers. One is holding their sleeping newborn and the other is wearing a shirt that says 'Queer and Here.' This photo represents the significance and impact of the presidential election and the hostile social climate surrounding the election during the time they were forming their family.

The appointment of Supreme Court Justice Amy Coney Barrett was also a frequently identified fear as it signaled an increased vulnerability of SGD rights. The consequence was that some SGD parents took immediate action to secure legal protection of their child:

I actually wasn't planning on doing second-parent adoption this time around [for our second child], because there's a new law being passed…. And then all of a sudden, in September, everyone [on a queer parents' listserv is] talking about second-parent adoption again. I looked into it more and everyone started doing it because of the Supreme Court shift… We have the adoption record [of our first child] as an email that's with a star on our phone, just in case we ever — we haven't gone anywhere where that could really happen. But just there's always this fear in the back of your mind… The picture is not so pretty. It's dark in there. It feels a little creepy. And I feel that's the experience of, "I don't really know what's going to happen." (White, lesbian, cisgender woman, high-equality state)

Figure 4.2

Never Safe: There's Always This Fear in the Back of Your Mind



Note. The inside of an outdoor dining 'bubble' which were popularized in cities during the COVID-19 pandemic. It's dark, but you can make out a table and chairs and a Christmas tree in the back. This photo represents how uncertain and fearful this participant is about what the future holds for their family given the Supreme court appointment of Amy Coney Barrett.

Events in response to the increased calls for racial justice, including the increased presence and visibility of white supremacy, further triggered anxiety and exhaustion, particularly among Black participants, as well as trauma:

> *The trauma that I endured during pregnancy because what happened last summer with [my neighborhood protest] was basically a civil war… I had to shut it down, my restaurant, we had shut down one night early because the tear gas got all the way down to my restaurant where I work. I had to serve both sides because I was at my job. I couldn't make a choice. I just had to politely serve everyone, but the thing was you could tell who the white supremacists were. It was traumatic having served food to people who wished I died. (Multiracial, pansexual, trans and nonbinary person, high-equality state)*

The social and political events occurring during the study fueled the already hostile social climate. The impact and fear of experiencing these events did not dissipate even after the election. Many participants seriously questioned whether they should move out of the country for the safety of their families:

> *I feel very relieved that my baby is not going to be born into a Trump presidency and I obviously don't know what that means moving forward, but it does feel like there's a little bit of pressure that has been released since the election. And then, I mean, at the same time, things still feel scary — even*

though I live in a really liberal bubble. I think the white supremacists, terrorists, super spreader events, the coup — that's scary to think about the possibility of more of that happening and what else could happen… It did lead us to have a conversation around whether or not we should have dual citizenship for [another country] and whether or not we should try to move there or elsewhere. (White, queer, trans and nonbinary person, high-equality state)

Subtheme 1.2: "Normally [Your Insurance] Covers This, But Your Particular Company Carves This Out": Toxic Workplaces Undermine Legislation

While workplaces were sites of support to SGD parents, they were also barriers to accessing support. For example, several participants struggled to obtain clear answers to insurance coverage questions and to access paid parental leave to which they are entitled through the Family and Medical Leave Act (FMLA). These struggles were often rooted in heterocisnormative assumptions where human resource personnel couldn't figure out how to accommodate SGD families, such as this participant's wife encountered:

The whole issue is that they wanted her [my wife] to have my doctor complete a form of medical necessity for FMLA… My wife kept telling them "It's a routine pregnancy, but I'm trying to take it off under the family portion of the FMLA. The bonding portion, not for medical reasons, but for baby bonding." What I think the issue was is that, because it was basically a game of telephone where they would forward this thing to this person. The HR [human resources] person saw the request for maternity leave and didn't read the details that she wasn't the birth mother because, for pregnancy that counts as a medical condition, they qualify you… She's having to fight for her right to use that FMLA sick leave instead of PTO [paid time off] to take that time. It's clear in the federal guidelines, but the state guidelines haven't been updated since 2003 so the wording isn't as clear… There were all these people that she was calling, and it was a constant daily thing that she was like, it may not be discrimination. It may just be incompetence. But to her, it really felt like discrimination. The clerk just ended up telling her, "Why don't you just, use your PTO instead of your sick leave, and then you can take it as vacation?" She's like, "No, that's not the point. I should be entitled to take my sick leave under this federal act that I keep forwarding and no one seems to be reading." It did get worked out, but it was probably about three months of back and forth, her fighting for what the federal guideline clearly outlined as being necessary. (Asian, lesbian, woman, medium-equality state)

Figure 4.3

Incompetence or Discrimination?

Note. A crinkled form to certify a serious medical condition in order to access paid leave. This photo represents the discrimination the participant's wife still faced when trying to access FMLA due to their HR insisting they get this irrelevant form signed.

Additionally, workplace culture influenced how and when participants were able to access accommodations across the family formation process. This included two participants, both trans men, planning to leave their jobs once their belly was visible to avoid workplace discrimination (the coronavirus [COVID-19] pandemic helped avoid that outcome). Work culture most starkly manifested as a company forbidding assisted fertility treatment despite their insurance company covering this service:

> *When the company [I work at] first started, it was essentially [a number of] Catholic hospitals. Part of the sales process was that none of the hospitals could ever perform abortions or give out birth control or support infertility treatment. So that has lived on and so I actually had [this insurance type], which is one of the better infertility slash fertility help — insurance companies or insurance plans in the country. But my company has a specific carve-out for infertility. So, although they normally cover it, they don't for us. I didn't find that out until we got deep in the process… I was literally on the table ready to get [my in vitro fertilization [IVF] transfer] and she came in and she was like, "I'm so sorry. I just realized that you have a subset of [this insurance], normally [this insurance] covers this, but your particular company carves this out, so you can proceed with it, and it will cost you $10,000 whatever, or you can hold and try to get another insurance… It's been an insurance chess game throughout the process. (Multiracial, bisexual, cisgender woman, high equality state)*

Supervisors were seen as key stakeholders who could wield their power to grant or restrict access to support. Even within workplaces that had supportive or inclusive policies, some supervisors denied accommodations for those working long hours on their feet or stigmatized requests for parental leave. Two participants reported being fired, one saying:

> *[My supervisor] told me I couldn't take FMLA, I had to take short-term disability. And so, I had this thing in the back of my mind and my wife was like, "No, no, no. It'll be okay"… I had tried to work in the hospital [was on bed rest for preeclampsia], but then I had to have my C-section [which resulted in preterm birth]. So, I took the short-term disability. I had been working with short-term disability to extend it, because of my health issues, and the HR person called me to tell me that they had eliminated my position. They were laying me off… [So, I got another job, but] it's definitely a huge pay cut from what I was making full-time. There's another pay cut there, of having to pay for additional benefits out of my wife's paycheck [since I'm on my wife's insurance now] which is a stress that we had not budgeted or were really ready for. (Hispanic, lesbian, cisgender woman, low-equality state)*

Although childbearing-related discrimination is not inherently unique to SGD people, there are important implications when the historical legacy of discriminatory hiring and firing practices against the SGD community is considered.

Subtheme 1.3: "I Got Told by Several Clinics That They Did Not Help LGBT People": Gatekeepers of Family Formation

SGD people also experienced discrimination when accessing services from family formation through postpartum support. These gatekeepers excluded SGD people or enforced specific requirements that prevented access, as this participant recounted:

> *When we first decided we were gonna try [to conceive] outside the home, I started to call around to local clinics here and I got told by several clinics that they did not help LGBT people… Then [I] went to this clinic that was top-rated, LGBT friendly, and we had a horrible experience there. They were very judgmental to my wife… [Also at] the first clinic [my doctor] was like, "No, I will only do it at this time." He very much wanted to follow a procedure and*

> *he wanted me to do six natural tries without medication before moving anywhere else. And I was like, "Okay, but that's a lot of money" because our insurance doesn't cover it and it's out of pocket… We found a different clinic through a support group that we found online and we went there, but they were very, very clinical. I had issues with some of the nurses. So, then my wife went down to be like, "We just need to know what's going on." And that nurse was terrible, and they flat out lied to her… At that point, I was feeling pretty desolate. (Hispanic, lesbian, cisgender woman, low-equality state)*

State laws also influenced family formation. For example, some state laws require a licensed physician to perform the conception insemination to establish parental rights and terminate the donors' rights to the child. Consequently, some SGD individuals feel obligated to use formal, expensive, and medicalized pathways to family formation to protect their parental rights even when less invasive and more private pathways are desired. As this participant cited:

> *They were saying in the state of [state] it's illegal to do an IUI in your house. And I'm like, "What?" In my mind, I was thinking maybe for the next time… maybe we could try it at home and see what happens. But when I was told it's illegal, I'm like, "How can you tell me what to do with my body in my own house?" (Black, gay, cisgender woman, negative equality state)*

Insurance companies similarly restricted pathways to family formation by only covering pathways commonly pursued by heterosexual and cisgender couples, such as requiring a set number of intrauterine insemination attempts before allowing IVF. Even the definition to access an infertility diagnosis was written within heterocisnormative standards: the failure to achieve a gestational status after 12 months or more of regular unprotected sexual intercourse. This automatically denies SGD people access to assisted reproduction as this participant experienced:

> *My insurance actually told [my doctor's office] that I have to be completely infertile. My infertility has to be medically necessary. And [my doctor] straight out told us that the insurance company told her that it's not their problem, that my spouse can't provide sperm… I actually made an appeal to my health insurance — demanding — because we felt like they were being prejudiced against not us, but in general, same-sex [couples]. (Hispanic, lesbian, cisgender woman, high equality state)*

SGD people on government-funded insurance had the most difficulties accessing competent perinatal providers. This resulted in participants going to an in-network provider and experiencing harm, or not seeking care to avoid anticipated harm like this next participant chose:

> *This is what you get [with Medicaid] and there are no queer options. There's no variety or diversity in preference, so I've just been feeling a little stuck around that because I'm like, "What cis therapist is going to understand my life?"... People don't understand our family so it's like, "You expect me to sit here and open up to someone who doesn't get it?" I'm not going to because this is very individual to us and personal. (Multiracial, queer, nonbinary person, high equality state)*

Subtheme 1.4: "[My Wife] Could Take FMLA, but It Would Be 10 Weeks Unpaid": Those Who Need It, Can't Get It

In addition to workplaces undermining legal rights, sometimes there were gaps in the policies themselves. FMLA provides up to 12 weeks of unpaid leave in a given year, but stipulations around coverage left those who needed this support most the least able to access it. This included participants or co-parents who worked for private, small businesses, those who hadn't yet worked for 12 months for the same employer, and those who were self-employed. Co-parents often fell through the FMLA cracks, and this directly influenced the level of support that they were able to offer to the child birthing parent:

> *He had already worked the number of hours that you needed to get paid — three months paid time off after having the baby. I feel cheated out of that time because he wasn't hired [back by his job after we moved due to COVID] and able to take that paid time off. Instead, when [our baby] was freshly — a brand new baby, he was working. One of the weeks, he worked 65 hours trying to make up for all of the lost income from not working. And we're an hour outside of town. So, 65 hours plus commute time. Sometimes he didn't come home, and he would literally sleep in his car between shifts. (White, queer, trans and nonbinary person, high equality state)*

Additionally, since FMLA does not require paid leave and because the percentage of compensation varies widely by state and workplace policies, some could not afford to take unpaid parental leave:

> *I think [my wife] is planning on taking two weeks and then going back [to work]… She could take FMLA, but it would be 10 weeks unpaid or whatever… Finances have been so tricky the whole pregnancy because of COVID and me losing most of my jobs. [Her decision to not take unpaid FMLA is] definitely — a piece of it is financial. (White, queer, cisgender woman, high equality state)*

Theme 2. The Burden Is on Our Shoulders

In this theme, SGD childbearing people and their partners faced impossible choices and were burdened by having to advocate for their rights and support needs, as well as securing legal protections for their families, during the perinatal journey. The failure of systems to support these families placed the responsibility and burden on their shoulders. This theme is made up of three subthemes.

Subtheme 2.1: "Using Savings That You Would Use to Put a Down Payment on a House": Impossible Choices

Many participants faced the difficult choice of either being near their support system (e.g., family of origin, chosen family, and/or friends) which meant living in a state with more discriminatory policies and conservative values, or living in a progressive state without an in-person support system. This participant talked about how painfully alone they felt being so far away from their family, yet so grateful to live where they do:

> *Because [my previous state] does not have any protections in place. On a state level, I can be abused, denied medical services, all kinds of stuff because it's a Trumper state… Moving to [my current city] was very big. I have very different support here than I did — I would have if I was still in [my previous state]. Here I have really good insurance… and with that, almost all of my medical bills are covered [and I was able to get chest masculinization surgery*

when I moved here]. And I've had access to not only trans-inclusive care, but a transgender midwife. And he is amazing. (Multiracial, pansexual, trans and nonbinary, high equality state)

Participants who needed assistance to conceive needed money to create their families. Several participants saved for years prior to conceiving to afford the process. Another talked about friends who "sacrificed themselves" by having sex with men to get pregnant to circumvent costs associated with reproductive services they couldn't afford. Finances were sometimes wrapped up in the emotional toll of the conception processes. This included both the hormonal aspect of being off testosterone while trying to conceive, as well as the hormonal and emotional rollercoaster inherent in the process. One participant describes:

It's been using savings that you would use to put a down payment on a house or something like that. To have a baby in the state that I lived in, there is no coverage for same-sex couples. We've never had any coverage, even though we've always had access to health insurance, which is great. And we're really privileged that we have access at all. Nothing was covered. We're talking tens of thousands of dollars… We're lucky that we didn't get into a position where we had to stop, but it was coming. You could see it in the distance if this didn't work. And it was the finances plus the emotional component. How much can you put yourself through before you, your relationship suffers, for instance. (White, lesbian, cisgender woman, high equality state)

Subtheme 2.2: "Now I Will Spend My Emotional Energy Educating You on Why It's Important to Me": The Extra Weight We Carry

Participants commonly made choices throughout the perinatal period based on anticipating harm or discrimination. Often this anticipation resulted in not accessing support due to fear of the repercussions like this participant described:

I was trying to explain to [my mom] what it's like to be queer and a parent and going through this. I was like, "I accidentally hit [my baby's] head on a piece of furniture, I cried hysterically the whole day… This is all normal stuff that many people think about themselves when they're parenting. My mom's like, "If it makes you feel better, why don't you call the pediatrician?" And I'm like,

> *"Well, I'm afraid to because then they have to write it down. And if they write it down, and they have to give documents to the adoption [agency], and we have the wrong caseworker, what if they think — they could use [that against us]. Literally the s--t you're thinking of because you're preparing for people to assess whether you can have your own child. (Hispanic, queer, genderqueer person, low-equality state)*

This extra burden manifested as additional emotional energy, labor, and time away from their families, as well as added financial burdens to form their family, hire providers that were safe and competent, or secure legal documentation that recognized and protected their family. The weight of this burden was profound as illustrated by the despair in participants' experiences:

> *I have spent so many f--king hours on the phone trying to figure out health insurance for a home birth. We do a home birth mostly because we're queer and I'm trans. And I want to be validated, and not be called a mom and 'she'd' during labor. I want to have somebody who works with queer families. I want to have somebody who has experience and education, around working with our family or our family structure… I literally spent three hours on the phone, and I would call, and I would say, "I want to have a home birth. I want to know how it's going to be covered. Dah, dah, dah"… The guy on the phone is asking me, "Why do you even want to have a home birth? "Why is that important?" Now I will spend my emotional energy educating you on why it's important to me. And then — I'm so tired. I'm just so f--king tired. I feel like I deserve to have access to that healthcare. It's not like we're asking for something extreme. We have already paid several thousand dollars [for midwifery prenatal care]. We are financially strapped. I want to know that something is going to get refunded to us. Why is it so hard to get the birth that I deserve covered? [long pause] I can't f--king handle it [crying]… It's called bureaucratic or administrative burden—basically bureaucratic s--t that you have to go through to access public services that [they] intentionally make it hard for you so that you don't access them... They're intentionally using forms as a way to control who is accessing the service — making it harder for you so that they don't have to cover things or pay for things. That's exactly what our state health is doing. Why did I spend three hours on the phone? Because they're trying to make it difficult so that they don't have to cover something. And it works. (White, queer, trans and nonbinary person, high equality state)*

Figure 4.4

The Emotional Energy and Education Required to Birth Safely

Note. A calendar that says to call insurance at 9:00 am and is blocked off until 3 pm. This photo illustrates how much time, emotional energy, and educational labor was demanded from this participant when trying to access support and coverage from their insurance company.

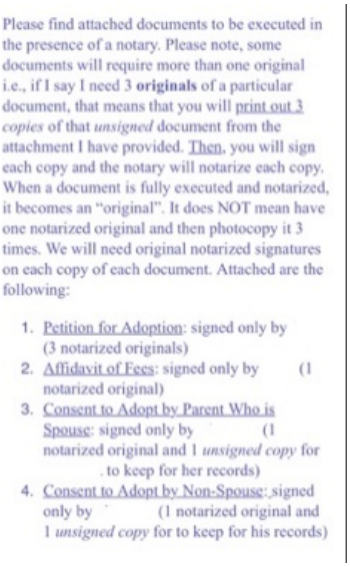
Subtheme 2.3: "If I Died, My Mom Would Have More of a Right to the Baby Than [My Wife] Would": Protecting Our Families

The appointment of Supreme Court Justice Amy Coney Barrett was seen as a threat to *Obergefell v. Hodges* which guarantees same-sex couples the right to marry. The desire to protect one's family was particularly heightened for those who lived in states, or visited family in states, that were most likely to ignore their parental rights if same-sex marriage was no longer recognized. As this participant describes:

> *We're even more on guard [now] around the adoption with the Supreme court nomination and our lawyers are too 'cause in [our state], there is no second-parent it's only stepparent adoption. If our marriage, for whatever reason is no longer recognized, [my partner] is f--ked essentially in terms of being able to have parental rights of our kid. So, all of that is just so heightened… A lawyer helped me draft guardianship stuff in case something happened to me, which, literally, as I'm bleeding out [from a life-threatening postpartum hemorrhage], one of the thoughts in my head was at least I have that document. (Hispanic, queer, genderqueer person, low-equality state)*

Figure 4.5

Documents That Protect



Please find attached documents to be executed in the presence of a notary. Please note, some documents will require more than one original i.e., if I say I need 3 **originals** of a particular document, that means that you will print out 3 *copies* of that *unsigned* document from the attachment I have provided. Then, you will sign each copy and the notary will notarize each copy. When a document is fully executed and notarized, it becomes an "original". It does NOT mean have one notarized original and then photocopy it 3 times. We will need original notarized signatures on each copy of each document. Attached are the following:

1. Petition for Adoption: signed only by (3 notarized originals)
2. Affidavit of Fees: signed only by (1 notarized original)
3. Consent to Adopt by Parent Who is Spouse: signed only by (1 notarized original and 1 *unsigned copy* for to keep for her records)
4. Consent to Adopt by Non-Spouse: signed only by (1 notarized original and 1 *unsigned copy* for to keep for his records)

Note. An email sent from a lawyer to the participant that explains the long list of items they need to complete for their partner to adopt their child. This photo represents the level of importance and meaning this document has to this participant to protect their family.

Legal guardianship also had immediate practical implications for this participant too:

> *We were thinking when the baby is born, [my partner] could get health insurance through the marketplace and add the baby. Well, he can't do that, because he's not the parent [yet]… instead, we had to get [our baby] their own health insurance plan. (Hispanic, queer, genderqueer person, low-equality state)*

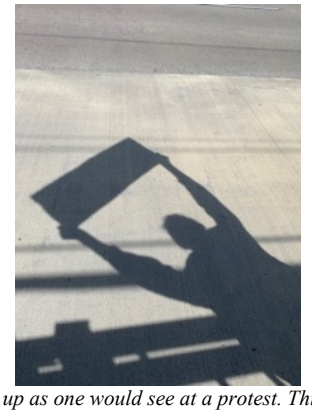
Many participants described the process to secure second-parent or stepparent adoption — depending on their state of residence — as an invasive and demeaning *"set of hoops to jump through."* This included paying thousands of dollars for the adoption, undergoing background checks and home visits from a social worker, disclosing personal information such as how much money they make and their education level, and putting their baby's name on a father registry. This next participant explained:

> *We'll have to put our baby's name on the father registry where for a month they sit on this registry that any man could come forward and claim them. You have to do this for 30 days. They sit on this public, father registry online. And if any man comes and claims them and says, "That's my baby." Then that opens up a whole can of worms. Even though our baby was conceived using an*

unknown donor, it does not matter. They have to do it… It makes us feel horrible… it feels so unnecessary and demeaning… [The meeting with the lawyer to discuss second-parent adoption] was heavy. We were really frustrated about the expense that goes into that process and the fact that we have to do it at all. And taking space to grieve that a little bit" (White, queer, cisgender woman, high equality state)

Figure 4.6

Demeaning Requirements to Parent Our Child



Note. A shadow of the participant holding a sign up as one would see at a protest. This photo was taken right after they had met with a lawyer to discuss second-parent adoption and represents how the participant is simultaneously advocating to change their state law while also pursuing the process for second-parent adoption to protect their family. The shadow represents the grief and demeaning nature of the process they must endure to access that protection.

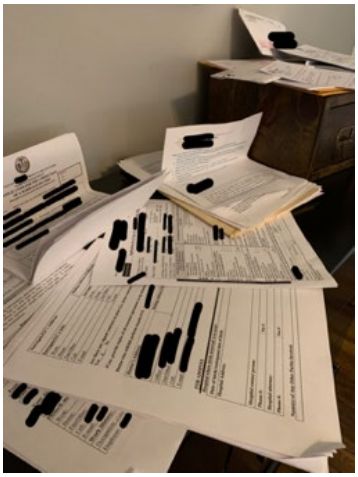
Sometimes engaging in this process required additional hoops to jump through which made the entire process that much more expensive, exhausting, and harmful:

Among the many things that the lawyers have said for [my partner] to get an order, they were like, "Do you have a passport? Because he needs multiple forms of ID. And his passport had his old name on it. And they were like, "Yeah, you might want to update that"… We had to amend our marriage certificate to have [my partner's] new legal name on it. It was recommended by our adoption attorney to do that. So that [my partner's] name was consistent across all documents and that it wouldn't trigger a judge who's transphobic. I applied for an amendment to our marriage certificate. We were rejected twice. The first time we were rejected… what pissed me off was the rejection letter was mailed to [my partner's] dead name [i.e., referring to a person by their birth name when that name has been changed as part of gender transition]. And I was like, "so y'all trying to get somebody killed. Cool. Don't do that."… Then we were rejected again for the same reason. And they mailed us the letter with the dead name again. I ended up being like, "This is f–ked up. Y'all can't do this. This puts people at risk"… I don't think you understand

how exhausting this s–t is, how frustrating it is, how I was — this is time and money and energy… [and] my colleagues don't have to f–king navigate s–t like this when they're pregnant, right? They're not having to amend their marriage license or worry about their partner having parental rights of their kids. (Hispanic, queer, genderqueer person, low-equality state)

Figure 4.7

The Rejection and Risk in Securing Parental Rights



Note. Several different documents are spread out across a table. This photo represents the layers of documents, fees, and emotional labor required to secure protection for this family and how each layer represents a potential opportunity for harm.

Theme 3. When Privilege is Protection

Those who formed families closest to heteronormative standards (i.e., two parents in a legal union), who had higher incomes and class status and were employed in places that supported family formation and paid parental leave were able to navigate the family building process easiest. They were protected and sometimes shielded from discriminatory policies and people by these privileges. This theme is composed of two subthemes.

Subtheme 3.1: "They Privilege What They Perceive to Be a Monogamous Couple": Privileging the Institution of Marriage

Our participants who were in monogamous marriages (n = 16) found that these served as facilitators to accessing structural-level support. Several participants who were married discussed

how it would have been harder for their partner to access leave if they weren't married and other ways that their marriage facilitated legal protection. One participant said:

> *Because [my partner] and I are legally married, he's able to be the second parent on a birth certificate in [our state], which I know is a state-to-state thing. So that was a nice — had a positive impact on that immediate postpartum moment... That policy just made, especially in those moments where any kind of extra paperwork feels so stressful, it was really nice to just get her birth certificate in the mail, have his name on it, et cetera… [It] was a positive feeling, but more in the sense of, "It should be this way." And it's nice that it doesn't have to be more difficult. (White, queer, trans person, high equality state)*

Participants in polyamorous relationships (n = 2), not legally recognized partnerships (*n* = 3), and had non-romantic co-parents (*n* = 5) found these family types to be a barrier to accessing structural-level support. One participant's partner couldn't access health insurance for their baby — despite being the genetic parent of the child — because the partner was married to another person. Some participants considered becoming a domestic partner to access benefits like parental leave. However, as one participant noted, *"culturally, not everyone in the LGBT community is onboard with marriage."* This decision to become married was a major compromise for some families like this participant discusses:

> *There was a question about whether we would have to become domestic partners for some work benefit or FMLA. I don't think that we will, but I think that could be a compromise that we might have to make. I don't know. It's not for her, but it would be for the state or for some legal recognitions. That would be one way we would not have structured our relationship but might with a child because of what we want to do to protect our family. (White, queer, trans person, high equality state)*

Importantly, the progressiveness or heterocentric climate and laws in each state facilitated or created additional barriers for participants in polyamorous relationships or who had non-romantic co-parents. This next participant recalls:

We live in a state where there is no second-parent adoption, there's only stepparent adoption. We live in a time where the Supreme court nominee is a f–king piece of s–t. Where talking about overruling marriage is now cute. You know what I mean? It's all that anxiety and the way that lawyers operate of "better safe than sorry, blah, blah, blah, blah, blah." We literally are having a different attorney other than the attorney, that's doing the adoption, do our guardianship and will… [because the first attorney] was like, "Don't put that [our donor co-parent] and [our donor co-parent's partner] will get guardianship because then if they find that out, they will not want to do the adoption [for my spouse], blah, blah, blah"… 'cause that's the world that we live in — someone has to relinquish rights in order for another person to have rights because we live in a culture that's monogamously oriented and within the confines of the institution of marriage… People privilege romantic relationships. They privilege what they perceive to be a monogamous couple. They privilege people that only have one partner. Especially when you have a baby… And it feels s–tty 'cause it's like this isn't just our kid. This kid is also going to have [our donor co-parent] and [our donor co-parent's partner] and this kid also is going to be raised in community with people. (Hispanic, queer, genderqueer person, low-equality state)

Subtheme 3.2: "You Get to Clear All of These Hurdles… Because of Money": The Shield of Class Status

Regardless of socioeconomic status, nearly every participant discussed being privileged. However, those with greater financial means, higher-class status, or access to families of origin with greater financial means were shielded from discriminatory and non-inclusive policies by paying for access to their support needs. This not only facilitated access to the formation and protection of their families but also allowed them to circumvent the emotional burden of having to advocate and fight for equal access to structural support. This next participant describes:

These trees started budding in [early Spring] a month before I was due when the weather started changing. By the time I gave birth in [late Spring] the leaves and flowers were in full bloom. When I gave birth, we had the structural support we needed — just like these trees — because of my middle-class status, because my wife is in a union, because I am self-employed and on her insurance we have the family leave support, healthcare, and structural support… It really comes down to money and class status. I feel it gives so much access to — I mean, there's still the queer discrimination in our healthcare... there are systemic really frustrating, and individual-to-individual

really frustrated discriminatory things that happen. My class status lets me get through them much easier… you get to clear all of these hurdles and work around them and be okay and it's only because of money. [Interviewer asked for an example] Every insurance [says] you need to try with your hetero person for six months or a year, and then you got to try IUI and only when that fails, you can do IVF. That's how we'll cover it for you… We paid out of pocket for [reciprocal IVF], and we were able to do that. (Asian, queer, cisgender woman, high equality state)

Figure 4.8

The Privilege of Paying to Access Structural Support

Note. Left photo: Trees that are mostly barren, with little buds just starting to bloom.
Right photo: Trees that are in full bloom with leaves and flowers. These two photos represent the structural support that was secured by the time of the birth that was afforded due to the class status and money both participant and their wife had which protected them from discriminatory policies.

However, there were several instances when employer support for family formation and for paid parental leave buffered those with lower socioeconomic status. Conversely, some without structural support from employers ended up being more vulnerable, despite having a higher socioeconomic status. For example, this participant had one of the higher household incomes in the study, yet both she and her wife did not have jobs that provided access to paid parental leave. The financial stress from pandemic cuts combined with unpaid leave resulted in this participant only taking two weeks off after birthing their baby before starting to work again:

Both [my wife and I] — none of us are being paid out in any capacity if we're not working. So, if we're not working and then there's no income... [My wife] made significantly less in 2020 than the years before. It's not like we can't pay

> *our bills, but we've had to rein things in and make some different choices and maybe pull from our savings, which is doable. We're fine, we're not worried about shelter, the basic needs, and stuff, but then I have felt much more pressure to be working. (White, lesbian, cisgender woman, high equality state)*

In contrast, work benefits — either insurance or other programs — supported the ability of those with lower socioeconomic status to form their family:

> *My job has really good benefits. They do. So, my job actually pays for IVF… The reimbursement program pays you a lifetime of $20,000. It covers surrogacy, adoption, and IVF… You may have the money to have a kid, but when they're expecting you to give $25,000 upfront, no one's thinking about that. No, one's expecting to have to give $25,000. It's like when you go to buy a car, are you going to give $25,000 right off the bat for a car? No. And then they don't do payment plans. (White, lesbian, cisgender woman, high equality state)*

Lastly, a White racial identity served as another shield of protection. This was both acknowledged by White participants and experienced by participants of color:

> *I have access to a certain amount of middle-class respectability and I'm a college-educated person — I have a bachelor's degree. Those are not going to protect me. Those are not going to be shielded for me. And to me — in an institutional setting — there's nothing more protective than a White guy who is assumed to be your backup… [My boyfriend's] this middle-aged, respectable, very White-collar guy… and he has no problems talking to [people with authority] and making demands. And people respond to it — I've seen it. (Black, bisexual, trans and nonbinary, high equality state)*

4.4 Discussion

To our knowledge, this is the first study to comprehensively examine facilitators and barriers to accessing structural support that SGD childbearing individuals experience at the policy, organizational, and community levels. Analysis of our qualitative data identified three essential themes: (1) *When Protections Fail to Protect,* (2) *The Burden Is on Our Shoulders,* and (3) *When Privilege Is Protection.* We found despite wider social acceptance, visibility, and

advances in legal rights, access to structural supports were not assured for all SGD parents. Compared to heterosexual and cisgender individuals, these failures placed undo financial responsibility and emotional burden on participants' shoulders. Moreover, administrative hurdles were particularly difficult barriers to navigate unless individuals had the knowledge, time, safety, and emotional bandwidth to advocate for themselves. Conversely, a higher income or access to wealth and employer benefits, a legally recognized marriage, and a White racial identity were protective. Taken together these data make important, novel contributions to what is known about SGD childbearing experiences, and have implications for structural change in communities, organizations, and public policies.

