The Experiences of Parenthood Amongst Transgender Parents in Australia

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First and foremost, I would like to acknowledge the traditional custodians of the Eora Nation on which I live and work. I would like to pay my respects to the elders; past, present and emerging, and acknowledge that their sovereignty has never been.

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Rosie Charter

Thesis by Publication

In 2015, I was awarded an Australian Postgraduate Award scholarship to complete my thesis, titled *Transgender Parents Experiences of Parenthood*. My primary supervisor was Professor Jane Ussher, and my auxiliary supervisors were Professor, Professor Janette Perz and Professor Kerry Robinson. With support from my supervisors, I was responsible for researching and selecting the scope of the study, developing the research design and methodology, as well as obtaining ethical approval. I was also responsible for the collection and analysis of the data which is reported in the four published referred journal articles that make up the chapters of this thesis. I wrote the first draft of each article independently, and with feedback, suggestions and critiques provided by my supervisors, completed each final draft. I have chosen to present the articles in the order listed below, rather than chronologically, as I feel that it is more representative of the overarching experiences of participants. Of my peer-reviewed journal articles, two are fully published, one has been accepted for publication and is currently in press, and the fourth has been submitted with final reviewer comments addressed

Peer-Reviewed Journal Articles Included in the Thesis

Charter, R., Ussher, J.M., Perz, J. & Robinson, K. (2018) The Transgender Parent: Experiences and Constructions of Pregnancy and Parenthood for Transgender Men in Australia, *International Journal of Transgenderism*, 19:1, 64-77, DOI: 10.1080/15532739.2017.1399496

Charter, R., Ussher, J.M., Perz, J. & Robinson, K. (2021). Transgender Parents: Negotiating 'Coming Out' and Gender Affirmation with Children and Co-Parents. *Journal of Homosexuality,* (Accepted for publication, currently in press).

Charter, R., Ussher, J.M., Perz, J. & Robinson, K. (2021) Negotiating Mental Health amongst Transgender Parents in Australia, *International Journal of Transgender Health,* DOI: 10.1080/26895269.2021.1875951

Charter, R., Ussher, J.M., Perz, J. & Robinson, K. (TBC). Experiences of Transgender Parents in Navigating Transphobia. *Family Relations,* (Under Final Review).

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Abstract

In Australia, parenthood within a heterocisnormative family structure is still privileged whereas those who parent outside of this hegemony are marginalised. Parenthood is a powerful symbol and 'performer' of gendered convention, and failure to conform can serve as a transgressive act. Trans parents are routinely subjected to significant institutional discrimination and marginalisation, particularly in the healthcare domain, which has a material impact on their lives and the lives of their family. There is a need for further research to help us understand the lived experiences of trans parents and how they can be supported. Moreover, there is a need to utilise inclusive methodological approaches to centre transgender experiences such as queer theory and intersectional frameworks.

In this thesis, I explore the reflective assessments trans parents make about their experiences of parenthood. In order to do this, I situate my thesis in a social constructionist epistemology, and pose two research questions: "What are trans parents' subjective experiences of parenthood?" and "What implications does heterocisnormativity have on their experiences of parenthood?". To address these questions, I use both queer theory and intersectional frameworks. Data collection for this study took place in 2015 and 2016. Sixty-six Australian trans parents aged between 24 and 67 years, took part in an online survey and 38 participants consented to a further one-on-one interview. Data was analysed using thematic analysis. The analysis is presented in four journal articles. The first article examines how trans parents navigate experiences of 'coming out' and pursuing gender affirmation with their children and co-parents. In this article, I found that changes around parental gender identity can have a profound impact on the lives of parents, co-parents and their children; and that navigating these changes requires ongoing, consideration and negotiation. Pursuing

gender affirmation was vital to the mental health and well-being of trans parents. Family was both a source of great strength and a site of vulnerability, for participants. Finding a balance between parental gender-related needs, and protecting relationships with children, was of fundamental importance. The second article explores how trans parents, and their children navigate transphobia. In this article, I found that transphobic harassment, discrimination and abuse was pervasive and had a profound impact. Navigating these experiences required much determination for parents and an ongoing, supportive dialogue with children. The third article examined how trans parents experienced their mental health and negotiated support. In this article, I found that many parents experienced significant challenges in relation to their mental health, which could make parenting challenging. Many participants struggled to find mental health professionals that were both clinically and culturally competent. However, pursuing gender affirmation, as well as family and social support, had a positive impact. The fourth article explored trans men's experiences of negotiating and pursuing pregnancy. In this article, I found that parenthood was initially described as alienating and complex, however transitioning enabled the negotiation and construction of their own parenting identity. Pregnancy was positioned as a problematic but "functional sacrifice," however formal assisted fertility experiences were rife with exclusion. At the same time dysphoria associated with withdrawing from testosterone and the growing fecund body were significantly troubling, with pregnancy-related changes to the chest of particular concern. Exclusion, isolation, and loneliness were the predominant features of transgender men's experiences of gestational pregnancies. Healthcare systems were not generally supportive of trans bodies and identities and trans men encounter significant issues when interacting with healthcare providers.

The conclusion, bringing together findings from these four articles, contends that, in spite of significant heterocisnormative marginalisation and discrimination, parenthood is a powerful source of validation and motivation for trans parents. Positive relationships with children allow trans parents to be positioned as both protector and protected. Additionally, transgender parents navigate parenthood under normative hegemonies, making them significantly vulnerable to transphobia and healthcare discrimination. This has material consequences for not only their physical and mental health, but also their families. These findings indicate that healthcare providers, and institutions more broadly, must be encouraged to challenge and deconstruct their heterocisnormative assumptions. With little social and institutional support, trans parents persevere and thrive in parenthood.

Preface

My research explores the experiences of parenthood amongst transgender parents, but I am not a transgender parent. I am a cisgender parent and that difference needs to be upfront and unambiguous. My position as a researcher is ultimately grounded in my lived experiences as, among other things, a white woman living in Australia. The issue of researchers as insiders or outsiders to the community that's sharing their experiences is a vital one in qualitative research (Dwyer & Buckle, 2009). My experiences as a cisgender woman makes me an 'outsider' amongst my participants in some ways, but my experiences of parenthood gives me some 'insider' understanding. I became a parent in a 'non-traditional way', as did many of my close gay, lesbian, queer and non-binary friends and, by extension, the broader community of which I am a part of. Drawing from my own experiences and those of the people around me, I have grown interested in the intersection of parenthood and marginalisation.

In undertaking this research, I acknowledge that my own personal experiences influenced my decision to explore transgender parents' experiences of parenthood. I chose this topic for my PhD thesis in 2015. At that time in Australia, there was significant public discourse around the lives LGBTQI+ people due to simultaneous political debates on both same-sex marriage equality and the Safe Schools program, an anti-bullying program aimed at educating school-aged children on sexuality and gender diversity. This created a 'perfect storm' of political grandstanding, and clickbait journalism; whipping up longstanding moral panic on the 'sanctity of the family', what children 'need', and the apparent societal emergency inherent in existences outside heterocisnormative binaries (Law, 2017).

At the time, my child was four years old and, as is the way with groups of friends, many people close to me also had young children, or were beginning to start families of their

own. Many people close to me, who were hopeful or loving parents but happened to be outside heterocisnormativity, found themselves suddenly the topic of talk-back radio segments, television debates, and vitriolic comments on social media. Their relationships and their decision to become a parent suddenly were thrust into a very harsh spotlight. Hope and joy turned to drawn faces and heavy conversations. Tears were shed. Friends who hadn't been overly concerned with hostility towards them previously, suddenly felt unsafe or were subjected to abuse or unwanted comments. Extended family and 'friends' felt emboldened to openly debate queer existences and their potential 'danger' to children on Facebook feeds. Many felt they had to suddenly justify their very normal wish to be a parent. For those who had children who were a little older, conversations were had about how to best insulate them from these very public conversations on how 'appropriate' their families were. This was the personal backdrop to selecting the subject for my PhD research.

Reflexivity is a fundamental aspect of qualitative research and involves an examination of the impacts of both the researcher's perspective, interrelational dynamics between researcher and participant, and a critical assessment of the research design (Berger, 2015; Dodgson, 2019). To reflect on my own motivations, perspectives, and personal experiences in my research is to engage in reflexive analysis. Whilst I have shaped this research, this research has also shaped me. I position my experiences and subjectivity not as an issue, or a bias needing to be controlled, but rather, as an opportunity to further understand myself and the research process (Mitchell, Boettcher-Sheard, Duque, & Lashewicz, 2018).

On a personal level, in many ways I feel like this project has come full circle. As I have been in the last stages of completing my thesis, I have found out that I am going to become a parent again. As I have finished writing about the experiences of parenthood amongst my participants, I have been navigating many of the systems and discourses touched

on by my participants, that can be so exclusionary for transgender parents. My privilege as a cisgender parent has been ever present and given my writing much perspective.

Glossary

Assigned female at birth (AFAB): A term that is sometimes used by people to differentiate the sex that was given to them at birth from their gender identity. For example, when a person was assigned female at birth but their gender identity differs from that, they might say that they were "AFAB".

Assigned male at birth (AMAB): See above.

Assigned gender/sex: When a baby is born, they are commonly identified as *either* male or female, based on their visible sex organs, including genitalia and other physical characteristics. As sex and gender are commonly viewed as interchangeable, their sex assignment and gender assignment are assumed to be the same.

Binary: A term used to describe phenomena of two mutually exclusive categories that supposedly exist in opposition to one another. Within trans discourses, the focus is typically on the 'gender binary'; that people are only ever *either* male or female.

Bottom surgery: A colloquial term used by some people to describe gender affirmation-related treatment that involves surgery of one's genitals. Sometimes referred to as sex reassignment surgery or gender reassignment surgery.

Cisgender: Refers to an individual whose gender identity aligns with the sex assigned to them at birth. Often shortened to 'cis'.

Cissexism: The assumption that everyone is, or *should* be, cisgender. Cissexism is the foundational belief that there are two compulsory and mutually exclusive genders, erasing the existence of those who do not adhere to the gender binary.

Coming out: Refers to the process of sharing or disclosing one's gender or sexuality with other people, perhaps for the first time.

Diagnostic and Statistical Manual of Mental Disorders (DSM): A handbook used by many healthcare professionals around the world, which lists and defines the official psychiatric diagnoses as determined by the American Psychiatric Association (APA). The current edition is the fifth full revision (DSM-5), however there have been numerous revisions over the years. Trans-related diagnoses that have been listed in current or previous past or current DSMs include Gender Dysphoria, Gender Identity Disorder, Transvestic Disorder, Transvestic Fetishism. These diagnoses have come under criticism for pathologising trans lives (Serano, 2007).

Gatekeeper: Refers to healthcare professionals who are in a position to facilitate, or obstruct, a trans person's access to the means of medical gender affirmation and aspects of legal recognition.

Gender affirmation: An umbrella term to describe a range of steps a person may take to feel more aligned with their gendered self. Gender affirmation is unique and means different things to different people. It is based on what is affirming to the individual, what is accessible, available and feels safe. Gender affirmation can include steps such as adopting different pronouns, a different name, and changes to one's appearance, to hormonal and surgical interventions.

Gender binary: Refers to the belief that sex is a strict dichotomy and directly determines gender. In this framework, sex and gender can *only* be *either* male or female.

Gender diversity: an umbrella term that is used to describe gender identities that demonstrate a diversity of expression beyond the binary framework.

Gender Dysphoria: A clinical diagnosis designated by the DSM-5 that is defined as "clinically significant distress or impairment related to a strong desire to be of another gender" (American Psychiatric Association, 2013). In the DSM-5, Gender Dysphoria became an officially recognised psychiatric diagnosis, replacing Gender Identity Disorder.

Gender identity: Refers to one's internal knowledge and understanding of one's gender.

Gender and sexual minorities: a broad umbrella term for people whose sex, gender, and/or sexuality falls outside of societal norms, and who often face marginalization as a result.

Gender nonconformity: An umbrella term used to describe gender expression, or behaviour that falls outside of heterocisnormative norms associated with a specific binary gender (Reed, Rhodes, Schofield, & Wylie, 2009)

Gender role: A term that is used to describe the social expectations of appropriate ways in which people are expected to behave, dress, speak and conduct themselves based upon the sex assigned to them at birth. Can also be referred to as gender expectations.

Gender variance: See gender nonconformity.

Heterocisnormativity: The hierarchical social system that seeks to presume and privilege "gender conformity, heterosexuality, and nuclear families over all other "deviant" forms of gender expression, sexuality, and families" (Pollitt, Mernitz, Russell, Curran, & Toomey, 2021, p. 1).

Intersectionality: First coined by Crenshaw (1989), intersectionality is the systematic analysis of the ways in which multiple social identities, such as race, class and ability, can interact and exacerbate marginalisation.

LGBTQI+: Although an acronym, LGBTQI+ is also often considered a term to refer to all identities associated with sexualities and gender identities that exist outside heterocisnormative assumptions. Whilst it is constantly evolving, its current iteration stands

for lesbian, gay, bisexual, transgender, queer, intersex, and + to recognise additional identities and individuals not explicitly described (ACON, 2021).

Marginalisation: Can describe both a process and a condition that prevents people or communities from being allowed to access and participate in social, economic or political life (Mowat, 2015).

Non-binary: Within trans-related discourses, typically refers to people or identities that fall outside of the gender binary.

Out: Within trans, and broader LGBTQI+, discourses, being 'out' refers to being open or unambiguous about one's status as a gender or sexual minority.

Pathologisation: The portrayal of a trait or identity as being abnormal, disordered, or diseased. Historically, trans people have been pathologised by the medical community, and society at large, people by claiming that they suffer from a medical or psychiatric condition.

Privilege: Refers to the benefits, advantages and opportunities a person may be granted due to their membership to a dominant or majority group.

Queer theory: A critical discourse that became influential in the 1990s, and which set out to challenge and deconstruct essentialist assumptions about gender, sexuality, bodies, and desires (Serano, 2007).

Sexual orientation: Refers to the gender or sex that an individual is predominantly attracted to.

Sexuality: A broad term that may refer to a person's sexual orientation, interests, fantasies, desires, acts, expressions, experiences, or some combination thereof.

Social construct: Refers to beliefs, meanings, or associations projected onto objects, events and identities that are created and shaped by social interaction. For example, whilst

chromosomes are objectively real, the expectations and assumptions that we attribute to their expression through gender are socially constructed.

Top surgery: Colloquial phrase to describe gender affirming surgery of the chest. Generally, either a bilateral mastectomy or breast augmentation.

Transition: See gender affirmation. Transition, or transitioning, was previously the commonly used term for pursuing gender affirmation. Whilst gender affirmation is now the preferred term 'transitioning' is still used colloquially.

Transgender: An umbrella term that can be used to describe people whose gender identity is different from the gender they were thought to be when they were born. 'Trans' is often used as shorthand for transgender.

Transphobia: The oppression, discrimination and marginalisation of transgender and gender nonconforming people. See also cissexism.

Transsexual: Historically, this term was used primarily to refer to a transgender person who had engaged medical aspects of gender affirmation. However, this term is now regarded to be objectifying and offensive.

Transvestite: First used in 1910, transvestite referred to someone who engaged in crossdressing. However, this did not necessarily mean that they were transgender or gender diverse. Cisgender people can and do engage in crossdressing. Whilst some people use this term colloquially, it is now viewed as dated and offensive (Beemyn, 2013).

Chapter One

Experiences of Parenthood Amongst Transgender People in Australia: An Introduction and Review of Existing Literature

This thesis explores the reflective assessments transgender (trans) parents' make on their subjective experiences of parenthood. Taking a social constructionist approach, I pose two research questions: "What are trans parents' subjective experiences of parenthood?" and "What implications does heterocisnormativity have on their experiences of parenthood?" To answer these questions, I use both queer theory and intersectionality theory frameworks.

My analysis is presented in four refereed journal articles which explore: how trans parents navigate experiences of 'coming out' and pursuing gender affirmation with their children and co-parents; how trans parents and their children navigate transphobia; trans parent's experiences of negotiating support for their mental health and trans men's experiences of pregnancy. This analysis tells a story of the multifaceted journey trans people take through parenthood whilst also negotiating gender identity and affirmation, in addition to balancing the relationships, needs and expectations of their family. Trans parents must navigate parenthood under socially and economically entrenched heterocisnormativity and are significantly vulnerable to pathologisation and healthcare discrimination. I argue that trans parenthood is not a vulnerability, as trans parents show great strength in spite of significant discrimination, and marginalisation.

In this chapter, I will examine existing literature on trans parenthood and explain how this thesis makes a novel contribution to this body of literature. I will explore perspectives around parenthood and heterocisnormativity. I will examine transphobia, the significant stigma and discrimination trans people are subjected to, and the consequences and outcomes associated with that, as well as the history around the medicalisation of trans identities and

current approaches to gender affirmation and healthcare, more broadly. I will then introduce research specifically focussing on trans people as parents and examine changes in the social, cultural, and historical perspectives of transgender identities and parenthood, in order to explain the need for queer and intersectional epistemological frameworks to ground this work.

Throughout this thesis introduction I review literature which reflects the focus of the articles I have written. This includes, how 'coming out' and pursuing gender affirmation is experienced within the family context; how transphobia is experienced within the context of parenthood; how trans parents experience issues around their mental health and the formal and informal support they may receive; and trans men's experiences of gestational pregnancy and how male pregnancy is received within the medical setting.

In the final section of the chapter, I present my research questions and provide an outline of how the thesis is structured.