Community-level influences on perinatal experiences among the SGD community are poorly understood. Prior qualitative work confirms the exclusion of SGD parents from perinatal resources and services (Abelsohn et al., 2013; Ellis et al., 2014; Fischer, 2021; Hennekam & Ladge, 2017; Hoffkling et al., 2017; Rippey & Falconi, 2017). We add important new understandings of the difficult decisions that many SGD individuals face. For example, when SGD parents had to choose between living geographically close to their family support systems in states with a poor record on SGD rights (Movement Advancement Project, 2021c), or in progressive states distant from family, it affected their perception of community-level support and their risk for targeted discrimination. This was particularly salient because at the time that we collected our data, our participants felt that federal SGD protections were in peril.

Prior research on perinatal SGD individuals has largely focused on the organizational level, specifically healthcare. By focusing on places of employment, insurance policies, and perinatal services, we identified additional organizational-level barriers and hostilities. These included a lack of training, knowledge, and policies around services for SGD families that

resulted in additional costs, less access, and increased administrative burden on SGD parents. This is unfortunate as the perinatal period is a challenging and stressful time for any childbearing individual without additional structural burdens that have tangible health consequences (Herd & Moynihan, 2020). Moreover, LGBT-supportive policies and workplace climates are known to improve health outcomes, job satisfaction, and productivity among LGBT employees (Badgett et al., 2013), and are important to validate new lesbian parents' identities (Hennekam & Ladge, 2017).

Little has been written about the impact of policymaking on SGD perinatal experiences and even less attention has been paid to the impact of intersectional identities on access to legal protections among SGD parents. For example, a racial minority SGD individual who is co-parenting with non-romantic partners face multiple complex threats to their identity and parental rights. Therefore, the emotional and financial stress participants experienced in accessing parental leave, accurate birth certificates, second-parent adoption, and affirming perinatal services was critically important new knowledge we documented, building on the prior work of others (Kazyak & Finken, 2020; McKelvey, 2014; Rogers, 2020; Zhang et al., 2022). Given that SGD families are more likely to live in poverty compared to heterosexual and cisgender families (Badgett et al., 2019; Wilson et al., 2021), the ability to advocate within these systems, or to access the financial resources needed to circumvent heterocisnormative and exclusionary policies, became all the more important to minimize distress and perceptions of being discriminated against.

Unfortunately, many of our participants reported that the financial strain of becoming pregnant, the costs associated with accessing services that were safe and affirming, and securing legal protections depleted their financial reserves, increased their financial stress, leaving them

without the ability to take unpaid or extended parental leave. Partners and co-parents faced challenges accessing leave based on their legal relationship with the childbearing parent and child which decreased their ability to provide support. The historical restriction of marriage and different values around marriage within the SGD community, a desire for non-dyadic relationship structures and for more than two people to parent a child, and increased equality in the distribution of caretaking labor in SGD families are critically important cultural factors to consider in inclusive parental leave policies, important documents such as birth certificates, and social services at the organizational, state, and federal levels.

Conversely, we also found SGD parents and their partners and/or co-parents who worked high-paying, salaried jobs had easier access to parental leave, including having more access to accrued paid leave (e.g., personal days, sick leave, and vacation time) which was often used to extend or substitute for unpaid parental leave. Although this is consistent with national trends (Bipartisan Policy Center, 2020; US Department of Labor, 2012), it has important health implications as parental leave has been associated with important outcomes such as increased birth weight and decreased likelihood of premature birth (Rossin, 2011). Infants of SGD parents are disproportionally at risk for low birth rate and prematurity and emerging evidence has documented these inequitable outcomes (Everett et al., 2019; Everett et al., 2022).

Taken together, our findings demonstrate that SGD childbearing individuals face unique structural challenges related to their marginalized identity at the community, organization, and policy levels. However, it is also necessary to recognize the complex relationships and interactions *between* levels in the SEM. Thus — similar to intersectionality theory — challenges encountered at each level should not be considered additive, but rather multiplicative in their impact. This framing is critical to comprehend and appreciate the profound mental health impact

on perinatal depression, distress, and anxiety. Future research should examine the correlations between structural stigma and perinatal health outcomes to understand SGD childbearing experiences from a multi-level perspective.

Notably, the COVID-19 pandemic was ongoing during our study and undoubtedly impacted access to structural support. Most relevant to this manuscript included increased flexibility within workplaces due to work-from-home policies, decreased social stigma due to less in-person interaction, decreased barriers to access social services (e.g., documents could be requested and filed remotely vs traveling to offices), and increased financial support from government stimulus checks. Thus, it may be that COVID provided more structural support and buffered against structural stigma in ways that would have been even more pronounced had it not been a global pandemic.

4.4.1 Limitations

This study is not without limitations. Individuals who participated are likely more motivated than those who did not and may not reflect the SGD population more broadly. There is a risk of a Hawthorne effect if participants changed their behaviors during the course of the study, knowing their experiences would be included in the study. While the study team employed different methods to reduce researcher bias, the risk of selection bias may still have been operative in our purposive sampling and data analysis. Disclosure may have differed between participants, with those whose marginalized identities differed from the interviewer being less likely to risk full disclosure. Despite these limitations, this study identified important gaps in structural support among SGD individuals across the childbearing period that had not been previously reported. These gaps may serve as important targets for future research.

4.4.2 Implications

Although protections exist, our SGD childbearing parents still had to navigate barriers; some experienced harm in attempting to overcome these obstacles. Thus, there is a need for increased national-level protection during the perinatal period. Two pieces of legislation currently (as of Spring 2022) in Congress that could help protect SGD families are the Equality Act (2021) and The Build Back Better Act (2021). The Equality Act would prohibit discrimination based on sex, gender identity, and sexual orientation. The Build Back Better Act (2021) would allow birth and non-birth parents to access paid family and medical leave, remove the requirement of a specific length of employment to access leave, and benefit workers with the lowest incomes through a progressive wage structure. The importance of this legislation cannot be overstated in reducing inequalities in access to parental leave and potentially birth outcomes.

Policymakers must also carefully consider how laws and policies are implemented to minimize administrative hurdles that SGD people face. This will likely require implementation training to ensure people with the authority to grant or deny access to structural support do not unintentionally become gatekeepers to services. In addition, there must be greater access to publicly fund assisted reproductive technology treatments, as is the norm in the majority of European countries (Calhaz-Jorge et al., 2020). Although many still exclude same-sex couples, these European standards provide public funding for treatments, serving as a model for increased equity in access to family formation in the US. Moreover, administrative data collection policies such as birth registration policies need to be more inclusive of SGD families. We advocate for recommendations proposed by Zhang and colleagues (2022) to both collect population health data and issue birth certificates more accurately. This includes collecting the following characteristics of parents: sex assigned at birth, gender identity, parental role, birthing role, and

genetic contribution. Lastly, second-parent adoption should be available in every state to provide a pathway to legal parenthood regardless of marriage and the number of parents.

At an organizational level, increased structural support and transparency around parental policies is also critical. The Skimm's #ShowUsYourLeave campaign has been an important movement to encourage private businesses to publicly share their parental leave policies. This greater transparency has the potential to normalize extended parental leave, include co-parents in parental leave policies, and support for other perinatal outcomes, like miscarriage.

Lastly, our results identified critical areas for future investigation. This includes research to enhance our understanding of structural stigma and the association between structural stigma and perinatal health outcomes. As support is an important modifiable risk factor for perinatal mood and anxiety disorders, interventions that target structural support such as employer benefits may also be a promising direction for future research. Future work should also examine how geographic location, racial identity, administrative literacy (i.e., the capacity to obtain, process, and understand basic information in order to receive public services), and socioeconomic status impact SGD family formation.

4.4.3 Conclusion

Access to structural supports were not guaranteed for all SGD parents and those with access still had to navigate administrative hurdles that required a burdensome financial and emotional tax. Our results provide compelling evidence of pervasive structural stigma and discrimination against SGD people across the perinatal period, a time of increased risk. Legislation that protects SGD childbearing people's rights, considers the potential harm and gatekeepers of policy implementation, and is inclusive of all types of relationships and family formations is critical in reducing perinatal health disparities among SGD childbearing people.

Chapter 5: Epilogue

This dissertation, guided by the Social-Ecological Model (SEM) of Health Promotion and resilience theory, explored perinatal experiences among SGD childbearing individuals to 1) evaluate and synthesize the qualitative literature on SGD childbearing experiences, 2) describe assets of and gaps in social support at the inter-and intrapersonal levels of the SEM among SGD childbearing parents, and 3) characterize multidimensional structural support at the community, organizational, and policy levels of the SEM among SGD gestational parents across the perinatal period. Together, these three studies provide novel insights on social support, risk, and resilience during the childbearing journey among a minoritized perinatal population. This final chapter synthesizes the findings from this dissertation then presents the strengths and limitations of the studies. It concludes by providing further implications for future research, clinical practice, and policy.

5.1 Summary of Results

5.1.1 Chapter Two

The first manuscript, *Childbearing at the Margins: A Systematic Metasynthesis Review of SGD Childbearing Experiences,* evaluated and synthesized the qualitative literature on SGD childbearing experiences to understand perinatal experiences at every level of the socio-ecological environment. This review comprehensively explored existing knowledge on this topic using Sandelowski and Barroso's (2006) metasynthesis method supplemented with Noblit and Hare's (1988) approach to analysis.

Among the 25 included studies, three key themes emerged from the review: 1) ubiquitous and inescapable experiences of systemic erasure, exclusion, and discrimination are experienced across the childbearing journey among SGD individuals, particularly within healthcare

environments; 2) key differences in perinatal experiences created unique challenges among SGD parents relative to heterosexual and cisgender parents, which, in combination with systemic invisibility, contributed to profound psychological distress; and 3) coping techniques and resilience strategies supported the management of increased stigma and heterocisnormativity during childbearing.

This review also identified several limitations and gaps in the prior research: poor qualitative rigor, only cross-sectional or retrospective study designs, non-generalizable samples (e.g., White, wealthy, educated), and a limited understanding of perinatal social support. The original research study conducted in Chapters Three and Four was designed to fill these specific research gaps.

5.1.2 Chapter Three

The second manuscript, "*Through Our Resiliency We… Find Joy": A Community-Placed Qualitative Study of Social Support Among Sexual and Gender-Diverse Childbearing People,* presented findings from The Study of Queer and Trans Perinatal Resilience and Experiences of Gestation (PREG). This study identified interpersonal social support and needs, as well as coping skills used by SGD individuals during childbearing to navigate this vulnerable time in their lives. Data was collected by interviewing twenty-four SGD childbearing adults in the US during the 2nd and 3rd trimester of childbearing and the 4th trimester postpartum (data regarding postpartum support was excluded from this chapter due to the volume of data collected). Participants additionally completed three quantitative assessments, a demographic survey, a birth and infant outcomes survey, and twelve photovoice prompts.

Four main themes (and thirteen subthemes) emerged from the data. The first theme, *Entering a New Season of Life,* identified how differences in identity fostered or inhibited

support, the importance of receiving emotional support during this time, and described how childbearing was a time of reconciliation and healing among families of origin. The second theme, *Community is Family,* described attributes of support that felt most supportive and the "village of support" that was essential in meeting perinatal support needs. The third theme, *The Pain We Bear,* highlighted the painful costs of childbearing — hostility, stigma, harms incurred, sacrifices made, and their negative psychological sequelae. *Obligatory Resilience* was the final theme that described how resilience was a burdensome requirement of gestating as an SGD person. This theme highlighted the energy and effort needed to access inclusive supports and the vulnerability in asking for help. It also described novel coping strategies to survive the childbearing experience as well as the joy and purpose that forming a family provided. Quantitative findings found high rates of self-reported social support, cesarean section and hemorrhage, distress, and clinical cases of depression and anxiety relative to national averages.

As this is among the first studies to ever examine multidimensional resilience across the perinatal period in a diverse sample of SGD childbearing people, the findings make an important contribution to the literature. Most significantly, the results describe how sources of support could be both harmful and helpful and how reconciliation with families of origin required effort and coping. It also identified the importance of safe spaces and people with shared lived experiences while navigating the childbearing journey.

5.1.3 Chapter Four

The third study, *"You're Preparing for People to Assess Whether You Can Have Your Own Child": Structural Failures to Support Sexual and Gender-Diverse Childbearing Parents,* explored structural factors (i.e., community, organizational, and policy levels of the SEM) that impacted SGD childbearing experiences across the perinatal period. Three main themes (and

nine subthemes) emerged from the data. The first theme, *When Protections Fail to Protect,* uncovered how a hostile social climate and toxic workplace undermined advances in legal protections for SGD individuals. Key gatekeepers of SGD family formation were also identified and how existing legislation leaves those who need protection unable to access it. The second theme, *The Burden Is on Our Shoulders,* discussed the impossible choices that SGD individuals face when trying to form a family, the extra emotional labor and time required to advocate for their rights, and how accessing legal protection is both a process of protecting one's family and one that opens oneself up to harm. The last theme, *When Privilege is Protection,* examined ways that the institution of marriage privileges rights and benefits to those who form relationships through marriage. It also illuminated how class status, access to wealth, and workplace benefits are key facilitators to accessing structural support and, to some extent, minimized discrimination and stigma.

Although inequitable access to parental rights, parental leave, accurate birth certificates, and challenges to family formation has been documented previously (Kazyak & Finken, 2020; National Center for Lesbian Rights, 2019; Zhang et al., 2022), we uncovered key findings and gaps in prior work. Namely, certain privileges (i.e., monogamous, romantic, and legalized co-parenting relationships, class status, access to wealth, and employer benefits) fostered access to legal protections. In contrast, those without these privileges had to educate themselves, advocate for themselves and their families, and pay out-of-pocket for access to legal protections. Together, these added burdens came at a cost to individuals' mental health.

5.2 Key Findings Across the Studies

Our findings indicate that SGD individuals' experiences of childbearing stress are consistent with the Minority Stress Model in that experiences of prejudice, stigma,

discrimination, and lack of culturally competent perinatal support contributed to reduced resilience (e.g., poor mental health outcomes). However, our data diverges from the model that posits that coping and social support buffer against adverse health outcomes. Instead, we found evidence that coping and social support is present for SGD childbearing individuals. Thus, these factors may be insufficient buffers against adverse mental health outcomes during the perinatal period. A socio-ecological perspective allowed us to further identify the systemic stigma and discrimination that permeates every level of SGD people's childbearing experience, creating an undue burden on the individual. Constantly needing to rely on internal assets to cope with minority stress and concomitantly cope with typical perinatal challenges left participants physically and mentally exhausted. Those with multiple marginalized identities — particularly regarding class and race — experienced even higher burdens and barriers.

Another common finding across our studies was that SGD individuals have similar support and assets (e.g., partner support, emotional support, and coping) as heterosexual and cisgender samples. However, coping demands often exceeded what support networks could meet, resulting in high levels of self-reported depression, anxiety, and distress. These findings support Ross and colleagues (2007) work, which hypothesized that stigma plays a more significant role than social support in adverse mental health outcomes among sexual-diverse women. Further, these findings are consistent with emerging evidence that suggests structural discrimination and stigma are associated with an increased risk of adverse birth outcomes (Everett et al., 2022) and other reproductive health disparities (Charlton et al., 2019) among sexual-diverse women. It may also be possible that the added levels of minority stressors experienced during childbearing moderate the relationship between social support and adverse outcomes and, consequently, reduces SGD individuals' ability to access support from those

relationships. These findings suggest that structural-level support and systematic change must target the root cause of inequities to minimize health disparities.

5.3 Reflections on Methods

Community-placed research methods — including intentional relationship-building with community leaders, engaging community members on the research team, employing community artists in the study's branding, and oversight by an advisory board — were likely key factors in successfully recruiting a diverse sample of SGD childbearing individuals. The advisory board provided critically important feedback on early materials and strategies to reach various audiences, supported purposive sampling decisions, and assisted with the analysis and synthesis of findings. This may have contributed, in part, to the large number of participants who mentioned how important the study was to them during their perinatal experience. This is reflected in our low attrition rate (12.5%) and signals the likelihood of future success in prospective or time-intensive studies as this population is highly motivated, eager to tell their story, and values having their experiences witnessed.

Moreover, the process of engaging in a modified, virtual photovoice method was crucial for participants to critically reflect on their experiences in different and, for many, more profound ways than was possible in individual interviews. The challenge of processing their perinatal experience and contemplating ways to metaphorically represent those experiences forced new ways to interpret and explain their support systems and needs. However, engagement in this method (i.e., participants submitting photos) was lower than anticipated, with nearly half of the photo prompts not completed during the postpartum period. Prompt hints and a practice photo prompt were added during the study to increase engagement without appreciable improvements in the completion of photo assignments. Future studies might consider a longer

training than we did (~1-hour) and additional opportunities for practice exercises. However, it should be noted that our participants largely attributed photovoice challenges to their restricted environments during COVID-19. In addition, the two policy-related prompts had the lowest completion rate, suggesting that representing distal experiences metaphorically was a significant challenge relative to proximal experiences in the participants' lives.

5.4 Limitations and Strengths of the Three Studies

There are several limitations to this dissertation. Most qualitative studies within the metasynthesis failed to demonstrate qualitative rigor and represented retrospective or cross-sectional, perinatal experiences of relatively homogenous and privileged White, educated samples from high-income, Westernized countries. These shortcomings limit our ability to generalize these findings to other SGD childbearing individuals and reduce the overall trustworthiness of the results. The dissertation work (Chapters Three and Four) achieved diversity among racial/ethnic identities, class, and geographic location, although most of our participants were still highly educated urban residents. The majority were also monogamously partnered and first-time parents.

Additional limitations related to the study design include the absence of baseline assessments before the second trimester and data collection points after the first three months postpartum. This may have been an insufficient window to understand perinatal social support and mental health and limited our ability to understand how SGD individuals plan in the early stages of childbearing and how their support networks and mental health fluctuate across the postpartum period. Additionally, quantitative assessments were self-reported; however, perceived social support, perinatal depression, and anxiety commonly are self-reported. These quantitative results should be interpreted cautiously due to the small sample size.

The study's intensive time commitment for participants and the photovoice aspect may have biased those who chose to participate. Many participants were motivated to participate based on a desire to support other childbearing individuals in the SGD community. This could have influenced the interviews by skewing the discussion to reflect more positively on SGD individuals and SGD-specific support. The interviewer's positionality likely also influenced differences in who enrolled in the study and disclosure among those who shared similar or dissimilar lived experiences. Specifically, it is possible that those with different lived experiences may not have felt safe enough to share their experiences with someone who did not share that same reality — especially in the context of historical distrust between academia and marginalized communities.

Lastly, this study took place during COVID-19. Consequently, access to in-person support and resources such as community classes and the ability to form new friendships were limited by pandemic-related restrictions. Thus, external supports, tangible support offered in-person, and new perinatal supports may exist at higher levels during non-pandemic times. Conversely, the pandemic may have protected participants from even higher levels of harm and stigmatizing interactions — and subsequent negative mental states — by allowing individuals to remain apart from the broader society and facilitating the use of virtual services.

Despite these limitations, this dissertation has several strengths. All our studies used rigorous methods. We identified new knowledge around risk and resilience at multiple levels of the social-ecological environment across the perinatal period, which is a critical step towards understanding factors to target in interventions that aim to promote the health and wellbeing of SGD childbearing individuals. Our study represents the most diverse group of SGD childbearing individuals studied to date, and our community-placed methods successfully recruited and

retained this population. Another strength of our study is that it used mixed methods, including qualitative interviews, surveys/assessments, and photos, to better understand the breadth and complexity of childbearing experiences. Consequently, this study produced rich data that filled gaps in the current understanding of SGD childbearing and identified specific stress-producing events during the perinatal period that can be targeted in future intervention work with the expressed aim of promoting health and wellbeing among SGD childbearing individuals.

5.5 Implications

5.5.1 Implications for Clinical Practice

Healthcare workers play a significant role in patient satisfaction and health outcomes. Recommendations for mental health screening range from at least once during the perinatal period (Committee on Obstetric Practice, 2018) to multiple times during pregnancy and again in postpartum (Kendig et al., 2017). Our findings support recommendations for frequent screening, from early implantation through postpartum, when coupled with culturally competent referrals. We recommend a trauma-informed and person-centered care approach to increase respectful and affirming care interactions and reduce mental distress (Hall et al., 2021; Rubashkin et al., 2018; Park et al., 2018). The role of shared decision-making, an aspect of patient-centered care, applied to this population may also flatten hierarchical power structures within the healthcare encounter, which may be particularly helpful for those with multiple marginalized identities (Chin et al., 2016; Ng, 2016). Healthcare curricula and professional societies' practice guidelines should mandate these approaches, especially in the context of reducing health disparities (McNicholas et al., 2021). Structural changes to healthcare models should also be considered, such as community-based group care led by and for SGD people. These care models have been applied among other marginalized communities during the perinatal period to reduce stress and promote

healthy outcomes (National Academies of Science, Engineering, and Medicine, 2020a; Vedam et al., 2019).

5.5.2 Implications for Policy

Laws and policies need to be inclusive and accessible to *all* SGD childbearing people, irrespective of social-economic status, marital status, or any other differences that privilege some SGD subcommunities over others. Laws and policies created without considering an intersectional, human rights-based approach will fail to protect against discrimination and fail to address perinatal health inequalities among SGD parents, an approach recommended by the United Nations Sustainable Development Group (2021) and perinatal experts (Crear-Perry et al., 2020.; Foster et al., 2021; Scott et al., 2019). For example, policies should provide universal paid parental leave for anyone parenting a child to ensure equal treatment of co-parents and partners.

Additionally, our findings highlighted that SGD childbearing in countries with progressive social policies did not protect against homophobia and transphobia during the childbearing period. For example, SGD individuals living in the Netherlands, one of the most progressive countries in the world, still experienced social exclusion and discrimination in workplaces (Hennekam & Ladge, 2017). Policymakers should also be mindful of barriers (e.g., organizations or stakeholders that undermine access to legal rights and anti-discrimination protections) and unintended health impacts of policies by evaluating the implementation of policies to ensure access to rights and health equity (Emmons & Chambers, 2021). For example, implementing a Learning Health Policy System could allow for continuous evaluation of policy implementation to track and improve how policies shape social and structural determinants of health (Oh et al., 2021), including how administrative burdens may influence health outcomes (Herd & Moynihan, 2020).

Furthermore, third-party reimbursement (i.e., Medicaid) for doula care may be an important step in increasing access to doula care and consequently improving perinatal health outcomes among minoritized communities (Kozhimannil & Hardeman, 2016). As our participants often cited limited or no access to birth workers who were culturally competent or safe, it will be important to increase reimbursement rates and remove scope of practice requirements (i.e., organizational certification) that can reinforce structural discrimination and create barriers to realizing a diverse doula workforce (Bakal & McLemore, 2021; van Eijk et al., 2022). Investment should be made in community-based organizations that have tailored educational content and birth worker training specifically to the needs of minoritized communities (van Eijk et al., 2022). We additionally recommend building partnerships with community doulas and birth workers who have become leaders and experts in supporting this perinatal population in lieu of gaps in structural support and evidence-based research.

Importantly, many of the calls to action outlined throughout this dissertation would not just benefit SGD childbearing people but would benefit other marginalized and stigmatized populations during one of the most vulnerable times in their life. For example, The Build Back Better Act (2021) would provide paid parental leave irrespective of current Family and Medical Leave Act (1993) restrictions which would benefit many working-class parents irrespective of identity.

5.5.3 Implications for Research

This work should be replicated with a larger sample, including a comparison group of heterosexual and cisgender childbearing individuals during non-pandemic times. Prospective assessments over longer time periods would be important as some evidence has shown depressive symptom trajectories increase across the first year postpartum period (Rosander et al.,

2021), lasting up to three years (Jacques et al., 2020; Putnick et al., 2020). Research should continue to evaluate birth and perinatal health outcomes among SGD individuals, including the influence of structural factors — both adversities and protective factors — on these outcomes. Additional research is also needed to study perinatal stress more comprehensively among this childbearing population. We would encourage future researchers to consider using more community-based methods and diverse representation on their study teams to engage more minoritized participants in perinatal research.

Interventions that may be most promising to explore are those that reduce external sources of systemic stigma (i.e., a root cause of minority stressors) and strengthen intrapersonal capacity or interpersonal support networks' capacity, preparedness, and competence. Studying the doulas' role in increasing capacity and support resources among SGD childbearing individuals and their support systems could be a promising future direction. Moreover, as doulas were identified as a critically important support person bridging emotional, informational, and tangible perinatal support needs, research studying the effects of doula care in this population should also be prioritized. As our study and others (Light et al., 2014; McManus et al., 2006) have reported a high prevalence of SGD people seeking care from non-OB/GYN providers (e.g., midwives, nurse practitioners), research should additionally explore qualities of care that contribute to trust and safety. Further research is also needed to identify the positive experiences within healthcare environments at both the interpersonal and organizational levels to establish comprehensive, evidence-based guidelines for improving perinatal care experiences.

Sexual and gender identity data must be collected in national databases and healthcare systems that contain sexual and reproductive health outcomes. This must be done in a culturally competent manner to understand what mental and physical health disparities may exist for this

childbearing population and their families. Best practices to accurately measure these key indicators of demographic diversity are readily available (National Academies of Sciences, 2022). As more sexual orientation and gender identity markers are included in nationally representative databases, conducting secondary analyses of representative population samples of SGD individuals will also become increasingly possible.

Lastly, there are limitations to the models we used. For example, the Minority Stress Model fails to account for multi-level adversities and the interaction between these adversities. Conversely, the SEM model doesn't explicitly consider adversities and promotive factors within each level. For these reasons, we propose a new working framework for future studies that may be useful in evaluating and understanding salient factors contributing to health outcomes during this particularly vulnerable time in this minoritized population. See Figure 5.1. and Table 5.1.

5.5.4 Conclusions

This dissertation explored experiences of childbearing, specifically assets and gaps in social support at the interpersonal, intrapersonal, organizational, community, and policy levels among SGD people. This dissertation has highlighted the overwhelming and persistent harm and stigma experienced during the perinatal period at every level of the socio-ecological environment. SGD individuals' robust social support networks and multifaceted coping skills may be insufficient buffers to mitigate these forces' adverse mental health effects. Consequently, structural-level stigma and discrimination at the interpersonal, organizational, community, and policy levels must be further explored and targeted for future interventions to address the mental health inequalities faced by SGD childbearing individuals.

Additional secondary analyses of our data are required to better understand the influence

Figure 5.1

A Social-Ecological Resilience Framework for Perinatal SGD Populations

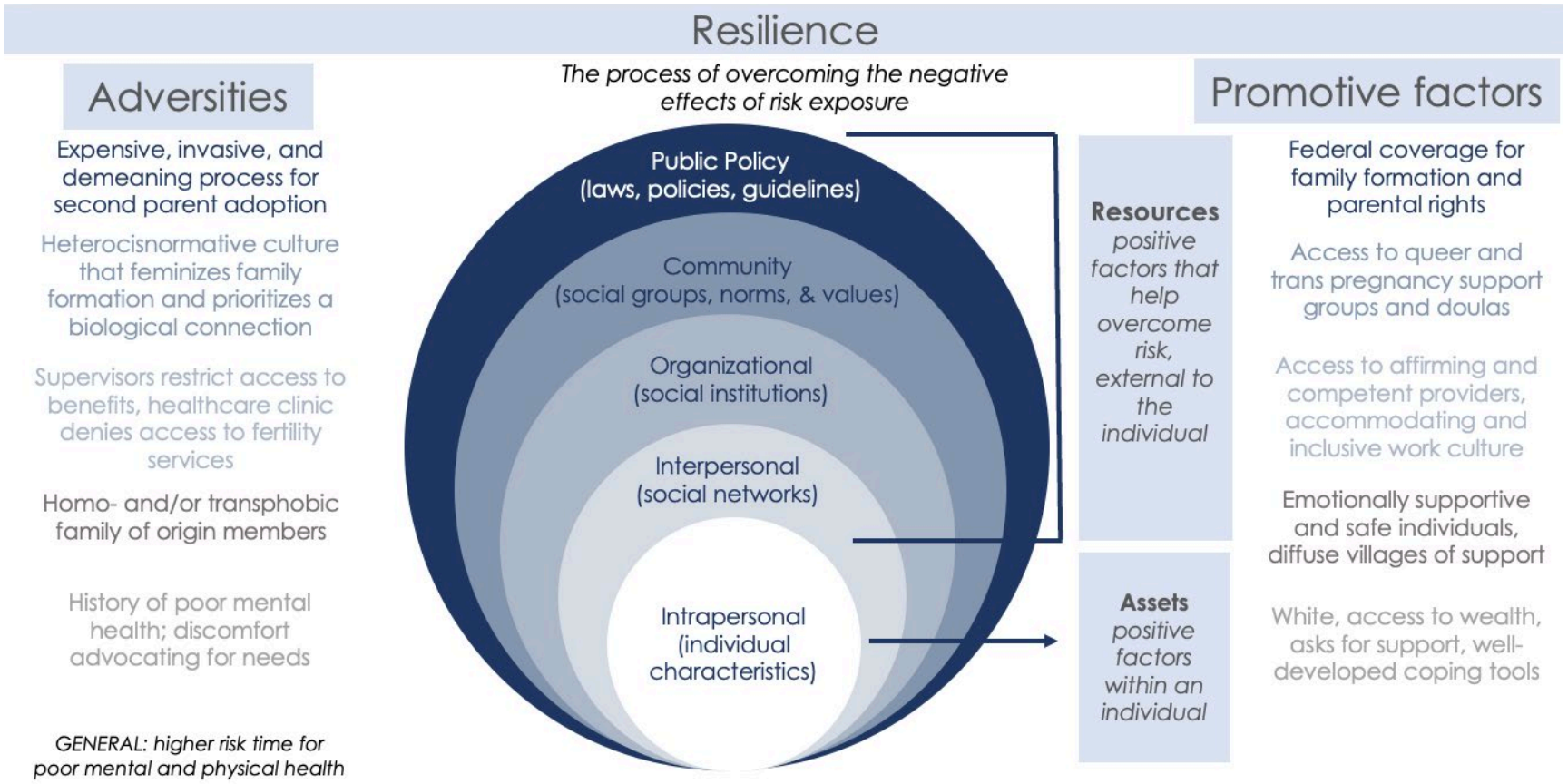


Table 5.1

Perinatal Adversities and Promotive Factors at each Level of the SEM

Adversities	Promotive factors
Public policy	

• Federal policies that
  ○ Restrict and promote unequal access to parental leave
  ○ Make parental leave for co-parents contingent upon marital status
  ○ Fail to support equal access to family formation
• State laws that
  ○ Make parental rights vulnerable (e.g., step vs second-parent adoption, specific pathways to family formation deny parental rights, steep costs to access legal services)
  ○ Make parental rights contingent upon marital status
  ○ Require invasive and demeaning actions to access second-parent adoptions (e.g., background checks, home visits, putting baby on a father's registry)
• Government-funded insurance that restricts access to culturally incompetent healthcare providers
	• State laws that
	  ○ Allow second-parent adoptions
	  ○ Establish paid parental leave for birth parents and co-parents
	  ○ Offer coverage for gender-affirming care
	• Jurisdiction laws that
	  ○ Allow all types of parents to be accurately represented on birth certificates
	  ○ Allow birth certificates to have 'X' gender markers

Community	

• Social climate that
  ○ Is discriminatory, hostile, and unaccepting of difference, particularly in one's place of residence (e.g., rural areas and low-equality states)
  ○ Has a presence or increased rate of hate crimes and hate groups speaking out
  ○ Threatens SGD rights by electing unsupportive government officials
• Communities that lack resources such as
  ○ Perinatal support groups, classes, books, and apps that are unsafe and center or comprise mainly of White, heterosexual, cisgender people, use gendered language and heteronormative mental models, stigmatize SGD parents
  ▪ Environments that lack privacy when accessing information, such as in-person classes
  ○ Birth workers, class instructors, and healthcare providers that identify as SGD or are SGD competent
• Heterocisnormative culture
  ○ Feminizes family formation and centers the nuclear family, which promotes dysphoria, erasure, invisibility, and delays parental identity development for both the childbearing and nonchildbearing parent(s)
  ○ Prioritizes the importance of genetically related families
  ○ Perpetuates historical narratives that SGD people shouldn't be parents
	• Social climate that
	  ○ Is progressive and inclusive, particularly in one's place of residence (e.g., liberal cities, high-equality states)
	  ○ Promotes SGD legal rights by electing supportive government officials
	• Communities that have resources such as
	  ○ Perinatal support groups and classes that are specifically for SGD individuals and (in order of importance) are 1) in-person, synchronous, and small; 2) online, synchronous, and small; 3) online, asynchronous, and large
	  ▪ Environments that facilitate privacy in accessing information such as asynchronous and/or online classes (if not SGD-specific), books, and apps
	  ○ Birth workers (e.g., doulas), class instructors, and healthcare providers that identify as SGD, otherwise that are SGD competent
	  ○ Mutual aid that promotes knowledge sharing, access to representation, and access to safe and competent birth workers and healthcare professionals (e.g., bartering, sliding scale, and reduced fees)

Organizational	

• Stakeholders with power restrict access to support services (e.g., insurance companies and healthcare restrict access to competent providers or access to assisted reproductive treatment, supervisors limit access to family leave or disability accommodations)
• Workplace
  ○ Culture is hostile or discriminatory against SGD employees
  ○ Restricts healthcare benefits until an employee has worked a certain amount of days
• Insurance companies
  ○ Regulate family formation through coverage stipulations
	• Employers and/or insurance companies offer
	  ○ Family formation benefits or coverage inclusive of SGM families
	  ○ Access to gender-affirming care
	• Workplace
	  ○ Offers paid parental leave, including parental leave for co-parent(s) regardless of marital status
	  ○ Culture has a positive and inclusive diversity climate
	  ○ Supervisor is flexible to accommodate childbearing needs (e.g., sick days, appointments, disability accommodations)

○ Restrict who can be a dependent based on marriage or legal parental rights • Healthcare ○ Clinics deny access to family formation services ○ Professionals and social services discriminate and stigmatize SGD individuals, in part due to a lack of training and education ○ Environments have strong heterocisnormative cultures (e.g., lack representation, ignore/deny co-parents, information systems structurally exclude SGD people)	• Insurance allows ○ Access to healthcare professionals that are SGD, otherwise SGD competent • Healthcare ○ Employees are knowledgeable and competent about providing care to SGD childbearing individuals, were respectful and provided equal treatment, and were accountable when systemic exclusion arose
Interpersonal	
• Rejection, abandonment, trauma, and harm inflicted during the coming out process • Supports that are ○ Actively homo/transphobic, even when internalized ○ Politically vocal about candidates or policies that threaten SGD legal rights ○ Stigmatizing or making harmful comments during the process of announcing expecting a baby ○ Judgmental of or stigmatize childbearing or parenting choices ○ Faraway and therefore can't provide in-person, tangible support ○ Conditionally supportive, requiring SGD childbearing individuals to compromise their values, be erased, or reduce themselves in other ways to access their support ○ Uneducated and require SGD individuals to manage their emotional reactivity before support can be accessed ○ Not understanding the needs and experiences of SGD childbearing people	• Romantic partner(s) that are also co-parent(s) • A diffuse support network made up of many people • Support people (co-parent(s), family of origin, chosen family, extended family including partner or co-parents family, peers, colleagues, neighbors, pets, religious community, SGD community) that ○ Are comfortable and safe individuals to be emotionally vulnerable around ○ Provide affirmation and validation ○ Live in close geographic vicinity, thus able to visit/provide tangible support ○ Have shared lived experiences (SGD identity, prior gestational parent, racial identity, and people at the intersection of all identities) ○ Offer support proactively versus waiting to be asked ○ Provide a spiritual component to the childbearing experience ○ Have access to wealth • A therapist that one trusts (commonly has shared lived experiences)
Intrapersonal	
• Characteristics: Minoritized racial identity, sexual and/or gender-diverse identity, doesn't have wealth, history of poor mental health, neurodiverse, experiencing a disability, and particularly those that encompass multiple of these identities • Growth opportunities: doesn't ask for help, doesn't anticipate future needs, doesn't advocate for needs, experiences internalized oppression, doesn't create firm boundaries, can't navigate bureaucratic systems, can't find new ways to cope (e.g., exercise limitations, inability to chest bind)	• Characteristics: White, heterosexual, and cisgender identity, has wealth, gender-affirming top surgery before gestating, neurotypical, able-bodied • Assets: asks for help, anticipates future needs, creates unique family narratives and parental identities, participates in mutual aid activism, finds joy and meaning in building their family, has well-developed and adaptable coping strategies, including the ability to advocate, navigate bureaucratic systems, establish firm boundaries, and identify new coping tools when prior strategies are no longer viable

of COVID-19 on SGD perinatal experiences and positive experiences within healthcare settings. A longitudinal trajectory analysis of the data is also needed to understand changes among support networks across the entire perinatal period. The next steps in the candidate's developing program of research will include quantitatively assessing the association of multi-level factors on obstetrical and birth outcomes among sexual-diverse women using several large, longitudinal population datasets.

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Appendix A. Prior Reviews Use of Standard Systematic Review Steps

Reviews	Searched >2 databases	Dual title/abstract/full-text screening	Dual data extraction	Dual coding	Clear/cited methodology	Dual quality appraisal assessment	Total *(Out of 6 stars)*	Rationale for last rigorous review
Sexual-Diverse Women								
Porter, 2005	⊗	✕	✕	✕	⊗	⊗	✕	Poor quality
McManus et al., 2006	★	⊗	⊗	⊗	⊗	⊗	★	Poor quality
Dahl et al., 2013	★	✕	✕	★	★	★	★★★★	Last rigorous review using literature through 2011
Hammond, 2014	★	✕	✕	✕	⊗	⊗	★	Poor quality
Wells & Lang, 2016	★	?	✕	★	★	★	★★★★	Limited to only Nordic countries
Gregg, 2018	★	✕	✕	✕	⊗	⊗	★	Poor quality
Transgender and Gender-Diverse People								
Brandt et al., 2019	⊗	⊗	✕	⊗	⊗	⊗	✕	Poor quality
de Castro-Peraza et al., 2019	★	✕	✕	⊗	⊗	⊗	★	Poor quality
García-Acosta et al., 2019	★	✕	✕	⊗	⊗	⊗	★	Poor quality
Besse et al., 2020	★	⊗	⊗	⊗	⊗	⊗	★	Poor quality
Agénor et al., 2021	★	★	★	★	★	⊗	★★★★★	Includes broad reproductive health topics & a wide scoping review
Greenfield & Darwin, 2021	★	✕	★	★	★	⊗	★★★★	Limited to traumatic birth & a wide scoping review
MacLean, 2021	⊗	✕	✕	✕	⊗	⊗	✕	Poor quality
Total *(out of 13 articles)*	10	1	2	3	4	2		

Note. ★ = criteria met; ✕ = criteria met partially; ⊗ = criteria not reported; ? = criteria inferred

Appendix B. Database Search Strategy

Database	Results	Search string
PubMed	787	((Pregnancy [MESH]) OR ("Postpartum Period" [MESH]) OR ("Maternal Health Services" [MESH]) OR (pregnanc* [tiab]) OR (fertil* [tiab]) OR (antenatal* [tiab]) OR (prenatal* [tiab]) OR (perinatal* [tiab]) OR (intrapartum* [tiab]) OR (parturition [tiab]) OR (childbirth [tiab]) OR (labour* [tiab) OR (postnatal* [tiab]) OR (postpartum* [tiab]) OR (co-mother* [tiab]) OR (lactat* [tiab]) OR (breastfeed* [tiab])) **AND** (("Sexual and Gender Minorities" [MESH]) OR (Homosexuality, Female [MESH]) OR (Bisexuality [MESH]) OR (Transsexualism [MESH]) OR (non-heterosexual* [tiab]) OR ("sexual minority" [tiab]) OR ("sexual minorities" [tiab]) OR (lesbian* [tiab]) OR (WSW [tiab]) OR (bisexual* [tiab]) OR (homosexual* [tiab]) OR (queer* [tiab]) OR ("gender minority" [tiab]) OR ("gender minorities" [tiab]) OR (transgender* [tiab]) OR (transsexual* [tiab]) OR ("trans-sexual*" [tiab]) OR ("gender-variant" [tiab]) OR (transman [tiab]) OR ("female-to-male" [tiab]) OR (FTM [tiab])) **NOT** ((Homosexuality, Male [MESH]) OR ("gay man" [tiab]) OR ("men who have sex with men" [tiab]) OR (MSM [tiab]) OR ("female to male ratio" [tiab]) OR (HIV [tiab]) OR (contracept* [tiab]) OR (fertility [tiab])) **Filters**: Humans (subjects); English (language)
Embase	813	(('sexual and gender minority'/exp OR 'lesbianism'/exp OR 'bisexual female'/exp OR 'homosexual female'/exp OR 'female to male transgender'/exp OR 'non heterosexual*':ab,ti OR lesbian*:ab,ti OR wsw:ab,ti OR queer*:ab,ti OR 'gender minorit*':ab,ti OR transgender*:ab,ti OR transsexual*:ab,ti OR 'gender varian*':ab,ti OR 'trans m?n':ab,ti OR ftm:ab,ti OR 'lgbt* people':ab,ti OR 'sexual minorit*':ab,ti OR 'female homosexual*':ab,ti OR 'same-sex female*':ab,ti OR 'gender diverse':ab,ti OR 'two-spirit*':ab,ti OR transm?n*:ab,ti) **NOT** 'homosexual male'/exp NOT 'bisexual male'/exp NOT 'male to female transgender'/exp NOT 'gay m?n':ab,ti NOT 'men who have sex with men':ab,ti NOT ('men who have sex with men':ab,ti AND women:ab,ti) NOT msm:ab,ti NOT 'human immunodeficiency virus':ab,ti) **AND** (('pregnancy'/exp OR 'puerperium'/exp OR 'childbirth'/exp OR pregnan*:ab,ti OR gestat*:ab,ti OR antenatal*:ab,ti OR prenatal*:ab,ti OR perinatal*:ab,ti OR intrapartum*:ab,ti OR parturition:ab,ti OR childbirth:ab,ti OR labo?r*:ab,ti OR postpartum*:ab,ti OR 'co mother*':ab,ti OR lactation*:ab,ti OR breastfeed*:ab,ti OR matern*:ab,ti OR postnatal*:ab,ti) **NOT** 'contraception'/exp NOT 'infertility therapy'/exp NOT 'birth control'/exp NOT contracept*:ab,ti NOT fertility*:ab,ti NOT inferti*:ab,ti) **AND** ([humans]/lim **AND** [english]/lim)
CINAHL	556	(((MM "GLBT Persons+") OR (MH "Transgender Persons") OR (MH "Bisexuals") OR (MH "Lesbians")) OR AB ((lesbian*) OR (bisexual*) OR (homosexual*) OR ("sexual minorit*") OR (WSW) OR ("women who have sex with women") OR (queer*) OR ("non-heterosexual*") OR ("same-sex female*") OR (LGBT*) OR ("gender minorit*") OR ("female to male transgender") OR (transgender*) OR (transsexual*) OR ("gender-varian*") OR (FTM) OR ("gender diverse") OR ("two-spirit*") OR (transm?n) OR (genderqueer*) OR ("gender expansive")) **NOT** AB (("homosexual male") OR ("bisexual male") OR ("male to female transgender") OR ("gay man") OR ("men who have sex with men") OR (MSM) OR ("human immunodeficiency virus") OR (HIV))) **AND** (((MH "Pregnancy+") OR (MH "Postnatal Period+") OR (MH "Childbirth+") OR (MH "Pregnancy Outcomes") OR (MH "Puerperium")) OR AB ((puerperium) OR (pregnan*) OR (gestat*) OR (antenatal*) OR (prenatal*) OR (perinatal*) OR (intrapartum*) OR (parturition) OR (childbirth) OR (labour*) OR (postnatal*) OR (postpartum*) OR (co-mother*) OR (lactation*) OR (breastfeed*) OR (matern*) OR (postnatal*)) **NOT** AB ((contracept*) OR (fertility*) OR (inferti*))) **Filters**: English (language)
PsychInfo	140	(AB(("sexual and gender minorit*") OR (LGBT*) OR (homosexual*) OR ("same-sex female") OR (lesbian*) OR (bisexual*) OR (non-heterosexual*) OR ("sexual minorit*") OR (WSW) OR (queer*) OR ("gender minorit*") OR (transgender*) OR (transsexual*) OR ("trans-sexual*") OR ("gender-varian*") OR ("female-to-male") OR (FTM) OR ("gender diverse") OR ("two-spirit*") OR ("gender non-conforming*")) **NOT** (AB (("homosexual* male") OR ("gay m?n") OR ("men who have sex with men") OR (MSM) OR (HIV) OR ("male to female transgender") OR ("bisexual male"))) **AND** (AB ((pregnan*) OR (postpartum*) OR (postnatal*) OR (perinatal*) OR (gestat*) OR (antenatal*) OR (prenatal*) OR (puerperium) OR (intrapartum*) OR (parturition) OR (childbirth) OR (labo?r*) OR (co-mother*) OR (lactat*) OR (breastfeed*) OR (matern*))) **NOT** (AB ((contracept*) OR (inferti*) OR ("birth control") OR (fertile*))) **Filters**: equivalent subjects (expanders); English (language); metasynthesis, interview, qualitative study (methodology); Boolean/phrase (search modes)

Appendix C. Excluded Studies with Rationale

Rationale: Not the perinatal period

1. *Appelgren Engstrom, H., Haggstrom-Nordin, E., Borneskog, C., Almqvist, A.-L. (2018). Mothers in same-sex relationships describe the process of forming a family as a stressful journey in a heteronormative world: A Swedish grounded theory study. *Maternal & Child Health Journal*, *22*(10), 1444–1450. https://doi.org/10.1007/s10995-018-2525-y
2. *Appelgren Engström, H., Häggström-Nordin, E., Borneskog, C., Almqvist A. L. (2019). Mothers in same-sex relationships—Striving for equal parenthood: A grounded theory study. *Journal of Clinical Nursing, 28*(19-20), 3700–3709. https://doi.org/10.1111/jocn.14971
3. Armuand, G., Dhejne, C., Olofsson, J. I., & Rodriguez-Wallberg, K. A. (2017). Transgender men's experiences of fertility preservation: A qualitative study. *Human Reproduction*, *32*(2), 383–390. https://doi.org/10.1093/humrep/dew323
4. *Cacciatore, J., & Raffo, Z. (2011). An exploration of lesbian maternal bereavement. *Social Work*, *56*(2), 169–177. https://doi.org/10.1093/SW/56.2.169
5. *Chapman, R., Wardrop, J., Zappia, T., Watkins, R., & Shields, L. (2012). The experiences of Australian lesbian couples becoming parents: Deciding, searching and birthing. *Journal of Clinical Nursing*, *21*, 1878–1885. https://doi.org/10.1111/j.1365-2702.2011.04007.x
6. Hayman, B., Wilkes, L., Halcomb, E. J., & Jackson, D. (2013). Marginalised mothers: Lesbian women negotiating heteronormative healthcare services. *Contemporary Nurse, 44*(1), 120-127. https://doi.org/10.5172/conu.2013.44.1.120
7. *Hayman, B., Wilkes, L., Halcomb, E., & Jackson, D. (2015). Lesbian women choosing motherhood: The journey to conception. *Journal of GLBT Family Studies*, *11*(4), 395-409. https://doi.org/10.1080/1550428X.2014.921801
8. James-Abra, S., Tarasoff, L., Epstein, R., Anderson, S., Marvel, S., Steele, L., & Ross, L. (2015). Trans people's experiences with assisted reproduction services: A qualitative study. *Human Reproduction*, *30*(6), 1365–1374. https://doi.org/10.1093/humrep/dev087
9. *Kerppola, J., Halme, N., Perälä, M.-L., & Maija-Pietilä, A. (2019). Empowering LGBTQ parents: How to improve maternity services and child healthcare settings for this community – 'She told us that we are good as a family.' *Nordic Journal of Nursing*, *40*(1), 41–51. https://doi.org/10.1177/2057158519865844
10. Light, A., Wang, L., Zeymo, A., & Gomez-Lobo, V. (2018). Family planning and contraception use in transgender men. *Contraception*, *98*(4), 266–269. https://doi.org/10.1016/j.contraception.2018.06.006
11. Lingiardi, V., Carone, N., Morelli, M., & Baiocco, R. (2016). "It's a bit too much fathering this seed": The meaning-making of the sperm donor in Italian lesbian mother families. *Reproductive BioMedicine Online*, *33*, 412–424. https://doi.org/10.1016/j.rbmo.2016.06.007
12. *Malmquist, A., & Nelson, K. Z. K. Z. (2014). Efforts to maintain a "just great" story: Lesbian parents' talk about encounters with professionals in fertility clinics and maternal and child healthcare services. *Feminism & Psychology*, *24*(1), 56–73. https://doi.org/10.1177/0959353513487532
13. Padavic, I. (2011). Mothers, fathers, and "mathers": Negotiating a Lesbian co-parental identity. *Gender & Society,* 25(2), 176-196. https://doi.org/10.1177/0891243211399278
14. Rozental, A., & Malmquist, A. (2015). Vulnerability and acceptance: Lesbian women's family-making through assisted reproduction in Swedish public health care. *Journal of GLBT Family Studies*, *11*(2), 127–150. https://doi.org/10.1080/1550428X.2014.891088
15. Somers, S., van Parys, H., Provoost, V., Buysse, A., Pennings, G., & de Sutter, P. (2017). How to create a family? Decision making in lesbian couples using donor sperm. *Sexual & Reproductive Healthcare*, *11*, 13–18. https://doi.org/10.1016/j.srhc.2016.08.005
16. Titlestad, A., & Robinson, K. (2018). Navigating parenthood as two women; the positive aspects and strengths of female same-sex parenting. *Journal of GLBT Family Studies*, *15*(2), 186-209. https://doi.org/10.1080/1550428X.2018.1423660
17. *Walks, M. (2013). *Gender identity and in/fertility* [Doctoral dissertation, University of British Columbia]. University of British Columbia Library. http://hdl.handle.net/2429/44284

18. *Alexandre Costa, P. A., Tasker, F., Anne Carneiro, F., Pereira, H., & Leal, I. (2019). Reactions from family of origin to the disclosure of lesbian motherhood via donor insemination. *Journal of Lesbian Studies*, *24*(1), 1–11. https://doi.org/10.1080/10894160.2019.1614378
19. *Bower-Brown, S., & Zadeh, S. (2020). "I guess the trans identity goes with other minority identities": An intersectional exploration of the experiences of trans and non-binary parents living in the UK. *International Journal of Transgender Health*, *22*(1–2), 101–112. https://doi.org/10.1080/26895269.2020.1835598
20. Carpenter, E., Everett, B. G., Greene, M. Z., Haider, S., Hendrick, C. E., & Higgins, J. A. (2020). Pregnancy (im)possibilities: Identifying factors that influence sexual minority women's pregnancy desires. *Social Work in Health Care,* 59(3), 180-198. https://doi.org/10.1080/00981389.2020.1737304
21. Carpenter, E., & Niesen, R. (2020). "It's just constantly having to make a ton of decisions that other people take for granted": Pregnancy and parenting desires for queer cisgender women and non-binary individuals assigned female at birth. *Journal of GLBT Family Studies*, *17*(2), 87-101. https://doi.org/10.1080/1550428X.2020.1773367
22. Carvalho, P. G. C., Cabral, C. D. S., Ferguson, L., Gruskin, S., & Diniz, C. S. G. (2019). "We are not infertile": challenges and limitations faced by women in same-sex relationships when seeking conception services in São Paulo, Brazil. *Culture, Health, & Sexuality, 21*(11), 1257-1272). https://doi.org/10.1080/13691058.2018.1556343
23. *Goldberg, A. E., Ross, L. E., Manley, M. H., & Mohr, J. J. (2017). Male-partnered sexual minority women: Sexual identity disclosure to health care providers during the perinatal period. *Psychology of Sexual Orientation and Gender Diversity*, *4*(1), 105–114. https://doi.org/10.1037/sgd0000215
24. Goldberg, A. E., & Scheib, J. E. (2015). Female-partnered and single women's contact motivations and experiences with donor-linked families. *Human Reproduction*, *0*(0), 1–11. https://doi.org/10.1093/humrep/dev077
25. *Kerppola, J., Halme, N., Perälä, M., & Maija-Pietilä, A. (2019). Parental empowerment—Lesbian, gay, bisexual, trans or queer parents' perceptions of maternity and child healthcare. *International Journal of Nursing Practice*, *25*(5), e12755. https://doi.org/10.1111/ijn.12755
26. Manley, M. H., Legge, M. M., Flanders, C. E., Goldberg, A. E., & Ross, L. E. (2018). Consensual nonmonogamy in pregnancy and parenthood: Experiences of bisexual and plurisexual women with different-gender partners. *Journal of Sex & Marital Therapy*, *44*(8), 721–736. https://doi.org/10.1080/0092623X.2018.1462277
27. *Maulod, N. (2016). *Exiles of heteronormativity: Queer reproduction and female same-sex families in Singapore* (Order No. 10190870) [Doctoral dissertation, Purdue University]. ProQuest Dissertations and Theses Global.
28. *McDonald, K. (2011). 'The old-fashioned way': Conception and sex in serodiscordant relationships after ART. *Culture, Health & Sexuality*, *13*(10), 1119–1133. https://doi.org/10.1080/13691058.2011.607242
29. *Naziri, D., & Feld-Elzon, E. (2012). Becoming a mother by "AID" within a lesbian couple: The issue of the third. *The Psychoanalytic Quarterly*, *81*(3), 683–711. https://doi.org/10.1002/j.2167-4086.2012.tb00514.x
30. Radis, B., & Nadan, Y. (2020). "Always thinking about safety": African American lesbian mothers' perceptions of risk and well-being. *Family Process*, *60*(3), 950-965. https://doi.org/10.1111/famp.12607
31. *Reed, S. J., Miller, R. L., & Timm, T. (2011). Identity and agency: The meaning and value of pregnancy for young Black lesbians. *Psychology of Women Quarterly*, *35*(4), 571–581. https://doi.org/10.1177/0361684311417401
32. *Reed, S. J., Miller, R. L., Valenti, M. T., & Timm, T. M. (2011). Good gay females and babies' daddies: Black lesbian community norms and the acceptability of pregnancy. *Culture, Health & Sexuality*, *13*(7), 751–765. https://doi.org/10.1080/13691058.2011.571291
33. *Ross, L. E., Goldberg, A. E., Tarasoff, L. A., & Guo, C. (2018). Perceptions of partner support among pregnant plurisexual women: A qualitative study. *Sexual and Relationship Therapy*, *33*(1–2), 59–78. https://doi.org/10.1080/14681994.2017.1419562
34. *Ryan, M. (2013). The gender of pregnancy: Masculine lesbians talk about reproduction. *Journal of Lesbian Studies*, *17*(2), 119–133. https://doi.org/10.1080/10894160.2012.653766
35. *Schwartz, S. (2012). *We're in this together: A phenomenological exploration of the decision-making process and relational dynamics of lesbian couples planning for conception*. (Order No. AAI3463685)

[Doctoral dissertation, The Chicago School of Professional Psychology]. ProQuest Dissertations and Theses Global.
36. *Suter, E. A., Kellas, J. K., Webb, S. K., & Allen, J. A. (2016). A tale of two mommies: (Re)storying family of origin narratives. *Journal of Family Communication*, *16*(4), 303–317. https://doi.org/10.1080/15267431.2016.1184150
37. *Suter, E. A., Seurer, L. M., Webb, S., Grewe, B. Jr., & Kellas, J. K. (2015). Motherhood as contested ideological terrain: Essentialist and queer discourses of motherhood at play in female–female co-mothers' talk. *Communication Monographs*, *82*(4), 458–483. https://doi.org/10.1080/03637751.2015.1024702
38. *Voultsos, P., Zymvragou, C.-E., Raikos, N., & Spiliopoulou, C. C. (2019). Lesbians' experiences and attitudes towards parenthood in Greece. *Culture, Health & Sexuality*, *21*(1), 108–120. https://doi.org/10.1080/13691058.2018.1442021
39. Wingo, E., Ingraham, N., & Roberts, S. C. M. (2018). Sexual minority women reproductive health care priorities and barriers to effective care for LGBTQ people assigned female at birth: A qualitative study. *Women's Health Issues, 28*(4), 350-357. https://doi.org/10.1016/j.whi.2018.03.002
40. *Zamperini, A., Testoni, I., Primo, D., Prandelli, M., & Monti, C. (2016). Because moms say so: Narratives of lesbian mothers in Italy. *Journal of GLBT Family Studies*, *12*(1), 91–110. https://doi.org/10.1080/1550428X.2015.1102669

Rationale: Not SGD people

41. Cazorla-Ortiz, G., Galbany-Estragués, P., Obregón-Gutiérrez, N., & Goberna-Tricas, J. (2020). Understanding the challenges of induction of lactation and relactation for non-gestating Spanish mothers. *Journal of Human Lactation*, *36*(3), 528–536. https://doi.org/10.1177/0890334419852939
42. Spidsberg, B. D., & Sørlie, V. (2012). An expression of love - midwives' experiences in the encounter with lesbian women and their partners. *Journal of Advanced Nursing*, *68*(4), 796–805. https://doi.org/10.1111/j.1365-2648.2011.05780.x LK
43. Vikström, A., & Barimani, M. (2016). Partners' perspective on care-system support before, during and after childbirth in relation to parenting roles. *Sexual & Reproductive Healthcare, 8*, 1-5. https://doi.org/10.1016/j.srhc.2015.11.008

Note. * Studies identified through formal, database search strategy

Appendix D. Sexual Orientation and Gender Identity Definitions

Identity	Definition
Bisexual	A person who is emotionally, romantically, or sexually attracted to more than one sex, gender, or gender identity though not necessarily simultaneously, in the same way or to the same degree
Gay	A person who is emotionally, romantically, or sexually attracted to members of the same gender
Genderqueer	A person who may see themselves as male and female, neither male nor female, or falling completely outside these categories
LGBTQ2S	An acronym for lesbian, gay, bisexual, transgender, queer, two-spirit
Lesbian	A woman who is emotionally, romantically, or sexually attracted to other women
Nonbinary	A person who may identify as being both a man and a woman, somewhere in between, or falling completely outside these categories
Queer	A person who may express a spectrum of identities and orientations that are counter to the mainstream
Pansexual	A person who has the potential for emotional, romantic, or sexual attraction to people of any gender, though not necessarily simultaneously in the same way or to the same degree
Queer	A person who may express a spectrum of identities and orientations that are counter to the mainstream
Transgender	A person whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth

Appendix E. Chapter Two Saturation Table

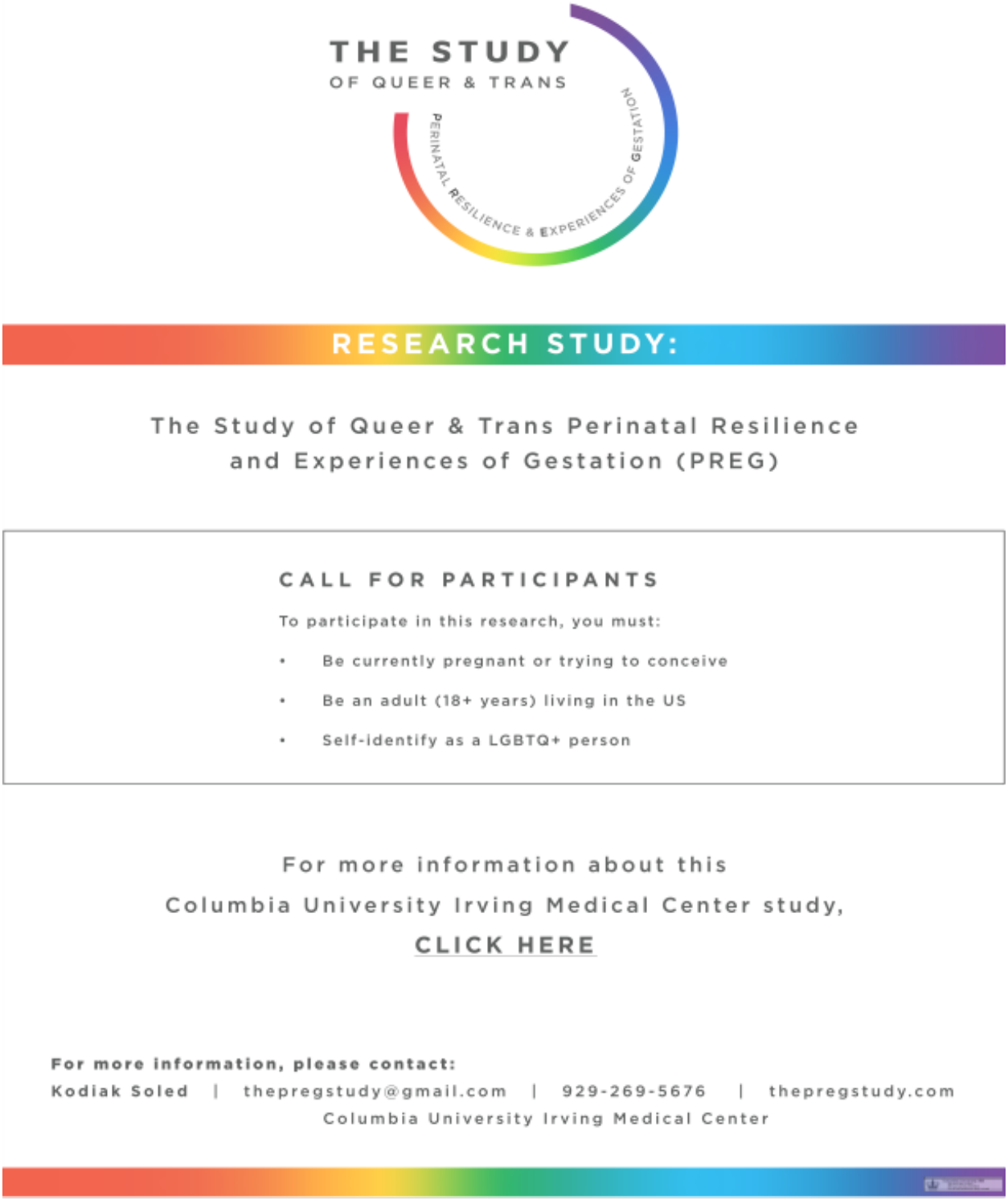
Subtheme and Codes	Included studies																							
	Abelsohn et al., 2013	Brennan & Sell, 2014	Burrow et al., 2018	Charlton et al., 2021	Charter et al., 2018	Cherguit et al., 2012	Dahl & Malterud, 2015	Ellis et al., 2014	Falck et al., 2021	Fischer, 2021	Hennekam & Ladge, 2017	Hoffkling et al., 2017	Juntereal & Spatz, 2020	Kazyak & Finken, 2020	MacDonald et al., 2016	MacDonald et al., 2021	Malmquist et al., 2019	Malmquist & Nieminen, 2021	Malmquist et al., 2021	McKelvey, 2014	Riggs et al., 2020	Rippey & Falconi, 2017	Rogers, 2020	Searle et al., 2017	Wojnar & Katzenmeyer, 2013
Theme 1: Systematic invisibility: Erasure, structural exclusion, and discrimination																								
Erasure																								
Heterocisnormativity	X																							
Lack of representation					X																			
Structural exclusion																								
Negative overshadows positive experiences												X [a]												
Mistrust/low trust			X																					
Social exclusion/isolation	X																							
Structural access	X																							
Discrimination																								
Anticipatory discrimination/bias	X																							
Enacted discrimination/bias		X																						
Trauma			X																					
Verbal harm		X																						
Theme 2: Creating personhood through parenthood																								
Journey to parenthood																								
Transitioning to parenting	X																							
Identity shift	X																							
Financial/legal factors								X																
Feeding choices					X																			
External environment	X																							
Grappling with gender																								
Gender affirming practices						X																		
Gender dysphoria				X																				
In a class of their own		X																						

Internal sense of masculinity/femininity					X								
When creating is losing													
Loss of autonomy			X										
Loss of privacy		X											
Loss of pregnancy								X					
Climbing mental mountains													
Changes in mind	X												
Theme 3. Resilient narratives of childbearing													
Strategies for emotional & social safety													
Self-protection/preservation					X [b]								
Feeling joy/appreciation						X							
Communities of Support													
Social support				X									
Partner/co-parent support													X
From the margins to the center													
Representation						X							
Structural competence		X											
Acceptance						X							
Queering childbearing narratives													
Claiming space				X									
Confronting the gender binary					X								
Conceptions of parenting		X											

Note. An 'X' indicates the first time a code was identified among the studies. [a] Saturation was met at the code level at the twelfth report. [b] Saturation was met at the category or subtheme level at the fifth report.