Heterocisnormativity & The Construction of Parenthood

Heterocisnormativity describes the hierarchical social system that seeks to presume and privilege "gender conformity, heterosexuality, and nuclear families over all other "deviant" forms of gender expression, sexuality, and families" (Pollitt et al., 2021, p. 1). It is an ideological amalgamation, fusing together gender-, sexuality- and family-normativity into a supreme hegemony, as such "doing sexuality and doing family properly are inseparable from doing gender properly" (Oswald, Blume, & Marks, 2005, p. 144). Heterocisnormative assumptions are so deeply engrained and established in culture and cultural practices that they almost resist identification (Bauer et al., 2009). In Australia, where this research is situated, parenthood within a heterocisnormative family structure is privileged and those who parent outside of this hegemony are marginalised (Davies & Robinson, 2013). Parenthood is

an historically, culturally and socially situated practice, as a role it has the potential to shape the attitudes and behaviours of individuals; parenthood is how 'doing family' is communicated more widely (Lind, Westerling, Sparrman, & Dannesboe, 2017; Worthen & Herbolsheimer, 2021).

People who identify as 'trans' affirm that their experience of gender is not consistent with the gender sex assigned to them at birth, many of who engage in a process of gender affirmation to establish their authentic gender identity (Johnson, 2013). The term 'cisgender', or 'cis', is used to identify people who experience a sense of congruence between their gender identity and the gender that has been assigned to them at birth (Stryker, 2006). The participants in our study referred to themselves as 'trans'. As such, throughout this thesis, we will also primarily use this term.

Many trans people are parents. Collection of gender diversity data in national surveys is in its infancy, if implemented at all, however, surveys from the United States and Europe estimate that 25-49% of trans people are parents (Carone, Rothblum, Bos, Gartrell, & Herman, 2020; Henderson, Blosnich, Herman, & Meyer, 2019; Motmans, Ponnet, & De Cuypere, 2015). Like their cisgendered counterparts, trans people become parents in a variety of ways (Goldberg, Tornello, Farr, Smith, & Miranda, 2020; James-Abra et al., 2015; Riggs & Bartholomaeus, 2016; Tornello, Riskind, & Babić, 2019). They can have children that are biologically related to them, or they can become a step-parent, or part of a blended family. They can become a carer for the child of a sibling, relative or friend. They can pursue fostering through an agency; and they can pursue assisted reproduction either formally in a medical setting or informally, through seeking a donor privately and at-home insemination. Whilst there has been a shift towards inclusivity and visibility for 'alternative families', the ideological power and associated rhetoric of the 'traditional family' still exerts its supremacy

(Collins, 1998). Parenthood is a powerful symbol and 'performer' of gendered convention, and failure to conform can serve as a transgressive act (Butler, 1999, 2011; Levitt & Ippolito, 2014b). A parent's trans status or development of a parenting style that does not rely on heterocisnormative gendered norms, can provoke a rethinking of what it means to perform parenthood, not just within the family context, but also on a broader societal level (Downing, 2003).

The Family as a Cultural Battleground

Challenges to heterocisnormative ideas of parenthood are positioned as 'dangerous to the child' and as a vehicle for the destabilisation and degradation of society itself (Riggs, 2006; Robinson, 2008). The centrality of family in the current neoliberal socioeconomic order is regarded as society's core moral unit (Fassin, 2020). Trans rights are seen as a challenge to this and can be misrepresented as a potential source of political, social, and economic devolution (Biroli, 2020). At the crux of this anxiety is fear that cultural change will come with a loss of status on the part of those who have historically benefited from heterocisnormative privilege (Cox, 2017). Religious and political organisations who wish to maintain 'traditional' paradigms use child protection rhetoric to cause moral panic and mobilise it against laws, policies that protect trans people. Outrage and fear about the wellbeing of children is easily manipulated and transformed into social and institutional support for restricting trans rights (Martínez & Rojas, 2021). Such rhetoric has also been weaponised in the form of 'protecting' children from education about gender diversity and inclusivity. Central to this discourse is the child as a symbol of innocence, "a blank slate" that can only truly flourish within the safe haven of traditional family" (Brock, 2019, p. 12).

Such alarm was evident in the public reception and discourse around Thomas Beatie, a trans man who sparked a huge media response when he announced his first pregnancy in

2008 (Beatie, 2008). Referred to widely as 'the pregnant man', photographs of Beatie cradling his heavily pregnant, bare stomach, being embraced by his wife, were published all over the world and generated international controversy replete with considerable harmful rhetoric (Halberstam, 2010; Riggs, 2014). Highly publicised op-eds and televised debates on the 'immorality' and 'absurdity' of him exercising his reproductive rights were accompanied by an almost frenzied concern of 'the harm he would do to his child' (Rosskam, 2010; Vargas, 2010). Implicit in this mode of enquiry is the heterocisnormative assumption that if trans parents had gender diverse children, or if their child were 'ostracised' due to transphobic bullying, then the fault lies with the parent and not the heterocisnormative supremacy they are subject to. Studies going back over 40 years have assessed the impact a trans parent may have on a child's own gender identity, sexual orientation, and mental health, and have consistently shown these children to have the same outcomes as the broader population (Freedman, Tasker, & di Ceglie, 2002; Green, 1978, 1998; Lev, 2010). Indeed, many of these studies have highlighted the social and psychological resilience exhibited by the children of trans parents, and illustrated that the well-being of children is affected by the quality of relationship they have with their parent, their parent's competency and the sense of security they offer, (Few-Demo, Humble, Curran, & Lloyd, 2016; Perrin & Siegel, 2013).

Transphobic Discrimination Enacted

Transphobia is one manifestation of heterocisnormativity that has a direct impact on trans people and their families, it encompasses a wide range of behaviours including "prejudice, discrimination, and gender-related violence due to negative beliefs, attitudes, irrational fear, and aversion to transgender people" (Mizock & Lewis, 2008, p. 336). Structural and interpersonal transphobic discrimination impedes many trans people from equitably accessing education, employment, housing and healthcare, as well as making them

vulnerable to the very real threat of violence and abuse (Bowers & Whitley, 2020; McKinnon, Waitt, & Gorman-Murray, 2017; Zeeman et al., 2019). As such, this has significant implications for, not only the individual, but also the subjective experiences and material reality of parenthood.

Every person is entitled to fundamental human rights (Rowland, 2021). Two central principals relate to, all people "being free and equal in dignity and rights", as well as the "right to life lived in freedom and safety" (United Nations, 1964, p. 3). However, for many trans people, these rights are extended in principle only. Trans people are routinely denied their fundamental human rights: to equality, dignity, health, privacy and security of being, to denial of their very personhood (Divan, Cortez, Smelyanskaya, & Keatley, 2016). These denials are grounded in cissexism and transphobia (McGeorge, Coburn, & Walsdorf, 2021).

It has been well-established that trans people are subject to significant and on-going discrimination (Chodzen, Hidalgo, Chen, & Garofalo, 2019; Schwartz, 2016; Stangl et al., 2019). One review of 19 studies on transphobic discrimination found that 40–70% of trans participants across studies had experienced some form of discrimination (McCann & Brown, 2017). Research conducted in Australia found that 64.8% of participants had experienced transphobic discrimination, ranging across the spectrum from social exclusion, to verbal abuse and physical violence (Hyde, 2014). A 2015 U.S. study found that 46% of trans people reported experiencing verbal abuse and harassment, and 47% reported sexual violence (James et al., 2016).Variability in discrimination rates can often be related to participants 'multiple identities' (Bower-Brown & Zadeh, 2021). Trans women are statistically more vulnerable to victimisation, in comparison to the broader trans community, with trans women who are black, indigenous, and people of colour (BIPOC) being subjected to the highest risk of violence, and homicide (James, 2020; James et al., 2016; Ussher et al., 2020). In 2020, 79%

of trans people murdered in the United States were BIPOC trans women, and in a 2020 European sample, over 50% of the trans people who were murdered were trans women who were also migrants (Connell, 2021; Fedorko, Sanjar Kurmanov, & Berredo, 2020). From an intersectional perspective, these women exist at the intersection of multiple marginalised identities: gender, gender identity, race, ethnicity, as well as, in some cases, sexual orientation, socioeconomics and housing status. These multiple identities create disadvantage that both overlap and are interdependent, highlighting how discrimination is cumulative intersectionally (Bower-Brown & Zadeh, 2021; Crenshaw, 1991; Fish, 2008). Trans women may be particularly vulnerable to dangers inherent in the intersections of both transphobia and misogyny (Matsuzaka & Koch, 2019; Serano, 2007). Transmisogyny enables the social and economic vulnerability and exclusion that are vehicles for the significant levels of violence faced by trans women, perpetuating impunity for abuse and restricting access to justice, which, in turn, enables and provides tacit permission for further victimisation (Matsuzaka & Koch, 2019) .

Structural & Interpersonal Discrimination

Transphobic discrimination can be enacted both structurally and interpersonally (Zeeman et al., 2019). Intersectionality theory asserts that multiple marginalisation's generate and reinforce one another to sustain a complex matrix of power that is rooted in, and actively maintained by, social and institutional structures (Wesp, Malcoe, Elliott, & Poteat, 2019). As such, structural discrimination refers to these multi-layered connections of social systems, institutions, ideologies and practices that manufacture, and maintain, inequalities (Kcomt, 2019). Interpersonal discrimination is enacted between individuals, and consists of a person's attitudes, beliefs, and values and how they are used to justify and perpetuate transphobic

discrimination. Interpersonal discrimination can be both blatant and subtle (Bandini & Maggi, 2014; Du Bois, Yoder, Guy, Manser, & Ramos, 2018; Müller, 2017). The key functionality of structural discrimination, that makes it so resistant to change, is that macro-level 'systems' operate independently of the individual, so much so that, even if interpersonal transphobia is challenged or unsupported, the conditions for inequity will remain (Gee & Ford, 2011). As interpersonal discrimination is enacted face-to-face, it has a salience which can sometimes obscure the systematic and structural erasure co-occurring (Kcomt, 2019).

Structural and interpersonal transphobic discrimination impedes many trans people from equitably accessing education, employment, housing and healthcare (Bowers & Whitley, 2020; McKinnon et al., 2017; Zeeman et al., 2019). These inequities mutually reinforce one another (Bower-Brown & Zadeh, 2021). In the educational arena, bullying and harassment from peers and teachers can have an adverse effect on academic performance and educational attainment (Domínguez-Martínez & Robles, 2019). Trans people also experience disproportionate levels of economic discrimination resulting in high levels of un- and under-employment, which can affect housing stability and access to health insurance (Leppel, 2021; Mizock et al., 2018). Interpersonal experiences of discrimination and violence work to further marginalise trans people, denying them access to much familial and social support (Klemmer, Arayasirikul, & Raymond, 2018). These multiple and significant exclusions can only have a deleterious impact on physical and mental health, as such there have been calls to designate gender identity as a social determinant of health: "Prejudice, stigma, transphobia, discrimination, and violence targeted at transgender people produce differential levels of social exclusion for populations defined by gender identity" (Pega & Veale, 2015, p. e59)

These findings highlight the very vulnerable position trans people are put in by society at large, and intimates at the significant, and compounding trauma that transphobic

acts perpetrate on the individual (Mizock & Lewis, 2008; Ussher et al., 2020). Additionally, this trauma has the potential to impact those close to them, known as secondary or 'associative' stigma (Stangl et al., 2019) and children can be particularly affected when their parent is harassed and discriminated against which in turn, may impact parent-child relationship satisfaction, and well-being (Bockting, 2009; Salter et al., 2010). Currently, there is little research focusing specifically on how children with a trans parent may be impacted by discrimination related to their parents' gender identity, however, some researchers look to the impact of homophobic discrimination and bullying on children with LGB parents to provide insight (Downing, 2013). One study on the impact of homophobic stigmatisation on teenage children (N=78) who have a lesbian parent, or parents, indicated that whilst stigmatisation was associated with increased behavioural issues, these issues were negated when the teenager had a positive and close relationships with their parent (Bos & Gartrell, 2010). Other studies concur that family cohesion, as well as broader social support, offer significant protective factors amongst nonnormative families (Brown, Porta, Eisenberg, McMorris, & Sieving, 2020; Lick, Tornello, Riskind, Schmidt, & Patterson, 2012; Prendergast & MacPhee, 2018).

Transphobic Barriers to Healthcare

The United Nations further decrees: "The right to health is a fundamental part of our human rights, and of our understanding of a life in dignity" (United Nations, 1964, p. 3). Access to healthcare is defined as the "timely use of personal health services to achieve the best personal outcomes" (Institute of Medicine, 2009, p. 4). It is characterised by the ability and ease in which a person is given access to, and can utilise; services, health care professionals (HCPs) and institutions, as well as an equitable balance between financial cost and therapeutic need (Culyer & Wagstaff, 1993; Levesque, Harris, & Russell, 2013).

However, research conducted across almost every continent on earth indicates trans people experience multitude pervasive barriers when interacting with HCPs and when accessing healthcare services more broadly (Bartholomaeus, Riggs, & Sansfaçon, 2021; Brown, Kucharska, & Marczak, 2018; Halliday & Caltabiano, 2020; Radusky et al., 2021; Yan et al., 2019; Zatloff, von Esenwein, Cook, Schneider, & Haw, 2021). Whilst there are some healthcare needs unique to gender dysphoria and medical gender affirmation, trans people also require the same healthcare as the wider population (Riggs, Coleman, & Due, 2014; Safer, 2016). However, their care is often problematised by HCPs and services alike, ascribing even basic needs and treatment as 'too hard' and 'too complicated' (Agénor, 2021; Armuand, Dhejne, Olofsson, & Rodriguez-Wallberg, 2017; Bower-Brown & Zadeh, 2021). As Johnson states: "In the absence of formal and informal trans-appropriate comprehension, normative ideological assumptions can replace standards of care for trans patients" (2020, p. 70).

Covert & Overt Healthcare Discrimination

Healthcare discrimination can be enacted in overt ways, such as treatment being openly refused, or legislated against, as well as in verbal, physical or sexual abuse perpetrated by HCPs or within healthcare settings (Grant et al., 2011; James et al., 2016). Discrimination can also be enacted in covert ways, such as making the cost of care, and the financial structure of treatment and healthcare coverage, significantly prohibitive for many trans people (Safer, 2016). For example, the National Transgender Discrimination Survey (Grant et al., 2011), conducted in the US, found that 48% of trans people reported delaying treatment when sick or injured as they could not afford even basic healthcare. Additionally, high costs associated with clinical mental health support and lifesaving affirming medical treatments inaccessible for many, even in countries like Australia that offer universal healthcare (Ho &

Mussap, 2017). Covert discrimination is also evident in administrative systems, and staff protocols, that do not make provisions for trans people to register, and be referred to by, the appropriate name and gender identifier they have designated (Zeeman et al., 2019). Discrimination can be implemented by a provider, or more broadly within a healthcare practice, and engagement with multiple agencies, such as pathology and testing, insurance providers and associated government support agencies, can increase exposure. This can put trans people at a very real risk of being 'outed' against their choice, or being required to repeatedly disclose and correct their gender status or name change, all of which has very real consequences not only for their mental health and well-being, but also their personal safety (Bartholomaeus et al., 2021; Progovac et al., 2018; Rowland, 2021). Bouman (2017) states "language has been used by political, religious, legal, and medical cultural institutions for the purpose of normalising (trans) marginalisation and discrimination" (p2). Covert discrimination can also create a self-fulfilling prophecy whereby trans people are made to feel so uncomfortable and unwelcome accessing a service, that they abandon treatment, confirming biases held by the service provider that trans people are not 'good patients' or 'good candidates' for treatment (Fish, 2008; Herald, 2010; Penner et al., 2013). Bauer (2009) states, "the existence of an actual trans person within systems such as health care is too often unanticipated and produces a social emergency of sorts because both staff and systems are unprepared for this reality" (p.356).

Cultural competence is broadly described as the ability to understand, communicate, and deliver culturally appropriate and necessary services to diverse populations (Vermeir, Jackson, & Marshall, 2018). Fundamentally, however, cultural competence is a process; an ongoing and dynamic commitment to community engagement, accountability and self-evaluation by providers who don't share the lived experiences of the community they are

engaging (Curtis et al., 2019; Patterson, Tree, & Kamen, 2019). In the healthcare context, cultural competence can be reflected in HCPs understanding trans identities, the use of appropriate pronouns and names and treating trans patients with dignity and respect (Haire, Brook, Stoddart, & Simpson, 2021; Lerner & Robles, 2017). HCPs who exhibit cultural competence *and* knowledge of trans healthcare have been identified by trans participants as vital to the equitable access of healthcare for themselves and their families (Hendricks & Testa, 2012; Johnson et al., 2020; Merryfeather & Bruce, 2014; Safer, 2016; Zeeman et al., 2019). Cultural competence requires HCPs to examine the way they may contribute to healthcare disparities in their own provision of care, as well as biases they may have (Vermeir et al., 2018; Wilkinson, 2014).

Many HCPs reportedly exhibit significant implicit and explicit biases towards gender diverse patients (Burgess, Van Ryn, Dovidio, & Saha, 2007; McDowell, Goldhammer, Potter, & Keuroghlian, 2020; Valentine & Shipherd, 2018). One study, of over 4000 first-year medical students, found that almost half reported explicit (consciously-held) biases, and over 80% exhibited implicit (outside of awareness) biases, towards gender-diverse patients (Burke et al., 2015). HCP biases are significantly correlated with quality of care; clinical decision-making; and patient health outcomes and their influence can heighten when HCPs are over-worked or stressed (Chapman, Kaatz, & Carnes, 2013; FitzGerald & Hurst, 2017; Morris et al., 2019). Biases are grounded in heterocisnormative assumptions, privileging cisgender experiences and ascribing trans bodies and lives as less of a priority and less deserving of care (Enson, 2015). Mitigating bias is vital across healthcare provision, especially so in critical care contexts such as mental health, where a strong therapeutic alliance is vital for successful treatment (FitzGerald & Hurst, 2017; McDowell et al., 2020).