Appendix F. Study Recruitment Materials

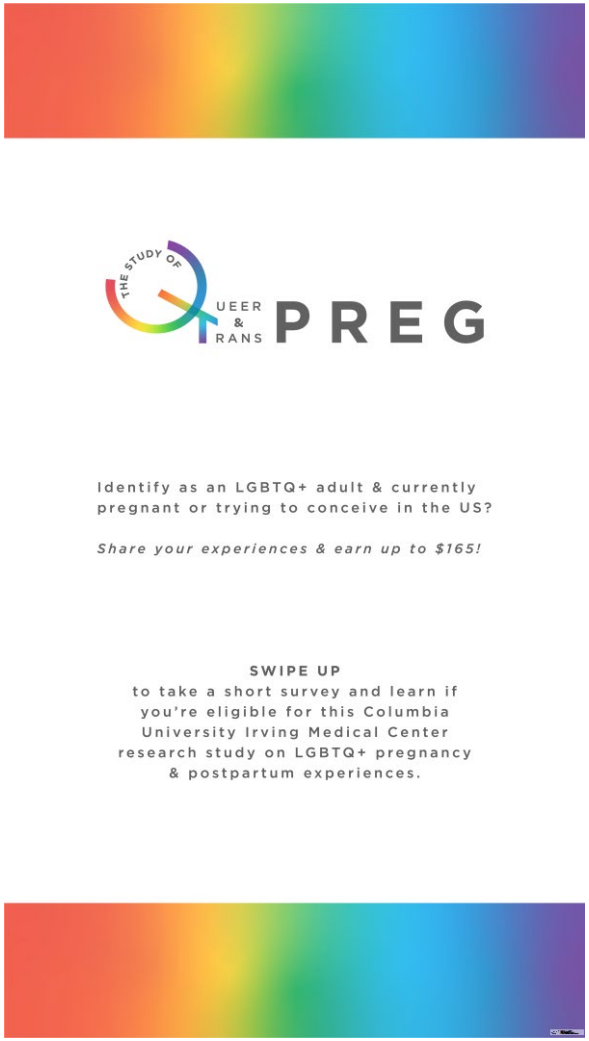
Flyer 1



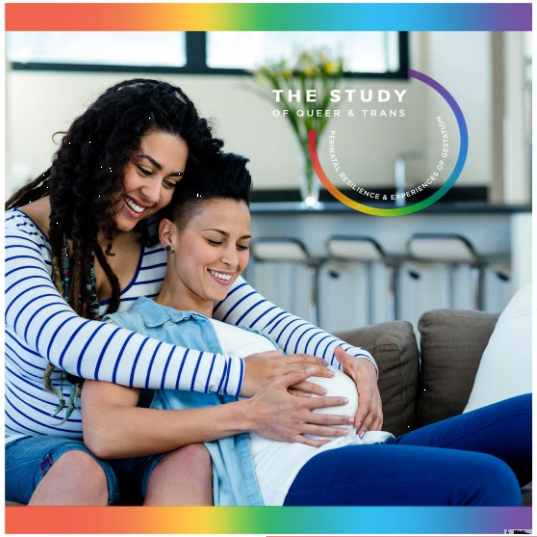
Flyer 2

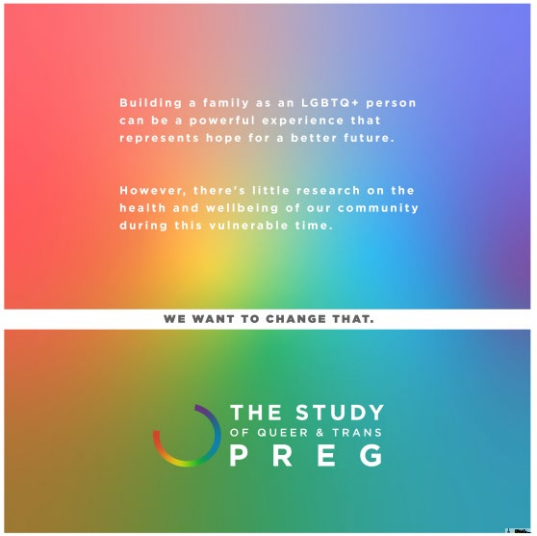

THE STUDY
OF QUEER & TRANS
PERINATAL RESILIENCE & EXPERIENCES OF GESTATION
Building a family as an LGBTQ+ person can be a powerful experience that represents hope for a better future.
However, there's little research on the health and wellbeing of our community during this vulnerable time.
WE WANT TO CHANGE THAT.
A groundbreaking study called Queer and Trans PREG
is interested in understanding the experiences and support
of LGBTQ+ people who are pregnant and postpartum.
COMPENSATION
You can be compensated up to $165 if you are eligible and complete all research procedures.
Your participation will also help the future health of our childbearing community.
PARTICIPATION
The study will take place online, over approximately six months, & consist of:
1. An enrollment meeting
2. 3x one-to-two-hour interviews with surveys
3. ~70 photos taken between interviews
CLICK HERE
to take a brief survey and
see if you're eligible.
For more information, please contact:
Kodiak Soled | thepregstudy@gmail.com | 929-269-5676 | thepregstudy.com
Columbia University Irving Medical Center

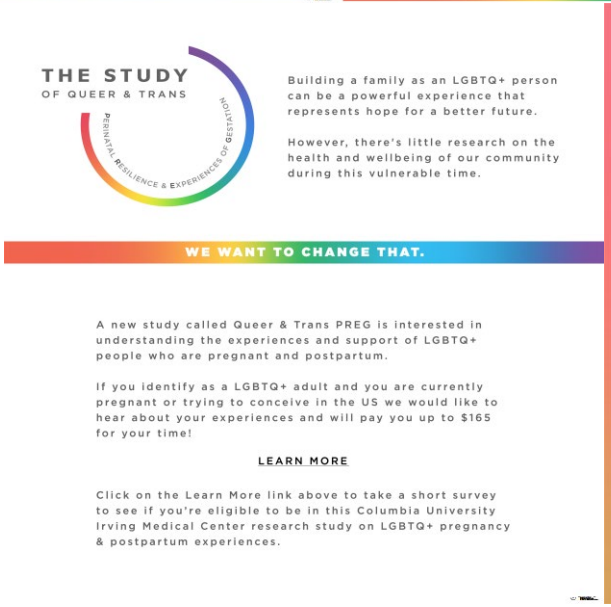
Social Media Posts 1

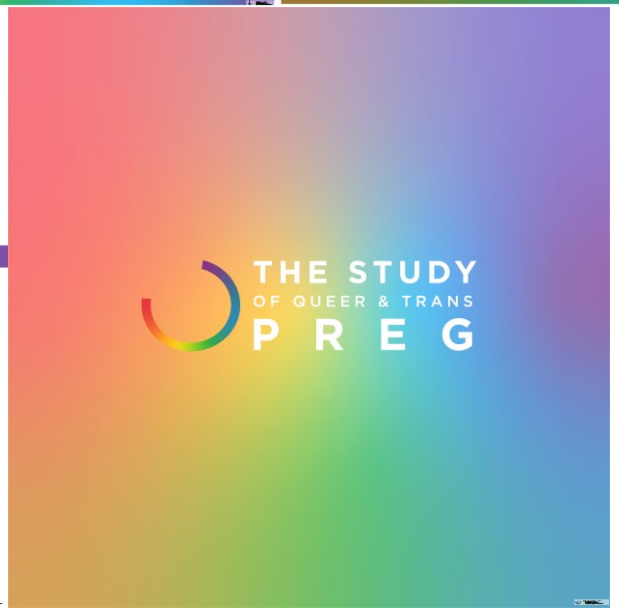


Social Media Posts 2









Study Logos

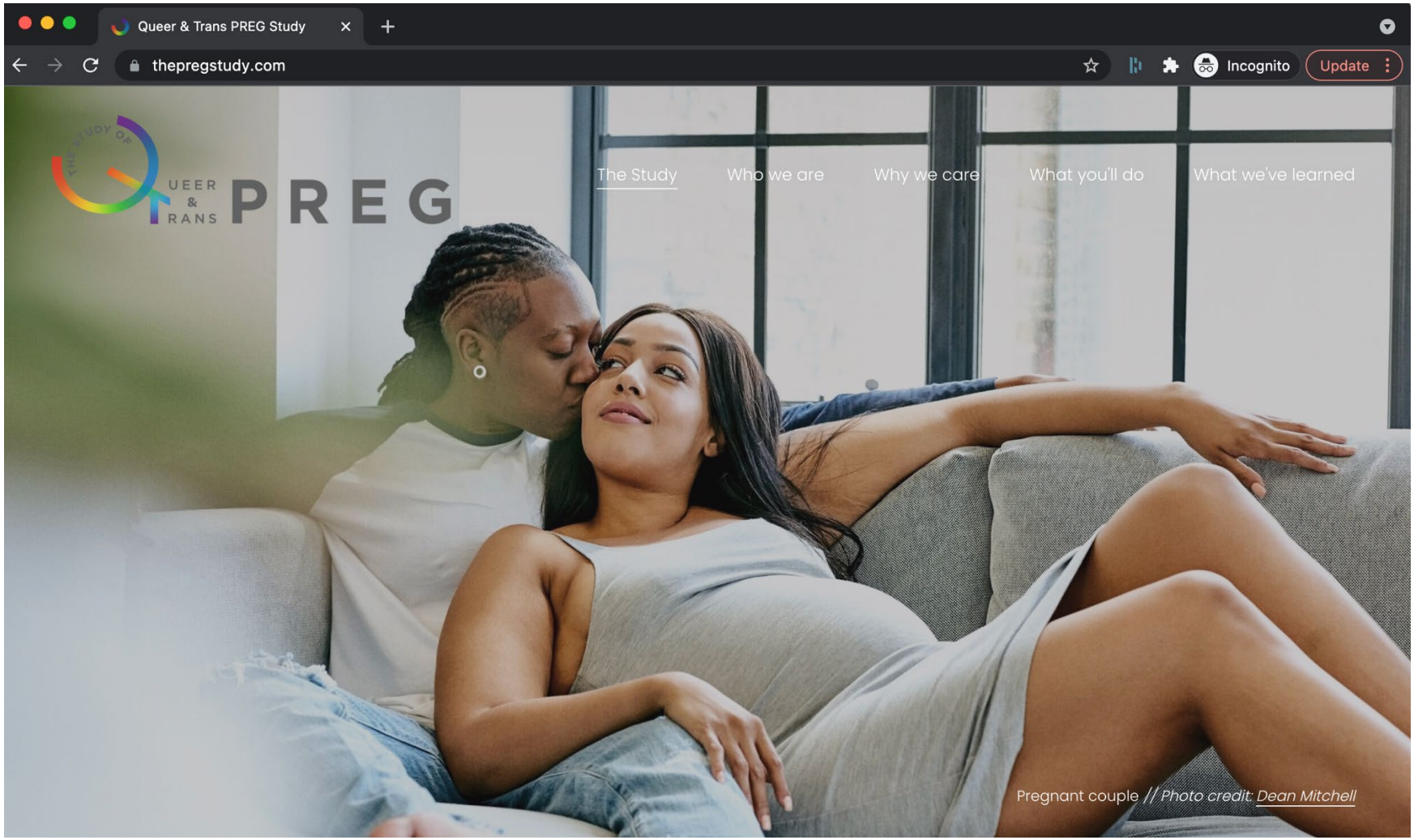

THE STUDY
OF QUEER & TRANS
PERINATAL RESILIENCE & EXPERIENCES OF GESTATION


THE STUDY
OF QUEER & TRANS
PREG


THE STUDY OF
QUEER
&
TRANS
PREG


PREG

Study Website



Appendix G. Eligibility Screener

Thank you for your interest in Queer & Trans PREG, our study on social support experiences among LGBTQ+ childbearing parents! We are a team of researchers, birth workers, healthcare professionals, and community members who are passionate about improving the health of LGBTQ+ people during their childbearing journey.

This short survey will assess your eligibility to participate in our study. It contains approximately 15-20 questions and should take you ~five minutes to complete. You can exit the survey at any time, but you will not be able to skip any questions.

If you are found to be eligible for the research study and complete all research procedures, you will be compensated up to $165. Your participation will also contribute to ongoing efforts to support the health and well-being of LGBTQ+ individuals.

Please click the link below to review the consent information. Be sure to save a copy of this information for your records. The consent form provides more detailed information about the survey.

Click below to download the IRB-approved consent form for this eligibility survey:

Eligibility consent form

If you are over the age of 18 and consent to taking part in this brief eligibility survey as part of a research study, please check "yes" to the question below:

Are you 18 years of age or over ***and*** willing to take this eligibility survey?
- Yes
- No

First, we're going to ask you a few questions about your identity.

What sex were you assigned at birth, for example, on your original birth certificate?
- Female
- Male

How do you identify?
- Man
- Transgender
- Woman
- Let me be more specific

We recognize that these categories do not reflect the full spectrum of identity, but for the purposes of this survey, which options below best describe your identity at present?

Please choose all that apply:

Agender
Cisgender Man (a person who identifies as a man and was assigned male at birth)
Cisgender Woman (a person who identifies as a woman and was assigned female at birth)
Genderqueer
Man
Non-binary
Transgender Man (FTM)
Transgender Woman (MTF)
Two-spirit (feel free to include your nation's specific language for your identity, if you would like) _____
Woman
Additional gender identity *Please specify:* _____

Do you think of yourself as:

Bisexual
Gay or lesbian
Straight/Heterosexual
Let me be more specific

We recognize that these categories do not reflect the full spectrum of sexual orientations, but for the purposes of the survey, which options below best describe your sexual orientation at present? *Please choose all that apply:*

Asexual
Bisexual
Gay
Lesbian
Pansexual
Queer
Questioning
Same-gender loving
Straight/Heterosexual
Another sexual orientation *Please specify:* _____

Thank you for your responses so far! We have included some questions throughout this survey to make sure you are a real person.

Please ignore the rest of the content in this passage and select the second response option. We appreciate your time and effort in helping us determine true participants that we need to follow up with.

I am probably not a human
I am a human and read the question carefully
I may be a human but did not read the question carefully
I am not a real participant

Which of these categories best describes your ethnicity?

Hispanic or Latinx: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race
Not of Hispanic, Latinx, or Spanish Origin
I don't know

Which of these categories best describes your race?

Please choose all that apply:

American Indian or Alaska Native
Asian
Black, African American, or African
Hispanic, Latino, or Spanish
Middle Eastern or North African
Native Hawaiian or another Pacific Islander
White
None of these fully describe me *Please specify:* _____

What year were you born? _____

How old are you (in years)?

Please respond to this question, it helps us determine if you are human. _____

Which country do you currently live in?

The United States (or a United States territory)
Another country *Please specify:* _____

Which state do you currently live in?

A dropdown list of every state

Can you speak and read English fluently?

Yes, I am fluent in English
I am working on my English fluency
No, I am not fluent in English

Now were going to ask you some questions about your childbearing and parenting status.

Who will be primarily responsible for parenting this baby?

I currently plan to be the sole parent or caretaker
I currently plan to co-parent with one other person
I currently plan to co-parent with more than one person
Not listed *Please specify:* _____

For the person you plan to co-parent with, what sex were they assigned at birth (for example, on their original birth certificate)?

Female
Male

Which option best describes the current identity of the person you plan to co-parent with? We recognize that this does not reflect the full spectrum of identities.

Please choose all that apply

Man
Non-binary
Transgender
Woman
Additional gender category *Please specify:* _____

For the people you plan to co-parent with, what sex were they assigned at birth, for instance, on their original birth certificate?

Only fill in for the number of co-parents you plan to parent with.

	Female	*Male*
Co-parent #1		
Co-parent #2		
Co-parent #3		
Co-parent #4		

If you had to choose from the list below, although we acknowledge that these terms are not an exhaustive list, what best describes the current gender identity at this time of the people you plan to co-parent with?

Please choose all that apply and only fill in for the number of co-parents you plan to parent with.

	Man	Non-binary	Transgender	Woman	Additional gender category
Co-parent #1					
Co-parent #2					
Co-parent #3					
Co-parent #4					

Are you currently carrying a pregnancy?

Yes
No
Unsure *Please specify:* _____

What are your current plans for the baby as far as parenting?

I plan to parent the baby
This pregnancy is a surrogacy I am carrying for someone else
I plan to find placement for this baby in adoption
I plan to terminate the pregnancy
Undecided *Please specify* _____

How many weeks along is your pregnancy?

Please fill in a number. _____

Are you personally planning to be pregnant in the near future?

Yes, I am currently trying to conceive or planning to become pregnant in the near future
Please specify your process and timing _____
No, ***I am a parent*** and ***not*** planning to become pregnant in the near future
Please specify _____
No, ***I am not a parent*** and ***not*** planning to become pregnant in the near future
Please specify _____
Undecided
Please specify _____

Lastly, we want to know how you found out about the study and the best way to contact you for follow-up.

How did you hear about this study? It's really helpful for us to know how you heard about the survey to continue to focus on the most effective channels.

Please choose all that apply.

Email *Please specify:* _____
Newsletter *Please specify:* _____
Social media *Please specify:* _____
Word of mouth *Please specify:* _____
Other *Please specify:* _____

Please provide your contact information so a member of the study team can follow up about your eligibility for the study.

Name _____
Pronouns _____
Email address _____
Phone number _____

Appendix H. Interview Guide

Interview 1

INTRO Hi (*participant's name)*. I want to thank you again for your willingness to have this conversation with me today. I will provide you with a quick overview of our time together today if that's alright.

This session will be approximately two hours. Let me know if you need to take a break during this session, and we can do so. If at any time we lose connection, please call back into the Zoom meeting or wait on the Zoom line for me to call back in. If that isn't working, I will contact you on the number you provided in the survey. We will chat for the majority of the time about your childbearing experience. I recognize that COVID-19 has altered so many aspects of our lives. When relevant, please share how COVID-19 has impacted the questions you will be asked. I'll leave some time at the end to review your photovoice exercise and allow you to ask any questions that have come up since the photovoice training.

I also just want to remind you of a few things about your participation in the study. There are no right or wrong answers. You can pass on any question that you don't want to answer or stop this conversation at any point for any reason. Please ask me to clarify anything, such as if you don't understand a question I ask. This conversation will be audio-recorded and transcribed, but your identity will be kept confidential. The only person that will review the transcripts for this study will be me, my advisor, and a second coder and no identifying information will be included. Let me know if you want any or all answers removed in the final transcript. That can be today, such as if you're going to tell me something for context but don't want it included in the final transcript, a few days from now, or in a few months from now. Anything you tell me will be kept in confidence, with the exception if you tell me that you want to harm yourself or harm others, I'm liable to connect you to support services.

Lastly, I want you to know that this is a safe and collaborative space. Please let me know if I use language that you don't use to refer to certain people, body parts, processes, or whatever it may be. We may dig into some sensitive issues during our conversation today, and I want you to feel empowered to let me know what I need to do to maintain this safe space for you.

Do you have any questions before we start?

INTRODUCTION

1. I want to start by getting to know you a little more and hearing about who you are. I know that can feel open-ended. Feel free to share about your background or identities you hold, communities you are a part of, hobbies you have, personality traits, or whatever you feel is essential for someone to know about who you are.
    - How do those identities [name them] influence how you experience the world?
    - It can sometimes be hard to talk about ourselves, so it can be helpful to think about how other people would talk about us. So next I'm going to ask how other people see you.
        - First, what would your coworkers say about who you are?

        - *Probe: If you don't have coworkers, this could be clients, colleagues, or other people you work closely with.*
    - Next going to ask about how your family would define who you are. But, first I want to understand who your family is. These can be both people that are biologically or legally related to you and/or people that you are emotionally close to and consider family, often called a chosen family. So, first, who is your family?
        - How would these people talk about who you are?
    - After thinking about how other people would define who you are, is there anything else that may have come up that would be important for someone to know about who you are?

EARLY SUPPORT

2. Announcing that you're expecting a child sometimes can and sometimes cannot be a momentous event. Especially in our community, that announcement can sometimes come earlier, such as during conception. If you've told people in your life that you are expecting, when and how did you tell them?
    - How did they respond to the news?
    - *Probe: What factors went into the timing of the announcement?*
    - *Probe: How did this shape when you received support from them?*
    - *For 2nd-time parents, add: It also may be important to think about how you shared the news of your family formation process for your first child. Were there differences or similarities between the two announcements? Differences or similarities in whom or when you shared the news or in how they responded?*

CHILDBEARING SUPPORT

3. When I say support, what does that mean to you in the context of childbearing?
    - *Probe: What has shaped that definition of childbearing support?*
4. Since conceiving, have you sought out new places, people, books, groups, apps, classes, et cetera to seek support?
    - Information (books, apps, classes, organizations)
        - Why did you choose that [book, app, class] over others?
            1. *Probe: What do you like most about it?*
            2. *Probe: Sometimes, people take classes to meet other childbearing people. Was that a goal for you?*
        - How did you learn about it?
    - Support Groups
        - How do you interact or engage with these groups? *For example, do you mostly read comments, search for specific questions, comment on other people's posts?*
            1. *Probe: How often do you engage with these groups?*
            2. What is an example of a question you've asked or a post you've responded to recently?
                i. *Probe: It sounds like you are mostly [looking for information, emotional support, people with shared experiences, etc.]. Do you ever use it [for emotional support, to ask for recommendations, ask a question]?*

3. *If they belong to multiple support groups*: What are the differences between these groups?
    i. *Probe: Do you find yourself going to one for a specific question or type of support over another?*
4. How do you imagine your need for this group would have been different or the same if it wasn't for COVID?

5. Are there places, people, groups, et cetera you used to seek support but haven't gone while childbearing?
    - *For 2nd time parents: How has your childbearing needs changed or remained the same between your first child and one? How has support changed or stayed the same? Why?*
6. Tell me about how the city/town that you live in influences your support during this time?
    - *Probe: There have been differences in how participants have continued accessing in-person support based on where they live. For example, a participant in Florida has continued social distancing outside long past the time that a participant in Maine has seen people in person. How have the seasons shaped the support you've been able to receive?*
7. If you're currently working, tell me about what support at work looks like?

SUPPORT PEOPLE

8. You may have already talked about these people, but I'd like to hear a little about who has been taking this childbearing journey with you so far.
9. Let's talk more about these people on your journey with you.
    - What are some important things I should know about them?
    - How do they or don't they show up in your life?
    - Where do they live in proximity to you?
    - How do you communicate with them (e.g., phone, FT, in-person)?
    - *Probe: How do they interact with or provide support to you?*
    - *Probe: Sometimes, there are differences in why we go to different people for different types of support. Sometimes it's because we trust them, or we know they won't be judgmental, or because of knowledge they have, or sometimes even due to a shared understanding or shared lived experience. Can you talk a little about which of these people you go to for different support needs and why you do that?*
    - Do any of these people identify as within the LGBTQ community? As a parent?
10. This next question can be a little tricky, but I'd like you to think about your supports who identify as within the LGBTQ community versus those who do not. Think about those different people and the types of support or questions or advice you go to them for. Can you notice any differences between the kind of support you ask for or receive from people who identify within the LGBTQ community vs. those who don't identify as LGBTQ?
11. I'm going to ask you the same thing, but now between supports who are already parents versus those who are not. Can you notice any differences between the kind of support you ask for or receive from people who identify as a parent vs. those who don't identify as a parent?

12. How has being an expecting parent changed or not changed your connection to the LGBTQ community? Your family? Your partner? Any other supportive relationships?

PRIMARY SUPPORT

13. Sometimes there are things people do to support us that matter more than other things. For example, making meals may not matter to you, but if my wife goes grocery shopping and cooks all the meals for the week, so I don't even have to think about how I'm getting fed, that's like a big gold star in my book that makes me feel really loved. Is there something like that, that sticks out to you about how [*primary support person*] shows you that they love you?
14. It's so great to hear about all the ways [*primary support* person] is supportive. In real life, there are always things that aren't supportive too, that we can't always control and may be harder to think or talk about. For example, I know I haven't always been there when my friends needed me while I've been in this doctorate program, and that's painful for me to admit. I want to hear about these parts too—how people may have fallen short of what your needs are.
15. It's human nature to get frustrated at people who are close to us. For example, my wife and I have different tolerance levels for when the trash needs to be changed. My tolerance is lower than hers, so I can get frustrated when I see the garbage overflowing. Is there something recently that [*primary support person*] has done that's frustrated you?
    - What kinds of support related to this experience does [*primary support person*] have right now?

Probes for sensitive topics that commonly arise in support compromises:

- *Dig deeper:*
    - *Can you tell me more about what that's like for you?*
    - *Are you willing to share a little more about [topic]?*
    - *It's important I learn about the specific challenges this presents you. If it's not too much of a burden, I'd like to hear more about what that means in your life right now?*
- *Neutral statement:*
    - *That sounds really tough.*
    - *I'm really impressed with how resilient your being.*
- *Permissive stem:*
    - *Feel free to skip this question if it's too personal, but this [topic] seems important.*
    - *As a reminder, you're free to skip any question you don't want to answer.*

HEALTHCARE

16. If you have chosen the place where you plan to birth your baby, like a hospital or your home, tell me a little about where that place is and the factors that went into choosing that place.
    - *Probes: Can you tell me more about the visits? What has the frequency of visits have been? Have they've been in-person or remote? Have you been allowed to bring someone along with you?*

17. Can you tell me about a recent experience of receiving care from your provider or in that care setting that upset you?
    - Can you tell me about a recent experience of receiving care from your provider or in that care setting that affirmed you?
18. Did you have any choice in who you chose to be your provider?
    - *Probe: What went into making that choice?*
    - *Probe: How has your experience been getting care there?*
19. If you've needed to engage with your insurance company, what did that look like?
    - *Probe: Can you say more about how you navigated what they would pay for?*
    - *Probe: Have you experienced any surprises, such as unexpected costs?*

COVID

20. People are affected by COVID-19 in many ways. I'd love to hear a bit of how your life has been changed, including possible positive changes. In what ways hasn't it changed?
    - *Probe: For example, some people have benefited from stimulus checks or being at home with their partners, not having to work, things like that. Conversely, other people have not been able to see their friends and family in person, or it's changed the frequency of their healthcare appointments or who can be at the appointments or birth.*
    - *Probe: How do you think your support would have been different if there was not a pandemic?*
    - *Probe: Are there other ways COVID-19 is affecting you or people close to you personally?*

IDENTITIES:

21. Tell me a little about the name if you have chosen a name that your child will call you [*look to see if included in demographic form*].
    - *Probes: What does the name mean to you? Why did you choose it?*
22. Can you talk a bit about how your ethnic/racial identity influences your support needs around childbearing?
    - *Probe: Sometimes, culture plays a part in our values, traditions, or norms. Specifically related to childbearing, this could be like eating certain foods after a baby is born or in the home, or wanting baby books in other languages that your family speaks, things like that. Is there anything like this that is important to your family?*
23. Has religion influenced any traditions or support your sought?
    - *Probe: Sometimes, religion plays a part in our values, traditions, or norms. Specifically, related to childbearing, this could be a baby naming ceremony or beliefs about whether you should have a baby shower or something else like spirituality?*

CONCLUSION

24. If you could wave a magic wand, what would your perfect childbearing support system and resources look like?
    - What support do you think would make the most significant difference to feel supported during your childbearing experience?

- *Probe: Is there something specific to your [LGBTQ] identity that you wish you had support around?*

25. Is there anything about your experience of social support during your childbearing experience that you would like to add to this discussion that I did not ask?

That concludes the questions I have for you. However, I like to make space to ask if you have any feedback about this interview, the study in general, or my communication with you. Anything I could be doing on my end to make this a more positive experience for you?

Now let's pivot for the last few minutes and review your photo exercise and what you will do between this visit and the next one. [*Go to photovoice review section*]. Do you have any questions about expectations, how to take the photos, or obtain consent from anyone you want to photograph?

END
Our next visit will be around [*insert approximate date*]. Would you like to schedule that now, or should I reach out closer to the date?

As a reminder, you should receive an Amazon gift card of $25 after this session from the study email account to acknowledge and compensate you for your time. If you don't receive it by the end of the day, please reach out to us.

I want to thank you for your vulnerability and authenticity in sharing your childbearing experience with me. I deeply value your reflections and hope I can do justice by understanding better what researchers, healthcare professions, and advocates can do to provide quality care and support to families like yours.

Thanks again [*insert participant's name*], and I look forward to seeing you again in a few months!

Interview 2

INTRO Hi (*participant's name)*. It's so good to see you again. I want to thank you for sending all those photos since the last time we talked and for your willingness to have another conversation with me today. Like last time, I will provide you with a quick overview of our time together today if that's alright.

[*Same introduction and disclosure as interview 1*]

Do you have any questions before we start?

I first want to start today by checking in and seeing how things have been going since we talked. *Probe*: *For example, have you experienced any significant changes related to carry a baby or important life events?*

Now we are going to talk about some of the photos you took over the past few months.

For those who haven't completed all photo prompts: Are you willing to share what went into your decision or ability to not participate in the photo part of the study?

For each photo presented, we will go through the following questions to understand a little better about what you wanted to say through this photo and its meaning to you:

- Please describe your photo
- What is happening in this picture?
- Why did you take a picture of this?
- What does this picture tell us about your life?
- How can this picture provide opportunities for us to improve your life?

After all the photos have been contextualized:

6. Are there any photos that you might have wanted to take but didn't? If so, can you tell me more about that?

Do you need to take a bathroom break or stretch before we get into the second half of this interview?

Now we are going to pivot to the second half of this session. To the best of your ability, put aside what we just talked about, and let me bring you back to interview one. Please answer these questions concerning the past two to three months:

CHILDBEARING SUPPORT

1. The last time we talked, you said childbearing support meant [*insert participant's words*] to you. Has this definition changed since the last time we spoke?
    - *Probe: Would you add or alter anything about this definition?*
2. The last time we talked, [*insert books, groups, apps, classes, et cetera*] was supportive.

- Are you still engaging with or using this resource?
- Are there new books groups, classes, apps, et cetera that you've been using recently to seek support?

3. The last time we talked, you talked about [*insert participant's words]* being a supportive experience. Tell me about a time in the previous week or two where you felt supported.
4. The last time we talked, you talked about [*insert participant's words]* being an area you needed more support. Tell me about a time in the previous week or two when your needs were not met.
    - *Probe: Think about an experience related to your childbearing experience that has been challenging. Tell me a little about that challenge.*
    - *Probe: When you're experiencing unpleasant symptoms, what do you do?*
5. By this point in the gestational period, it often becomes pretty hard to do things you used to be able to do, such as bending down to unload a dishwasher. What are some recent things you needed to do that you couldn't do yourself but couldn't and what did you do?
6. Last time, you talked about how living in [*city name*] influenced the support you have been able to receive.
    - Have there been other ways that you have felt restricted by the place that you live?
    - Have there been other ways you feel resourced and grateful about the place that you live?
    - How have the seasons shaped the support you've been able to receive lately?
7. *If working:* Last time, you talked about work support [*insert experiences*].
    - How have your boss/coworkers/employees/organization failed to meet your needs as you're closer to the due date?
    - How have your boss/coworkers/employees/organization supported your needs as you increasingly neared the due date?

SUPPORT PEOPLE

8. The last time we talked, you said [*insert participant's words*] have been essential sources of support for you. How has this changed or remained the same since the last time we talked?
    - *Probe: How else have your relationships changed since gestating?*
    - *Probe: Have there been other changes since the last time we spoke?*

PRIMARY SUPPORT

9. The last time we talked, you talked about [*primary support's name*] doing [*insert participants' words*] to show you they love you. How have they shown you they love you recently?
10. Last time we also talked about [*primary support's name*] doing [*insert participants' words*] that was not so helpful, or you wished was different. It's human nature to get frustrated at people who are close to us, and it can be hard to acknowledge the ways those we love have let us down or not been able to meet our needs [*insert permissive stem*] Are there other ways [*primary support's name*] have frustrated or disappointed you lately?

SUPPORT COMPROMISES

11. Last time we talked, you mentioned [*compromises made to receive support]*. Has there been an experience recently where you needed to make a compromise to receive support?
    - *Probe: Sometimes things can come up with parents or grandparents like, "Oh, well, we did it this way, and you're choosing to do it a different way," and sometimes this can also happen with friends from your same generation. Has there been something like that has happened?*
12. Last time we talked, you mentioned [*boundaries made to maintain support]*. Has there been an experience recently where you needed to set a boundary related to expanding your family to maintain support?

Probes for sensitive topics that commonly arise in support compromises:

- *Dig deeper:*
    - *Can you tell me more about what that's like for you?*
    - *Are you willing to share a little more about [topic]?*
    - *It's essential that I understand the specific challenges this presents you. If it's not too much of a burden, I'd like to hear more about what that means in your life right now?*
- *Neutral statement:*
    - *That sounds really tough.*
    - *I'm really impressed with how resilient your being.*
- *Permissive stem:*
    - *Feel free to skip this question if it is too personal, but this [topic] seems really important.*
    - *As a reminder, you're free to skip any question you don't want to answer.*

HEALTHCARE

13. Last time we talked, you talked about [*upsetting provider or organization experience*]. Has anything else occurred recently that was upsetting in that setting?
14. Last time we talked, you talked about [*affirming provider or organization experience*]. Has anything else occurred recently that was an affirming experience in that setting?
15. Last time we talked, you talked about healthcare visits [*frequency, location, and visitor restrictions*]. What has that looked like over the previous two months?

CURRENT EVENTS

16. The last time we spoke, you talked about being impacted by COVID-19 [*insert participant's words]*. Since then, please share any experiences of how your life has been changed, including possible positive changes.
17. Sometimes other social or political events of this year, such as BLM or political events such as the supreme court justice appointment, the election, or the coup, have shaped support needs or shifted relationships. Has anything like this impacted your relationships or influenced your childbearing needs?

IF APPLICABLE (or didn't know last time)

18. Tell me a little about the name if you have chosen a name that your child will call you [*look to see if included in demographic form*].
    - *Probe: What does the name mean to you? Why did you choose it?*

19. The last time we talked, you said your ethnic/racial identity influences your support needs around childbearing [*insert participant's words]*. Has anything any come into the picture since the last interview?
20. The last time we talked, you said your religious identity influences traditions or support needs around childbearing [*insert participants words]*. Has anything any come into the picture since the last interview?

CONCLUSION

21. How were your expectations around support different from what the reality has been?
22. The last questions I ask at every interview: If you could wave a magic wand, what would your perfect childbearing support system and resources look like?
    - *Probe: What support do you think would make the most significant difference to feel supported during your childbearing experience?*
    - *Probe: Is there something specific to your [LGBTQ] identity that you wish you had support around*
23. Is there anything about your experience of social support during your childbearing that you would like to add to this discussion that I did not ask?

That concludes the questions I have for you. However, I like to make space to ask if you have any feedback about this interview, the study in general, or my communication with you. Anything I could be doing on my end to make this a more positive experience for you?

END

Our last visit will be around eight to twelve weeks postpartum. However, this interview window is more flexible than the first two interviews as we don't have to worry about your due date. I mention this if you already know of something we need to navigate around, such as going back to work at nine weeks or visiting with family. Otherwise, I typically email people a few weeks out from that time to schedule that interview. Is there anything we need to consider, or does reaching out around eight to ten weeks postpartum sound okay to you?

As a reminder, you should receive an Amazon gift card of $50 from the study email account to acknowledge and compensate you for your time. If you don't receive it by the end of the day, please reach out to us.

I know today was a long day, and I want to thank you for your time and patience in getting through all those questions. I also want to express my appreciation for your vulnerability and authenticity in sharing more of your childbearing experience with me. Your perspective is essential and deeply valued and will help people like me and your healthcare providers understand what we can do to provide support, care, and resources to families like yours.

Thanks again [*insert participant's name*], and I look forward to seeing you again in a few months!

Interview 3

Interview 3 had the same introduction, questions, and overall format as interview #2, except the word 'postpartum' was exchanged anytime there was 'childbearing.'

END
You made it to the end of this visit and the end of the research study!

I want to acknowledge again your time and willingness to participate in this study over the past six months. I also want to say what an absolute privilege it has been to be a witness to your childbearing and postpartum journey. Your experiences and stories are important, valued, and will make a difference for future LGBTQ childbearing individuals.

As a reminder, you should receive an Amazon gift card of $75 from the study email account to acknowledge and compensate you for your time. If you don't receive it by the end of the day, please reach out to us.

Thank you again [*insert participant's name*] for helping us get one step closer to realizing health equity for LGBTQ childbearing people.

Member Check Interview

Themes and subthemes with exemplar quotes were provided to participants in an emailed document, then a ~30-minute one-on-one Zoom Videoconference interview was scheduled to receive feedback guided by five open-ended questions:

1) Does this match your experience?
2) Do you want to change anything?
3) Do you want to add anything?
4) How do you think a queer or trans person in the community would react to this idea?
5) How do you think this finding could positively or negatively impact our community?

Participant feedback was integrated into the final presentation of findings. For example, the last subtheme 'Finding our Joy' was modified from 'Fighting for our exitance' to better reflect the joy and purpose childbearing provided participants.

Appendix I. Quantitative Assessment and Screening Tools

Construct	Definition	Instrument	Measurement
Depression Severity	Mood components of depression symptoms during ante-and postpartum periods, measured by symptom severity: 'none to minimal,' 'mild,' 'moderate,' and 'severe.'	Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987)	Continuous (Range 0–30); 10 items scored on a 4-point Likert Scale (0–3) Reliability: α = 0.87, Good overall validity (McBride et al., 2014) Case: Possible depression (≥9) (McBride et al., 2014) Depression ≥ 11 (Thombs et al., 2015)
State and Trait Anxiety	State anxiety is subjective feelings of tension, apprehension, nervousness, and worry activated by arousal or the autonomic nervous system. Trait anxiety includes differences between people in the tendency to perceive a stressful situation as dangerous or threatening.	State-Trait Anxiety Inventory (STAI) (Form Y) (Spielberger et al., 1983)	Continuous (Range 20–80 for each subscale); 2 subscales of 20 items scored on a 4-point Likert Scale (1–4) Case: Clinical anxiety (39-40 each subscale) (Julian, 2011) Reliability: α = 0.92 (S-Anxiety) and 0.90 (T-Anxiety), Good overall validity (Spielberger et al., 1983)
Pregnancy-specific stress	Stress originating from a variety of childbearing-specific issues, including physical symptoms, parenting concerns, relationship strains, bodily changes, anxiety about labor and delivery, and concerns about the baby's health (Yali & Lobel, 1999)	Revised Prenatal Distress Questionnaire (Nu-PDQ) (Lobel et al., 2008)	All items scored on a 3-point Likert scale (0-2) Timepoint 1: Continuous (Range 0–18); 9 items Timepoint 2: Continuous (Range 0–24); 12 items Timepoint 3: Continuous (Range 0–34); 17 items Reliability: α = 0.83 - .86; Good convergent and predictive validity (Lobel et al., 2008; Rosenthal & Lobel, 2018) Mean score: 11.92 for 17-item scale (Ibrahim & Lobel, 2020)
Informational Support	The perceived ability to obtain helpful advice or information.	PROMIS Informational Support — Short Form 8a (Northwestern University, 2015)	Continuous (Range 8–40); 8 items scored on a 5-point Likert scale (1-5) Reliability: α = 0.95; Good content, criterion, and construct validity (Hahn et al., 2014) Mean score: 29 (Northwestern University, 2015)
Instrumental Support	The perceived availability of assistance with material, cognitive, or task performance.	PROMIS Instrumental Support — Short Form 8a (Northwestern University, 2017b)	Continuous (Range 8–40); 8 items scored on a 5-point Likert scale (1-5) Reliability: α = 0.96; Good content, criterion, and construct validity (Hahn et al., 2014) Mean score: 30.5 (Northwestern University, 2017b)
Emotional Support	Perceived feelings of being cared for and valued as a person and having a confident relationship.	PROMIS Emotional Support — Short Form 8a (Northwestern University, 2017a)	Continuous (Range 8–40); 8 items scored on a 5-point Likert scale (1-5) Reliability: α = 0.99; Good content, criterion, and construct validity (Hahn et al., 2014) Mean score: 33 (Northwestern University, 2017a)

Appendix J. Modified, Virtual Photovoice Training Outline

~50-minute Microsoft PowerPoint presentation

1. Introduction to Photovoice
    - Brief history and overview of photovoice
    - Value of using photovoice
    - Examples of photovoice used in manuscripts and in society
2. Introduction to The Study of Queer and Trans PREG
    - Community-placed research methods: advisory board and photovoice methods
    - Modified, virtual photovoice process and participant responsibilities
    - Goal of photovoice within the study
3. Introduction to visual literacy
    - Visual literacy basics
    - Critical photo analysis activity
    - Key elements and common mistakes in photography
4. Principles of ethical photography
    - Potential ethical concerns and confidentiality
        - Review of photo ethics agreement consent form
        - Review Media Records release consent form
    - Obtaining consent for photos
        - Review photo release form
5. Question and answer

Appendix K. Photovoice Prompts

Number	Name	Level of SEM	Question	Hint
			Interview 2	
1	Self-portrait	Intrapersonal	Take 1-3 photos (without showing your face) that represent who you are.	*This is just an exercise to get you comfortable taking photos. Remember there are no right or wrong ways to take photographs! However, we encourage you to push yourself a little to think creatively about how you can represent who you are through images. Have fun with it!*
2	Community	Community	What does the word community mean to you? What or who is part of your community?	*Remember, you do not need to take a picture of an actual person or place! You can take a picture of something around your house or nearby environment that reminds you of or represents how your community makes you feel, why your community is important to you, or the meaning that community has in relation to your childbearing experience. Whatever comes up for you as essential regarding the word community is perfect, and we want to see it!*
3	Childbearing support	Interpersonal	How do you get support as a childbearing person? When do you feel most comfortable asking for or receiving support?	*It can also be helpful to just think about this question as a snapshot of your experience versus your entire childbearing experience to date: did I need support this week? Would I have liked/benefitted from support this week? How did I get support this week? Where was I? Why did I need that support? Why did I go to that person in particular for that specific support need? Remember, there is no wrong way to do this. Your experiences are what matter to us!*
4	Work Support	Organizational	Compared to other gestational people at work, how do you feel the same? How do you feel different? *If nobody else is gestating right now, think about people who have been expecting in the past at work.*	*If a work setting doesn't make sense to you, think about other gestational people in your community. Think about the shared childbearing experiences of all gestational people. What are the supports every gestational person needs? Then think about how your experience, needs, or support system may be different from theirs. What makes your experience or needs different? How does this influence how you feel or interact in that space, with colleagues or community members? We're asking you to go a little deeper this week. We recognize this may be hard, but we know you can do it!*
5	Childbearing feelings of support	Intrapersonal	How do you feel when you get support as a gestational person? How do you feel when you need support but don't get it or can't find it?	*This prompt may seem similar to #3, but we want you to dig deep into your emotions here—move beyond how you get support (e.g., phone) or who supports you (e.g., a co-parent) and focus on what support or lack thereof, *feels* like. The photo should ideally symbolize your feelings or thoughts of when people or places fall short of meeting your emotional, physical, and/or informational needs, as well as your feelings or opinions of how it feels when your needs are met. We recommend cozying up with a cup of tea and getting deep into your feels as you think about this one ☺*
6	Childbearing law	Policy	How has a law or policy directly affected you and your childbearing experience as an LGBTQ+ person? How has this made you feel different or the same as other gestational people?	*We know the last prompt we asked you to go deep into your feels, and now we're asking you to look at support from a 30,000-foot view. All we ask is that you give this your best shot! For this prompt, think about any structural factors (e.g., benefits provided/not provided by your job or the state, provider knowledge/training, hospital/clinic policies, insurance benefits, et cetera) that influence your childbearing experience (e.g., how you could form your family, where you could give birth or who could provide your care, access to information or support resources, et cetera.) You don't have to know or name specific laws. What matters is how those laws or policies affect your family personally. What difference would it make in your life if those laws or policies were different? How does this make you feel towards non-LGBTQ parents?*

			Interview 3	
7	Birth support	Interpersonal	Who do you intend to be at your delivery? What role will that person have? Why is it important for that person(s) to be there?	*You do not need to take a photo of an actual person! It may be helpful to think about taking a picture representing how that person makes you feel and why the support they provide is important to you, especially during your delivery. You also may want to think about how the place you're going to give birth, other health factors, or the location of your support people possibly influenced who can be there or how you will deliver. How does this shape how you're preparing for birth? Remember, there is no right or wrong way to do this!*
8	Healthcare Support	Organizational	How do you feel the same compared to other gestational people taken care of by your healthcare provider? How do you feel different?	*This prompt is similar to the work support one, but we want you to think about how your care differs from other gestational people your provider cares for. IS your care different? Why? How is your care different? Do you have different needs? Do care providers treat you differently? How does this influence how you feel or interact in that setting or with those people? Then apply the same series of questions to how your care is the same as other gestational people. You're basically a photovoice expert by now, but in case you need more encouragement, YOU GOT THIS! Eight out of twelve prompts down!*
9	Local Support	Community	What places do you go to get support? Does the location of support (virtual, in-person, etc.) impact the kind of support it offers?	*Are you going to a provider's office? A childbearing course? A yoga class? Friends or families homes? Meeting in parks? In coffee shops? Only interacting with people on the phone (e.g., Facetime, calls, texts, Marco Polo, etc.) or online (e.g., support groups, social media, telehealth, virtual classes)? Do these places influence who can provide you emotional, information, or physical support? Does where you live influence the resources or supports available to you? We're asking you to connect dots here in ways you may not have given much thought to before. Think about it for a few days, and see if you notice any patterns in how the location of supports influences the kinds of support it provides. You may be surprised at what you find!*
10	Parenting laws	Policy	How has a law or policy directly affected your postpartum or parenting experience as an LGBTQ+ person? How has this made you feel different or the same as other parents?	*This prompt is similar to the childbearing law one (back to that 30,000-foot view!). However, this time we now want you to think about structural factors that influence your *postpartum or parenting experience* (e.g., parental leave or other benefits provided—or not provided—by your job or the state, parental rights, insurance benefits for your child or postpartum care, et cetera). How do these laws or policies affect your family personally? What difference would it make in your life if those laws or policies were different? How does this make you feel towards non-LGBTQ+ parents?*
11	Feelings of support postpartum	Intrapersonal	How do you feel when you get support as a new parent? How do you feel when you need support but don't get it or can't find it?	*You're a pro at these prompts by now! You know what to do. Unlike the first time we asked this question, you're probably reading this at 2 am while bouncing a crying baby instead of sitting quietly with a cup of tea, pondering your feels. Whatever way you're thinking about this is great, and we support it! Nonetheless, prompt #5 was a long time ago, so it may be a helpful reminder to think about this prompt as symbolizing your feelings or thoughts of when people or places fall short of meeting your emotional, physical, and/or informational needs as well as your feelings or opinions of how it feels when your needs are met. This is your second to last photo prompt—you got this!*
12	Postpartum support	Interpersonal	How do you get support as a new parent? When do you feel most comfortable asking for or receiving support?	*THIS IS YOUR LAST PROMPT! You did it! You're on the home stretch of the study, and we are so proud of you and grateful you've stuck it out until now. We're not asking you to unveil your deepest emotions or get super meta this week, so hopefully, this will be a nice and easy prompt to end on ☺ For this prompt, we just want to know how you are getting support right now. It may be helpful to ask yourself: Where am I when I am receiving support? Why do I need this support? Why am I going to that person in particular for that specific support need? How do I feel about asking for support now compared to when I was expecting?*

Appendix L. Chapter Three Codebook

Meaning Unit	Condensed meaning unit	Exemplar Quotes
Theme 1: Entering a new season of life		
		Subtheme 1.1: Layers of difference
Layers of difference	Differences between sexual and gender (SGM) minority and heterosexual, cisgender people	*Even figuring out what words we want to be, or what parent titles we want to be known as to our child. Thinking about our gender identities and everything wrapped up into that has been something we've talked about a lot throughout the pregnancy that I think for the average straight couple is a non-conversation. It's mom and dad automatically, and that hasn't been what it's been for us. (White, queer cisgender woman)* *When I'm looking for information, I looked to the queer and trans group for information about like birth itself, right? Like how did I want to give birth? And I had some ideas and then I read the group and then I was like, maybe I would want a different plan, but I wouldn't probably look at the [heterosexual and cisgender] mommy's group for that because people are going to really experience their bodies maybe differently than I would in that process. If I want maybe tips about clothing or how to feel affirmed in my body during pregnancy, I would probably look to the trans group…in terms of just the sort of like embodied part, I would want trans and non-binary people telling me about how they've managed. But certainly, in terms of just like family or navigating other people's hang ups, I think the broader LGB is helpful. (White, queer, trans man)* *There are different concerns. I mean, when I tell people that even though [wife's name]'s on the birth certificate and everything, she still has to adopt him, even if a straight couple used a donor it's assumed. People don't really realize those things…It's definitely a different, it's a different thing that we go through that, I think only other people who've gone through it in a way can really understand, if that makes sense. (Hispanic, lesbian, cisgender women)*
	Differences between SGM people of color and White SGM people	*As a biracial family, you know, both of my partners are White dudes and that in itself creates a certain type of alienation that doesn't get addressed in a lot of parenting spaces—that in White parenting spaces people pretend doesn't exist. And then in Black parenting spaces, there's the "Well, you made your choices" kind of attitude. "You picked them, so you got to deal with it." Cool, cool. Glad that me marrying a White guy, means my family is less worthy of support. (Black, bisexual, trans and nonbinary person)* *If I didn't have this job then I probably wouldn't be like I'm not having kids…I think it's that White queer folks dominate these spaces because they are usually the only people who can afford to go and do what they need to do to have children. (Black, same gender loving, nonbinary person)* *A lot of trans parenting communities are predominantly White, because that's a privilege mostly reserved for White people (Native, queer, nonbinary person)*
	Differences between SGM childbearing people or parents and non-childbearing people or parents	*I need to be around people that can share this experience because it's literally like—parents that are straight, they can help with certain things but it doesn't feel great, right? And then queer people who don't have kids, they can help, but there's still something missing…Other queer parents have been like what I've needed—queer parents and queer people who've been pregnant and given birth have been, who I've gravitated to most just because of knowing the embodied experiences that I'm having. (Hispanic, queer, genderqueer person)*
	Differences within SGM childbearing communities	*Not only am I weighing the emotional piece of it, but I'm just also weighing the hormonal piece of it and the gender piece of it, which I think people who are cisgender don't experience that, right?...I had to choose between like the trans Facebook group or people who got mostly easy access to sperm and got pregnant easily versus the queer, mostly cisgender women Facebook group that had fertility challenges. (White, queer, trans and nonbinary person)* *You'll see like two dads or two moms or whatever, but to see like two dads and two moms raising one kid in the same household, I think it's kinda like what's going on over there? Like how did that happen? Type of thing. (Black, gay cisgender woman)*

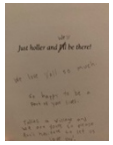
	Differences between people that were expecting and parenting for the first time and those that were expecting but already parenting		*I used a car as like a metaphor of like kind of being, it's the only red card that you see. It's on a different side of the street than everything else….I don't have really any friends right now who are pregnant. And I feel like all my friends have older kids. So in some ways I feel like I'm sort of like alone in this like journey. (White, lesbian cisgender woman)*
		Subtheme 1.2: Healing old wounds	
Healing wounds	Healing old wounds of trauma, pain, and distance within family of origin and extended family from rejection and disownment during the coming out process		*[My mother-in-law's] been excited, which actually has felt really good. And the whole time with IVF, she would text me and ask me how I was feeling. She frequently asks for updates when I go to doctor's appointments, and I send her updates. She's so excited. She cries about it. She squeals. She's so excited. This is like the best our relationship has ever been…it just feels like [my partner] and her are in a different place and she and I are in a different place. And I'm really grateful for it. (Hispanic, queer, genderqueer person)* *She has actually been very emotionally supportive, which I would never have said have been characteristically her trait before. She calls multiple times during the day and checks in and asks me how I'm doing, we have Saturday night movie nights, we do a watch party from Disney Plus. And my mom's not very motherly person, but I feel like she has really shown up in a way that I would've never had expected her to. And when I've been emotionally upset or I was depressed or something, I cried to her, and she has actually been very supportive. (Hispanic, lesbian, cisgender women)*
	Parents were able to heal the loss of thinking their child wouldn't have a family and be supportive due to the prospective of a grandchild		*I think there is for my mom this just one extra piece of—she had gone through this experience of mourning this, this experience that she thought I would never get to have…she has talked about how it's been just this amazing door reopened that she had closed. And how sort of special it is for her that we do get to share this when she had thought that we wouldn't get to share this…There's an extra piece of like, I didn't think it would happen that I think can be significant. (White, queer trans man)* *For like maybe the past four years, she would always say to us, like, "I love you, but I can't be in your corner." "I can't like defend you in any way." She's like she's a sort of famous Christian author and motivational speaker. So she has like sort of this large platform, that's really an added fun piece…she would post like anti anti-gay things on her Facebook and with her platform and things…[since the pregnancy] she's been an advocate for us privately in a way that she never was before…I think she feels sort of defensive of the baby. In a way that maybe it's easier for her then being defensive of me. (White, queer cisgender woman)*
		Subtheme 1.3: Feeling let down	
Disappointment	Feeling disappointed in the lack of support by chosen family and best friends		*It's probably been the most challenging part of pregnancy, to be honest… we got to a point where she didn't acknowledge my pregnancy at all. When she knew I was pregnant, she said the words, "congratulations," but there's nothing behind it. And then there's no follow up, no questions, no like nothing. Radio silence for probably eight weeks after I told her. So that was super tough. (Mixed race, bisexual, cisgender woman)*
	Feeling disappointed the last of support by family of origin or extended family		*I think she [wife] thought that there would be more of a family getting together, or maybe her mom spending more time here with us or something. So, I think she felt a little bit of a disappointment. (Hispanic, lesbian, cisgender women)* *My mom should be the one who I can call on for support but she can't be, has never been and like usual, I'm left to rely on myself…My mom always has an excuse for why she can't show up for me. My family's not reliable, but [partners name]'s family is being reliable. (Mixed race, pansexual, trans and nonbinary)* *It's funny that I still have expectations of my blood relatives when I—all the evidence points to that not being very wise. But around a pregnancy, I kind of expected maybe more support from family, but it's really come from friends. (White, lesbian, cisgender woman)* *This whole time, even when we were going through IVF, they [partners' dad and step mom] didn't really talk to us about it. They didn't ask questions. They weren't excited. They were just like, "Well, if y'all want to go through all this, like I guess?" I guess they thought they saw it as really selfish. I don't know. But that really kind of strained that relationship. And so now they're excited and I'm resentful because I'm like, "Oh, you want to be excited now? Where the f**k have y'all been?"…so that's been s**tty cause it's like, we were initially very close to them and now it's gotten worse. (Hispanic, queer, genderqueer person)*

Centralization	Centralization of supports on the nuclear family	*It's kind of painful to think about all the support I would have if I wasn't going through COVID right now. I don't see a lot of my friends, they've disappeared and they're each going through their own difficulties right now…so he [partner] shouldered a lot of the burden of being my emotional support, through so much of the pregnancy…so in some ways I feel very stuck and I'm forced to rely on my partner so much when normally I prefer to, if I need help, I spread it out amongst a bunch of people. (Mixed race, pansexual, trans and nonbinary)* *I would have been able to spread out the receiving of care among all my friends, which is usually how I've gotten by, when I've been in tough situations before I spread it out. I'll go to a different person's house for dinner every night or ask one person for this thing and one person for this thing and just spread it out between people, but with COVID everyone has—the nuclear family is winning right now for people. If you don't have that, you're in a different situation. (White, queer, trans and nonbinary person)* *If I need something, there are only a few people who are in my germ bubble anyway, who can provide it so I'm not calling them. And, and some of them don't even live here or live where I live. There are people who I might in a different time, jump on a plane for. But now it's more of a matter of picking up their call at 2:00 AM or whatever. And I'm not calling them at 2:00 AM 'cause, again, if I need something immediate—unless the only way I could see those people coming into play more heavily is if something like happened to [my boyfriend] or [my nesting partner] who are my in-person supports. (Black, bisexual, trans and nonbinary person)* *All my other friends have kind of decreased. So I don't rely on them for much emotional support anymore. I rely on them for distraction, not emotional support. So I'll call to be distracted or something, but I won't tell them what I'm feeling. [Asked to elaborate] It's like, what are they going to do about it? They can't hold me or assuage me in any way. So why bother? (Asian, queer, cisgender woman)*
	Subtheme 1.4: Emotional support at the center of it all	
Emotional needs	Increased emotional needs during and across pregnancy	*I don't feel like my body feels like feminine to me, but I do feel I'm less in control of my feelings. I'm certainly crying a lot more and more emotional. It's not the worst thing to have more access to my feelings, but it's also I think harder for people around me. (White, queer, trans man)* *I've just been really emotional. So venting a lot, or just getting validation about how I'm feeling. (White, queer trans and nonbinary person)* *One of those 2:00 AM meltdowns of being very uncomfortable being sleep deprived for several days….[my wife] rubbed my head for, I don't even know, until I fell asleep. So an hour or more at two in the morning which is so simple and just perfect at the time. That was probably one of my lowest nights. I just couldn't get through it on my own type of thing. (Mixed race, bisexual, cisgender woman)* *When I decided to have a baby, I knew and have remained really aware of the fact that this has really shifted who I am in the world, particularly around like how much support I need. I knew from a survival strategy that if I wasn't honest with people about the fact that I'm re-imagining my whole life and I'm going to need a lot of help that I haven't needed that I was gonna fail…This was a big turning point for me also in being like, "Okay, I'm going to be a little bit more vulnerable with people in my life and just be real about the fact that I'm going through an unexpected situation." (White, queer, trans and nonbinary person)*
	Emotional support desired more than tangible and informational support	*As independent as I feel like I am, I know going into labor and all that, it's a lot. And being around people that like you love and that love you, I feel like it's more important and it physically, I feel like it does something to you compared to just having doctors and nurses poking. And even if they're being supportive, it's still not the same type of support that like you really, really want. (Black, gay cisgender woman)*
	Synchronous, intimate support groups were better at providing emotional support than massive social media groups	*I have to be careful about social media stuff because screen time in general is getting harder and harder for me. I think it just creates like too much mourning around not actually being in physical community, but the support group just feels different. And just like being able to like talk to people individually, like DM or text or whatever feels really, really good. And I honestly, I'm just like—I don't think I could have made it through these experiences without that space, and this space, honestly, this study. (Hispanic, queer, genderqueer person)*