Extensive research indicates that there are significant deficits in HCPs knowledge of trans health (Bartholomaeus et al., 2021; Haire et al., 2021; Halliday & Caltabiano, 2020; Johnson et al., 2020; Riggs et al., 2014; Rowland, 2021). For example, Rowe et al. (2017) found only 50% of accredited HCPs reported competence in their care of trans patients. Irwig's (2016) survey of endocrinologists found that the majority rated their competency as "not at all" or "a little", and over one third refused to provide hormonal care for trans patients. Many researchers and HCPs attribute lack of knowledge to their clinical training (Chatterjee et al., 2018; Hollenbach, Eckstrand, & Dreger, 2014; Obedin-Maliver et al., 2011; White et al., 2015). Data from 132 medical institutions across Canada and the United States reported students received a median of five aggregated hours of LGBT-education across their clinical training, with forty-four institutions reporting zero clinical training (Obedin-Maliver et al., 2011). A separate study of students at a Boston teaching hospital reported zero hours of education pertinent to caring for trans patients (Honigberg et al., 2017) and seventy percent of medical students in a separate US study reported they did not feel comfortable even discussing gender affirmation and affirming medical treatments (White et al., 2015). Many HCPs report that their lack of experience, and uncertainty around appropriate care options, and resources for trans people, makes some reluctant to treat this population which can result in difficulty finding care, increased complications and poor outcomes (James-Abra et al., 2015). There is a push to increase trans-specific training and education amongst healthcare students in order to address healthcare disparities (Cohen, 2019). Increasing education seems a logical solution to address gaps in HCP knowledge. However, research increasingly indicates that without addressing biases and structural barriers, provision of care does not significantly improve; clinical competency and cultural competency go hand-in-hand (Hearn

et al., 2011; Henderson, Horne, Hills, & Kendall, 2018; Marcelin, Siraj, Victor, Kotadia, & Maldonado, 2019; Stroumsa, Shires, Richardson, Jaffee, & Woodford, 2019).

Mental Health as a Locus of Inequity

Few areas illustrate both the severity and consequence of discrimination so starkly as trans mental health and wellbeing (Haire et al., 2021; Halliday & Caltabiano, 2020; Puckett, Maroney, Wadsworth, Mustanski, & Newcomb, 2020). In a recent Australian study, trans participants were reportedly five times more likely to experience and be diagnosed with depression and anxiety; six times more likely to self-harm; and 15 times more likely to attempt suicide, compared to the broader population (LGBTQI+ Health Australia, 2021). A study conducted in Ireland found that 80% of trans respondents had contemplated suicide, 40% had attempted suicide and 44% had self-harmed (Department of Health, 2013). Whilst all of these outcomes are striking, such findings have compelled researchers such as dickey (2020) to state that suicidality rates amongst trans people are a public health crisis. Historically, trans mental health research focused almost completely on the assumed 'pathology' behind gender variance: What was its origin and how could it be 'fixed'? (Ault & Brzuzy, 2009; Haraldsen & Dahl, 2000; von Krafft-Ebing, 2011). Trans people were viewed through the narrow lens of their assumed 'disorder', pathologising their lived experiences in a way that limited therapeutical potential (Alegría, 2010; McCann & Sharek, 2016). When trans people are asked directly about the distress they experience, studies conducted across the globe find similar responses: gender dysphoria, family rejection, stigma and violence (Bartholomaeus et al., 2021; Global Rights; Halliday & Caltabiano, 2020; McNeil, Bailey, Ellis, & Regan, 2013; Stangl et al., 2019; Ussher et al., 2020). Minority Stress Theory (Meyer, 1995) proposes that the enduring psychological stress from exposure to this systematic discrimination depletes emotional, cognitive and social resources, conferring risk

of psychopathology and decreasing coping skills and overall wellbeing (Hatzenbuehler, 2009; Hendricks & Testa, 2012). Additionally, negative experiences can be compounded by 'internalised transphobia', a process whereby "discomfort with one's transgender identity as a result of internalizing society's normative gender expectations" (Bockting et al., 2020, p. 15) generates guilt and shame, perpetuating negative self-appraisals, creating a vicious cycle of mental health vulnerabilities (Chodzen et al., 2019; Cronin, Pepping, & Lyons, 2019). As such, supportive, accessible and culturally competent mental healthcare (MHC) should be available. However, the issues within the broader healthcare system are echoed within MHC (Halliday & Caltabiano, 2020; Puckett et al., 2020; Radusky et al., 2021). Lack of both clinical and cultural competency amongst mental healthcare provider's (MHCPs) have been identified as key issues, as well as perceived 'gatekeeping' around aspects of pursuing gender affirmation (Haire et al., 2021; Hughto, Reisner, & Pachankis, 2015; McNair & Bush, 2016; Riggs, Ansara, & Treharne, 2015; White & Fontenot, 2019).

There is limited research looking specifically at the experiences of trans parents and their mental health, however, we do know that these issues can complicate perceived vulnerabilities and existing marginalisation's (Downing, 2013; Freedman et al., 2002). Broader research illustrates that there is significant self-stigma associated with poor parental mental health, as it is a "perceived violation of social and cultural norms related to parenting" (Reupert et al., 2021, p. 6). Given the existing heterocisnormative pathologisation and positioning as 'disordered' of trans people, trans parents could experience heightened vulnerabilities. This pathologisation has a long and established history within medicine and the health sciences.

A Brief History: The Pathologisation and Medicalisation of Trans Bodies & Identities

> Medical science has always been a two-edged sword – its representatives' willingness to intervene has gone hand-in-hand with their power to define and judge (Stryker, 2008a, p. 36).

In western society, our contemporary understanding of gender identity and diversity has been fundamentally shaped by a medicalised framework in which the trans experience has been positioned and contextualised in regard to 'pathology' (Ault & Brzuzy, 2009; Barbieri, 1999). As Mackinnon states: "Embedding the human phenomena of gender-variance within a medical model is a relatively recent Western development" (2018, p. 75).

Sparked by an ideological shift away from primarily theological conceptualisations, medical and psychiatric specialists began in earnest to investigate and quantify sexuality and gender expression in the late-1800's (Chess, Gordon, & Fisher, 2019; Stryker, 2008b). Early research from the perspective of the science of sexology, was concerned with the taxonomy of sexuality and gender, degrees of 'difference' in sexual and gender expression, and the most appropriate ways in which to "diagnose, label and then cure (gendered) pathology" (Haefele-Thomas, 2019, p. 18). Early sexologists drew few, if any, distinctions between gender identity, expression, and sexual orientation, as well as an almost complete focus on people who were assigned male at birth (AMAB) (Reis, 2014). First published in 1886, Richard von Krafft-Ebing's highly influential medical compendium '*Psychopathia Sexualis'*, proffered one of the earlier diagnostic taxonomies of, what he referred to as, psychosexual disorders; primarily relating to 'cross-gender identification', sexual expression and attraction (Beemyn, 2013). von Krafft-Ebing categorised those who believed that the sex assigned to them at birth was wrong as particularly disturbed, considering it a form of psychosis, and the distress of

what we now know as gender dysphoria interpreted as further evidence of abnormality (Beemyn, 2014; Heidenreich, 1997; von Krafft-Ebing, 2011).

Hirschfields' 'Transvestites'

Although the term 'transvestite' is now outdated, and felt by some to be inappropriate or even offensive (Stryker, 2017), its originator, German physician and sexologist Magnus Hirschfeld (1868-1935), held a more contemporary perspective on the health and well-being of the sexually- and gender-diverse, seeking to demolish the prevailing male/female binary and gain equality for this population (Mancini, 2010). Coining the term in his 1910 treatise on the treatment of trans people, *'Transvestites'*, Hirschfeld (1991) stated that 'transvestites' were not mentally unwell, nor was it a sexual fetish, rather they experienced "feeling of peace, security and exaltation, happiness and well-being" (p.125) when able to present in the gender they truly aligned with. Hirschfeld was an early advocate for the trans community, differentiating sexual orientation from gender identity at a time when they were viewed as one and the same, and advocating for trans people to have official documentation reflecting their 'change in gender' in order to avoid persecution from the Berlin authorities. He also helped pioneer early medical interventions, with colleagues specialising in endocrinology and surgery (Beemyn, 2013; Haefele-Thomas, 2019). Hirschfeld saw the significant distress experienced by his patients due to their inability to live authentic lives and wished to develop clinical ways to alleviate some of that suffering (Mancini, 2010). However, as a gay Jewish socialist living in Nazi Germany, Hirschfeld's situation became extremely precarious. Publicly denounced by Hitler as 'the most dangerous Jew in Germany', Hirschfeld was forced to flee, leaving behind his extensive research and life's work, all of which was completely destroyed by political extremists (Stryker, 2008a).

Inquiries into how to treat gender dysphoria were essentially halted due to World War II and when they re-emerged, much of the understanding and innovation found in Hirschfeld's approach was abandoned (Beemyn, 2014). Sexuality and gender diversity were once again amalgamated and viewed through the lens of pathology. Psychological treatments aimed at healing the 'unconscious wound' that created such disordered thinking and 'curing' people of their malady led to the use of 'aversion therapy', for example, administering electric shocks when trans women were shown images of 'female' clothing (Smith, Bartlett, & King, 2004). 'Conversion therapy' involved individuals being told their gender diversity was the result of childhood trauma or an incomplete bond with their 'same-gendered' parent and could be repaired though intensive psychotherapy, rejecting symbols of their preferred gender, and even intensive prayer (King, 2019). As Stoller wrote in his influential text *Sex and Gender'*, originally published in 1968 *'*

> I would consider a transvestite to be cured of transvestism if, without the need for conscious control-inhibition, suppression, denial, avoidance or courage – he no longer cared to cross-dress…and now potently and pleasurably was using a woman with whom he had an affectionate relationship for his sexual gratification. (This last would be asking a lot of most men, not just transvestites (1994, p. 243).

'Aversion therapy' was, and is, deeply ethically unsound (Przeworski, Peterson, & Piedra, 2021; Schroeder & Shidlo, 2002) , however, 'conversion therapy' is still being practiced in many parts of the world. 'Conversion therapy' is primarily delivered from a faith-based perspective even though extensive research shows that it significantly exacerbates many negative outcome measures, including self-hatred, depression and suicidality (Byne, 2016; D'Angelo et al., 2021; Turban, Beckwith, Reisner, & Keuroghlian, 2020). There is currently growing political support within Australia to ban conversion therapy, which has successfully

lobbied many state governments to change their policy towards the widely discredited and harmful practice (Ryan & Callaghan, 2021)

A Lone Trans Voice

In 1939, British physician, Michael Dillon, became the first known trans man to document and take hormones for the purpose of affirming his gender. He also went on to have several ground-breaking surgical procedures, including the first recorded phalloplasty. Up until this point, literature about trans people were written solely, as far as we know, by cisgendered clinicians and theorists. Dillon was the first known trans clinician to investigate and develop interventions (Chess et al., 2019) and was especially critical of doctors who believed that they could 'treat'/'cure' gender dysphoria through psychotherapy, when what their clients really needed, in his estimation, was access to gender affirming treatments such as hormonal and medical interventions (Beemyn, 2014). The publication of American endocrinologist Harry Benjamin's seminal (1967) work, *'The Transsexual Phenomenon'*, also emphasised the use of hormones and surgical interventions to alleviate dysphoria, 'adjusting the body to the mind', and saw an explosion in research around 'the trans phenomenon' in the '60's and 70's, coinciding with the opening of the first U.S-based gender clinic at Johns Hopkins University (Smith et al., 2004).

Psychiatrists and the Dismantling of Medically Assisted Gender Affirmation

This burgeoning field of medical treatment for gender dysphoria (Siotos et al., 2019) elicited a renewed wave of opposition within healthcare more broadly. Hormonal treatment was viewed with great suspicion and surgery as highly unethical and, to many, an egregious and unnecessary mutilation (Meerloo, 1967). Psychiatry had its own theories on the 'transsexual phenomenon', with a particular preoccupation around childhood attachment (Barlow, Reynolds, & Agras, 1973). Psychoanalysts and psychiatrists generated much of the

criticism directed at surgeons, proposing that those wishing to have medical interventions to affirm their gender were obviously mentally ill (Carr & Spandler, 2019).

In 1979, the pioneering surgical program at the Johns Hopkins Gender Identity Clinic was shut down, largely due to the efforts of the hospital's psychiatrist-in-chief Paul McHugh, a vocal opponent of trans legitimacy, drawing on the findings of a single, widely refuted, study by Meyer and Reter (1979), that suggested psychosocial outcomes in trans people who had medical treatment were no better than those who went without (Selvaggi & Bellringer, 2011). In the conclusion of their study, Meyer and Reter wrote: "surgery is not a proper treatment for a psychiatric disorder, and it's clear that these patients have severe psychological problems that don't go away following surgery" (1979, p. 1013). Many conservative leaders in the medical and political spheres leapt at this opportunity to invalidate the legitimacy of medical treatment for trans people and, in the United States, numerous gender centres followed suit, either closing completely or ceasing to offer surgical treatment (Stryker, 2008a; Zurada et al., 2018). To address political and institutional criticism and regression, a movement towards the standardisation of care for gender diverse populations was introduced (Harry Benjamin International Gender Dysphonia Association, 1985). Now known as the World Professional Association for Transgender Health (WPATH), this organisation developed the first 'Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People', to address all aspects of therapeutic care for transgender people (Selvaggi, Dhejne, Landen, & Elander, 2012).

Disordered or Dysphoric?

In 1980 'Gender Identity Disorder' (GID) was added to the American Psychiatric Association's third edition of the Diagnostic and Statistical Manual (1980), meaning that transgender identities were now formally classified as a psychiatric disorder (Ault & Brzuzy,

2009; Drescher, 2015). The introduction of GID was viewed by many as a 'replacement' for the 1973 removal of "homosexuality" as a psychiatric disorder from the Diagnostic and Statistical Manual, and a continued attempt to control sexual and gender expression within a medical framework (Ault & Brzuzy, 2009). Positioned by many in the psychiatric community as a move to ostensibly 'assist' trans people in accessing the healthcare system by virtue of offering an 'official diagnosis', the true impact of the psychiatric control of those identified as transgender included use of pharmaceuticals, institutionalisation, psychoanalysis to address childhood 'trauma', and aversion therapy (Dreger, 1998; McHugh, 2004; Zurada et al., 2018). Additionally, diagnostic labels not only defined trans people as 'disordered', but also meant that healthcare professionals were given complete control of the process of gender affirmation (King, 2019).

The impact of formal pathologisation continued in an array of additional forms of discrimination, such as loss of custody of children, loss of health insurance, employment, the ability to marry and, for a time, even evident in a legally established defence for the murder of trans people (Cooper, 2013; Kari, 2006; Lee & Kwan, 2014). It took 33 years for the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) to formally remove GID, replacing it in the fifth edition with the diagnosis of 'Gender Dysphoria' (American Psychiatric Association, 2013). However, many researchers assert that this still equates trans experiences with psychiatric conditions (Ault & Brzuzy, 2009): "Trans experiences are not expressions of ill health…and diagnosis of gender incongruence should not, therefore, imply pathology" (Walsh & Krabbendam, 2017, p. 98). As Conrad argues, through medicalisation "nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders." (2004, p. 32).

This history shapes much of the present-day rhetoric on trans bodies, identities and lives, monopolising discourses around gender diversity more broadly. Trans people have long been subjected to 'prevailing wisdom of the time', dictating much of their care but also the acceptability of their existence (Waszkiewicz, 2006). Contemporary research around 'transgenderism' must acknowledge that medicalisation and pathologisation of trans and gender diverse identities have been enacted *upon* trans people by researchers, not uncovered by them (Butler, 1988; Reis, 2014; Riggs, 2014). Only once we have a full understanding of the historical underpinnings of trans healthcare can we contextualise contemporary approaches and identify where needs are being met or missed.

Current Approaches to Gender Affirmation

Contemporary experiences and perspectives around gender affirmation are significantly more individual, varied and unique. gender affirmation, also commonly referred to as 'transitioning', is a dynamic process, rather than a single action or acquirement whereby a person may affirm their gender by bringing it into alignment or congruence in relation to their own gendered-experience, with what is available to them (Burnes & Chen, 2012). Trans people are *diverse*; with needs, wishes, expectations, abilities and circumstances just as varied as the broader population. As such, gender affirmation means significantly different things to different people (Hughto, Gunn, Rood, & Pantalone, 2020). A person may affirm their gender through social means, such as adopting a different name, different pronouns and titles, changing their clothing, grooming or appearance (Burnes & Chen, 2012). They may affirm their gender legally, by pursuing formal, government-recognised changes to their legal documentation, such as changing or removing the gender on their birth certificate or other I.D. (Jellestad, 2018). A person may pursue medically assisted affirmation, such as the use of hormone therapy with a view to reduce certain secondary sex characteristics of their 'birth

sex' and enhance the production of hormones they may not normally produce at significantly effective levels (Gorin-Lazard et al., 2013). Some people may affirm their gender using surgical treatments, such as the removal of breast tissue, often referred to as 'top-surgery', body and/or facial contouring surgery, breast augmentation, as well as surgical removal or alteration of existing genital organs or tissue (Dhejne C., 2011; Selvaggi & Bellringer, 2011). A person may also affirm their gender through interactions with others, by being treated in ways consistent with, and that validates, their sense of the gendered self (Sevelius, 2013). It is vital to note that not all trans people pursue gender affirmation in these ways, or in any ways that may be discernible to an outside observer. This may be because they are not physically or financially able, because they do not have the support of those around them, or it would not be safe for them to do so (Pyne, 2012). It may also be because they choose to express themselves in a different way (Hughto et al., 2020).