Homemade/second hand	Tangible gifts and acts of service represented emotional support, especially handmade things	*I got like a Black Lives Matter onesies and I got an RGB onesies. My people get me…* *Interviewer: What does that mean to you to have people that get you?* *Participant: Well, I mean, it's everything really. It's feeling like you're not alone in the world. That there are people who reflect yourself back to you. You're getting nurtured and cared for and loved. (White, lesbian, cisgender woman)*
		*[This is] how you know people are your people. They had bought books for the baby before I put the registry together. And two of the three books they bought were books that I had picked out. And I was like, of course, because you f**king know that I want my kid to learn about Fannie Lou Hamer and gender. Cool. I love you. You just f**king know me. (Hispanic, queer, genderqueer person)*
		Acts of service is definitely my love language. So kind of like this, the fact that like both [wife's name]'s aunt and my mom and sister took the time to plan and do these things really felt especially supportive to me…I never want to assume that someone would want to do those things, you know? Or I don't want them to feel like they have to do it out of obligation. So the fact that they then did them anyway you know, it definitely meant a lot for sure. Like more than the, more than the gifts or the physical book or anything like that. (White, lesbian cisgender woman)
		One of [my wife's] best friends, two best friends put together a virtual shower for us…38 of [our friends] sent some snippet of parental advice or just funny antidotes or whatever and they put together a video for us…it turned out to be a 35-minute video and we laughed and sobbed the entire time. It was just amazing. (Mixed race, bisexual, cisgender woman)
	Spirituality and rituals were an important aspect of emotional support	*I choose to go to the healing circles with like the QT BIPOC individuals, because they are majority are all non-binary, trans people of color. I feel seen there, no one's pregnant. I'm the only one, but I still feel very much supported and seen and held. They're very open to just like listening to my experience. (Mixed race, queer, nonbinary person)*
		There was a weekend long healing circle, so two sessions on the weekend that were like four hours long each or something. We were all in this healing space talking about how to heal our bodies outside of Western medicine, then also giving each other emotional support and sharing our stories. (Native, queer, nonbinary person)
		I joined a moon circle...It's all these wise women and they specifically use the term wise women. They're all like in their eighties with gray hair down their backs. It's amazing. They do moon witchy things and I joined it…They've been meeting every single full moon for the past 45 years. They're so cool and full of wisdom and…it could be a really great place for me to not be a mom there and just like be just a person. (White, queer cisgender woman)
		[I wish] I could have my fairy godmother midwife person who reminds me that this is so special and that my body's amazing and some more emphasis around—less about the physical and more about the spiritual magical component…Someone who can hold that, this happens all the time, but this is like my one time. I think I worry about the medical system really being a conveyor belt and providers seeing so many hundreds of babies born each week and each individual is not actually that special. I want an opportunity to feel special in the process. (White, queer, trans man)
		I have stacks and stacks of books and many of them are about the magical mystical parts. I want to be in that space. I don't feel I have a natural inclination to do that on my own, without an outside influence. I want a little bit more of "remember this is magic." (White, queer, trans man)
Emotional supports	Partner(s) are key emotional supports and primary people responsible to care for the participant's emotional wellbeing	*[My wife] is my number one support. That has absolutely not changed. And it's almost, I would say it's like even increased. I feel like I wasn't super needy emotionally throughout the pregnancy until recently where I feel like just my hormones are really in whack and I'll cry for no reason and can't name it. She's like just been amazing with that. And always feeding me and holding space for wherever I'm at. She's been amazing. (White, queer cisgender woman)*
		He's [partner] just so great about knowing how hard this has been. Trying to like do anything that he can do to make me feel supported and bring me joy and make me laugh. Make me feel human in this time. (Hispanic, queer, genderqueer person)

	In the last five weeks or so, I've really called them (mom and sister) a lot and opened up to them in deeper and deeper ways and cried to them without thinking too much about what that would mean or if I would be burdening them. That is at an all-time high. (Asian, queer, cisgender woman)
Increased support from female family, extended family, and community members (e.g., moms, mother in laws, sisters, cousins, sisters-in-law, aunts, second moms,)	*I've been really surprised by how there's a couple of people in my life (female people who were parents), who were not particularly close friends, who I've been talking to who've gone through that experience. And I've been really surprised by how helpful it is, and how much less lonely it makes me feel to talk to them. (White, queer, trans and nonbinary person)* *My parents and my sisters have become really, really primary for me which is so different than the past 10 years of my life has been. They've been really big for me. (White, queer, trans and nonbinary person)* *There are a few people (female friends) who are like, "I didn't even think of you in the clutch, but you're just here." Like, "Thanks." People have just been good at showing up, even though we may not be as close. They may not be part of my deep inner circle, but they're really just surprising me in the best way. (Black, bisexual, trans and nonbinary person)*
Pets providing deep comfort and emotional support	*They're more than just animals to me. They're my emotional support. I struggle with PTSD and all of that and they definitely know it and they know how to like show up in those spaces for me as well...Perfect example was this morning. I woke up at, baby woke me up at 5:50 am. My child inside of me. Just kicking me really hard and I'm tiny so I can feel everything deeply. I woke up, I was awake for two hours. And she came and she cuddled up on top of my chest just like this. And she fell asleep and like was comforting me and I ended up falling asleep back to sleep. And it just like soothed me so much. And once I was asleep, I felt her move off of my body. And she went back down to the, to her area and I was like, "Oh, you knew." (Mixed race, queer, nonbinary person)*  *I think it's been difficult to get support during pregnancy and, but I do feel comforted by like this one, the, one of the cats loves to like snuggle the bump and that feels very cute and supportive to me. But I can't ask her for that. I can't be like, "Could you please get on the bump and snuggle." [both laughing] But it feels really good to like have that connection to some, it feels like she's sort of helping me gestate a little bit. (White, queer, trans and nonbinary person)*
Additional communities (religious, neighbors, colleagues) that provide emotional support	*They (neighbors) have just been like so sweet, almost I'd say like at least once a month for the whole pregnancy, the mom has just brought over food, like bags and bags of food. And she didn't even know we were pregnant until very recently. It was just something she was doing and that was just felt so nourishing, especially because most of the time it would come at like these like freakishly weirdly good times. One time it was during the George Floyd riots and we had no food in the house and all grocery stores were closed. We didn't ask her for support, but she just like came over with like food for the week for us. (White, queer cisgender woman)* *We have a really supportive church community actually where our pastor is queer and she's engaged to a woman…Once we told our pastor that we were telling people publicly, she started putting us in the prayer log. So they say it every week at church that they're praying for baby [name]. The whole church community has been really supportive and excited for us which has been really, really nice. (White, lesbian cisgender woman)*
Doulas filling in emotional support gaps	*We connected very quickly, and I felt like I can definitely trust this person. And it was very easy. From the moment I met her, I was like, we're definitely moving forward together. And so that has been really cool. I mean, she's not a friend, but as a doula, I can text her whenever I have a need or an anxiety or a question. And that has reduced significant anxiety about what happens if labor starts here at home at night, for example…she's like a branch off of [wife's name] versus a branch off of my friends, that I feel like I could tell her more about my emotion. She's just more in tune and ready for all of the emotions. And there's less barriers there. She'll just get it because that's what her job is. (Asian, queer, cisgender woman)*
Theme 2: Community is family	
Subtheme 2.1: Feeling at home (when being supported)	

Comfort and safety	Reasons why there is a need to be surrounded by people who are safe	*I told my queer friends while we were trying. Just because there's an understanding there about what that entails financially, time, medically, emotionally. And I was less inclined to tell people who are not part of that [queer] community about it…I think that there's a lot of stigma still, or it might be just internalized homophobia, but [pauses] it's hard enough to try to start a family when you're part of the LGBTQ community. But if you add in like being stigmatized by cisgender, heterosexual people—it can kind of take the wind out of your sails. And I try to keep the positivity level high when I'm doing challenging things. And this is the hardest thing that I've ever done—is to try to make family. 'Cause we don't have any control over it. (White, lesbian, cisgender woman)* *My wife and I both agreed, we wanted someone who would be affirming. We didn't want to have that extra stress of having to advocate for ourselves while also dealing with pregnancy and COIVD, 'cause it was just, that's too much. (Native, queer, nonbinary person)* *While I know that straight people get that it's just a different layer because the world tells us we shouldn't be parents. [crying] And so like, the guilt and shame that I think all parents feel get exacerbated by a historical narrative about our community that we shouldn't have kids or be around kids. And so just like being able to talk to other queer parents, who are like, have kids of all different ages and in all different ways, has been the biggest comfort. (Hispanic, queer, genderqueer person)*
Positive feelings	Comfort, safety, validation, and affirmation was important from every relationship: partners, family, chosen family, community, support groups, and informational resources	*Partner: [My wife]'s support has grown a lot, like a thousand percent. And thus, she is the main person I lean on and I try not to lean too much. But she handles the sadness I feel. I feel inexplicable sadness like once a week or twice a week. And she just sits there and listens. And she's become very, very attuned. She always was, but even more attuned. And is always prepared to just listen… I cried every day and [my wife] held space for that and just listened and didn't offer any solutions and just supported me saying, "Yeah, this is really hard. You're doing a really great job." Yeah, just validating. (Asian, queer, cisgender woman)* *Family: [My wife] doesn't want to feel like she has to be, you know, put on a show or anything and she wants to just be absolutely be herself. And she's a lot more comfortable with being herself in front of her mom. (Hispanic, lesbian, cisgender woman)* *Chosen family: I've also got a couple of my friends that I'm like, okay, these people are safe to have around. These people will respect me. These people will respect my child. (Mixed race, pansexual, trans and nonbinary)* *Community: The way that they are always asking about [my wife]…I feel like I can suss out really quickly who holds space and who acknowledges or who uses specific gendered or non-gendered language or whatever. And that helps me feel like someone is safe or not safe. (White, queer cisgender woman)*
Facilitators of local environment	Place shapes access to comfortable/safe support	*We're really lucky living in [city name] is one of the biggest birth communities in the United States. So that's been huge. There's like more midwives, doulas, and birth workers here than I think anywhere else, honestly. I feel like there's like a plethora of competent people that we have around us and that has been a huge additive of living here. (White, queer cisgender woman)* *It's not guaranteed, but in my experience, a lot of places like in [city name], it's kind of the outlier if you're not going to be queer friendly. I guess it was a piece of privilege that I didn't have to necessarily seek that out. (White, lesbian cisgender woman)* *I'm sure that the place where I lived shaped the level of work I needed to do. I can imagine places that I might live where I might not have felt comfortable doing this [childbearing] at all…I take a lot of comfort in where I live...I wouldn't have some of the privileges that I have and I would have to handle my life a little bit differently. (White, queer trans man)* *I know I'm very lucky I live in [my state]—which thank God, I couldn't imagine trying to do this in [a southern state]. (Hispanic, lesbian, trans and nonbinary person)*
Shared lived experiences	Shared lived experiences provides unique kind of comfortable/safe support	*I feel most at ease and comfortable and comforted and I don't have to shield or shy away or filter too much in spaces that are explicitly queer…the more different anchors that I have with the person or with people, the more I feel comforted and seen and held and all the good things. (White, queer trans man)*  *I was thinking about the idea of what community is: supporting each other, working together, [and] having a certain synchronicity or unspoken rhythm. I think I was thinking mostly about other queer and trans people, and having shared experiences that make supporting each other feel really natural and easy…I've been finding it really helpful throughout my pregnancy. The times that I talked to friends of mine who have been pregnant and given birth who are queer or non-binary or trans, because somehow, even if we're not talking about things that are directly related to gender, I can identify with their experience and imagine myself in their place. And they know the right questions to ask about how I'm*

		doing—almost instinctively or something…There's something implicit in the way that they ask them [question], or the fact that they've had a similar experience that makes me feel more comfortable sharing. (White, queer, trans and nonbinary person)
		Just another level of comfort, another level of support, another level of I see you, I'm here, let's work through this together. (Mixed race, queer, nonbinary person)
		I feel, in general, more comfortable talking about the things about my experience of parenting that will be different because I'm queer and trans, but also will be different because I'm solo parenting with other queer and trans people. Because I think the structure is more familiar and less—I think a lot of my friends who are queer and trans, even if they aren't parents, they have like a queered idea of family in general…[and we have shared ideas about] not being trapped within the nuclear family system and imagining different ways of looking at care and family and wanting to stay really rooted in a non-traditional model of dispersed care and queer family. (White, queer, trans and nonbinary person)
		I can talk to my cousin and say you know how stressful this election is, and she can kind of grasp intellectually why this is such a big, big deal. But if I talk to my partner or my best friend [people in the LGBTQ community], it's like—they understand that this is viscerally important to me. Because I'm a lesbian who's going to be marrying a trans woman and we're having a child together and that could put us in danger, in the near future, if things don't go well. Knowing that they understand that, and my cousin just can't—she doesn't have that experience and it's not anything against her, but she just doesn't have that deep understanding of, I could very well be risking everything I love and everything that is important to me because of that. (Hispanic, lesbian, trans and nonbinary person)
		When I'm feeling I really am alienated from my body or I'm having like some kind of identity-based anxiety or when, yeah. I think that community [trans Facebook group] helps me kind of like get connected to—is more soul nourishing and reassuring. (White, queer, trans man)
		To be supported by other folks who are pregnant and in the similar parts of their pregnancy, or even a little bit ahead, because most of the people who ended up getting pregnant got pregnant before I did. When somebody is going through it or has just gone through it, or even if they're like a little behind or about to go through it, they have a lot more sympathy. (Black, same gender loving, nonbinary person)
	Subtheme 2.2: It takes a village	
Co-parent support	Co-parents beyond partners	*I want a co-parent. I don't want the relationship like that with the dad, but I do want to raise a kid with them having a relationship with their dad. (Black, gay cisgender woman)*
Tangible support	Tangible support from partners	*[boyfriend's name] basically scooped us up and was like, "You're living at the lake house with us now." They have a lake house in [town name], and it has central air unlike their house here which is 100 years old and unlike our apartment which is built in the 70s with a little unit. So [boyfriend's name], [boyfriend's wife's name], his dad, [nesting partners' name], and I were all living together for a week, basically, five days during the heat wave. (Black, bisexual, trans and nonbinary person)*
		Upon the positive test, we made a 40 week spreadsheet and worked on it for several hours a day until it was done…I can't possibly remember what all the columns are about, like possible symptoms, possible remedies, things to eat, things not to eat, non-physical agenda items like when to buy a stroller, physical agenda items like when to take your gestational diabetes tests—which the doctor's definitely going to take care of. But he's got it in there too. And there are so many more, there are so many more columns in the spreadsheet. He is really taking on the burden of preparation in many different ways. (White, queer trans man)
	Tangible support from community and chosen family	*Community chipping in to buy all the things that the baby needs. The baby registry was a big support. And then like also the community helping pay for my postpartum doula [through a GoFundMe]…It's been like a lot of like resource contribution, like material resource contribution. (Native, queer, nonbinary person) [also, midwife and doula volunteered services for free]*
		 *They're definitely a huge part of our hospital plan and our postpartum support and our queer chosen family…They dropped off this card to be like anything y'all need—we're here…it's one thing to like send a text, but that they picked up this little cute card and they changed the "I" to 'Y'all." For me it's all about relational connection. I really do believe that that's what gets us free, it is the ways that we can take care of each other because the state sucks and society fragment us. (Hispanic, queer, genderqueer person)*

	Tangible support from family of origin and extended family	*Both of our parents—while none of them are wealthy—they could part with a couple hundred here or there if needed to—if we needed it. My boyfriend was never going to let us be out of rent…There's no situation which would get on the streets, you know? We're highly privileged in that way. (Black, bisexual, trans and nonbinary person)* *[Partners name]'s family, they're supporting us financially, they're going to pay for a year of rent. And they're willing to co-sign, if we need a co-signer for an apartment…without [partners name]'s family supporting us through this, I don't know where we would be. I probably wouldn't—it would be very, very, very difficult. (Mixed race, pansexual, trans and nonbinary)* *When I found out I was pregnant, I just was like, "Oh my God, I don't have any—I'm not really able to [physically] break down in any of these relationships or structures that I'm in." That got pretty extreme pretty quick, because by the time I was six weeks pregnant, I was in the ER for dehydration 'cause I got so, so morning sick. I was really, really, really sick. And it got really scary because I really didn't have anyone to pause their life and like come take care of me…Being here [at my parents' house] is really—felt very motivated by the amount of physical, real, needing really, really dependable physical support in order to be able to specifically to feed myself…I needed to be in a place where I could be 95% sure at all times that someone else would do that if I couldn't. (White, queer, trans and nonbinary person)*
Theme 3: The pain we bear		
Subtheme 3.1: Hostility and harm from others		
Harm from others	Harmful interactions with others	*Whenever he [step-dad] wants to tell people how to live their life he has all the words. When he's trying to like fix the situation or whatever. He won't open his mouth to do that. (Black, gay cisgender woman)*
Harm coming out	Hostility and stigma expressed during spontaneous reflections of the coming out process or when describing their family formation announcement	*When she [mom] found out I was gay, she was like, "don't get married, don't have a baby, just have a career. That's all you need." It definitely taught me a lot about, you know, not everybody is allowed to deserve it—they're not deserving of a family. (Black, same gender loving, nonbinary person)* *We had mentioned that we might be interested in adopting or doing IVF. And my mom said, "Well, that wouldn't be a real grandchild." I don't know what I'm supposed to do with that. I didn't mention—I didn't really bring up the conversation again for a long time after that. And that kind of kept them at arm's reach throughout the pregnancy. (White, lesbian, cisgender woman)* *When I told her [a colleague] I was pregnant, she said—it was a text conversation. But she said, "Not" with a smiley face or an exclamation mark "WTF". And I said, "Just telling you like it is." And she said, "Huh. You really do transcend gender." And I said, "I can see why you would think about it that way." And she said, "Now you really are female and male." And I said, "I can see why you would think about it that way. It doesn't really match how I think about it." And she said "Not really about feelings, it's just about facts." I actually remember it in a very verbatim way. It wasn't that long ago. And I said, "This is actually the first objectively female thing about me and still I can decide how I'm going to live my life." And then we moved on. (White, queer trans man)* *My best friend, who's going to be the godparent. She told her mom like, "Oh, [participant's name] asked me to be the godparent." And she was like, "You're going to be the godparent to that gay baby?" (Black, gay cisgender woman)* *The worst was probably two friends that I'm actually still not speaking to cause—and they were primary people in my life—and our relationship became completely estranged over this cause they didn't agree with my decision to keep the pregnancy and were pretty judgmental about it and offered their judgment verbally to me. Our friendship hasn't recovered from that yet. Which has been pretty destabilizing in a support way and in a people can suck way. (White, queer, trans and nonbinary person)* *Every person's reception [to the idea of being pregnant] had to do with their relationship with the same topics and to what extent it made them feel closer or less close…I have a friend who is also trans and has taken testosterone with the same amount of time as me. He was like, "You really want to do that?" Which I just I read that through his own—not that he wasn't hearing me, but he was also having his own experience around [the pregnancy] creating distance between us and separation and difference of experience. And also feeling like, "Is that really allowed?" That was how I experienced his experience. (White, queer trans man)*

	Normalization and confusion expressed when describing their family formation announcement	*"[Brother-in-law's name] fathered the baby" or whatever. That's how her side of the family explains how we made this kid. She gets a little bit uneasy with her grandmother, for instance, calling her brother the kid's father. She wants to make clear, especially as they grow up, "No, that's not your father. He helped, but that's your uncle." ...She definitely does more of the advocating probably because it's her fighting for her position in who this child is to her… I think to her it's, if you're just looking at it out of context, it's this is the mother and this is the father and where am I in this picture? (Asian, lesbian, cisgender woman)* *The questions I kept getting asked again and again and again were firstly who's the father…I would say 90% of the people, 85 to 90% of people I've told about the pregnancy, their first question is "who's the father?"...I think part of it is that families consist of two parents. I can tell people I'm parenting this kid with both of my partners, but they still want to find the nuclear family in that arrangement, the traditional nuclear family within that arrangement to acknowledge. It's I feel like it's similar to when people ask gay couples or lesbian couples, so who wears the pants, you know? It's like, okay, I get it, I get it. I get it. But fit my schema… And then people asked, "Oh, so does this mean you're a girl now?" Or "does this mean you're a woman now?" (Black, bisexual, trans and nonbinary person)* *My aunt I had told her at first about it and once I actually conceived, she told my uncle and she was like, "Hey [participant's name]'s pregnant. He's like, "Oh, that's what's up." Then he's like, "Wait, how did that happen?" She was like, "Don't worry about it. Just be happy for her." And he's like, "okay, okay, okay." [laughs] A lot of people were kinda confused and, even when I made a post on social media about it, people were like, "Who's baby, is that?" (Black, gay cisgender woman)* *My mom has told friends of hers that were pregnant, and they literally will be like, "Oh, so exciting!" 'Cause I think they forget for a moment that [partner's name] is trans and then there'll be like, "Ohhhh"...so they feel uncomfortable to be very excited about the pregnancy. We've found that because they don't know how to think about, they don't understand the process. Like for some reason they understand IVF if straight people are doing it, but us not being straight just confuses them. (Hispanic, queer, genderqueer person)* *I did get one comment, when I made my announcement of someone that I had a loose acquaintance with a while ago, commented like, "wow, how did that happen?" When I was pregnant. And I was kinda like, [clapped] "I don't even know that I want to respond to this question." (Hispanic, lesbian, cisgender women)*
Gendered experiences	Being gendered in ways that caused discomfort and distressing	*The really sort of alienating aspect of being pregnant and trans, I don't know how to discuss…I would post something on Facebook about being tired or being annoyed that I have to stay in bed or whatever. Inevitably two or three women would pipe up to say, enjoy it! Just like enjoy being a princess and being taken care of and dah dah dah. And I'm like, firstly, this isn't a vacation, all right? You know better, you've been pregnant. This is not enjoyable. This is deeply uncomfortable…I like being the person who provides for, not the person who's provided for. And I like being—I like holding my space in the world, in a I guess a public way. I like feeling as though I contribute to my home in, in ways that aren't necessarily traditionally feminine...I am a pretty independent person, but, and the loss of independence to a certain degree has bugged me, but that hasn't really been the crux of it for me. It just the role that I play in specifically my home....I get really frustrated with how that space has been feminized by people in a way that so often comes from women. (Black, bisexual, trans and nonbinary person)* *When I told a few other people like people I was close with when I worked in [old city lived in] and stuff, everybody's like, you know, you gotta start dressing like a mom. And I'm like, what does that even mean? Like, I'm supposed walk around with a Mumu on or something? [both laughs] It didn't sit right with me. And I'm like, you can still be true to yourself. I just, it was like, everybody had their vision of exactly what a mom is. And to me it's like there's no blueprint on anything in life. (Black, gay cisgender woman)*
		Subtheme 3.2: Hurting on the inside
Negative internal feelings	Statements that encompassed feelings of internalized oppression (homophobia, transphobia, etc.)	*The world tells us we shouldn't be parents. [crying] The guilt and shame that I think all parents feel get exacerbated by a historical narrative about our community that we shouldn't have kids or be around kids. (Hispanic, queer, genderqueer person)*

		 *We felt very isolated from my friends and family during what was such a vulnerable season…Especially in the beginning of the pregnancy, it was way more isolating. Having been [number of] weeks pregnant when COVID began and when everything shut down. So really not having seen a single person from week [number] of the pregnancy until week 16, I think it was the first time we saw anybody at all. It felt like I was having this experience that was really profound and beautiful, but also doing it very much veiled and on our own…there's this huge sense of like, "No one can save me from this because it's my body that has to endure it all and I have to do it alone." (White, queer cisgender woman)*
	Statements that encompassed feelings of isolation and loneliness	*There're things, feelings I have that they don't understand. And so sometimes when those things collide, I often feel really kind of alienated...I don't actually have anybody I talked to about this [gender stuff]. I can attempt to talk to my partners about it, but they don't really know what to say. They don't have anything. They'll listen but they don't, and I don't know what they would, should say, right? (Black, bisexual, trans and nonbinary person)*
		I feel like very lonely and confused as to why I did this [got pregnant]. But then there was no alternative. And I'm trapped in this denial of where I am right now. And it's only hurting me and making me feel even more alone. (Asian, queer, cisgender woman)
		I felt very, very lonely many, many times. Very lonely, very low. And while I have the support of my partner, which totally buoys me, I still felt very lonely not having my friends...I feel very detached from my pregnancy. I feel very detached from my body and yet I'm feeling very lonely. And then I have to reconcile and acknowledge my connection to this growing being inside of me. All of that was very uncomfortable for me. (Asian, queer, cisgender woman)
	Statements that encompassed feelings of anxiety and depression	*I'm wondering if I am having prenatal depression. I'm crying literally all the time. I can't make it through a class. I'm turning off my zoom because I'm just like bursting into tears. (White, queer trans and nonbinary person)*
		Doing all of these things and investing all the money and time and energy and effort into it, and then not knowing if it was even going to work just the uncertainty of it. I was like just obsessed with the process and maxed out on anxiety in a way that it wasn't totally normal for me. (White, queer cisgender woman)
		Subtheme 3.3: Sacrificing the self
Sacrifices of support	Enduring harm to access support people and loosing support people over putting their needs first	*I have only four more years before I don't have to deal with her because as long as my baby sister, baby sibling is in their custody, if in her custody, there's nothing I won't do for them. (Mixed race, pansexual, trans and nonbinary)*
		A bunch of different things happened, but it involved me pretty quickly extricating myself from that situation which was really hard for my friend that I lived with. She still is pretty angry about it. I think it was the right thing to do 'cause I've just needed a lot of physical help and support and I feel more confident of my ability to get that where I'm at right now. (White, queer, trans and nonbinary person)
		My baby sister was living with my mother—who, again, I didn't really have contact with the last two years due to her behavior. But she'd recently moved up here to go to college. So I might be seeing a bit more of her, especially now that I'm speaking with my mother again. (Hispanic, lesbian, trans and nonbinary person)
	The pain and cost of compromises made to access support	*I'm in so much pain. I don't, I don't f**king care. As long as she's [acupuncturist] not yelling at me or telling me to leave, I can handle being called "mom" for an hour or being misgendered for an hour, like poke some needles, I mean, make me feel better. (White, queer trans and nonbinary person)*
		My parents say that about my Trump supporting family members–they [parents] say, "We don't talk about politics with them. It doesn't come up. So they're fine with you. 'Cause we don't talk about it." So it's like I don't exist at all. Because they don't talk about politics, they never talk about me, 'cause it's political because I'm gay. (White, lesbian, cisgender woman)
		Those [parenting] groups, which are people that like I connected with in person and I'm friendly with, but like, they're not queer. They don't always know what's going on. I'll get mis-gendered. They don't, they don't fully understand certain things. (White, queer trans and nonbinary person)
		*Its honestly, usually when I'm desperate [go to cisgender people in life for support]. There's that. And it's usually around things that I feel like they're going to f**k up around how they say it, how they answer it, or how they try to connect with me and they might erase me, but it's more important that I get the information. (Hispanic, queer, genderqueer person)*

	Support with strings attached (owing people for their support)	*I mean they [family of origin] just don't really give a f**k…I have to promise stuff to get stuff in return or I just don't ask at all. (Black, same gender loving, nonbinary person)* *His [partners'] mom is from wealth and wealth is weaponized. So you owe her s**t if she gives you s**t, which is one thing that's anxiety provoking about her buying so much for the baby. (Hispanic, queer, genderqueer person)*
	Pregnancy forces coming out people that that didn't previously know their sexual orientation(s) and/or gender identity(ies)	*"Well, this speeds up coming out to your [partners'] family." [laughs] Cuz his family didn't know about him being polyamorous or pagan or that he and his wife aren't living together. And so it was incredibly stressful trying to support him. And at the same time, I was also having my own anxieties around meeting his family. What kind of support might they offer? Will they actually want to get to know me or are they going to try to shove me into a box? And trying not to let all the anxiety and overthinking overwhelm me and just take it day by day interaction by interaction. (Mixed race, pansexual, trans and nonbinary)*
	Pregnancy forces hyper visibility and "being on display" in support groups and in childbirth classes that are not specifically queer and trans	*We also did this hypnobirthing class that's local to us and not queer specific or trans specific. And while the people there were extremely welcoming and did their best to adjust and accommodate, it was really all about the mother, all the time….Some people will say they feel invisible. I actually feel really hyper-visible. Even as we're doing these read aloud and other people are following [my partner's] lead on adjusting the language as they read from mother to birthing person or whatever. Every time they do that, and they sort of pause or hesitate or have to work through it I experience—whether it's true or not—all eyes on me. The reminder that we are different than you…It's an experience of being on the outside of the space and that's quite different in a space that is focused around queer and trans people. (White, queer trans man)* *It would have been really empowering to see other people like us. I definitely wouldn't have gone to a different, I wouldn't have felt comfortable going to a group that is not catered to the queer community. If it's a group that's all cis hetero folks, I would be too focused on like how are people perceiving me. Are people confused why we're even here? I wouldn't be able to even focus on the content. (White, queer trans and nonbinary person)*
Support that's not supportive	Support that isn't outright harmful but still not supportive (makes them feel different or just isn't the support they want or need)	*My mom isn't a reliable source of support. She's not a source of support for me... She's just here. Cause I know like she loves me the best way she can. Even though it's not the way I need to be loved, but like I can appreciate what she does have to offer. (Native, queer, nonbinary person)* *Our experiences are so vastly different. The same thing around how we want to parent—what books we want our kids to read, what clothes we want our kid to wear. All these things are so informed by our worldview and our consciousness and it's like "No, I don't want your hand me downs of this because like, they're highly, highly gendered in ways—and they're super f**king problematic…and don't you know me by now? Is kind of how it feels. Did you forget who I am? 'Cause like that ain't it. (Hispanic, queer, genderqueer person)* *Having straight people give advice of like, well you just can't be stressed about it. If it's going to happen, it's going to happen. I'm like, "b***ch, you have sperm access all the time." I don't have that. So it's not the same. And so that was frustrating and could feel like I get that you're trying to be there for me. And I appreciate your effort. And also just do less, just listen. (Hispanic, queer, genderqueer person)* *Our neighbor across the street, her sister had a baby in [month], so he's like five months now and is huge and just like outgrowing things like really quickly. And so she's been giving us a ton of hand-me-downs already. And so, which is great, we've gotten two huge boxes of like mostly clothes. But in there there's been a few that have been like "daddy's little slugger" or you know, things like that. Or even just there was one onesie that was like 'all muscle'. And I was just like, "I would never put my tiny child in this." It was so highly gendered. Which I would assume that she would know. (White, lesbian cisgender woman)*
Compromises of support	Not receiving support, celebration, and validation of gestating a child because don't want to have to come out	*I'm getting to the point where people probably suspect, but don't really want to ask outright, "Oh, are you pregnant?" and I tend to avoid it. You can tell that they're fishing. But I'm like, "Okay, let's move on to something else." And I don't really know. I'm not embarrassed to be pregnant, but I think because I know subconsciously it will lead to, "Oh, what does your husband do?" And that sort of thing. So I think I just try to steer around it and avoid talking about it, especially with people that I'm not necessarily close with. (Asian, lesbian, cisgender woman)*