Regardless of how a person may affirm their gender, it is becoming increasingly established that gender affirmation has a demonstrated and highly significant positive impact on the quality of life for trans people, across all psychosocial and health-related measures, as well as satisfaction with interpersonal relationships (Glynn, 2016; Hughto et al., 2020; Sevelius, 2013; Siotos et al., 2019; Zurada et al., 2018). Restricting access to, and support for, an individual's gender affirmation heightens negative outcomes, such as depression, anxiety, suicidality, and substance abuse (Fontanari et al., 2020; Hughto et al., 2020; Lelutiu-Weinberger, English, & Sandanapitchai, 2020). It is vital to acknowledge then, that for many, the pursuit of gender affirmation is often rendered highly problematic. For example, whilst the legality of changing one's gender on formal documentation such as birth certificates varies widely depending on specific laws. In New South Wales Australia, where the research for this thesis was conducted, in order to change the gender on one's birth certificate, the

applicant must, as the law states: have undergone a 'sex affirmation procedure', which is defined as "a surgical procedure involving alteration of a person's reproductive organs" (New South Wales Government, 1995). This means that anyone who wishes to have their birth certificate reflect their gender, but does not wish to, or is not able to, surgically alter their "reproductive organs" is ineligible. Internationally, complete medical sterilisation is an existing requirement for official recognition of updating gender status in 16 countries, such as Japan, Finland, and The Czech Republic (Honkasalo, 2018; Ostrowsky, 2020; Riggs, Pfeffer, Pearce, Hines, & White, 2021; The Lancet, 2019). This is despite the fact that such a requirement contravenes international human rights obligations and is opposed by multiple international health and social justice organisations, including the World Health Organisation (European Court of Human Rights, 2017; World Health Organisation, 2014; World Professional Association for Transgender Health, 2012).

Epistemic Knowledge – Gatekeeper or Informed Consent?

Access to medical treatment for gender affirmation often requires engaging multiple healthcare providers (HCPs). For trans people, supportive engagement with HCPs is vital to ensure, not only safe and positive outcomes with hormonal or surgical interventions, but also ongoing support (Heng, Heal, Banks, & Preston, 2019). As touched on previously, not all trans people wish to access medical treatments for gender affirmation, nor is it an option available to all. However, for those who do, these treatments are of critical importance and, for many, can be lifesaving (Bartholomaeus et al., 2021; Hughto et al., 2020).

There are two primary ways in which to access treatment. The 'gatekeeper model', common in healthcare, refers to a key HCP through which the patient accesses specialists, diagnostic tests, prescriptions and other treatments (Greenfield, Foley, & Majeed, 2016). The 'gatekeeper model', sometimes referred to as the 'approval letter model', is the standard

recommended by the WPATH's Standards of Care (2012). It involves a psychosocial assessment by a mental health professional after which, if certain criteria have been satisfied, an approval letter will be used to engage further specialists (Haire et al., 2021). If surgical gender affirmation treatment is required, two mental health professionals must assess and write approval letters (World Professional Association for Transgender Health, 2012). In this model, access to care is dependent upon the assessment. The second pathway is the 'informed consent model', under which a person can access gender affirming hormones through a single HCP, potentially your regular doctor, without outside referrals, after an extended consultation and full medical evaluation (Haire et al., 2021). However, for surgical interventions the WPATH model is still viewed as best practice by surgeons, as it partly protects them from liability, and serves as a guide to assist patients finding accredited specialists (World Professional Association for Transgender Health, 2012). For many trans people, 'gatekeeping' is perceived in far more colloquial terms, the act of controlling or limiting access (Waszkiewicz, 2006). It is experienced, by many, as problematising access to affirmative care, requiring trans people to jump through hoops in order be granted treatment (Riggs et al., 2014). Trans scholar, Ashley, writes of their experience: "assessment and referral requirements are dehumanising and unethical, foregrounding the ways in which these requirements evidence a mistrust of trans people (2019, p. 480). Ashley furthers that trans people have epistemic authority over their mental states and that there are multitude ways to 'transition' and experience gender that cannot fully be captured by the gatekeeping model (2019). Medicalising gender variance by way of a psychiatric diagnoses perpetuates the hegemonic medical model by attempting to assert epistemic authority over trans people's experiences of their own gender (Johnson, 2015). By virtue of this, there is a ripple effect within the lives of trans people that goes beyond how they may be permitted to 'access'

gender affirming treatments and stretches into their ability to dictate their own terms around fundamental human experiences such as their reproductive health and choices around biological parenthood, especially in relation to trans men and gestational pregnancy.

Pregnancy and Masculinity

Arguably, there is no human experience more gendered than pregnancy. Dominant reproductive discourses are founded on that irrevocability; pregnancy is gender done 'correctly', the natural progression of femininity, and its accomplishment is socially and institutionally reinforced and rewarded (Cameron, 1998; Ryan, 2013; West & Zimmerman, 1987). Even though we have witnessed the development of new technologies that challenge and expand our understanding of human reproduction, it still seems to firmly privilege heterocisnormativity. Hegemonic cultural representations of pregnancy as unique to cisgender women reinforces this. Thus, "pregnancy ceases to be a "condition" and becomes an identity" (Radi, 2020). Certain reproducers are privileged as legitimate and others as illegitimate (Weissman, 2017). Pearce and White write: "There exists a tendency to both exceptionalize and render invisible trans reproduction, through sensationalized coverage of "pregnant men" (2019, p. 765). Whilst Thomas Beatie may have been positioned as an oddity, as noted above, many trans men retain their reproductive organs and pursue gestational pregnancy (Epstein, 2016; Hoffkling, Obedin-Maliver, & Sevelius, 2017; Obedin-Maliver & Makadon, 2016; Riggs et al., 2021). In Australia, official health records indicate 246 men gave birth between 2013 and 2020 (Medicare, 2020). However, given not all trans men are legally recognised by their gender marker, or may not at the time of giving birth, the actual number may be higher. Trans pregnancy essentially is, as Dietz (2021) states, "unexceptional" (p.191), people who have both the capacity and wish to become pregnant,

can and will. However, the response, from many HCPs, institutions and the broader community transforms male pregnancy into a social and medical 'emergency', deeply troubling the sanctity of hegemonic femininity and repronormativity (Dietz, 2021; Weissman, 2017).

Barriers to Pursuing Pregnancy

There are numerous systemic barriers designed to regulate who is, and who is not, permitted to become a parent (Dietz, 2021). As mentioned previously in this thesis, there are many countries which require trans people to undergo complete sterilisation in order to attain legal recognition of their gender marker (Honkasalo, 2018; Riggs, Pfeffer, Pearce, Hines, & White, 2020). Even in New South Wales, where this project was based, there is a requirement for trans people to undergo a 'sex affirmation procedure' (New South Wales Government, 1995). These types of policies have been referred to as 'passive eugenics', legislating the relinquishing of reproductive rights in order to prove trans authenticity (Bowman, 1996; Lowik, 2018; Radi, 2020). Another example of systemic reinforcement that parenthood and trans identities should be antithetical, "a single narrative enacted into law that establishes and reifies a dominant norm" (Lowik, 2018, p. 427).

For trans men who are living in countries where they *can* exercise their reproductive rights, this freedom is still not necessarily guaranteed. As Dietz writes: "systematic barriers are quotidian aspects of reproductive institutions: of the doctors, hospitals, insurance policies, ethicists, and other actors that together produce the conditions of possibility for contemporary western reproduction" (2021, p. 190). With equitable treatment, trans men who have retained their reproductive organs have similar pregnancy outcomes to cisgender women (Leung, Sakkas, Pang, Thornton, & Resetkova, 2019). Whilst every pregnant person has individual

clinical considerations, a shared issue for some trans men relates to the use of hormonal treatment for gender affirmation. For those who do use it, hormonal therapy, such as testosterone, will have to cease for the duration of the pregnancy. Whilst it is possible to become pregnant when taking testosterone, it is highly teratogenic to a foetus and must be discontinued if a viable pregnancy is to continue (Hembree et al., 2017). Most trans men cease taking hormones in preparation for pregnancy (Hoffkling et al., 2017). However, this can have significant implications for mental health as, for many, hormones can be a vital component of a healthcare plan and ceasing their use can exacerbate gender dysphoria and associated mental health issues (Ellis, Wojnar, & Pettinato, 2015). If medical interventions are able to be bypassed, by conceiving using known donor sperm and at-home insemination, or through intercourse, positive and straight forward experiences are generally reported (Riggs et al., 2020). However, for the many trans men who need to access medically assisted reproduction (AR), experiences are often challenging (James-Abra et al., 2015; Riggs et al., 2020).

Ethical debates regarding medical AR and who has "the right to reproduce" (De Wert et al., 2014, p. 1859) have long upheld heterocisnormative regulation of who can and cannot become a parent, accompanied by paternalistic discourses around 'the best interests of the child' (Ethics Committee of the American Society for Reproductive Medicine, 2015; Hembree et al., 2017). Australian heterosexual couples have been accessing AR since 1980 (Baird, 2012; Leeton, 2004), whereas federal legislation ostensibly enshrining trans people's medical right to equal treatment was not enacted until 2013 (Australian Human Rights Commission, 2013). However, as with many aspects of trans healthcare, 'permission' to access a service does not mean that service will be granted, nor that it will be of an equitable standard. Trans people are still routinely subjected to discrimination and suboptimum care

when trying to access AR (James-Abra et al., 2015; Riggs et al., 2020). In these environments, heterocisnormativity is the default, in which all systems are grounded (Light, Obedin-Maliver, Sevelius, & Kerns, 2014). Trans identities, bodies and relationships are deeply troubling to reproductive *and* medical hegemony. As such, trans men engaging these institutions are often subjected to significant problematising of their care by HCPs and ancillary staff, gatekeeping, and potentially having to engage multiple facilities to find one who will both grant, and then fulfil, treatment (Hoffkling et al., 2017; Moseson et al., 2021; Nixon, 2013). Thus, Riggs et al. (2020) argues that trans men must ultimately weigh "suboptimal treatment against the desire for conception" (p.14).

An additional barrier concerning trans men and gestational parenthood exists in the dialectical tension between masculinity and fecundity. Research by Riggs (2013) details the complex negotiations pregnant trans men must engage in to navigate tensions between their masculine self and the gendered expectations from inhabiting a fecund and pregnant body. Trans men may need to reconcile, or reach a personal compromise, between heterocisnormative assumptions around pregnant bodies and their own experiences of gendered embodiment. Whilst not universal, many trans men experience significant gender dysphoria throughout pregnancy, birth, and well into the postnatal period (Riggs, 2020). Ongoing gendered assumptions can be highly challenging to someone already experiencing dysphoria, especially in a medical setting. As such, gender affirming obstetric care has significant benefits in alleviating pregnancy-related dysphoria and distress (Besse, Lampe, & Mann, 2020; Hahn, Sheran, Weber, Cohan, & Obedin-Maliver, 2019; Jarin, 2019). As Obedin-Maliver and Makadon (2016) assert: whilst clinical care for trans men is in the realm of routine obstetrics, culturally competent medical and mental health care is vital for the well-being of parent and child.

Pursuing Gender Affirmation in the Context of Parenthood

Previous research indicates that amongst trans people, likelihood of being a parent is related to the age at which a person pursues gender affirmation (Stotzer, Herman, & Hasenbush, 2014). Those who pursue gender affirmation later in life have higher parenting rates, in recent studies reported to be 82% of those 55 years or older, compared to 38% of those who pursue gender affirmation at younger ages (Grant et al., 2011; Pyne, 2012). A person who 'comes out' and pursues gender affirmation whilst already being a parent negotiates gender affirmation alongside relationships with their children and, for many, their co-parents, and family support can be especially crucial during this time (Lev, 2004). Much of the existing research around parents pursuing gender affirmation focuses on children's adjustment and relationships with co-parents, with less research specifically looking at how these events are experienced and approached by the parent themselves (Dierckx, Motmans, Mortelmans, & T'sjoen, 2016; Dierckx & Platero, 2018; White & Ettner, 2004). The present study addresses this gap in the literature.

When a child experiences parental gender affirmation, a number of protective and risk factors have been identified (Imrie, Zadeh, Wylie, & Golombok, 2020). Previous research has suggested that a child's age at the time their parent 'comes out' and pursues gender affirmation can influence how they adjust to associated changes, with older children and adolescents reportedly initially 'less accepting' than younger children (Gold, 2008; Petit, Julien, & Chamberland, 2018; Veldorale-Griffin, 2014; White & Ettner, 2006). Negative outcomes have been observed if the co-parent exhibits transphobic attitudes and behaviours (Haines, Ajayi, & Boyd, 2014; Hines, 2006; White & Ettner, 2004). In some cases, interpersonal and family conflict can coincide with a parent 'coming out', which can have a deleterious impact child adjustment (Imrie et al., 2020). For example, children may be

exposed to conflict between parents or feel 'caught in the middle'; or they may witness parental distress, or the rejection of their 'transitioning' parent by extended family members, all of which can elicit a negative emotional and cognitive response (Reynolds, 2014; Veldorale-Griffin, 2014; Zadeh, Imrie, & Golombok, 2021). Historically, assumptions around the psychological adjustment of children of a trans parent has been skewed towards possible negative effects (Downing, 2013; Lev, 2010). At its most extreme, these assumptions have resulted in trans parents losing custody, or having their parental rights restricted, under the belief that it was 'not in children's best interests' to have a relationship with their trans parent (Perez, 2009; Pyne, Bauer, & Bradley, 2015; Zadeh et al., 2021). In Grant et al.'s (2011) survey of over 6,000 trans people in the United States, 29% of parents reported an ex-partner limiting contact between themselves and their child and a study by Pyne et al. (2015) found that 10% of trans parents reported losing custody of their children.

As referenced previously in this literature review, the most significant influence on child well-being and adjustment is the quality of relationship between parent and child, and positive rapport between co-parents, regardless of their relationship status (Freedman et al., 2002; Hines, 2006; Imrie et al., 2020; Zadeh et al., 2021). Open and supportive communication between parent and child, stability in parenting and family arrangements, acceptance by the co-parents, as well as the meaning attributed to parental gender affirmation have been identified as factors that can aid adaptive family functioning when a parent 'comes out' and pursues gender affirmation (Dierckx et al., 2016; Dierckx & Platero, 2018). As Dierckx et al. (2016) state: "a transition is never just an individual process" (p.6). When a parent 'transitions' the whole family 'transitions' alongside them (Haines et al., 2014).

The preceding sections of my thesis illustrates just some of the myriad ways in which trans lives are effected by the heterocisnormative assumptions and attitudes that shape

society. This hegemony is projected on the collective minds of the community through its enshrining in our institutions: social, economic, political, educational, and, overwhelmingly, medical. This systematic perpetuation of marginalisation impacts trans people on a broader scale but also carries into their interpersonal lives, their families and community.

Thesis Aim and Research Questions

Given the extent of heterocisnormative pathologisation, stigma and discrimination to which trans people are subjected, there is still much to understand in regards to how this is navigated within parenthood and the family context. Qualitative research methods using a social constructionist epistemology, queer theory and an intersectional approach can help to illuminate these experiences. Social constructionism was a rebellion against 'essentialist' views that "bound gender roles, gender identity, and sexual orientation tightly within a binary, biologically based, heterocisnormative gender schema" (Nagoshi & Brzuzy, 2010, p. 434). Social constructionism asserts that all meaning is both socially created and politically driven, bestowing privilege on accepted constructs (Cuichi, Bragaru, & Cojocaru, 2012; Peterson, 2013). Queer theory offers a philosophical and political understanding of nonnormative gender identities and intersectional perspectives illustrate how multiple marginalisations compound and reinforce systematic oppression (Bower-Brown & Zadeh, 2021; Kirczenow MacDonald, Walks, Biener, & Kibbe, 2021). These perspectives have proven to be an effective way to critically and inclusively explore the experiences of trans parenthood (Few-Demo et al., 2016; Haines et al., 2014; Wesp et al., 2019). Given these factors, I adopt a social constructionist epistemology and draw on queer theory and an intersectional approach in this thesis – to address the following research questions:

1. What are trans parents' subjective experiences of parenthood?

2. What implication does heterocisnormativity have on their experiences of parenthood?

Structure of the Thesis

This thesis contains seven chapters. In this first chapter, I have introduced the topic of trans parenthood, heterocisnormativity and the family as a 'cultural battleground' as well as research around transphobia and its impact on trans-parented families. Structural discrimination and the medicalisation and pathologisation of trans bodies and identities has been introduced. Current approaches to gender affirmation were discussed as well as the ways in which HCPs can help, or hinder, trans parents. I then reviewed literature on trans men and pregnancy, as well as research around 'coming out' and pursuing gender affirmation in the context of parenthood. Finally, I briefly explored the use of a social constructionist epistemology, queer and intersectionality theories to inform this research.

In Chapter Two I describe the theoretical, epistemological and methodological approaches used in this research. I then explain the design of the study, the recruitment procedure, as well as participants' demographics. The two data collection stages are then outlined: online surveys and one-on-one interviews, as well as interview co-construction and ethical considerations. Finally, I discuss the phases involved in the thematic analysis of the data, and discuss researcher reflexivity.

Chapters Three, Four, Five, and Six of the thesis contain my journal articles. Three of these articles have been published, fourth is under final peer-review. In these articles, I analyse the research findings and discuss these findings in relation to existing empirical and theoretical understandings of trans parenthood. Slight variations in chapter formatting reflect the requirements of respective journals in which they are published.

Chapter Three, *The Transgender Parent: Experiences and Constructions of Pregnancy and Parenthood for Transgender Men in Australia,* explored transgender men's experiences of negotiating and pursuing pregnancy. The analysis illustrated that, for many

trans men, prospective parenthood was experienced as alienating and complex, however pursuing gender affirmation enabled the negotiation and construction of their own parenting identity. Pregnancy was positioned as a problematic but "functional sacrifice," however formal assisted fertility experiences were rife with exclusion. At the same time dysphoria associated with withdrawing from testosterone and the growing fecund body were significantly troubling with changes to the chest being of particular concern. Exclusion, isolation, and loneliness were the predominant features of transgender men's experiences of gestational pregnancies. Healthcare systems were not generally supportive of trans bodies and identities and trans men encounter significant issues when interacting with healthcare providers. Chapter Four, *Transgender Parents: Negotiating 'Coming Out' and Gender Affirmation with Children and Co-Parents,* considers how trans parents navigate experiences of 'coming out' and pursuing gender affirmation with their children and co-parents. The analysis illustrates that changes around parental gender identity can have a profound impact on the lives of parents, co-parents and their children; and that navigating these changes requires ongoing, consideration and negotiation. Pursuing gender affirmation was vital to the mental health and well-being of trans parents. Family was both a source of great strength, and vulnerability. Finding a balance between parental gender-related needs, and protecting relationships with children, was of fundamental importance. Chapter Five, *Experiences of Transgender Parents in Navigating Transphobia,* explores how transgender parents, and their children, navigate transphobia. The analysis of this article explores the pervasiveness of transphobic harassment, discrimination and abuse, and its profound impact on trans parents and their children. Chapter Six, *Negotiating Mental Health amongst Transgender Parents in Australia,* examines how transgender parents experienced their mental health and negotiated support. The analysis illustrates the significant challenges in relation to their mental health,

which could make parenting challenging. Many participants struggled to find mental health professionals who were both clinically and culturally competent. However, pursuing gender affirmation, as well as family and social support had a positive impact. Chapter Seven is the conclusion to the thesis. In this chapter I return to my original research aims and discuss the overall findings from the four articles. I consider the implications of these findings for trans health and wellbeing, and come back to my own experiences of researcher reflexivity. The strengths and weaknesses of the study are reviewed, and recommendations for future research are made.

Chapter Two

Theoretical Framework and Methodology

In this chapter, I outline the theoretical approach, methods, and methodological framework used to answer my research questions. In the first half of the chapter, I discuss my epistemology, social constructionism, and present queer theory as my primary theoretical approach, with an acknowledgement of the importance of intersectionality. I explain how these theories shaped the way I researched and analysed trans parents' accounts of parenthood.

In the second half of the chapter, I describe the research methods. I begin by giving an outline of the recruitment procedure and the 66 trans parents who participated in the study. I then explain the research procedure, which involved two stages: stage one featured an online survey, stage two involved one-on-one interviews. Finally, I describe the steps of the thematic analysis I carried out, reflect on how my subjectivity influenced the analysis, and conclude the chapter.

Social Constructionism

This thesis is grounded within a social constructionist epistemology. Social constructionism is a perspective that "locates meaning in an understanding of how ideas and attitudes are developed over time within a social, community context" (Dickerson & Zimmerman, 1996, p. 80). 'Constructions' is used to refer to those meanings and understandings. Literature from the social constructionist perspective proposes that: there is no singular reality; rather, reality can be understood in multitude ways. The way one understands reality is the result of social interactions that vary according to the vicissitudes of time; normative conceptualisations of reality may endure because of perceived utility rather

than ‘empirical validity’; and how one person constructs their reality may affect how others construct their reality (Cuichi et al., 2012; Galbin, 2014; Gergen, 1985a, 1985b). Social identities and behavioural expectations are habituated by these practices, “becoming embedded in the institutional fabric of society” (Berger & Luckmann, 1966, p. 77). As such, the dominant cultural social reality influences the creation of meaning.

In western society, heterocisnormativity upholds and maintains gender essentialism (DeCecco & Elia, 1993). This epistemology asserts that there are fixed, innate biological and psychological features that differentiate the ‘two genders’, men and women (Heyman & Giles, 2006). In this cultural schema, the ‘naturalness’ of a binary gender system in which there are two, and only two, genders is purported to reflect human biology and the ‘complimentary’ nature of their respective reproductive functions (Bornstein, 1994; Schilt & Westbrook, 2009; West & Zimmerman, 1987). Biological explanations appear attractive and authoritative since “reference to “biology” and “science” lends any suggested trait or combination of traits the appearance of neutrality and thus objectivity” (Karkazis, 2019, p. 1898). Gender has been imbued with the explanatory power to dictate how a ‘man’ or ‘woman’ should look, speak, behave, experience and express emotions, as well as what are appropriate occupational choices, extending to parenting and relationship styles (Schilt & Westbrook, 2009).

Social constructionists view gender as a social institution, one that organises and dictates myriad aspects of life, rather than an essential trait (Lorber & Farrell, 1991; West & Zimmerman, 1987). ‘Masculine’ and ‘feminine’ are not characteristics transmitted through our chromosomes, but rather are constructed and reinforced through social interactions. Theorising the social construction of gender brings together the collective interplay of identities, interactions, and institutions in shaping the gendered distribution of power,

privilege, and resources (Coppola, 2021; Cuichi et al., 2012). However, this thesis is not grounded in deciding what sex *is*, or what gender *is*, rather, sex, as much as gender, is conceptualised as culturally conditional (Karkazis, 2019; Pearce, 2018) and, in concordance with the work of Butler (1999) and Serano (2007), sex and gender are *both* socially constructed.

Although social constructionists acknowledge that multiple stories and realities co-exist, they assert that not all stories are treated with equal validity; the lived experiences of those outside normative constructions of gender, sexuality or culture are often marginalised and their stories erased in favour of hegemonic discourses (Berkowitz, Manohar, & Tinkler, 2010; Rapmund & Moore, 2000). As such, social constructionists caution against the power of emphasising "undisputed authority" over accounts based on a person's lived experience and how these accounts can be understood within a particular system (Doan, 1997, p. 128). The intention is to actively deconstruct stories that dominate others and when these are examined, alternative choices become available (Dickerson & Zimmerman, 1996). These underlying assumptions form the epistemological basis for the present study. I take the social constructivist position that trans parents co-create their own reality about parenthood within their social and cultural context. The social constructionist perspective also acknowledges that the way in which participant stories will be shared within the research, will reflect the researcher's way, my way, of viewing and making sense of the world. This is influenced by my own subjectivity, and my individual social and cultural reflexivity.

Queer Theory – Queering the Family

> Queer is by definition *whatever* is at odds with the normal, the legitimate, the dominant...'Queer'...demarcates not a positivity but a positionality *vis-à-vis* the normative…Queer describes a horizon of possibility whose precise extent and

heterogeneous scope cannot in principle be delimited in advance (Halperin, 1997, p. 62)

Queer theory concerns itself with the destabilisation of discourses that hold privileged norms in their place, such as what is known and taken for granted about parenthood and 'doing family' (Few-Demo et al., 2016; Rowland, 2021). From a family scholarship perspective, the process of 'queering' the family involves interrogating the heterocisnormative privileging of certain families over others (Oswald et al., 2005). Whilst this hegemony influences all families, it is most significant for LGBTQI+-parented families, as it is weaponised to both generate and justify their exclusion and erasure (Few-Demo et al., 2016). Once a pejorative and potentially dangerous slur directed at people who allegedly exhibited non-normative gendered behaviour, the term 'queer' still elicits debate around how, by who, and even whether, it should be defined and utilised (Butler, 1994; Greteman, 2014; Sicurella, 2014; Weber, 2014). Butler (2011) argued that queerness "derives its force precisely through the repeated invocation by which it has become linked to accusation, pathologization, insult" (p.226). Whilst Sedgwick (1990) described queerness as "the open mesh of possibilities, gaps, overlaps, dissonances and resonances, lapses and excesses of meaning when the constituent elements of anyone's gender, of anyone's sexuality aren't made (or *can't be* made) to signify monolithically" (p. 8). As such, queerness can encapsulate political and academic perspectives and discourses, as well as a personal, individual and community identities (Fish & Russell, 2018).

When using queer discourses, it is vital to acknowledge, however, that people positioned as 'outside' normative sex, gender or family expressions, including participants in this study, may not personally identify with, or describe themselves as 'queer', they may not position themselves as 'outside' of heterocisnormative binaries at all. Nevertheless, inherent

in ‘queerness’ is a call to action, to interrogate social acts, practices, and ideas that attempt to construct and define what is ‘normal’ (Oswald, 2009). Thus, queer theory challenges how we conceptualise parenthood, and provides opportunities to ask different kinds of questions about ‘doing family’, about what children ‘really need’ and a broader critiquing of the typical normative discourses around the ‘sacred’ domain of family (Few-Demo et al., 2016; Goldberg, 2007). Queer theory provides a lens for untangling that which cultivates and nourishes heterocisnormativity, and for unpacking how those structural elements contribute to the privileging of some parents and family arrangements over others (Oswald et al., 2005). Analytically, a queer theoretical perspective ‘denaturalises’ heterocisnormativity as an authoritative biological ‘truth’ and brings to the forefront the material, discursive and systematic mechanisms that ensure preservation of heterocisnormativity as accepted and natural (Ingraham, 1994; Oswald et al., 2005). However, to more fully critically analyse and understand the normative forces that shape experiences and “possibilities” of queer families, it is vital to also consider other ‘axes of oppression’, such as cultural background and socioeconomic status amongst other identities, and how they intersect (Fish & Russell, 2018, p. 13).

Intersectionality - The Multiplicity of Marginalisation

The theoretical framework of intersectionality brings attention to the reality that heterocisnormativity “is more than the processes of patriarchy, heterosexism, and compulsory heterosexuality; it also contains elements of racial and class ‘othering’” (Battle & Ashley, 2008, p. 5). Intersectionality is the systematic analysis of the ways in which multiple social identities can interact, providing a lens to examine how trans parents engage in the politics of their social location, as “racialized, gendered, and sexualized bodies that challenge heteronormative conformity” (Few-Demo et al., 2016, p. 84). Intersectionality theory was

conceptualised by Kimberlé Crenshaw (1989) as a critique of the marginalisation of black women within feminist discourses, law and anti-racist politics. Crenshaw posited that "dominant conceptions of discrimination condition us to think about subordination as disadvantage occurring along a single categorical axis" (p.140). Crenshaw furthered that the single-axis framework erases people who may exist at multiple axes, such as black women, excluding them from antiracist *and* feminist discourses as the "intersectional experience is greater than the sum of racism and sexism" (1989, p. 140). Patricia Collins (1994; 1998) proposes that, rather than examining identities as distinct social categories, intersectionality references the power of these social phenomena to mutually construct one another. Consistent with queer theoretical perspectives, intersectionality also examines how privilege and marginalisation interact and are enforced by institutional and systematic social structures, accepted patterns of social interactions, and other established social practices that influence the appearance and availability of choices, opportunities, and identities that individuals and groups make and claim as their own (Collins, 1994; Collins, 1998). As such, 'traditional' heterocisnormative family ideals function as a privileged exemplar of intersectionality (De Reus, 2005; Shields, 2008).

An intersectional approach also disrupts mainstream discourses on 'LGBTQI+ family life' that, traditionally, have been heavily informed by the experiences of white, middle-class cisgendered lesbian or gay parents, and their families (de Vries, 2015; Divan et al., 2016; Few-Demo et al., 2016). For example, extensive literature on lesbian-parented families established that these couples negotiated more egalitarian divisions of housework, paid work and childcare (Ciano-Boyce & Shelley-Sireci, 2003; Patterson, 1995; Rawsthorne & Costello, 2010; Sullivan, 1996). However, much of this research was grounded in the experiences of white, professional, lesbian parents who also "share an ideological commitment to a

particular type of egalitarian relationship—an egalitarian relationship defined and encouraged by second-wave feminists of the 1970s women's movement" (Moore, 2008, p. 336). Research by Moore (2011; 2008) exploring the experiences of Black lesbian parents challenged normative discourse around economic independence and the division of household labour by offering a multifaceted, culturally informed, account of parenting experiences. Moore (2008) described how non-biological parents shared the providing role but the gestational parent undertook significantly more household chores, which was used to negotiate greater authority over other aspects of the household, including finances and childcare. For this population, racial identity and group membership were purposefully considered in the formation of sexuality and identity, and tempered by the intersection of their cultural values, and shared group historical experiences. Whereas white lesbian parents were more likely to reject participation in traditional family and community structures, a potential attribution of racial privilege making them less reliant on these 'traditional' support networks (Mezey, 2008). As such, the addition of queer *and* intersectional lenses can grant a more inclusive picture of parenthood and 'doing family', and provide a forward-thinking integrative theoretical framework (Allen, Floyd Thomas, & Gillman, 2001).

Incorporating queer and intersectional theories is not without some dialectical tensions (Gambino, 2020). Historically, queer theory developed as a method to reject identity categories. Queer theorists interrogated the power established by identity categories, and took the position that identity categories are problematic social constructions that should be dismantled (Chan, Steen, Howard, & Ali, 2019; Few-Demo et al., 2016). In contrast, intersectionality would emphasise the material realities and lived experiences associated with identity categories, critically analysing personal experiences of marginalisation to reflect relationships with social structures responsible for the historical reproduction of oppression

(Chan et al., 2019). By incorporating both perspectives a balance can be struck to the interrogation of social discourse and materiality thus enhancing the ability of both perspectives to engage persistent inequalities and transform the grounds of identity politics (Gambino, 2020).

Research Methods

Design

The study had a two-stage qualitative design. As both social constructionism and queer theory emphasise process and the contextualisation of lived experience, qualitative methods were deemed most relevant (Burr, 2015; Oswald et al., 2005). Queer theory principles require "a sensitivity to the complicated and multi-layered lived experiences and subjectivities of individuals, and to the larger cultural, discursive, and institutional contexts of these lives where resources are allocated, images created, and taxonomies are given power" (Valocchi, 2005, p. 767). Stage one involved an online survey with 66 Australian trans parents. Thirty-eight participants chose to go on to stage two, which was a semi-structured interview. Participant accounts were analysed using a reflexive thematic analysis, as set out by Braun and Clarke (2006; 2012). The reflexive aspect of TA acknowledges the researchers own reflexive engagement with theory, data and interpretation, highlighting the researcher's subjectivity as an analytical resource (Braun & Clarke, 2019). A combination of both inductive and deductive driven TA were used as I was primarily driven by the *content* of the data but also drew on *theoretical* constructs from queer scholarship around heterocisnormativity (Marchia & Sommer, 2019) to "render visible issues that participants may not explicitly have articulated" (Braun & Clarke, 2012, p. 60). As such, this research

design allowed me to explore transgender parents' experiences around parenthood through the patterns of meaning in their accounts interpreted within a queer theoretical framework.

Recruitment

Several methods were used for recruitment. Participants were primarily recruited through online advertising on the social media platform, Facebook, from December 2015 to March 2016 (Appendix A). I also direct messaged administrators from informal Australian Facebook transgender support groups with details of the study and asked them to share with their members. Additionally, I direct messaged administrators of Facebook pages of Australia-based formal transgender health services and asked them to distribute study details amongst their users. These online groups are a means for trans people to connect with peers, as such I made the decision to only go through group administrators and not directly post study advertisements on Facebook group pages as I was conscious of the ethics around privacy and respectful engagement with online spaces for trans community members (Fileborn, 2016; Sevelius, dickey, & Singh, 2017). Lastly, I utilised 'snowballing' and gave consenting participants and colleagues the option to share study information within their own social networks (Noy, 2008). Recruitment advertising gave a brief description of the study and directed interested parties to a Western Sydney University webpage with more detailed information (see Appendix B). Participation was open to any trans parent in Australia, aged over 18 years. All online resources were edited in March 2016 to note that all gender diverse parents were invited to participate, not just those who identified as trans. From the invitation:

"Who is invited?

Any transgender parent living in Australia, or from Australia, who is aged 18 years or over.

Please note: All gender diverse parents are welcome to participate. You do not have to identify specifically as transgender."

Those who wished to participate were directed to an online survey run through the Survey Monkey website (see Appendix C).

Participants

Sixty-six trans parents completed the online survey. They were aged between 24 and 67 years old, mean age 40.28. Thirty-six participants were trans men and thirty participants were trans women. The sociodemographics of participants are included in Table 1. The children of participants ranged in age from 18 months to 39 years old, with the majority being aged 6- to 16-years old. One participant had a pregnant partner at the time of the study. Participants had between one and five children. Fifty-five parents (83%) had children that were biologically related to them, including 25 gestational parents (38%), a number of these participants also co-parented children in blended families. Eleven participants (17%) were stepparents.

Ethical Approval

Ethical approval was awarded for this study from the Western Sydney University Human Research Ethics Committee in August 2015 (see Appendix D). Data collection took place between December 2015 and March 2016.

Stage One: Online Survey

Access to the survey was available through a link on the study information webpage. The survey was hosted through Survey Monkey (see Appendix C). Before the survey started,

information about participant consent was restated and if a participant electronically gave consent, access was granted. The survey was divided into two sections containing a series of open-ended questions. The first section collected sociodemographic information: age, sex assigned at birth, sexual orientation, cultural background, education, their current relationship status, and number and age of children they cared for. Some of these questions were accompanied with suggestions to serve as prompts, for example "Current relationship status? (e.g., single, partnered)".