	Not getting access to information or people as the cost of setting boundaries	*It's a way that I am in my body that I feel like makes me not [pauses] have an exp-, have the experience that I should have—that is like holistic and cared for and connected and curious and present. I'm instead suspicious and scared and defensive and on guard and reserved in ways that I would never be. (Hispanic, queer, genderqueer person)* *It [the presidential race] has polarized other supports that we likely would have used had we not known that they're avid Trump fans. And it's fine. I don't feel like I'm in a deficit of support by any means, but it would have looked much wider prior to all of the political stuff that's been going on. It's the only other crazy influential thing that we were like, "Oh my God, we used to go barbecue with the family all the time and they painted Trump on their truck." That's deep level Trump right there. And now we can't even imagine like bringing our children over there…I have an aunt who was a Trump fan. Blows my mind, but yeah, just die-hard Trump. And we had to have conversations of, if you want to continue to hear about the pregnancy, be a part of our core group once the baby's born, you cannot talk about politics anymore. (Mixed race, bisexual, cisgender woman)*
		Theme 4: Obligatory resilience
		Subtheme 4.1: Laboring for support (the effort and energy to access support)
Information gaps	The effort, time, and labor required to access inclusive resources	*I am not going to any pregnancy groups right now because I, even the online ones outside my groups on Facebook, I don't trust them to necessarily be good about me, being trans. And I don't want to hear all the gendered stuff. I know that there's more support out there. I might be able to get it, but it would also come with a lot of trouble and a lot of effort. (Mixed race, pansexual, trans and nonbinary)* *So we did hypnobirthing classes…I found the organization, I emailed them and I said, "We're a same sex couple, is it okay for us to participate?" That is something that I feel like we have to do sometimes. And a lot of straight people don't do stuff like that. "Is it okay if me and my husband join your Lamaze class?" "Of course it's fine, Bob." (White, lesbian, cisgender woman)* *There was just a lot of education we had to do before we could get to the like emotional support. (White, lesbian, cisgender woman)* *I'm grateful that I am someone who seeks out information and gets information for myself. But it's also a lonely experience because I shouldn't have to put all this labor forward. (Hispanic, queer, genderqueer person)*
	Bearing the burden to seek information an seek everything themselves due to lack of inclusive resources	*It's kind of all me in a way, right. I purchased the books. I made the support group. I do the research. It's me…I'm my only rock [laughs]…In general unless I'm dying, I'm gonna, I'm just gonna push through it by myself. (Black, same gender loving, nonbinary person)* *The resources that I need don't exist so I'm kind of piecing it together on my own. [Midwife's name] is working on a gender-neutral book, but it's not out yet. It's interesting being at a time when everything is just starting to form so there's these glimmers of hope, but then to have it just out of reach. (Mixed race, pansexual, trans and nonbinary)* *The pregnancy scene, the self-help books, the, all of the blogs, they're all full of so much earth goddess sacred femininity, woo woo bulls**t crap. (Black, bisexual, trans and nonbinary person)* *They'll [books purchased] maybe mention like, "or any partner" they have like a throwaway line, but it's not really inclusive. (Black, same gender loving, nonbinary person)*
Unique needs	Topics that are unique to queer and trans people beyond language and representation (inducing lactation, support as a non-gestational parent, support for co-parents that want to be highly involved, feelings or needs around birth due to relationship with body, determining parental names, vetting providers/doulas/daycares, how to educate others on their family formation dynamics, navigating healthcare when giving birth, going back on T after giving birth, etc.)	*Being a birthing parent and having these feelings of alienation because all the spaces are so mom oriented. That's the stuff that I didn't know how to handle necessarily. And there's no book for that—that I know of…[and] there's a lot of binary gender role thinking in a lot of parenting resources where it's like, "This is the stuff for mom's and this is the stuff for dads. And the stuff for dads is all about like supporting mom in a particular way. And the stuff for moms is all assuming almost a certain ineptness and uninvolved from the dad." That seems really problematic to me. Why are we assuming that I'm doing all this alone? What the hell? (Black, bisexual, trans and nonbinary person)* *A lot of conversations among parents [in my support groups] about how they talk to their kids' teachers about queerness or how they do or don't sort of vet schools and daycares and care providers of different sorts for inclusivity and queer comfort. (White, queer trans man)*

	Dealing with defensive and emotionally reactive responses to taking care of needs or setting boundaries	*With not wanting to gender to the baby or assign a sex to the baby, I explained that to my mom and she was like, "Okay, yeah. Cool. Can I ask, can I ask if it's a boy or girl?" I'm like, what?...I just didn't trust that she was getting it afterwards. And so my wife like sent her these really informative and like funny, nice educational messages, like videos even explaining to her the background behind why we didn't want to do this and how she cannot do this. And she called me afterwards like crying and was like, you know, "I feel like you attacked me." (Native, queer, nonbinary person)* *A couple of weeks ago [my mom] came over, she was like, "I shouldn't tell you this, but I was so angry at you when you told me that I couldn't come for the whole weekend. And I just feel like if I say one thing wrong, you're going to take away the baby for me for my whole life. And I'm never going to get to hold her or touch her or anything." And it was really intense…She sat on the couch with me for five hours and drilled me about my religion and her identity as grandma and why she feels like she doesn't have enough of a role in the baby's life. And I ended up holding her while she cried for many hours and it was just so inappropriate and crossing a million boundaries. (White, queer cisgender woman)*
Managing others	Quelling fears of family members around being a queer/trans pregnant person or around their unique parenting structure	*I want a co-parent. I don't want the relationship like that with the dad, but I do want to raise a kid with them having a relationship with their dad…I told my mom, and she was like, "What? Are you crazy?" She's like, "Do you have to pay him?" And a lot of people were like, "Make sure you get a contract because what if they try to steal your kid." And like just, it was just so many things. And from a certain perspective, it was like, okay, cool. They're trying to look out for me and make sure I'm protected. But then at the same time it's kind of inserting fear into the situation. And I wasn't fearful of the situation. (Black, gay cisgender woman)* *"Your kid is already going to be so made fun of, and so teased because they have two moms. Why are you doing anything to make their life harder?" [in discussion circumcision with her mom the mom said] And so I think, I didn't even know that she felt that way at all. I think it is present on her mind that our child is going to have a harder life because they have two moms. (White, queer cisgender woman)* *That's another thing, right? Of like, "Oh like, well what is [genetic parent's name]? And what about [genetic parent's]'s family and what is [genetic parent's]'s partner?" And then people moving a lot from a fear and scarcity place of like, what's that gonna mean for [partner's name] adopting the kid. And that sucks, you know, navigating lawyers and navigating the s**t, the advice they give you of, like, "You shouldn't tell people who is the genetic father, because the state could like use that against you" for whatever f**king reason, if they just f**king feel like it. It's just frustrating. 'Cause that's the world that we live in—someone has to relinquish rights in order for another person to have rights because we live in a culture that's like monogamously oriented and within the confines of the institution of marriage. (Hispanic, queer, genderqueer person)* *[My grandma's] afraid of the gaze of others. She asked me a lot of questions about like, "Are the reporters going to come to your house? Are the television cameras going to come?" She was very afraid that I was going to be a spectacle of some sort. Afraid for me, not for herself. (White, queer trans man)* *I'm not sure what her initial reaction was born out of except for probably just general like cis-heterosexual fears about like queerness. I want my grandchild to be safe and this feels scary and risky and unknown. (White, queer, trans man)* *She had some fears and anxieties about like a trans man birthing a child, even though she's really supportive of our relationship...my mom hasn't ever really totally understood my gender identity in the first place…She's pretty influenced by like what she hears. So the common narratives are about trans experience. And so I think that for her, there must be a lot of pain. There must be a lot of like angst or like maybe body dysphoria. I think she does a lot of laying on a narrative to my experience that's not totally true for me that, I have trouble disrupting because it's just vulnerable to talk frankly about these things with her. (White, queer, trans man)*
Barriers of local environment	Extra effort required to find inclusive resources and representation when local environment is more rural/conservative	*Now I live in a very rural area in the most rural state in the country. And there isn't really a community. We don't have any LGBTQ community here to speak of, yet… and while we have made some friends, it's being a city person and being gay can be a double whammy…This is different and it's scary because of that. I guess I'm saying that what's that word—when people are out, when you can see them, it's really meaningful. So not being able to see any other people who are different is kind of sad for me. (White, lesbian, cisgender woman)* *We live an hour away from [city name], which is where most of our community is. I think if we lived in [city name], I would've gotten a lot more support. (White, queer, trans and nonbinary person)*

Subtheme 4.2: To ask is too much

Barriers asking for support	Support isn't asked for because having to ask is a barrier	 *To an extent it's really tranquil out there and peaceful out there. And I think that's how I feel when I'm getting the support, is that there's a sense of peace and calmness and quiet. And then I don't know that it's, that I'm not getting the support, but when I'm not feeling as safe and secure or confident, it feels a little bit more shattered. So that's the beginning part of going out there to find the peacefulness, but sometimes it's a little bit broken, along the way. (White, lesbian cisgender woman)*
	Support isn't asked for because having to ask is vulnerable	*I don't necessarily often ask for help. And I think it would be a compromise that I would have to make for myself of like, asking for help. If I needed it, they [parents] don't necessarily proactively offer it, I guess. In the way that like [wife's name] does, like anticipating and things like that. I think it's the compromise I'd have to make is like making myself vulnerable in a way...once we're there, you know, it's like my mom like sends us back with like so much food and like, you know, she's like showering us with stuff. It's just like kind of like the hurdle of like, you know, asking for that help. (White, lesbian cisgender woman)* *I did have like a moment of tears where I was like, "I can't do this." It was the independence that was killing me. It wasn't that I was in pain or anything like that. It was just like, I actually physically can't do this. I was having contractions—the Braxton Hicks all the time. Walking to the mailbox, I was getting them where I was, you know, it's 300 feet down the road and I'd had to take like six breaks and asking my wife to do that, which is something, I mean, who can't walk to the mailbox? So that was a very hard point. But it got so bad that I actually had to ask for help. And so for me, it had to get to an extreme for me to ask for help. (Mixed race, bisexual, cisgender woman)* *I hate crying. So sometimes talking about it, like if I'm texting about it, it's fine, I can cry by myself. Nobody really knows. But talking in person and then going through the emotions of crying is just like, I hate it so much. Even after having [baby's name] I would cry every day, but I would cry in the shower. So nobody knew I was crying or anything. (Black, gay cisgender woman)* *I have trouble putting myself out there and asking for support. And so the times when I have tried to reach out, it hasn't really gone so well have felt very isolating or lonely. (White, queer trans man)*
	Support isn't asked for because of rejection and abandonment from family during coming out process	*Also asking for help has definitely [been] influenced [by] the fact that I didn't get that [support] from my family the way I should have…and I've attempted to ask like my sister for help in like some ways too. And it wasn't until we had a really hard conversation that she like stepped up, but I've always been viewed more of—when I go on these and embark on these journeys that I'm oftentimes like needing to be independent in it and like support myself a lot of the time. (Mixed race, queer, nonbinary person)*
	Support isn't asked for because of a need to of fear of having to prove they are capable as a queer and/or trans parent	*I was trying to explain to her [mom] what it's like to be queer and a parent and going through this. I was like, "I accidentally hit [baby's name] head on a piece of furniture, I cried hysterically the whole day….This is all normal stuff that many people think about themselves when they're parenting. My mom's like, "If it makes you feel better, why don't you call the pediatrician?" And I'm like, "Well, I'm afraid to, because then they have to write it down. And if they write it down, and they have to give documents to the adoption, and we have the wrong caseworker, what if they think—they could use [that against us]. Literally the s**t you're thinking of because you're preparing for people to assess whether you can have your own child. (Hispanic, queer, genderqueer person)*
	Support isn't asked for because layered with other things (feminine role and neurodiversity)	*I like being the person who provides for, not the person who's provided for. And I like being—I like holding my space in the world, in a I guess a public way. I like feeling as though I contribute to my home in, in ways that aren't necessarily traditionally feminine...I am a pretty independent person, but, and the loss of independence to a certain degree has bugged me, but that hasn't really been the crux of it for me. It just the role that I play in specifically my home....I get really frustrated with how that space has been feminized by people in a way that so often comes from women. (Black, bisexual, trans and nonbinary person)*
	Support isn't asked for because they can't find the resources or don't know where to look for their support needs	*In some ways maybe I'm not asking so much because I feel like I'm supposed to know. [long pause] And in some ways I do know more, I think, than a first time, because I have gone through this before and I was like really invested in [wife's name] journey. I mean, I have friends who have husbands whose fathers know nothing (White, lesbian cisgender woman)*

	COVID reduces organic opportunities for connection and forces more asks when support is needed	*There's the second barrier of having to explain what you're going through. You can't see it on my face or you're not looking at me throughout the day. So you don't know. Or we can't meet, not like I would meet for a drink, but we can't go out to a restaurant and I can get a mocktail or something. And then at least my friend could see on my face what I'm going through. So it feels artificial even to text my sister who I'm very close to and complain or express how I'm feeling. It's just too many barriers entry to the conversation. So I just talked to her, I just talked to my partner. (Asian, queer, cisgender woman)*
Influences on asking for support	Comfort and safety informs who is asked for support	*I can text her whenever I have a need or an anxiety or a question. And that has reduced significant anxiety about what happens if labor starts here at home at night, for example…she's like a branch off of [wife's name] versus a branch off of my friends, that I feel like I could tell her more about my emotions. She's just more in tune and ready for all of the emotions. And there's less barriers there. She'll just get it because that's what her job is. (Asian, queer, cisgender woman)* *It's really challenging for me to ask for support from people who maybe don't understand what it's like to be part of the LGBTQ community or who maybe don't understand minority stress or things that I worry about in terms of my family being discriminated against or how the current political situation could impact my family. It's hard for me to open up and ask for support from people who I don't feel really understand that. It kind of shrinks my core group a little bit. (White, lesbian, cisgender woman)*
		Subtheme 4.3: Putting the oxygen mask on first
	Disassociating to access support people or resources that were harmful	*I personally am able mentally, emotionally to dissociate very good. I don't know if that's a good thing. But it helps me and it's a good practice that I've had for a while…I also just have to be the higher person because like, I do need this resource. I do need this moment. You know what I'm saying? And so yet again, it's always accommodating to the more dominant—whether it be a dominant race, sex, identity…I'm very resilient in that way…[but] where's my medium of enjoying my child's birth and not letting this consume me and dissociating the way I always do. (Mixed race, queer, nonbinary person)* *At the end of the day, whatever knowledge and information that I need, I'm still kind of making it my own when I do read it, when it's written for a cis hetero female. I still kind of just take in the information and read it, find it of value and then like put it into my own context of like how it applies to me. (Mixed race, queer, nonbinary person)*
	Withdrawing from relationships that didn't feel safe any longer	*I completely stopped telling them [friends] about any of the complications because it was just like so clear that they weren't safe people anymore....I think one thing is that I stopped this is such a 21st century thing, I stopped texting individually with that person and only communicated with them in the group chat with the four of us—four moms. And that way it just seems like it's a little safer. (White, queer cisgender woman)*
Coping (emotional strategies)	Avoiding public places and settings where harm was anticipated to occur	*It's been like a lot of internal struggle with that and it's looked a lot like me just kind of giving up on sorting out my appearance will be especially cause I don't have to go anywhere. So if I grow an neck beard, I grow a neck beard, no one's going to see me. I'm not going to look in the mirror. I'm good. I'm in—all my clothes now are just like baggy because like I'm trying to hide the belly but, that's not, what's comfortable. So yeah, there's been a lot of dysphoria and so I just kind of avoided it all. Avoidance has been my way of coping. (Native, queer, nonbinary person)* *I think it's been helpful to be in this in some ways to be a pandemic, because I feel like I don't have to contend with as much mis-gendering or as much curiosity about my body. (White, queer, trans and nonbinary person)* *I'm not on any of those other groups [heterosexual or cisgender pregnancy or parenting support groups]. Because just to start with, I don't join them 'cause I don't see myself fitting there. And I mean, I worry about even things like...when I'm on those groups, I feel so self-conscious, "Are people looking at my profile? Can they tell that I'm trans? Are they assuming that I'm female because I'm on here?" It's not a comfortable place for me to be. (White, queer trans and nonbinary person)* *I don't really want the world to see me like that…people staring. Looks of maybe disgust. There's a lot of crappy people out there. (White, gay trans man)* *When people started being crappy or difficult or hard to talk to, I just stopped talking to them more or less...strategically avoiding those conversations with a lot of people I would see in person. (Black, bisexual, trans and nonbinary person)*

		*I also frankly, didn't want to tell people…Cause I didn't want to deal with people's bulls**t. Even in just the few people who I told one-on-one who were friends, who were whatever, there's just a lot of, [sigh] not a lot, but enough stupid questions and comments that I just didn't have the energy to deal with. (Black, bisexual, trans and nonbinary person)* *It feels scary honestly. 'Cause, I mean, I've definitely tried to go there and just, well, I haven't. But my wife has tried to go there and just get simple answers and there's just a bunch of more oppression within those answers. And so that's kind of, that's a reason also that I've stayed away from those spaces [online groups]. (Native, queer, nonbinary person)*
	Setting low expectations for others so didn't have to feel disappointed	*I imagine [my mom's] going to want to do grandma things and, take pictures with the kids that she can post on Facebook and look like the doting grandma. And I don't expect a whole lot more from her….and if I don't expect a lot from her, I can't really be disappointed by her. (Hispanic, lesbian, trans and nonbinary person)* *I don't expect any support from them [parents] is what I'm saying. And if anything nice happens. It's like it's noticeable, but it's not expected. I would never ask them for help or I would never ask them to, I would never ask them to help me with anything in life because I don't think it's—it's not that kind of relationship. I have other people in my life who do those things, who I can be myself with. (White, lesbian, cisgender woman)* *I feel like things have shifted. I don't have expectations toward anyone anymore. I'm like, "This is not your responsibility, nor duty, nor obligation." I'm not going to rely on anybody except my family unit, and even so, then I rely only on myself and [wife's name], and then we figure it out like that. So, it's definitely shifted. Yeah. It's just different now. A lot of the time, your friends just don't understand where you're at any more....when we need it and we really need it, we do ask for it. Even then—so if we can't find it, then we create the situation so that we can accommodate the baby. (Mixed race, queer, nonbinary person)*
Proactive coping	Maintaining a sense of privacy supports access to information and resources	*We found a black queer woman who does like those kind of classes…those have been my wife and I on a Zoom meeting. So very private…I think I would probably hate it [taking the class if it was in person]. Absolutely hate it, but I would still make myself take the class, but I think it would cause extreme dysphoria and extreme anxiety, but I would still do it. (Native, queer, nonbinary person)* *I think it's the medium—if you're reading something, it's not the same as someone standing in front of you calling you a dad when you're clearly a woman. That level of discomfort isn't there when you're reading something or going through an app versus a face-to-face class. (Asian, lesbian, cisgender woman)* *I did announce that I'm going to go on parental leave soon. And I spent a lot of time thinking through my language around it. The [people I work with] haven't asked any invasive questions. I assume that they assume that we're adopting because they know that I'm married to a man and I'm okay with that. I sort of offered them that as a way of thinking, right? I said, "My husband and I are going to become parents."…I spent some time stressing out about telling the [people I work with]. Feeling anxious about that…I figured the [people I work with] would ask me all kinds of questions and I was really ready with like, "I'm going to actually choose not to share that part, but it's okay that you asked. I'm just gonna keep that part private." That was a thing I never had to say, but I practiced saying a lot of times. (White, queer trans man)* *If we were in a class, a child birthing class [educational series vs an interactive course] with all heterosexual couples that really rubs my wife the wrong way. And I think we would have struggled to find racial diversity, sexual orientation diversity in the area that we're in. And so it would have added another layer of complexity to finding these courses and feeling comfortable in the courses and asking questions that—we're the only ones that have two women as parents and our questions are different than everyone else's questions...even if we found one that didn't have language that was as inclusive, there was an internal conversation between my wife and I, and not something we had to air with a room full of strangers. It was a conversation that we could have had that said, "That's really stupid. It should have said same-sex partners too." And then our conversation is over, but it's two people who could clearly see eye to eye on this subject so there's no animosity or adversity. You're talking to someone who feels the same way as you. Very different in a public space where you have to air your emotions to strangers. So I was actually grateful not to have to do that in this process personally. I was actually a little nervous about going through that…We didn't feel like we had to educate anyone about the process. We got to take it in as we wanted to take it in. (Mixed race, bisexual, cisgender woman)*

	Queer and trans online support groups where knew safety would be ensured	*I found it [other queer families] through those online groups—being able to see other families and sometimes people post things like post a picture of their family. I need to see other queer families and people will post. You get resourceful. You find ways to fill that. (White, queer trans and nonbinary person)*
	Hiring support and relying on professionals when there were needs and no one to fill them	*We don't have any family really here plus the pandemic. So she'll [doula] probably come help out a little bit after the baby's born for like a little bit of respite. That was like something we prioritized. (White, lesbian cisgender woman)* *I was super intentional before getting pregnant about just like building up a huge support team of professionals... I just wanted to be more intentional about not burdening our friends quite as much and relying more on birth professionals. I was working with an acupuncturist who became like an integral part of my week, and a chiropractor who became a huge support. And an abdominal massage therapist, a therapist. Gosh who else? And now being pregnant, having a birth doula and postpartum doula—I don't know, just a lot of people. And I'm seeing a midwife that we are really connected with. So a support team of people that we're investing in. (White, queer cisgender woman)*
	Mentally and physically preparing for anticipated future support needs	*I really made a decision upon embarking upon this of I'm not going to be thin skinned about it. People are going to say things that I wish they wouldn't say, and I'm just not going to be hurt by that. And I have found that effective…I [also] spent the last few years doing some inner work to prepare for this because I wouldn't have been ready a few years ago…I've done a pretty good job predicting the parts that will be hard and setting up safeguards within myself or within my community for how those aren't going to hurt too much…. My experience is that the anticipation of a challenging situation can take the teeth out of it. For me, not for everybody, but for me that's been true. So I've spent some time anticipating…listing what I thought would be hard, doing some Q and A with myself about like, "Will I be able to handle this? Will I be able to handle that?" I found it helpful to just like process in advance, what is likely to be challenging. (White, queer trans man)* *We have a meal train set up and I'm in a couple of different online support groups that meet every week with other parents and people. And I think those things are going to be really life-giving—just on a social level of getting nourishing meals and connecting with people online (White, queer cisgender woman)*
Boundaries	Family	*Needing to set up quite a lot of boundaries there in order to protect our baby from that interaction. And so just little things—I don't send her updates, I don't send her photos. And she will ask, she sent a couple of cards in the mail since that [painful] conversation earlier on. And I'm thankful for that and will respond to those, but without any information. (White, queer cisgender woman)* *It was more about when I was emotionally ready to talk to each person. I took it very much as a case-by-case basis...a lot of family politics to think through and asking people to keep the secret for a couple of weeks. (Mixed race, pansexual, trans and nonbinary)* *In terms of difficult dynamics in my family and trauma and stuff like that—there's some pretty intense don't ask, don't tell policies around things…I have a lot of boundaries around certain things with my biological family. (White, queer, trans and nonbinary person)*
	Social media	*I wrote a post that was—so basically in three parts, "Hi. By the way, I'm pregnant. 'case you hadn't heard yet, I'm having a baby. Here's why I haven't, you may not have heard about it yet. Its cause people are asking stupid ass questions, please don't be that person. And also, I'm going through these complications, and I can really use your support. So be happy for me. Be supportive. Don't make me educate you. I'm dealing with some s**t." (Black, bisexual, trans and nonbinary person)* *I'm either going to be dealing with racism or, or queer-phobia [in online support groups]. But the group so that, because I do run the group that I'm in, when somebody says something that's queer-phobic, I just kick them off the group (Black, same gender loving, nonbinary person)*

Advocating	A responsibility to leverage privileges and advocate for others in the community	*Y'all think I'm having fun [by having boundaries/advocating for inclusivity]? I'm not having fun. I'm doing this because if I don't—I'm going to feel badly that I didn't say something and someone else is going to have to f**king go through this after me...because not everybody gets to have the relationships in the community that I have. (Hispanic, queer, genderqueer person)* *I feel an obligation—it's an honor and an obligation to leverage said cushion, right? To leverage those advantages.... it may not be Jim Crow anymore, but our health outcomes tell the story. The statistics tell the story. And I refuse to just be a passive victim of the statistics. Not that anyone chooses to do that, but where I have the leverage, I will use it. (Black, bisexual, trans and nonbinary person)*
	Others advocating takes obligation off participants to not have to be resilient and advocate for themselves	*Prior to me being pregnant, she [mom] would have answered the questions [from her church about how they got pregnancy and who is the father] and been like, "Yeah, I know it's weird, isn't it?" and now she's been more like, "That's private information that I'm not going to share and it, and it's inappropriate that you would ask." She's been an advocate for us privately in a way that she never was before. (White, queer cisgender woman)* *[My husband] shared [to his cousins] the pregnancy info first and trans info in the same breath, but next sentence. If that makes sense with the understanding that the young people would ask them questions, but have some context [since their younger]…They started to share the info with their parents in the context of telling their parents that we wanted to have this meeting. And they sort of supported their parents through this meeting. So their parents came, they and their parents came with not a ton of knowledge, but a knowledge about why they were here. (White, queer trans man)*
	Subtheme 4.4: Finding our joy	
Mutual aid	Reciprocity of receiving and providing support to the community	*I actually had a few people comment [on a TikTok video] of like, "Oh my gosh, I'm so grateful that I'm seeing another non-binary individual whose actually bearing and open about it because a lot of people aren't. And they're like, "You inspired me 'cause I've always wanted to be a parent. You've inspired me after this." A 30-second TikTok—not even. The power of visibility is huge. (Mixed race, queer, nonbinary person)* *Almost on the weekly, I get a private message on Instagram or something from a queer couple who's like, "How did you do it? What was the process like?" And then we are able to dive into these conversations…alot of them are people I've never actually spoken to before. (White, queer cisgender woman)* *Community chipping in to buy all the things that the baby needs. The baby registry was a big support. And then like also the community helping pay for my postpartum doula [through a GoFundMe]…It's been like a lot of like resource contribution, like material resource contribution. (Native, queer, nonbinary person) [also, midwife and doula volunteered services for free]*
Visibility	Just existing as a queer and/or trans child birthing person is racial and defiant	*The significance of being two women and bringing this new life into the world right around the election—it felt very pivotal. Nothing about our marriage or my pregnancy or birth or anything really has felt very radical or subversive or anything. It really feels in general, pretty benign in a way. But the timing of all of that, I felt like we were doing something radical and different. (White, lesbian cisgender woman)*
Purpose/joy	The joy and meaning derived from forming one's family	*I'm in class, and I was fine having [my baby] with me in class, and…[our dog's] in the bottom corner at my feet, and then there's a basket of my knitting supplies. I was working on crocheting [our kiddo's] Christmas unicorn hat. Just a general feeling of pleasure. It's just delightful to have [my baby] on me. It feels good to feel needed by [my toddler] or to be able to support them when they're struggling through transition. [My partner's] sleeping because he needs that cause he's supporting our family. [My sister-in-law] is there and ready to take [the toddler]. Everything was covered…I felt full. (White, queer trans and nonbinary person)*

Appendix M. Guba's Criteria for Qualitative Rigor Applied to Queer and Trans PREG

Term	Guba's (1981) definition	Application of rigor to Queer and Trans PREG
		Credibility
Prolonged engagement	To overcome, so far as possible, distortions produced by the presence of researchers and to provide the opportunity to test their biases and perceptions, as well as those of their respondents	Participants disclosed vulnerable and sensitive information suggesting that the researcher was able to gain participant trust
Persistent observation	To identify pervasive qualities as well as atypical characteristics through extended interaction with a situation	A prolonged amount of time was spent with participants through multiple, lengthy interviews (M = 116 minutes per interview), suggesting an in-depth understanding of the phenomenon was achieved
Peer debriefing	To provide inquirers the opportunity to test their growing insights and to expose themselves to searching questions through exposing their thinking to a "jury of peers"	Two team members (KS & MD) coded a sample of the transcripts to co-create a consensus-based codebook. There were weekly peer debriefing meetings during the analysis process with the research team (MG & WB) and biweekly meetings with a peer (EM) and qualitative debriefing group
Triangulation (*study design*)	A variety of data sources, different investigators, different perspectives (theories), and different methods are selected in the study design to cross-check data and interpretations	The study was designed to include multiple methods (e.g., assessments, interviews, photos, and field notes), investigator backgrounds (nursing, public health, and psychology), and data from different time points and locations
Referential adequacy	Data collection: Documents, videos, audio recordings, and other "raw" data are collected during the study Data analysis: Analyses are tested against the data collected during the study	An archive of materials (audio recordings, photos, assessments, fieldnotes) were collected and stored. Recordings were transcribed verbatim by a professional transcription service Rev.com then cleaned and deidentified by KS and coded using Atlas.ti qualitative software (Version 9.1.2) The analysis and findings were tested against the archive of materials
Member Checks	Data collection: Interpretations are continuously tested as they are derived with various audiences and groups Data analysis: Test the overall report with the source group before casting it into final form	Emerging findings and interpretations were continually tested in participant interviews, and the interview guide was constantly iterated as themes emerged Results were presented to the advisory board, and a sample (25%) of participants and their feedback was integrated into the final manuscript
Structural Corroboration or Coherence	Testing every datum and interpretation against all others to be sure that there are no internal conflicts or contradictions	Results provide thick exemplars, highly abstractive themes, and overall presents a coherent narrative
		Transferability
Theoretical/ Purposive Sampling	Sampling that is not intended to be representative or typical but that is intended to maximize the range of information uncovered	Maximum variation sampling methods were employed to maximize the breadth of childbearing experiences. Only 9.7% of those who took the eligibility survey were invited to participate. Participants were purposively sampled based on their race, gender, partnership, and co-parenting configurations, gravidity, and geographic location

"Thick" Descriptions	A full description of all contextual factors impinging on the inquiry permits comparison of this context to other possible contexts	Data collection procedures and the sample are described with enough detail to replicate study procedures and test fittingness in another sample The complete interview guide is provided Exemplar quotes are attributed with important participant characteristics and are representative of the sample of participants (i.e., majority of participants are attributed in quotes)
		Dependability
Overlap Methods	One kind of triangulation, whereby ≥2 methods are used so the weakness of one is compensated by the strengths of another, strengthening the stability of the results	Multiple, complementary methods were employed (photos, interviews, and assessments) and integrated to complement one another (e.g., visual and auditory processing and expression of emotionally sensitive topics) and strengthen the findings
Stepwise Replication	The research team splits into halves to analyze data separately. Communication between teams should occur at important milestones to cross-check developing insights and determine the next steps	A consensus-based codebook was created from two coders who independently coded 15 transcripts from diverse participants and different time points. The coders were from different disciplinary backgrounds and lived experiences The coders frequently met throughout the study to revise the codebook
Audit Trail	Documentation that will allow an external auditor to examine the processes whereby data were collected and analyzed and interpretations were made	A running account of the ***process*** of the research was kept in a study journal and email memos. This included when and why research activities were redirected, such as developing photo prompts hints when challenges in photovoice arose or updating the interview guide based on the order and flow which participants organically talked about their experiences
Dependability Audit	Someone competent examines the audit trail and comments on the degree to which the procedures used fall within generally accepted practice	The ***processes*** of the inquiry were externally audited dissertation committee, Columbia University Irving Medical Center's Institutional Review Board, the National Institute of Nursing Research, and the Association of Women's Health, Obstetrics, and Neonatal Nurses
		Confirmability
Triangulation (*study findings*)	A variety of data sources, different investigators, different perspectives (theories), and different methods are pitted against one another in the results and discussion to cross-check data and interpretations	The manuscript integrates multiple methods (e.g., assessments, interviews, photos, and field notes), perspectives (nursing, public health, and psychology), and data from different time points and locations in an explicit effort to minimize avoidable bias and increase confidence in the findings The secondary coder (MD) was explicitly recruited to balance the disciplinary background and lived experiences of the primary coder (KS)
Confirmability Audit	An audit is conducted to certify that data exist in support of every interpretation and that the interpretations are consistent with the available data	A supervisor will audit the ***products*** of the inquiry to verify there is data to support every interpretation
Reflexivity	To intentionally reveal to the audience the underlying epistemological assumptions which cause them to formulate a set of questions in a particular way and present their findings in a specific way	A reflexive journal and practices (e.g., bracketing) were maintained throughout the study, and introspections were tested during peer debriefing meetings A statement was provided on how the interviewer's positionalities may have impacted and biased data collection and, consequently, the results

Appendix N. Study Duration and Involvement

	Transgender and gender-diverse participants		Cisgender participants		Total sample	
	Weeks	*Mean*	*Weeks*	*Mean*	*Weeks*	*Mean*
Entered study (weeks' gestation)	21 – 27	24.3	21 – 27	23.9	21 – 27	24.1
Exited study (weeks' postpartum)	7 – 16	10.5	8 – 12	9.3	7 – 16	10.1
Study duration	20 – 28	25.2	20 – 40	26.0	20 – 40	25.6
	n	*Minutes*	*n*	*Minutes*	*n*	*Minutes*
Average length interviews		112		110		116
Study Tasks (*not including photos)*		552		498		528
Enrollment visit	14	60	10	60	24	60
Demographic survey	14	20	10	14	24	17
Assessments	14	40	10	44	24	42
T1	10	34	9	18	19	26
T2	12	25	10	26	22	26
T3						
Interviews	14	115	10	109	24	112
T1	10	121	9	106	19	114
T2	11	130	10	116	21	123
T3						
Birth/Infant Outcomes survey	12	8	10	6	22	7
	n prompts/photos	*Mean per person*	*n prompts/photos*	*Mean per person*	*n prompts/photos*	*Mean per person*
Photovoice	67	6.3	82	8.2	149	7.1
Prompts completed, 12 per participant	140	12.7	122	12.1	262	12.5
Total photos, 1-3 photos per prompt						
	n missing	*%*	*n missing*	*%*	*n missing*	*%*
Missing Data						
T2 interview	4	28.6	1	10.0	5	20.8
T3 interview	3	21.4	0	0.0	3	12.5
Any interview (N = 42, 30, 72)	7	16.7	1	10.0	8	11.1
Lost to follow up	3	21.4	0	0.0	3	12.5
Photo prompts (N = 132, 120, 252)	65	49.2	38	31.7	103	40.9

Appendix O. Chapter Three Saturation Table

Subthemes and codes	Transcripts in order of coding												
	1	2	3	4	5	6	7	8	9	10	11	12	13…24
Theme 1: Entering a new season of life													
Layers of difference													
Layers of difference								X [a]					
Existing children										X			
Healing old wounds													
Healing wounds	X												
Feeling let down													
Disappointment		X											
Centralization	X												
Emotional support at the center of it all													
Emotional needs	X												
Homemade or second hand			X										
Emotional support	X												
Theme 2: Community is family													
Feeling at home (when being supported)													
Comfort and safety	X												
Positive feelings												X [b]	
Facilitators of local environment	X												
Shared lived experiences			X										
It takes a village													
Co-parent support	X												
Tangible support	X												
Theme 3: The pain we bear													
Hostility and harm from others													
Harm from others	X												
Harm coming out		X											
Gendered experiences			X										
Hurting on the inside													
Negative internal feelings	X												
Sacrificing the self													
Sacrifices of support		X											
Support that's not supportive	X												
Compromises of support	X												

Theme 4: Obligatory resilience					
Laboring for support (the effort and energy to					
Informational gaps			X		
Unique needs	X				
Managing others		X			
Barriers of local environment			X		
Asking is too much					
Barriers asking for support		X			
Influences on asking for support		X			
Putting the oxygen mask on first					
Coping (emotional strategies)	X				
Proactive coping		X			
Boundaries	X				
Advocating				X	
Finding our joy					
Mutual aid		X			
Visibility		X			
Purpose/Joy					X

Note. An 'X' indicates the first time a code was identified among the studies. [a] Saturation was met at the category or subtheme level at the eighth report.
[b] Saturation was met at the code level at the twelfth report.