Table 1. Sociodemographic characteristics of participants

Variables	Participants (*N*=66)	
	n	*M (SD)*
Age	66	40.28 (9.87)
		%
Sex assigned at birth [a] **-**		
Male	27	50.00
Female	24	46.29
Intersex	0	0
Unsure	2	3.70
Gender Identity [a] **-**		
Man	13	26.00
Woman	18	36.00
Trans man	10	20
Trans woman	6	12
Not Sure	3	6
Sexual Orientation[a] **-**		
Gay	3	5.55
Queer	5	9.25
Pansexual	9	16.66
Straight/Heterosexual	14	25.92
Bisexual	9	16.66
Lesbian	9	16.66
Asexual	3	5.55
Fluid	2	3.70
Cultural Background [a] **-**		
Australian	36	66.66
Polynesian	2	3.70
British	8	14.81
Malay-Chinese	1	1.85
New Zealand	4	7.40
Hungarian	1	1.85
German	2	3.70

Education [a] **-**		
Left school before completing	2	3.70
Finished high school	5	9.25
Trade/certificate/diploma	15	27.77
University degree or higher	27	50
Other	5	9.25
Do you currently live full time in your preferred gender? [a] **-**		
Yes	41	87.23
No	6	12.76
Relationship status [a] **-**		
Partnered	28	68.29
Divorced/Separated	9	21.95
Other	4	9.75

[a] Where $N < 66$ = missing data

Each question also had an open-response option, with the prompt "If your experience is different, please describe below". The latter was implemented in order to make space for participants to describe their personal circumstances in their own words (Danaher, Cook, Danaher, Coombes, & Danaher, 2013)

The second section consisted of open-ended questions asking: how participants were related to the children they cared for; care or custody arrangements for children if applicable; how participants would describe their relationship with co-parents; how participants would describe their relationships with other family members and support systems; any other information about parenthood that they felt was important; and comments about the survey. At the conclusion, participants were invited to take part in a one-on-one interview with space to leave their contact details.

Stage Two: One-on-One Interviews

Thirty-eight participants opted to take part in the interviews, which were all conducted over the phone. This method was selected as it allowed for people located

anywhere in Australia to participate. Phone interviews have also been found to increase participant disclosure, particularly when gathering sensitive information (Lechuga, 2012). Additionally, participants could select a day and time that was convenient for them, which felt particularly appropriate for interviewing parents. Moreover, phone interviews meant that I could take detailed notes without it being obtrusive or off-putting to participants. At the designated time I called participants, and before starting the interview I briefly reminded them of the purpose of the study, read them participant consent information (see Appendix E) and asked if they consented to being interviewed. I also asked permission to record our conversation and let them know that the recordings would be sent away for professional transcription. Once recording started, I reminded participants that the interview was confidential and anything that could identify them, such as names and places, would be removed from the transcripts. I also advised them that they were under no obligation to share information they weren't comfortable with, and they could take a break, stop the interview at any time or withdraw from the study altogether should they wish. To reimburse them for their time, participants were offered a $25 supermarket gift card. I conducted all 38 interviews. Of the participants who were interviewed, 20 were trans men and 18 were trans women. Interview participants were aged between 24 and 62 years old, 35 identified as being Australian, two identified as Polynesian and one as Malay-Chinese.

A semi-structured interview style was adopted as the means of data collection, as they are well suited to exploring "perceptions and opinions of respondents regarding complex and sometimes sensitive issues" (Barriball & While, 1994, p. 330). A brief interview schedule was constructed based on the research questions, and participant responses from the online survey were used to inform and guide individual interviews. This was piloted for the first five interviews. Early pilot interviews were quite broad, and delivered in a conversational style, in

order for participants to self-identify and explore the experiences that they believed were important. Following transcription of these interviews, they were read through by myself and my primary supervisor. We then discussed how the interview schedule could be further developed and improved on. Subsequent interviews opened with the question, "think back to when you first had children, what was life like for you then?". The final interview schedule can be found in Appendix E. Interviews ranged from 45 minutes to two hours in length, with most lasting for one hour.

Interview Co-Construction and Ethical Considerations

Greenwood (1994) states that social reality is "a function of shared meanings, it is constructed, sustained and reproduced through social life (p.85). Interviews are reality-constructing and interactional events, with the interviewee and interviewer constructing knowledge together (Koro-Ljungberg, 2008). An interview can be collaborative and active process or, as Miller and Crabtree (2004) describe: "a partnership on a conversational research journey" (p.185). From the perspective of social constructionism, interviews provide a rich social framework in which to "observe and investigate the production and negotiation of ideas, normative influences, commonalities and differences" (Koro-Ljungberg, 2008, p. 440). However, it is vital to acknowledge the unequal balance of power amongst 'knowing subjects', and interpersonal differences that might hinder the process. When designing interview schedules and interviewing trans participants, it is vital to interrogate the language used, and the appropriateness of related topics, as there are many ways to inadvertently uphold cissexism (Zimman, 2017). In the case of data collection for this thesis, I learnt and adopted preferred nomenclature, i.e. he, she, they, for each participant. I also educated myself to avoid cissexist descriptors, such as gendering physiology (e.g. 'women's reproductive organs') or participant history (e.g. 'when you were a little boy'). Language used to describe

and communicate the diversity of the trans community is always evolving. As such, it can be a challenge to identify language that is inclusive of all identities but also descriptive enough for research purposes (Sevelius et al., 2017). There were words or terms that fell out of use, even since this project began, such as using the word 'preferred' to qualify pronouns or other descriptors, (e.g. 'what are your preferred pronouns' or 'living in your preferred gender'). Preferred implies choice whereas gender is a statement of fact. The phrase 'opposite gender' was used in one of my papers, which is not appropriate anymore. Also, the term 'transitioning', although used colloquially, has fallen out of favour in academic and organisational writing and the more inclusive 'gender affirmation' now used in its place. The expression 'identifies as' has also come under scrutiny; do people identify as their gender? Does someone 'identify as trans' or are they simply trans? Ashley (2019) has proposed adopting the term 'gender modality', rather than gender identity to describe "how a person's gender identity stands in relation to their gender assigned at birth" (p.1), to create space for a critical reflection on the lack of inclusion within the trans-cis binary. In the interest of transparency, I have left these terms where they have originally been used, such as in the survey, however more up-to-date terminology is used in current writing.

Another issue for examination was the 'appropriateness of related topics' (Zimman, 2017). When designing the survey and the interview schedule I referred to previous research, but I also looked at op-eds written by trans writers, online forums and discussed 'appropriateness' with friends in the queer community. As a result, I made the decision to omit certain lines of enquiry from the research. For example, I didn't enquire specifically about gender affirmation surgeries. If participants volunteered information, I would explore it in relation to parenting, such as financial strain, but I did not specifically ask about it. Many trans people find questions about surgery inappropriate and I felt it wasn't integral to the

research to justify its inclusion. For these reasons, I also did not specifically ask participants about intimate relationships or questions about sexual orientation, unless specifically highlighted by them.

Another concern was participant privacy. Adams et al. (2017) states: "research (with trans participants), must take the highest precautions to ensure and protect participants' privacy, confidentiality, and, unless otherwise explicitly agreed on, anonymity." (p.170). As stated previously, phone interviews were adopted as they were geographically inclusive and convenient for participants. However, phone interviews also allow increased privacy and an increased sense of safety, as participants can "remain on their own turf" (McCoyd & Kerson, 2006, p. 399). The collection of identifiable data can place trans participants at risk, even basic demographic information could be enough to identify someone (Sevelius et al., 2017). As such, participant anonymity was treated very seriously with pseudonyms used, geographical place names removed, as well as specific healthcare services, schools, universities, or specific employment. Additionally, after the first paper, I moved towards using an age bracket for participants (e.g. 30's, 40's) and their children (e.g. toddler, primary-school aged), as I was concerned specific ages could also make participants identifiable.

Analysis

As stated previously, the data collected for this thesis was analysed using a reflexive thematic analysis (TA). Reflexive TA recognises the inherent subjectivity in the coding process. Themes do not *emerge* from the data, they are generated by the researcher through *engaging* the data (Braun & Clarke, 2019, 2021). Reflexive TA involves six recursive stages: familiarisation with the data; coding; generating initial themes; reviewing and developing themes; refining, defining and naming themes; and writing up results (Braun & Clarke, 2021).

Phase One: Data Familiarisation and Initial Coding

To begin with, all interview recordings were sent away for professional transcription. Interview recordings were transcribed verbatim, with non-verbal expressions and pauses preserved. Each transcript was then read through, in tandem with listening to the audio recording, in order to check for any errors. Quotes from interview transcripts that are cited in the analysis chapters have been subjected to the following transcription conventions: to improve readability and meaning, some excess non-verbal expressions such as 'hmm', 'um' and 'er', as well as repetitions of 'yeah' and 'like' have been omitted. Contextualising words have been included in brackets "()", and three periods "…" have been used to indicate removal of extraneous dialogue from the quote. Transcripts were then de-identified, pseudonyms assigned, and any other identifiable information removed. After this, de-identified survey and interview data were re-printed, and a closer reading conducted with each document. Concurrently, some preliminary manual notetaking took place, in the margins of each document, as well as highlighting accounts or phrases that caught my attention. Notes were taken for each individual interview, and the data set as a whole. Once this process was completed and the dataset had been read a second time, it was imported into the NVivo software program to assist with coding and further analysis. Data from open-ended survey responses and interviews were analysed together.

Using my notes as a starting point, I began identifying first order codes within NVivo. Codes are "the building blocks of analysis", they identify a feature of the data that is potentially significant to the research question (Braun & Clarke, 2012, p. 61). Initial coding was performed at both the latent and semantic level. Semantic themes operate at an explicit level, on the 'surface', while latent themes are on an interpretative level, and recognise underlying ideas and concepts (Braun & Clarke, 2006). For example, "relationship with co-

parents" or "accessing support" are first order codes which capture semantic themes, while "renegotiating gendered parenthood expectations", and "pregnancy as a subversive act" are first order codes which capture latent meaning. Some codes were taken directly from participants' language and expressions; others were expressed through conceptual and theoretical frameworks. For example, the code "comfort zones" stayed close to the participants' use of language (e.g., 'Sam' said "I definitely created a comfort zone, I just stayed very close to home, especially when I was first transitioning"). In contrast, the code "heterocisnormative assumptions of healthcare workers" was using the lens of our theoretical reference, as no participant specifically used the term heterocisnormative but their accounts were understood through this framework (Worthen, 2016). This process involved multiple reads through the dataset. Reflexive journaling was done in tandem during the entire process, from the beginning of the project, through analysis and during the final writing up phases. Initial codes, personal reflections on the process, and discussions around the 'so what' of the project were also had with my primary supervisor.

Once first order codes were established, I re-read through the codes looking for similarities, differences, as well as modifying, expanding and collapsing codes as deemed necessary and, finally, organising them under thematic higher order codes. For example, the first order codes "safety in numbers" and "avoiding specific places" were subsumed under "behavioural strategies to keep safe". The process of creating higher order codes led to the development of an initial coding framework, which was reviewed by my supervisors. Once all data was coded, summaries were written for each code, identifying recurring and distinctive ideas both within participant accounts and across the dataset as a whole. For example, within the data coded as "perspectives on parenthood", I noted the idea "gendered expectations". I referenced quotes and motifs from participants. A sample coding summary is

included in Table 2. These summaries helped to organise the data and helped with the second phase of analysis.

Table 2.

Coding summary sample: 'Negotiating 'coming out' and pursuing gender affirmation with children and co-parents'	• Fear and anxiety around disclosure (Connie, Maury, Damon, Ty, Noni) • Secrets create stress/burden (Marilena, Lynette, Nadia, Leoni, Ty) • The 'process' of disclosure with co-parents: openness (Tina, Nadia, Clarence, Jay, Regina, Sonia, Frank, Raina), or vulnerability (Marilena, Suzette, Connie) • Disclosure with younger children "simple" (Tina, Nadia, Damon, Frank, Tilda), but may change over time (Frank, Bailey, Lyndall) • Disclosure with older children/teens difficult (Marilena, Maury, Lynette, Sonia, Roger, Sandy) • Positive understanding and support from adult children (Marilena, Maury, Sonia) • Balancing gender affirmation and parenthood, 'excitement' vs 'complication' (Del, Connie, Sonia, Marco, Tony, Regina, Lynette) • gender affirmation made participants a "better person" and a "better parent" (Sandy, Jonnie, Wyn, Del, Marilena, Maury, Lynette, Sonia, Roger, Ty, Noni)
	Changes around parental gender identity can have a profound impact on the lives of trans parents, co-parents and their children; and that navigating these changes requires ongoing, consideration and negotiation. Pursuing gender affirmation was vital to the mental health and well-being of trans parents. Family was both a source of great strength, and vulnerability, for participants. Finding a balance between parental gender-related needs, and protecting relationships with children, was of fundamental importance. Communication is vital, as is being cognisant of the way children's' different ages may impact the way they navigate changes.

Phase Two: Generating and Reviewing Themes

The second phase involved reviewing higher order codes and identifying the broad issues around which they are clustered. This is how themes and subthemes were generated. Themes are iteratively developed from the coding, capturing "something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). For example, in this data I identified codes clustering around transphobia. Examining these in more detail, I identified that the codes either focused on experiences of transphobia, or responses to and ways of managing transphobia. I then constructed one theme using all the codes relating to the participants' experiences around transphobia (e.g., "incident of (naming) transphobia"; "transphobic abuse") and another using the codes relating to participants' management of overt, or covert, transphobia (e.g., "assessing social situations for the possibility of transphobic abuse"; "modifying behaviour to stay safe from transphobic abuse").

Phase Three: Revising, Defining and Reporting Themes

The third phase involved revising, defining and reporting 'final' codes and themes (Braun, Clarke, Hayfield, & Terry, 2019). Codes and coding frameworks were reviewed and discussed with my principal supervisor. Themes and theme names were discussed to ensure that they were clear, comprehensive, concise, and "capture what is meaningful about the data"(Braun et al., 2019, p. 857), in relation to the research questions. For example, one theme that was initially titled "Changing Perspectives on Parenthood" was separated into two subthemes "Growing up female: The assumption of motherhood" and "Orientating toward fatherhood: Parenting on my own terms", to more accurately reflect the temporal shift in parenthood perspectives.

The final phase of the analytic process was writing up the themes. Braun and Clarke (2019) refer to this as 'producing the report' which can function as a method to assess how the themes 'work', both individually and in relation to each other and how the overall 'story' of the data reads, "the story should be convincing and clear yet complex and embedded in a scholarly field" (Braun & Clarke, 2012). In TA, writing and data analysis are both iterative and recursive. During the 'final' write up, research questions were revisited, alongside consulting notes that I had taken throughout the entire project, from data collection to final coding. Additionally, I chose to include and emphasise direct quotes from participants in order to aid in the understanding of specific points and demonstrate the prevalence of the themes. The use of direct quotations "illustrate the complex story of the data, going beyond a description of the data and convincing the reader of the validity and merit of the analysis" (Nowell, Norris, White, & Moules, 2017, p. 11). The final stage of writing up the 'report' is to provide a compelling story based on the analysis that was performed, with final themes reflecting detailed experiences and meanings described by our participants. The credibility of the research process depends on the coherence of the concluding arguments.

Establishing Legitimacy and Trustworthiness

Qualitative research methods are designed to explore the inherent complexities of human behaviour and generate deeper understanding of lived experiences (Agius, 2013; Johnson & Waterfield, 2004). The true value of this knowledge is for it to be put into action, to address inequities and improve the health and well-being of the community (Zatloff et al., 2021). Therefore, it is vital for this research to establish its legitimacy and be recognised as trustworthy by other researchers, policy makers, healthcare providers and, most importantly, those in the trans (and broader) community (Nowell et al., 2017). Lincoln and Guba (1985)

developed a model of 'trustworthiness' specific to qualitative enquiry examining four criteria: credibility, transferability, dependability, and confirmability to assess validity and reliability.

Credibility addresses the fit between participants experiences and how researcher's represent them (Tobin & Begley, 2004), "so that those who live the experience instantly recognize its description and interpretation" (Sandelowski, 1986, p. 32). Lincoln and Guba (1985) suggest peer debriefing as one method to establish credibility, and I looked to my supervisor, academic peers, and peers within the LGBTQI+ community for debriefings and member checks throughout the study. Transferability is concerned with the generalisability of the findings (Nowell et al., 2017). It was vital to me to keep in mind participant experiences were theirs alone, however, there may also be some transferability, being that the participants shared commonalties such as being trans, *and* a parent, this type of selection may have provided for duplication of study (Lincoln & Guba, 1985). Dependability refers to a traceable and transparent research process (Tobin & Begley, 2004). As a PhD candidate with a supervisory panel, my choices and actions around participant selection, data collection, analysis, and interpretation were open to ongoing examination and inspection. Additionally, going through the peer review process for each article opened my research process up to additional scrutiny.

Confirmability concerned with establishing my interpretations as clearly derived from the data and require demonstration of how conclusions were drawn and, in the next section, my own biases and perspective coming into this project (Tobin & Begley, 2004). Lincoln and Guba (1985) assert that confirmability is established when credibility, transferability, and dependability are accomplished. Ideally, as the process of TA is engaged, the analysis will transform results from the predominantly descriptive, where data has been essentially

organised and summarised, to interpretative, where "researchers attempt to theorize the significance of the patterns and their broader meanings and implications" (Nowell et al., 2017, p. 11). The trustworthiness of the research process will be determined by how the researcher uses the data to support the main points, building toward a convincing explanation (Nowell et al., 2017).

Researcher Reflexivity – the impossibility of objectivity

Frank (2005) poses a key question regarding qualitative research: "What can one person say about another?" (p. 966). At its most fundamental, qualitative research is one person's representation of another (Doan, 1997). There is always a risk in how we represent 'others' through "monological discourse" (Frank, 2005, p. 967). A person's words are not a fixed representation of their world and analysis cannot be neutral. Qualitative research requires hearing participants' stories not as "surrogate observations of their lives outside the interview" but as an act of engagement and co-creation with researchers (Mishler, 1991, p. 73). Reflexivity is vital for anyone conducting research, but has particular significance for qualitative researchers. Dodgson (2019) describes reflexivity as the "contextual intersecting relationships" between participants and researcher (p.220). Teh and Lek (2018) concur, defining reflexivity as "an interactional process creating change through repeated awareness, reflection and action related to our similarities and differences" (p.520). Reflexivity requires researchers to be explicit about their position as a group insider or outsider, and consider their shared experiences with participants (Berger, 2015; Dodgson, 2019; Teh & Lek, 2018). Dodgson (2019) states that the value of qualitative research is dependent on the consideration and articulation of the similarities and differences between researcher and participant. As Mitchell et al. (2018) states: "we cannot untangle *our* processes from the research itself"

(p.673). From the outset of this project I have tried to be cognisant of how much research reproduces systems of oppression (Kincheloe & McLaren, 1994). Whilst, reflexivity has become one means for researchers to attempt to identify the strands of their own complicity in this systematic reproduction (Coburn & Gormally, 2017), Mitchell et al. (2018) caution that pursuing reflexivity needs to be more than researchers "pacifying the burden of privileged positions...or *self-soothing"* through disclosure*,* and ask how we can take reflexive practice further (p.674).

I am not a trans parent. I am a cisgendered, middle-class, single parent. I became a parent in a 'non-traditional way', as did many of my close gay, lesbian queer and non-binary friends and, by extension, the broader community of which I am a part of. However, I am not a trans parent. The experiences of myself and, more importantly, those around me have illustrated that, whilst parenthood is a source of tremendous joy, there is also a significant vulnerability attached for those who parent outside of accepted narratives. From a personal perspective, and as an emerging researcher, the intersection of parenthood and marginalisation has increasingly commanded my attention. There is the broad question: How do parents negotiate marginalisation? Or the more personal query: How does the joy that can exist within parenthood interact with the negativity that can be projected from outside that experience? In this path of enquiry, it has become more evident to me that, whilst we seem to understand that discrimination and marginalisation are enacted *upon* people, in so much discourse the onus still seems to be put upon 'the marginalised' to demonstrate that it is not, somehow, existent *within.* Trans parents are not marginalised due to their gender identity, they are marginalised because they must live in a society that privileges and upholds heterocisnormativity. However, the most salient point of my personal reflections and

perspectives coming to this research is that, whilst I may be, and believe, the things stated above, I am not a trans parent and that needs to be made explicit.

Conclusion

In this chapter I have detailed the epistemological and theoretical approaches I draw on in this thesis, and the research methods utilised. In the next four chapters I present the findings from my analysis, which are published as journal articles.

Chapter Three

The Transgender Parent: Experiences and Constructions of Pregnancy and Parenthood for Transgender Men in Australia

This chapter contains the journal article *The Transgender Parent: Experiences and Constructions of Pregnancy and Parenthood for Transgender Men in Australia*. This article is also included in Appendix H.

Charter, R., Ussher, J.M., Perz, J. & Robinson, K. (2018) The transgender parent: Experiences and constructions of pregnancy and parenthood for transgender men in Australia, International Journal of Transgenderism, 19:1, 64-77, DOI: 10.1080/15532739.2017.1399496

Abstract

Background: Transgender (trans) men are commonly born with the reproductive anatomy that allows them to become pregnant and give birth and many wish to do so. However, little is known about Australian trans men's experiences of desiring parenthood and gestational pregnancy.

Aims: The present study aims to address this gap in the literature through addressing the following research questions: how do Australian trans men construct and experience their desire for parenthood? And, how do Australian trans men construct and experience gestational pregnancy?

Methods: This study aimed to explore these experiences, through a mixed-methods research design using online survey data and one-on-one interviews, with 25 trans men, aged 25–46 years old, who had experienced a gestational pregnancy. Data were analysed using thematic analysis.

Results: For our participants, parenthood was initially described as alienating and complex, however transitioning enabled participants to negotiate and construct their own parenting identity. Pregnancy was positioned as a problematic but "functional sacrifice," however formal assisted fertility experiences were rife with exclusion. At the same time dysphoria associated with withdrawing from testosterone and the growing fecund body were significantly troubling. Changes to the chest were of particular concern for participants. Exclusion, isolation, and loneliness were the predominant features of trans men's experiences of gestational pregnancies. Healthcare systems are not generally supportive of trans bodies and identities and trans men encounter significant issues when interacting with healthcare providers. As such, the results reinforce the importance of inclusive and specialized health services to support trans men through pregnancy.

Introduction

A transgender man is a person who identifies as male, but whose sex may have been designated female at birth. As such, transgender (trans) men are commonly born with the reproductive anatomy that allows them to become pregnant and give birth (Obedin-Maliver & Makadon, 2016). With recent cultural shifts in community and legal attitudes around the trans community, the openness of trans men desiring parenthood and becoming parents through gestational pregnancy may be more a reality now than ever before (Tornello & Bos, 2017). Whilst there is a growing body of research around trans parenting (Riggs, 2013; Walks, 2015) there is still little known about the experiences of Australian trans men negotiating parenthood and gestational pregnancy, the focus of this article.

Many trans men elect to transition to bring their internal and external experiences of gender into alignment (Burnes & Chen, 2012). Transitioning is a process, rather than a single event, and can take a variety of forms. A trans man may transition physically by using

hormonal or surgical treatments; they may change their appearance, their name, and their gender pronoun to transition socially; and they may pursue recognition of their gender identity legal and formally (Biblarz & Stacey, 2010; Pyne, 2012; Weiner & Zinner, 2015). However, it is important to note that not all trans men pursue a transition. This may be because they are not medically or financially able to, because they do not have the support of those around them, or because they choose to express themselves in a different way (Pyne, 2012).

Many trans men wish to be parents (Haines et al., 2014; Riggs, 2014; Riggs, Power, & von Doussa, 2016). However, hormonal and surgical transitioning can impact significantly on their ability to biologically reproduce (Light et al., 2014). For example, as testosterone therapy leads to anovulation and amenorrhea, fertility is adversely affected (Amato, 2016; Light et al., 2014; Wierckx et al., 2012). This effect can be reversed if testosterone use ceases; one study found that 80% of trans men who stopped testosterone therapy resumed menstruation within 6 months (Light et al., 2014). Whilst the impact of long-term or continued testosterone use on ovarian functioning is not fully known, trans men have successfully conceived and carried a pregnancy after suspending testosterone therapy (Ellis et al., 2015; Mitu, 2016; Obedin-Maliver & Makadon, 2016). For trans men who have undergone a surgical transition, such as hysterectomy, metoidioplasty, or phalloplasty, gestational pregnancy will no longer be a viable option (Amato, 2016; Obedin-Maliver & Makadon, 2016). Trans people may access-assisted reproductive technologies to save their gametes or reproductive tissue, or if they need assistance in conceiving their children (James-Abra et al., 2015). In general, reproductive options for trans men include cryopreserving embryos, oocytes, and ovarian tissue, which can be carried out on its own or during a hysterectomy (De Sutter, 2009; James-Abra et al., 2015; Jones, Reiter, & Greenblatt, 2016).

It has been argued that it is vital trans men are informed of the impact of hormonal and surgical treatments on their ability to reproduce, pretransition, in order to make decisions regarding the preservation of their fertility (De Sutter, 2009; Light et al., 2014; Wierckx et al., 2012). Health organizations, such as the World Professional Association for Transgender Health (2011), and the Ethics Committee of the American Society for Reproductive Medicine (2015) have recommended that healthcare providers (HCPs) counsel their trans patients about their fertility preservation options before commencing transition. However, it is not known if, or how routinely this information provision actually takes place, as current research illustrates that many trans men lack the information and requisite support to control their reproductive health (C. A. Jones et al., 2016; Mitu, 2016; Veale, Watson, Adjei, & Saewyc, 2016) with some researchers concluding that trans men, and the broader trans community, are "invisible" within health research (Merryfeather & Bruce, 2014).

Accessing general healthcare can be significantly challenging for trans men, including outright discrimination and refusal of treatment, as well as a lack of relevant clinical knowledge and cultural understanding amongst HCPs (Byron, 2017; Coleman et al., 2012; Grant et al., 2011; Scheim, Zong, Giblon, & Bauer, 2017). Multiple studies report that around half of the trans people surveyed forgo medical assistance when they need it, due to significant experiences of transphobia and discrimination (Coleman et al., 2012; Grant et al., 2011; Johnson, Mimiaga, & Bradford, 2008). In surveys from the United States and the United Kingdom, up to a third of trans patients report being turned away by HCPs, who have refused to treat them due to their trans status (Reisner, Perkovich, & Mimiaga, 2010; Roller, Sedlak, & Drauker, 2015). For those HCPs who do treat trans patients, many lack basic knowledge about trans people and their health needs. For example, in a US survey, 50% of transgender people reported having to teach a HCP about providing appropriate care (Grant et

al., 2011). This suggests that whilst many trans men desire to become a parent, they may not experience the same support and encouragement as their cisgender counterparts (Riggs et al., 2016). Many researchers suggest that this stems from the heteronormative social model that excludes trans men and women from being seen as suitable parents (Downing, 2013; Oswald et al., 2005; Riggs, 2014), wherein the only family structure of worth is comprised of a cisgender male and female heterosexual couple and their cisgender heterosexual offspring (Fish, 2008; Hudak & Giammattei, 2014; Mamo & Alston-Stepnitz, 2015; Nordqvist, 2012; Oswald et al., 2005). Thus, a trans man who wishes to become a parent through a gestational pregnancy is disruptive to heteronormative ideals (von Doussa, Power, & Riggs, 2015).

Research on pregnancy is also centred within a heteronormative framework (Karaian, 2013). The pregnant body is a powerful symbol and "performer" of gendered convention, and failure to conform to homogenous expressions of the pregnant body as female, can serve as a transgressive act (Butler, 1988, 2011; Levitt & Ippolito, 2014b). A parent's gender transition or gender nonconforming identity, or development of a parenting style that does not rely on gendered norms, can provoke a rethinking of what it means to perform "mothering" and "fathering" within the family context (Downing, 2013). Therefore, trans parents may be uniquely positioned to challenge hegemonic constructions of gender around the family, that consider certain parenting behaviours as inherently "masculine" or "feminine" (Ryan, 2009).

To date, there is a need for research exploring Australian trans men's desire for parenthood, and the ways in which they negotiate and construct gestational pregnancy. This research is needed in order to allow HCPs to offer an informed dialogue around fertility preservation, conception, and prenatal support, and to support trans men's wellbeing during their pregnancy and into the postnatal period. A greater understanding may also help expand the inclusivity and visibility of trans people in reproductive and broader health literature. The

present study aims to address this gap in the literature, through addressing the following research questions: how do Australian trans men construct and experience their desire for parenthood? And, how do Australian trans men construct and experience gestational pregnancy?

Method

Participants and Recruitment

This study is part of a larger project titled "The Constructions and Experiences of Parenthood amongst Transgender Australians." This larger study was open to any transgender person in Australia who was also a parent. A mixed-methods research design using online survey data and one-on-one interviews was used to explore the parenting experiences of 66 trans individuals. This article examines the experiences of a subset of that broader study population; 25 trans men who had experienced a gestational pregnancy. These participants were aged 24–46 years old (*M* 35.6, *SD* 6.66), and had gestational children ranging in age from 3 years to 12 years old. Twenty-four participants had one gestational pregnancy, and one participant had experienced two gestational pregnancies. The majority of participants also parented other children, whom they had not carried gestationally. Full demographic details are presented in Table 1 (p.59).

Participants were recruited from within Australia, through the distribution of an information sheet to transgender support groups and community organizations as well as advertisements for the study posted on social media. After reading the information sheet outlining the research and participation details, participants were asked to complete an online survey collecting demographic information as well as open-ended questions related to their experiences of transitioning, their family history, relationship history, experience of support, and any other information about their experiences of parenthood that they felt was important.

At the end of the survey, participants indicated whether they would like to take part in a one-on-one interview to further discuss their experiences as a parent. Sixteen of the 25 trans men who had experienced a gestational pregnancy consented to being interviewed. Data used in this article is taken from the 25 survey and 16 interview responses. The University Human Research Ethics Committees granted ethical approval for this study, and all participants gave informed, individual consent.

Measures and procedure

The survey items consisted of a series of closed- and open-ended questions collecting information related to four areas: demographic data, such as age, education, and sexual orientation; participants' experiences of their gender identity, such as the term or terms they use to describe their gender identity, and steps they may have taken toward transitioning; parenting information, such as number and age of children, care arrangements and relationship with co-parents; and support systems. Additionally, participants were asked to share any other information about their experiences of parenthood that they felt were important.

One-on-one semi-structured interviews were conducted, by telephone, to examine the subjective experiences of parenting, personal relationships, wellbeing, support systems, gender identity and transitioning within the family context. A semi-structured interview style was utilized as the means of data collection, as this was best suited to exploring "perceptions and opinions of respondents regarding complex and sometimes sensitive issues" (Barriball & While, 1994, p. 330). Interviews opened with participants being asked, "think back to when you first had children, what was life like for you then?". Participant responses from online survey items were used to inform and guide individual interviews, eliciting prompts about subsequent children, relationships, experiences growing up, their own parents and siblings,

support networks, employment, and other experiences. Interviewees were reimbursed for their time with a modest-value supermarket gift card.

There were strengths and limitations to this study. One strength is, as this area is currently under researched, employing a qualitative method allows us to ask trans men directly about their desire for parenthood and experiences of pregnancy. It also allows them the space to inform those with an interest in reproductive and health research of what they require and where support is needed. Two limitations are that firstly, whilst the broader study, from which these data were taken, sought to include gender-diverse populations, it was primarily advertised through trans support groups and as a result, may have inadvertently not captured a wider variety of parents who do not identify specifically as trans but may identify in other gender diverse ways. Secondly, the data for this article come from a larger study looking at a variety of experiences around parenthood. As such, there may be gaps in our knowledge of the full range of participant experiences in relation to their pregnancies.

From a qualitative perspective, researcher reflexivity is vital for understanding how one's own personal assumptions and experiences influence the way research is conducted. In keeping with the writing of Galupo (2017) we believe that our work is shaped by our own backgrounds and perspectives, and it is vital to acknowledge that these differences may impact on our scholarship. The researchers conducting this study have diverse gender identities and sexualities. The first author, a cisgender researcher, conducted all interviews. As a cisgender researcher working with a gender-diverse population it is imperative that one understands one's own impact and position within the research process. Some of our reflexive practices included a commitment to interrogating our use of language within the study, being led by each participant on their individual preferences for terminology, discussing and incorporating participant observations and suggestions as well as consulting

with other researchers and colleagues in the trans community on the context of surveys and interviews.

Analysis

Open-ended survey data and interview data were analysed using thematic analysis. Thematic analysis is an analytical tool, which seeks to identify and describe meaningful patterns across data by searching for implicit and explicit themes related to the research question (Braun & Clarke, 2006). All interview data were transcribed verbatim and integrity-checked for errors in transcription. An initial thematic coding framework was then generated from the data. Examples of themes include "orientating toward fatherhood" and "chest distress." Data were then coded using the NVivo software program. The initial coding framework was used to organize data, identifying commonalities, differences, and patterns. Coded data were repeatedly reread and themes refined in order to distil data whilst simultaneously searching for new patterns and relationships. Each theme was considered, not only in the context of the individual theme itself but also how it related to the overall story told within the data (Fielden, Sillence, & Little, 2011).

Three major themes were identified that addressed the research questions in this article, under which a number of subthemes clustered. These were: (1) Perspectives on parenting, which consisted of two subthemes: "Growing up female: The assumption of motherhood" and "Orientating toward fatherhood: Parenting on my own terms"; (2) Pursuing pregnancy, which consisted of three subthemes: "A functional sacrifice," "The struggle: Living without T," and "Accessing reproductive assistance"; and (3) The pregnant man, which consisted of three subthemes: "Inhabiting the pregnant body," "Chest distress," and "The Isolation of Exclusion." In the presentation of results, participant details are provided for longer quotes, including pseudonym and age.

Results

Perspectives on Becoming a Parent

"Growing up female" — The assumption of motherhood

In contemporary western society, the "successful" expression of womanhood is grounded in fecundity, with motherhood positioned as central to female identity, and described as a "motherhood mandate" (Clisby & Holdsworth, 2016; Lowe, 2016; Nash, 2012). The majority of participants in this study reported that the expectation of future motherhood was impressed upon them from an early age. As these participants were growing up questioning or feeling at odds with their female gender identity, this mandate was reported to be particularly troubling:

> They always seemed to put it (motherhood) right at the forefront of my future, right from the get go. Be good girl, you grow up, have kids, be a mum. Everything else felt very…secondary to that…. (For me) those were extremely troublesome ideas at the time. I just really shut off (Tony, 34)

Many participants echoed this account and reported that "when you're growing up female" motherhood is positioned as "nonnegotiable" or "assumed" and that to diverge or question that narrative, as Stevie (46) notes, "makes you feel even less normal than you already do." This "assumption of fecundity" was reported to be "deeply isolating" and, for many, exacerbated struggles with gender identity, as Regan (37) said, "I just felt so shut off…from the future. I couldn't imagine that future version of myself (as a mother), or any version, and it made me feel quite alone and angry, actually."

Many participant accounts detailed isolating messages from the people close to them, which reinforced this sense of isolation or "estrangement":

> When I was growing up, people always talked about becoming a mum, my family, their friends talked about it…You'd see women on TV being pregnant and having

> babies. I think I pretended to feel the same but truthfully I felt completely estranged by the idea…I could in no way picture myself doing the same. (Roy, 24)

Others described these early notions of becoming a parent, or specifically a mother, as "alien" or "unimaginable," as Stevie (46) said, the "idea of becoming, and being, a mother was completely foreign to me." Tommy (27) shared this account from when he was 11 years old:

> (An employee of my parents) reached out and, kind of, gently squeezed my (breast). It wasn't sexual at all. She made this comment about how it would breastfeed a baby one day, like it was already marked out just for that…it made me feel so mixed up and horrible about my body.