Appendix P. Comparison of Mental Health Scores and Rates

Study Sample Scores of Anxiety and Depression Compared to Sexual-Diverse, Cisgender Samples

Mental health disorder	Goldberg & Smith, 2008	Yager et al., 2010	Ross et al., 2007	Flanders et al., 2016	Study sample scores	
	Mean (% cases, when provided)					
Depression (EPDS)						
2nd trimester				7.1	9.9	
3rd trimester			7.4 [b]		8.8	
4th trimester		7.4 [a]		8.9	10.4	
					State anxiety	Trait anxiety
Anxiety (STAI)						
2nd trimester					36.9 (33%)	40.4 (54%)
3rd trimester	33.8 (23%)				40.9 (53%)	38.4 (53%)
4th trimester	33.2 (26%)	34.4 [a]			43.1 (64%)	45.1 (73%)

Note. [a] Birth through one-year postpartum [b] Gravid through one-year postpartum

Study Sample Rate of Anxiety and Depression Compared to National Perinatal Samples

Mental health disorder	National perinatal prevalence	National perinatal samples during COVID-19	Study sample prevalence	
			Possible case ≥9	Case ≥ 11
Depression				
2nd trimester	8.5 – 11% [a]	21.2% [c]	62.5%	37.5%
3rd trimester			47.4%	21.1%
4th trimester	11.9% [b]	20.8% [c]	68.2%	41.9%
			State anxiety	Trait anxiety
Anxiety				
2nd trimester	19.1 – 20.7% [d, e]	16.6% [c]	33.3%	54.2%
3rd trimester	20.7 – 24.6% [d, e]		52.6%	52.6%
4th trimester	15.0 – 20.7% [d, e]	16.3% [c]	63.6%	72.7%

Note. [a] Gaynes et al., 2005 [b] Woody et al., 2017 [c] Werchan et al., 2021 [d] Dennis et al., 2017 [e] Fawcett et al., 2019

Appendix Q. Chapter Four Codebook

Meaning unit	Condensed meaning unit	Exemplar quotes
		Theme 1: When Protections Fail to Protect
		Subtheme 1.1: Legal rights can't shelter from a hostile social climate
Social and political events	Presidential election and US Capitol attack (2021) increased general sense of fear and anxiety about adverse feelings towards LGBTQ+ family structure	*We had a lot of stress leading up to the election and what happens if we have to raise our daughter in a Trump world? Even though she would have been super young in not remembering much of it, there's just—there's so much hatred and chaos that we were trying to navigate. How would we do that? Having conversations about that on a regular basis. We don't really have those conversations anymore, which is nice. (Mixed race, bisexual, cisgender woman)* *I'm a little bit more cautious about really giving details about my family. And I think that that's because of the political environment that we're in right now and not feeling safe. (White, lesbian, cisgender woman)* *Trying to be someone like we are [a lesbian partnered with a trans women], in the world right now, and the extra layer of stress that is on top of everything else...Trying to deal with that and cope with that on top of COVID and the election being between someone who would throw my family into a Gulag is not exactly the best thing to be going through. (Hispanic, lesbian, trans and nonbinary person)*
Need for legal protection	Supreme Court nomination of Amy Coney Barrett increased need to secure legal protections	*Especially with the Supreme Court—with Amy Coney Barrett—it's been a thing that's been concerning…we're even more on guard [now] around the adoption with the Supreme court nomination and our lawyers are too. 'Cause in [state], there is no second-parent it's only step-parent adoption. If our marriage, for whatever reason is no longer recognized, [my partner] is f**ked essentially in terms of being able to have parental rights of our kid. So all of that is just so heightened. (Hispanic, queer, genderqueer person)*
Unsafe social climate	Social climate sparked many to consider moving out of US to protect their family	*I have been wondering if I should leave the country. [laughs] So I've been like calling all my people in other countries… I just need to get out of this country before this country locks down and doesn't let anybody leave and goes whole Nazi Germany, only the Black are the Jewish folks in this case. I just need to get out before that happens. (Black, same gender loving, nonbinary person)*
	Events in response to increased calls for racial justice (e.g., increased visibility of White Supremacy) led to added anxiety, exhaustion, and trauma	*White people are discovering that racism exists, and it's stressful. At the same time, other White people are realizing that they can say the quiet part loud all the time and still have a certain level of consistent support…It's this weird time where racism has just become so much more overt nationwide, whereas in some places, it's always been this overt. But in many places that I have lived in—sort of a bubble of liberal politeness in the [region of country]—has allowed people to be ignorant or play dumb about racism and its effects and its scope for so long. Those bubbles are being shattered, and it's simultaneously validating and exhausting as f**k. (Black, bisexual, trans and nonbinary person)* *Two weeks after George Floyd's murder, we weren't super safe in our neighborhood. People were like spraying down their houses every night with water because of the fear of our houses being put on fire. There was definitely fear during those two weeks. And those were some like really stressful couple of weeks—if I can even say that. I'm not even sure, because as a White person, I never feel that so that was a new thing to not even fear but, just have like some of that added anxiety. A lot of things were shut down that week, so we actually had a hard time finding groceries for a week. (White, queer cisgender woman)*
		Subtheme 1.2: Toxic workplaces undermine legislation
Workplace challenges	Challenges at work to get parental leave	*I work for an organization that doesn't have a great paternity leave. It's basically, if you're the mom great, you get your FMLA time beyond that—when my wife gets pregnant, I think we'll struggle to it figure out. I need to use all my vacation time to take leave. (Mixed race, bisexual, cisgender woman)* *Figuring out how to structure it is always a headache for anyone with temporary disability insurance versus paid time off versus sick leave, when you can take which one and that sort of thing. I've called HR a bunch of times and got slightly different answers each time…I feel like overall, through the entire experience, that's probably been the biggest headache. Just work. And figuring out the work leave piece for both of us has been more stressful than the medical appointments then getting the home prepped. (Asian, lesbian, cisgender woman)*

Supervisor challenges	Barriers at work to get support (emotional and tangible) for family formation	*I didn't want to tell anybody, because I didn't want them to start thinking—because I had a new boss at this point, so I didn't want my boss to think anything…I've always been the one where people accepted me right away, because I never had kids. I'm like, "Okay, I have no kids. I have a car and I'm completely reliable and 300% responsible." And they always see it. It's wrong because they really don't see moms like that…they really do look at you a different way. And my boss is a 45-year-old woman that's never wanted kids. (Hispanic, lesbian, cisgender woman)* *I was planning to take this semester off if I successfully became pregnant to not be in school while visibly pregnant…The whole reason that 2020 was the year to try this [pregnancy] is that I would have been in the [work system] long enough to be eligible for a sabbatical. It was all really sort of planned around this idea of this sabbatical...over the years in sort of conceptualizing this plan looked up the sabbatical requirements and processes and I had learned that is up to the principle's discretion. I was aware that she could say, no. (White, queer trans man)*
	Experiences of discrimination at work	*It definitely felt that way [discriminatory firing] to my lawyer boyfriend. [He] was like, "These guys fired you for being pregnant."…I had a marked dip in my productivity and my ability to do my job in my first trimester, because I was basically bed-bound for a while between the spotting and the nausea attacks and just all of the—it was like having a flu for 10 weeks….People would say things later like, "Oh, you know, when you're pregnant, you can take disability and you can do this and can do that." But again, if you don't know the system already, you think that being transparent with your employer [supervisor originally agreed to an improvement plan, then ambushed them with HR] is the best move and will get you where you need to go. And it isn't. And it doesn't. I got to learn that the harder way. (Black, bisexual, trans and nonbinary person)*
	Supervisors (vs policies) held the power to grant or restrict flexibility around meeting support needs	*He [supervisor] calls me to his desk and he's like, "I know you're pregnant, but do you have proof that you're pregnant?"…To cover all basis, I printed out all the paperwork that the doctors gave me. He's looking over it and he's just like, "Do you have any other proof that you're pregnant?" And I was like, "All the paperwork that the doctor filled out is in your hand." And he's like, "Yeah, but... Okay." And he just kept looking through the papers and I'm like, what? And to me, it came off as "I'm not feminine, because I don't wear the maternity shirts for work. I just wear my regular shirt with my jacket." But all my supervisors know I'm pregnant, management knew I was pregnant. The fact that they kept asking me specifically for additional proof kind of was insulting. He kept looking at me up and down. There's no way you're pregnant, type of look. It was offensive. (Black, gay cisgender woman)* *I had to go home over a dozen times because I started getting really bad migraines and dropping at about 11 o'clock at night. I've also brought in a doctor's note for my migraines and they're [manager] arguing with me over accommodations I'm asking for. (Mixed race, pansexual, trans and nonbinary)* *I've been talking to my manager about—I plan to be out at this time, and then they're like, "How long are you going to take off? Four weeks? Six weeks?" I'm like, "Oh I was planning to take the full 12 weeks." It was through texts and then I got no response after that. Then I was like, "Oh, I hope that's okay?"...The culture as a whole is pretty supportive in terms of getting coverage and that sort of thing, but just unfortunate that my direct supervisor, whom I have to sort of negotiate my leave with—I wouldn't say she's not supportive, I just think she's hard. Not my favorite person to interact with, so it just makes the whole process not pleasant. (Asian, lesbian, cisgender woman)*
		Subtheme 1.3: Gatekeepers of family formation
Gatekeepers	Clinics, providers, perinatal group leaders prevented access to support/care	*I tried to get into a postpartum group that's a day program and they said I don't fit. That was my last hope for finding a program that would actually suit my needs. They're like, "Oh, this is for people who are having trouble bonding with their babies." And it's like, I still need help. Just because my postpartum depression and psychosis doesn't look like other people's doesn't mean I don't need help. And I'm being told that I'm unwelcome in this space. And I'm—part of me is like, "Am I being discriminated against for being trans? Am I being discriminated against for how I show up?"…no matter where I go, I'm going to be the outlier. No matter what, I'm going to be the one sitting on the sidelines, trying to put together something for myself, because there's no support for someone like me, not in the systems…And I can't help but think that part of it is because I'm trans. And because, if I was a cis woman, maybe I would be treated better because I wouldn't be having an identity crisis at the same time as having my baby. (Mixed race, pansexual, trans and nonbinary)*

Policies that gatekeep	State laws around parental rights dictate family formation pathway	*I sought out a doctor because of the laws in my state, which are, you have to do it [insemination] through a doctor if you want to actually be able to have your kid be yours and not the donor's…all those needles were a direct result of trying to use the laws to whatever little advantage I could get out of them. (Black, same gender loving, nonbinary person)* 
	Insurance company policies around family formation coverage dictated pathways	*I again had pretty good coverage. I mean it dictated like how long to stay at a job I'm not like super in love with. But I think there are not many jobs in my area and probably even less so elsewhere that would have the coverage that I had. Even if I moved beyond the level of IUI and had to pursue IVF, there would have been, I think a 70% reimbursement from my insurance and that would have been a bunch of money for me, that wouldn't have been insignificant and would have maybe prevented me from having access to other things that I would've wanted or needed and the ability to provide for my family. I think it's confusing to take out of one pot for something where there's other need. I think I had a requirement of maybe four or five, like medicated IUI before I could access IVF trials. And I mean, so in that way, the insurance criteria dictated the pathway. (White, queer, trans man)*
		We don't have great insurance. That's sometimes feels stressful of, if I make a choice [during the conception process], how much money is that going to cost me? (White, lesbian cisgender woman)
Insurance restrictions	Insurance company policies restricted access to culturally competent providers and resources	*It's actually state law in [our state] that home births are covered by insurance. It's state law. When we had our first kid, we paid for it out of pocket. They didn't have anyone in network, so they had to cover it…what's crazy is the midwives, the birthing place, they know this is a thing they're like, "Here's the whole process." They told us on our first appointment, "They will pay, it will take a whole year. You will have to submit it, submit it again, submit a complaint to the state health board, do this one more thing, and then they'll finally pay out and it might not be the full amount." They know. So part of this is they don't want to cover this s**t....[My insurance] now has gotten wiser about this and they have someone in network, so you have to go to that in network person, otherwise it's not covered...For me [that] made it trickier as a queer person, because they're not taking that into consideration. They're giving you one option and I feel like that's BS, in general, like "Here's your one option for a health care provider." (White, queer trans and nonbinary person)*
		I am around a lot of very privileged individuals who have good insurance and are like, "Oh yeah, this care and this care and dah dah dah. It's great and they provide these trainings and dah, dah, dah" and I'm like, "Cool, do they accept Medicaid? Do they accept [my state insurance]? No? Cool. All right." (Mixed race, queer, nonbinary person)
		We went with them cause our insurance that's who took our insurance, but they definitely were not inclusive of a lesbian couple. (White, lesbian cisgender woman)
		If my insurance was like, "Here is your doula and midwife starter pack, these are the people you're going to be working with. That would have been great…Even if they'd been like, "You have a choice" I would have been like, "Oh great, I'm going to try this out. And if it doesn't fit, then I'm pretty sure I know what an OBGYN does. I can always have that backup plan." I think—absolutely—the expense and the accessibility and the funneling through—it's the path of least resistance through the medical system because it was already so medicalized in the setting of the doctor's office that it was like, "Well, this was all teed up for me. I'll just be in their stream."…as someone who likes a lot of information before making a decision, I felt like I couldn't—I don't know how much those things cost or if the systems articulate together in ways that make sense or are easy for people. So, yeah, I think that the insurance informed the place [healthcare was accessed] entirely. (White, queer, trans man)
	Subtheme 1.4: Those who need it, can't get it	
Policy gaps	FLMA excludes small business <50 employees	*That's also difficult to explain to people who have not working-class commission jobs. He [my partner] can't, he doesn't get paid paternity leave. He doesn't have health insurance with his job, all these things... he only asked off for three weeks. We literally crowdfunded those three weeks. People gave us money and his clients like tipped him really big. (Hispanic, queer, genderqueer person)*

	FLMA excludes those who haven't worked for employer for 12 months	*The new job that she got is in her [specific] field. It's really entry-level but really a good step—she's really passionate about it and excited…[but] she just started it, so I think she'd have to be at that job for like a year before she'd get any benefits. (White, queer cisgender woman)* *They [co-parent] took a couple of days off around the birth, but that's all unpaid time....there is FMLA for that, but [co-parent's name] just started the job [recently moved to live and co-parent with them] so regardless they didn't have that option because FMLA requires you to work for a year...we do have two week parental leave at a lot of places here for any parent who has a child in their home, but [co-parent's name] didn't have a job that would allow for that. (Black, same gender loving, nonbinary person)*
	FLMA excludes self-employed people	*I don't get parental leave [being an entrepreneur] and I don't get paid time off. If I don't work, I don't get paid, period. (Mixed race, queer, nonbinary person)*
Parental leave	Compensation of parental leave varied by state and workplace	*[My wife] was going to be able to get, I think, 10 weeks at 50% pay. (White, lesbian cisgender woman)* *What my job does is the first two months…is all of the state stuff, the paid FMLA...the next two months that I have is my maternity leave that my job gives me…it's 10 weeks unpaid. (Hispanic, lesbian, cisgender woman)*
Theme 2: The burden is on our shoulders		
	Subtheme 2.1: Impossible choices	
Compromises of support	Choosing to be near family of origin and chosen family but encounter with more discrimination or live in a progressive place but have less in-person supports	*In [state name] home birth is illegal. If you have a home birth, you're you could be charged with child endangerment. And we're already illegal. [laughs] We have to have—[my partner] has to legally adopt this child…I know some straight anarchists who are like, "Do a home birth anyway." Be like, "Oh s**t, I waited too long or whatever." And I'm like, we can't f**king do that s**t because we're already f**ked… It sucks. It's like, "Oh, do I have to just move somewhere else?" No, 'cause I don't want to move somewhere else because I very deeply love this place. (Hispanic, queer, genderqueer person)* *Once we decided to start a family, we realized, "Okay, if we move to [state], where I'm from, we have a lot more family support. She's from [city]. So it's close-ish…That was kind of the main reason of coming back here was knowing that we'd have a little more support once we started a family…It was nice living in [past state, a little more progressive state. Not that [current state] is not progressive, but it's more lagging. (Asian, lesbian, cisgender woman)* *There's stuff like the medical benefits in [my old state] with Medicaid are a lot better than they are here [where my family lives]. Would that push me back there? I get more food stamps when I lived in [old state name], would that push me back? (White, queer, trans and nonbinary person)*
Influences on family formation	Weighing the financial costs of how much to spend to have a baby	*We saved $30,000 for three years before getting pregnant so that we would have money to pull for the insemination itself, which was $17,000 I think we put into making this baby. And then just all of those extra costs—the homebirth that we're planning is $6,000 and not covered by any insurance. (White, queer cisgender woman)* *I have met a lot of lesbians that have done it at home, or they really sacrificed themselves and that whole free thing, I'm going to do it with a guy or whatever the case may be. So that they can have a kid with their family. I mean it's hard. Money can be a really big thing. (Hispanic, lesbian, cisgender woman)*
	Weighing the emotional costs of how much one can withstand before impacts life too profoundly	*I've been off to testosterone now for three years. Before this, I was trying actively for like a year and a half so it's like contending with all of that, plus the hormonal shifts…We were considering doing IVF, which was going to be like our very next and last step, basically if that didn't work. So not only am I weighing like the emotional piece of it, but I'm just also weighing the hormonal piece of it and the gender piece of it (White, queer, trans and nonbinary person)*
	Subtheme 2.2: The extra weight we carry	

Anticipated harm (structural)	Anticipated or enacted harm and discrimination preventing accessing support	*Our friends who are going through the adoption process right now in [state name], where you're allowed, at least in [city], to put unspecified on your child's birth certificate for gender. We're told by their lawyer that the judge might not like that. So they might want to rethink that and they might want to rethink disclosing, that they're raising their kids gender expansively, because it could hurt their adoption case. I'm like, cool. So then what is that for straight people to raise their kids for that way? (Hispanic, queer, genderqueer person)* *It's a Christian health share 'cause it's the only one that we could find. Every time that we call them, they first ask if they can pray for us, then they like quote us some Bible verses while we wait on hold to talk to a representative. Then we have to lie and say that we're not a married couple, that I'm a single mom because they won't accept us if we're a queer family. It's definitely a headache every time we have to call them to work out a paperwork thing.... It's really, truly horrible…We signed up for it because it's the only—insurance doesn't cover home birth, but this health share would. So we were like, "Okay, we'll get like $5,000 back after the birth potentially." (White, queer cisgender woman)*
Emotional burden (structural)	Emotional energy, labor, time required to get needs met	*The progesterone in oil wasn't covered [needed during pregnancy due to IVF] and when I called the insurance company, they said, "You're not infertile." And I was like, "I'm inherently infertile by definition." And they're like, "No, you have to try six IUIs before we cover your IVF." That's not the choice that we made. We decided to do Co-IVF. IUI was never on the table. I didn't want to use my egg at all, and they were like, "To cover, you have to use your egg," and that felt just—it was so—where do you even start on explaining that? No human on the phone, it doesn't even matter if you tell that person over the phone because they're not in charge of making the policy. I just felt like pulling my hair out and crying, which is why the tissues are there. I just felt in a mess communication-wise. Everything is so layered and hard and hetero that it's so messy—that corner. And I also felt cornered into explaining through a hetero lens what I was doing. The progesterone in oil is very expensive. It was really expensive medication, so it was very frustrating. (Asian, queer, cisgender woman)*  *"I'm pulling my hair out and the cost of IVF meds not covered by insurance and feel cornered by the inequality and frustration of homophobic health insurance policies" (Asian, queer, cisgender woman)* *The sex of the child obviously is non-binary legally. And I've fought. We fought for that. They were like, it's not possible. And I was like, "It's f**king possible. Look at my ID." I showed them my ID. I'm like, "It's f**king possible, make it happen." (Mixed race, queer, nonbinary person)*
Costs beyond conception	Additional financial burdens beyond conception	*In [city], the birth parent has to be listed as the mother [on the birth certificate] so being able to acquire accurate and legitimate documentation for my baby hasn't happened yet. Not having that peace of mind has been really—has also added to my anxiety because we can't get health insurance…to apply for insurance for the baby, they have to have a social security number. You can't get a social security number without a birth certificate. I was under the impression that my insurance would cover them for the first year, but we found out when they had their vaccines earlier this week that my insurance wouldn't cover them…* *Interviewer: So, it's all coming out of pocket until you get this resolved?* *Participant: Basically, yeah. (Native, queer, nonbinary person)*
	Subtheme 2.3: Protecting our families	
Documents that protect	Reasons why protecting families with legal means is critical	*It was this little tiny voice where we were like, "Man, if I died, my mom would have more of a right to the baby than [wife's name] would." And not that we think that my mom would fight that and want our baby, but it's this little voice. We're not totally sure. It felt like too much to gamble with. Even if I died or I was in the hospital and sick or something, and the baby was with my mom, even for like a few days before [wife's name] could legally get the baby, it just didn't feel like worth it. We were like, "we'd rather spend a couple thousand dollars and have that protection. (White, queer cisgender woman)* *There's a law in [state] that's going into effect in [month] where basically [my wife] can be federally recognized as his parent. We had talked about it for a while, like "Are we going to do second-parent adoption? Are we not?" And we had kind of been on the fence, but then Once Amy Coney Barrett got confirmed, we were like, "Let's just do it [second-parent adoption]." Especially just knowing that we go to [conservative Western state] where [my wife's] parents are. And [my wife's] grandmother is in [conservative Southern state] and those are states where she might not be recognized as his parent if God forbid something were to happen while we were in either of those places so we wanted something that would be federally recognized versus just the state recognition of our marriage in [state]. (White, lesbian cisgender*

	Obtaining legal protection subjected people to invasive, demeaning, expensive, and exhausting process	*We were finalizing all of our paperwork for our second-parent adoption. So that's a weird process. Not only does [wife's name] have to adopt the baby. I have to adopt the baby… [My wife] has to have a background check done and it's like, there are people, parents leaving hospitals right now that are not going to have to have a background check done. We had to put like a list of our addresses and personal information—what our education level is, how much money we make, what our job is just, it's kind of invasive and weird...[my wife's] well-educated, we're privileged people, but what if she didn't have a high school education or only had a high school education? And what if she only made $25,000 a year? What are the right answers here? (White, lesbian, cisgender woman)* *We had to pay thousands of dollars for a donor contract. Then we have to go through lawyers for [partner's name] to legally adopt this kid, even though [partner's name] and I are legally married. Even though [donor co-parent's name] relinquishes rights. And part of that process, we have to have two home visits! And they recommend that we pay a private agency so that we're not up to the biases of whatever social worker we're assigned. Here's the intersections of class 'cause it's like, we can do that because our parents are willing to do that for us. It's literally like, f**k! (Hispanic, queer, genderqueer person)* *We're lucky that the county we live in is actually the only county in [state] where we don't have to do criminal background checks to do a secondary adoption...it's a frustrating set of things to have to jump through...Not the thing I want to be spending my energy on right now. (White, queer trans man)*
Theme 3: When privilege is protection		
Subtheme 3.1: Privileging the institution of marriage		
Heteronormative laws	Ways support was denied if not married	*There wasn't anything available for him legally for being in charge of [baby's name]…it makes things more complicated with the fact that he is married, but not to me....It's been an issue because [baby's name] wasn't able to be put on my health insurance until their social security card came. I just got those documents filed yesterday. So, [baby's name] will finally be put on my health insurance, but that meant that [baby's name] was on a temporary health insurance thing, but they needed my approval for things, but I was in the psych facility so [partners name] was up a creek without a paddle. (Mixed race, pansexual, trans and nonbinary)* *Marriage sets the tone for this. So if we weren't married and just a long term, same-sex couple, my wife would've had a lot of difficulty trying to prove that in order to get her leave...but culturally, not everyone in the LGBT community is onboard with marriage. And so you could be together for 20 years and now you're still fighting to be on leave? Makes no sense. (Mixed race, bisexual, cisgender woman)*
	Heterocentric laws created barriers to accessing parental rights	*Honestly being in [state] and the major health care system here is a religious institution. It's like, "Okay, I want to make sure that there's not going to be an issue of my wife getting on the birth certificate so we don't have to worry about it." 'Cause she still has to legally do a step-parent adoption for [state] to recognize her as a parent. (Hispanic, lesbian, cisgender women)*
Parental rights	How marriage facilitated access to supports	*Hetero people who don't have fertility issues, just kind of there are no barriers regardless of their class, because they're hetero. So they can, if their fertility is not in question there's no issue there, then they can just have a baby and no one questions who the—even if you're not married. It's just assumed that the person you're with at the time is at that person. It doesn't even matter if they're not the one who fertilize the egg, they can still be on the birth certificate. There're all these ridiculous benefits of the doubt that hetero people have. (Asian, queer, cisgender woman)*
	Progressive laws facilitated access to parental rights	*The state of [state] allows kids to have as many... We've seen it, there's case law for up to four legal guardians per kid…he's her parent. He's on this journey with us, he's going to be taking care of her. And there's certain things that just from a paperwork perspective, if we decide to do this would be nice to have the ability to help guide her healthcare and access her records that a parent would traditionally access growing up to make decisions as a full member of this parenting team, without always having to go through one of us, we can just go to the school or go to the doctor's office and blah, blah, blah, blah, talk to her pediatrician. (Black, bisexual, trans and nonbinary person)*
Subtheme 3.2: The shield of class status and race		
Privilege	Money and class sometimes allowed people to circumvent discriminatory policies, laws, or people	*The things that I've had access to and experience because of mainly class and race privilege…They [my parents] paid for the IVF procedures, my insurance through [employer] covered the meds, but they paid for the procedures…[my partners' parents are] helping pay for the adoption...pay a private agency so that we're not up to the biases of whatever social worker we're assigned [and] we have a friend that's going to come for a month that my mom's gonna help us pay her [so I don't have to worry about] trusting somebody around gender stuff—with changing the baby and stuff. (Hispanic, queer, genderqueer person)*

	White privilege provides protection to advocate for one's rights and needs	*I absolutely know Whiteness plays a role—the way that I sound and when people see me they will—my Whiteness will make them take me seriously in ways that if I was a person of color, they absolutely would f**king not. And they would probably be even more hostile to me trying to hold them accountable. (Hispanic, queer, genderqueer person)*
Access to wealth	Money and access to wealth can dictate who has ability to form families biologically	*Actual access to care. Let's say like you're facing the decision about whether or not you are going to try IVF and take out a loan or go into more debt to do that which some people do versus your parents. I know people whose parents have paid for it or who can pay for it themselves…that's really different than taking out a loan or putting yourself into more debt. (White, queer, trans and nonbinary person)*
Workplace benefits	Benefits can allow access to certain family formation options (over salary)	*If I had a job that was making the same money, but did not have this insurance, I would have gone through the ICI route, which is just the turkey baster route, but if I didn't have this job then I probably wouldn't be like I'm not having kids (Black, same gender loving, nonbinary person)*

Appendix R. Chapter Four Saturation Table

Subthemes and codes	Transcripts in order of coding									
	1	2	3	4	5	6	7	8	9	10…24
Theme 1: When protections fail to protect										
Legal rights can't shelter from a hostile social climate										
Social and political events									X [a]	
Need for legal protection			X							
Unsafe social climate		X								
Toxic workplaces undermine legislation										
Workplace challenges	X									
Supervisor challenges	X									
Gatekeepers of family formation										
Gatekeepers	X									
Policies that gatekeep									X	
Insurance restrictions			X							
Those who need it, can't get it										
Parental leave									X	
Policy gaps	X									
Theme 2: The burden is on our shoulders										
Impossible choices										
Compromises of support	X									
Influences on family formation	X									
The extra weight we carry										
Anticipated harm (structural)		X								
Emotional burden (structural)	X									
Costs beyond family formation	X									
Protecting our families										
Documents that protect			X [b]							
Theme 3: When privilege is protection										
Privileging the institution of marriage										
Heteronormative laws			X							

Parental rights	X		
The shield of class status			
Privilege	X		
Access to wealth			X
Workplace benefits	X		

Note. An 'X' indicates the first time a code was identified among the studies. [a] Saturation was met at the code level at the ninth report. [b] Saturation was met at the category or subtheme level at the third report.