Experiences of a schism between how one feels and how one is perceived are not uncommon in accounts of young trans people (McGuire, Doty, Catalpa, & Ola, 2016). However, what can make these experiences so acutely alienating is that they are often driven by those closest to us, thus depriving young trans people of a support system (Johnson & Amella, 2014; McConnell, Birkett, & Mustanski, 2016).

In the majority of accounts, participants drew on experiences across their childhood, adolescence, and into young adulthood, when they had little control over how their gender was constructed and categorized by those around them. At this time, they were particularly vulnerable to dominant cultural narratives that associated femininity with fecundity. Many participants chose to deal with perceived "maternal pressures" when they were younger by actively resisting and rejecting the motherhood mandate, as Marco (27) states: "For a long time I think I overcompensated by being very anti-children and, sort of, belittling motherhood as weak." Colin (46) said: "I was very much against becoming a mother, actually, before I came out…I thought at the time it was about keeping my independence." Other participants described parenthood variously as "a feminist issue" and "a form of control" over parents, or

specifically mothers, that they wanted to resist. When asked what about parenthood was initially unappealing to him, Stefan (41) gave the following account:

> In retrospect, I think it was part of my dismissal of all things, sort of, feminine about myself and (motherhood) seemed a huge part of that female character…It just seemed easier to put it aside. I threw myself into work and tried to forget about it.

Over time, however, participants began to reconcile notions of parenthood with their bourgeoning understanding of their gender identity and how they fit in their individual world.

Orientating toward fatherhood — "Parenting on my own terms"

Previous researchers have noted that when dominant narratives are exclusionary, people will seek meaning through the creation of alternative narratives, which are crucial in allowing them to make sense of their experiences (Dryden, Ussher, & Perz, 2014; McKenzie-Mohr & Lafrance, 2011). For many participants, the desire to become a parent was kindled when they came out as transgender, or started transitioning. This shift of identity from "potential mother" to "potential father" was a powerful experience, giving many "a way to imagine parenting" (Tommy, 27). As Tommy (27) says: "Once I came to terms with being trans, the idea of being a parent, and a father, began to really excite me." Others had similar experiences of "beginning to orientate toward fatherhood" postcoming out, describing experiences such as "picturing myself as a father made it all seem suddenly very possible and exciting" (Stefan, 41) and "realising that I could negotiate parenting on my own terms, as a dad, was really liberating" (Regan, 37). Noel (36) shared this account:

> It was right after I started on T (testosterone)…I just felt so well, I was finally living authentically and I could have a family. That, that part of my life didn't have to be, sort of, denied. I was always meant to be a father.

These accounts demonstrate the transformative power of coming out and transitioning, wherein participants renegotiated parenthood identities to bring them into alignment with their experiences of masculine gender. This shifting of identities facilitated the ability to challenge both personal and societal assumptions around their capabilities of parenthood. In keeping with Berkowitz (2007) work on procreative consciousness, as trans men create and negotiate "new" narratives around parenthood and gain acknowledgment of their fatherhood identities, the potential for other trans men to imagine themselves as parents and fathers also grows significantly.

Pursuing pregnancy

Whilst becoming a parent does not always necessitate carrying a child and giving birth oneself, each of the trans men in our study made a deliberate and informed decision to pursue a pregnancy. However, in doing so, they had to engage in a complex negotiation with their masculine identity, the traditional association of pregnancy with femininity, and the material reality of the medical and biological aspects of pregnancy posttransition.

A functional sacrifice

The participants in our study chose to pursue pregnancy for a variety of reasons. Some participants had cisgender female partners whose fertility was affected by medical issues, as Sam (32) describes:

> (My partner's) endometriosis was really severe…when we started talking about a family I just knew it wasn't going to be possible for her (to get pregnant) so I decided that I'd do it. It wasn't an altogether happy decision but I knew it was the right one for us and I feel, actually, very grateful that I could do that for us.

For other participants, being able to have a child that was biologically related to them was positioned as important and valuable: "It just seemed like a huge privilege to be able to have a child that shared my DNA" (Justin, 30). Equally, Bill (31) commented:

> We'd had some close friends who'd really struggled with not being genetically related to their kids… it really made an impression on me and (my partner)… so we decided we'd take turns having a baby.

Some participants reported that they wanted to have a child before transitioning "took them too far" whereas others expressed the desire to "get something positive out of a body that had always felt like a curse." In these accounts, pregnancy was positioned as a "functional sacrifice," which Epstein (2016) describes as "something to endure in service of a long-term pragmatic goal" (p. 751).

"The struggle"— Living without T

For many of the trans men in our study, going on testosterone represented their first line of treatment postcoming out as trans, and was experienced as a significant validation of their masculine gender identity. However, the first step for many participants wanting to conceive, posttransition, was tapering off their dosage of testosterone. For many this was a significantly challenging experience, as Zak (29) states:

> It was really gradual at first. Then I noticed my body started to change, like my fat started to kind of shift, redistribute, around my body…my hips started coming back…my empty boobs started to really ache and then I got my period. Even though I knew it was going to happen that was still a huge shock. I had a real moment then. Like, I questioned whether I could go through with everything.

Other participants echoed these sentiments, stating that "going off T was extremely stressful," and that it "felt like my lifeline was being taken away." Trent (36) stated: "It really triggered

old feelings I had about myself, I kept flashing back to being 16 again, wondering what the hell was wrong with me." Other participants described feeling distressed as a result of perceived changes such as "losing my muscle," accompanied by "lack of energy," "intense mood swings," "feeling depressed," and "flat." These are common experiences when withdrawing from testosterone (Davis & Colton Meier, 2014), but are also "symptoms" associated with the "monstrous feminine" changes across the reproductive life cycle, and signifiers of a fecund body out of control (Ussher, 2005). Some participants "fell pregnant straight away," whilst others, such as Jonnie (28) took longer, having to live with dissonance at inhabiting a feminine body not feeling "normal":

> We didn't get pregnant for almost a year, so my body had reverted back to much of its former self. I still had a little fluff on the face but everything else was really soft and round. I hated it so much. I didn't always 'pass' anymore, which was really demoralising…Ultimately, getting pregnant was a huge relief because then I had a timeline to when I could get back to normal (laughs).

The decision to go off testosterone can be a physically and emotionally complicated one. As mental health-related quality of life, depression, and anxiety are significantly improved in trans men who receive testosterone, withdrawing from this medication could have significant implications for wellbeing (Davis & Colton Meier, 2014; Gómez-Gil et al., 2012; Newfield, Hart, Dibble, & Kohler, 2006). Additionally, the loss of the masculinizing effect of testosterone, combined with the visual presentation of a pregnancy, can have a deleterious impact on a trans man's ability to "pass." This can be highly distressing (Light et al., 2014; Newfield et al., 2006) and for many can compound experiences of isolation.

Accessing reproductive assistance

It has been well established that trans men face significant difficulties when accessing care and support for their reproductive health and wellbeing, and assisted fertility is no exception (Coleman et al., 2012; Pitts, Couch, Mulcare, Croy, & Mitchell, 2009; Reisner et al., 2010). As 18 of the 25 participants in this study were partnered with cisgender women at the time of conceiving children, they would not be able to conceive their children without accessing some form of external support, such as pursuing formal or informal assisted fertility, including the acquisition and insemination of donor sperm, and, in some cases, in vitro fertilization.

For many participants, accessing sperm was the first step toward conceiving their child. This generally involved two options. Firstly, using a known donor, such as a friend or colleague and generally doing a "DIY" insemination in an informal setting such as a home. The alternative, using an unknown donor, which relies on accessing a fertility clinic and having insemination done at a facility by a medical professional. The majority of participants in our study used informal channels to acquire and use sperm, as Colin (46) explains: "For us, using a (known donor) was so much easier cause we could just do everything at home…We were extremely lucky and it worked on the second go." Mickie (33) explains further:

> Once we decided to use a known donor… it was really just a matter of approaching them and discussing what we were proposing. It's tricky because the legal side of it was a bit of grey area at the time and we really just had to keep it to ourselves and hope for the best, to be honest…We were really lucky that (the donor) was keen and shared our feelings about what his relationship would be with (our child).

These accounts were echoed by other participants, who found "the negotiation process much easier" with a known donor, and DIY insemination "much easier," "more personal," and "less

confronting" than accessing formal facilities. As Trent (36) describes: "We did (the insemination) at home…and, you know, rather than being weird or impersonal it was actually all very special." However, experiences of assisted fertility were very different for those participants who chose to use formal fertility services. Many described it as a "nightmare process" that none were able to see through to completion. We were rejected from multiple clinics due to "reasons unknown." "We had a range of appointments and each time the discussion centered almost completely on my gender identity…everyone just seemed so uncomfortable seeing us." (Justin, 30). Other participants echoed this account, describing "embarrassing" and "awkward" appointments followed by "cancelling our follow-ups." Trent (36) stated: "The doctor we saw was so awkward with us, kept misgendering me and repeatedly asked why my (cisgender) partner wasn't the one to have the baby." For these participants dealing with negative experiences with fertility service providers was "the first in many pregnancy-related rejections and disappointments" (Noel, 36).

Whilst trans people are protected legally in Australia from discrimination by HCPs (New South Wales Government, 1977) these protections are not necessarily born out in their actual experiences. No participant in this study who attempted to access a fertility clinic was actually granted treatment. This type of rejection and discrimination is reported to be pervasive in the trans community, and has a very significant impact on mental health and wellbeing (Rood et al., 2016). As such, like many in the broader LGBTQI+ community, trans men turn to informal networks and methods, indicated in the above accounts of using known donors and at-home insemination, to assist them in achieving their goal to conceive.

The Pregnant Man

Inhabiting the pregnant body

For many participants, pregnancy-related physical changes brought with them an unexpected psychological and emotional toll. Bill (31) explains: "The happiness at getting that (positive result) was pretty quickly replaced with sense of real dread…the early hormones made me feel really sick and shaky and I think the enormity of what I was doing really started to sink in and I got scared." For others, the pregnant body was experienced as "frightening," "distressing," and "extremely difficult to handle." Tommy (27) noted "the changes (to my body) really disgusted me. It was a very stressful time." Changes such as "weight gain," "breast growth," "breast tenderness" as well as looking both "more feminine" and "less masculine" were the most commonly cited causes for distress. For these participants, pregnancy was an overwhelming experience that compounded and complicated what Regan termed the experience of a "complete dysphoria of the body":

> I felt completely in the wrong body, my flesh, the roundness and bulges, the way it felt and looked, really frightened me, so foreign, like the more pregnant I got the more alien my skin felt. It terrified me. It wasn't the female-ness of it, it was the intense changes, the physical changes. (Regan, 37)

Many participants reported dealing with these acute experiences of pregnancy-related dysphoria by "distancing," "detaching," and "disassociating" themselves from their pregnant bodies. As Wyn (42) says: "In order to cope, I had to detach…I ended up so detached from my (pregnant) body that I sometimes needed to be reminded that I was pregnant." Tommy (27) echoed this account, stating that: "As (the pregnancy) kept progressing I got more and more anxious…detaching kind of helped me cope in the short-term…I gave myself permission to do whatever I needed to just get through."

Detaching, as a coping strategy, is not uncommon when dealing with acute stressors and is viewed as an adaptive coping method (Elklit, 1996; Roger, Jarvis, & Najarian, 1993). Creating distance between oneself and the stressor can bring with it the cognitive space needed to cope and get through challenging experiences (Elklit, 1996).

Chest distress

The visual presence of "breasts" is a key signifier of adult femininity (Goin & Goin, 1981; Spencer, 1996). Many trans men refer to this area of their body as their "chest," whilst some refer to it as their "breasts," or use the terms interchangeably depending on factors, such as, pre- or posttransition status (Davis & Colton Meier, 2014; MacDonald et al., 2016). As such, for the trans men in our study, changes to the chest were experienced as the most challenging pregnancy-related physical change. As Regan (37) describes: "it was really stressful feeling my breasts grow so much, it made me feel sick." Stefan (41) concurs "they (chest) got huge and it was extremely stressful, I didn't like to look at them, or touch them." Other participants stated that they "hated looking at" themselves due to chest changes. Strategies normally used to conceal the chest, such as binding (MacDonald et al., 2016) were not as effective during pregnancy, with many participants unable to bind at all. This was described as "a real struggle," "very difficult," "challenging," and "extremely uncomfortable." As Jason (26) explains: "not being able to bind was a nightmare. My chest was getting so big it was totally impossible to cover…people started misgendering me, a lot, which hurt." For many, being unable to bind led to the decision to completely isolate themselves, and "hide out," due to "fear of being outed," or experiencing "shame" or "self-consciousness." As Noel (36) says:

> (Towards the end of pregnancy) I just stopped leaving the house completely… I felt really unsafe and anxious when I was out and it just wasn't worth it, in the end…I

> couldn't bind and I felt so uncomfortable in my body. I hated being seen. I felt like everyone was staring.

For some, this period of isolation was not just confined to pregnancy but continued well into the postnatal period:

> (My chest) was huge and leaky after I had (my child)… It was so horrible and totally stressed me out… I couldn't bind because it was way too painful… it was also right in the middle of summer and it was so hot. I couldn't cover up, I couldn't bind. I ended up just staying home for months, which sounds simple but it was super isolating (Sam, 32).

Postbirth chestfeeding was also a significant issue for participants. For many, it was described as "trigger(ing) intense dysphoria" and was "deeply distressing." As Bailey (25) says: "breastfeeding, for me, represented the absolute pinnacle of my dysphoria, unbelievably bad." Support from partners was integral during this time, with many participants stating that it "saved" them: "I was so relieved when my partner supported me to not chestfeed, I really don't think I could've coped with that" (Clarence, 43).

Given their overwhelming association with fecundity and femininity, "breasts" are considered by some to be the physical attribute most in conflict with a male gender identity (Davis & Colton Meier, 2014; Spencer, 1996). As illustrated by participant accounts, changes to this area of the body can have far-reaching and significant implications for the wellbeing of pregnant trans men making this period of their lives much more difficult.

The isolation of exclusion — "Am I the only one?"

People who deviate from normative expectations of gender disrupt the societal assumption that gender expression strictly adheres to one's assigned biological sex (Ryan, 2013). To diverge from this assumption can open oneself up to acute discrimination and social

exclusion. It could be argued that the pregnant man transgresses these normative expectations of gender more than any other (Karaian, 2013). As such, for the men in our study, pregnancy brought with it much isolation and exclusion. As one participant stated, "For all the joy pregnancy should have brought, there were a huge amount of constraints put on me, and it was very, very isolating" (Jason, 26). Some participants expressed that they were "locked out of being able to really experience pregnancy," or as Colin (46) explains:

> I can't express how lonely it was to go through a whole pregnancy in hiding. I couldn't be 'out' as a pregnant person and it was really hard. Like, yes my friends and family knew but to the rest of the world I had to hide it to protect my own safety and my mental health from strangers. The loneliness was profound.

Others concurred that social exclusion stemming from "not confirming to what a pregnant person is supposed to look like" fueled isolation and loneliness:

> I just felt so lonely, like "am I the only one?". There was no one at the Drs or the clinic or in the pregnancy books or anywhere like me. I felt like a complete anomaly (Noel, 36).

Although there have been no studies on perinatal depression in trans men, experiences of isolation, and loneliness during pregnancy have been linked to perinatal depression in cisgender women (Bonari et al., 2004; Leung & Kaplan, 2009), and thus our participants could also be vulnerable to developing this condition. Within the context of this isolation and loneliness existed also the "lack of representation" of what a male pregnancy might look like. Zak (29) gave this account:

> Not seeing yourself (represented) anywhere is so hard. I felt like I was really excluded from the whole thing (of pregnancy) and I didn't get any enjoyment from it. Reading

the books, or looking on the internet for pregnancy advice was so depressing. It felt like it was just a constant barrage of information confirming how wrong I was.

These feelings were contextualized by others, commenting on the "complete lack of resources," "invisibility of trans men" in pregnancy literature and the "complete lack of specialized support" for pregnant trans men. Invisibility and marginalization due to gender identity is common in health research, and trans men, amongst others in the broader LGBTQI+ community, have been excluded from mainstream health-promotion research, policy, and practice (Mulé et al., 2009).

Discussion

This article examined trans men's constructions and experiences of desire for parenthood and pregnancy. For the participants in our study, early experiences of pressure to become a parent through fulfilling the "motherhood mandate" were both confronting and alienating, leading to feelings of exclusion from dominant parenting narratives. Heteronormativity creates an expectation of motherhood for all those who are identified as "woman" (Obedin-Maliver & Makadon, 2016; Page & Peacock, 2013), with "woman" and "mother" being synonymous. The fecund body has thus "been socially gendered as unquestioningly feminine because of its association with female-bodied people" (Ryan, 2013, p. 119). In the majority of accounts of negotiating desire for parenthood, or of resisting the motherhood mandate, participants drew on experiences across their childhood, adolescence, and into young adulthood, when they had little control over how their gender was constructed and categorized by those around them. At this time, they were particularly vulnerable to dominant cultural narratives that associated femininity with fecundity. However, upon coming-out and commencing transition, participants were able to negotiate and construct their own parenting identity. These findings illustrate the significance that coming-out and

transitioning can have in bringing a sense of congruence to trans men's lives (Fein, Salgado, Alvarez, & Estes, 2017), which in turn enables them to move forward within ways important to them, such as pursuing a pregnancy.

Trans men who make the decision to become parents must do so whilst navigating in a world designed to exclude. Healthcare systems are not generally supportive of trans bodies and identities (Conron, Scott, Stowell, & Landers, 2012; Pitts et al., 2009) and it is telling that none of the men in our study were treated at any fertility clinic that they attended, even though their right to treatment is, technically, protected in Australia (Anti-Discrimination Board of New South Wales, 2011; Easten, 2002; New South Wales Government, 1977). The majority of the participants in our study thus relied on informal methods to conceive their children. However, this leaves them "locked out" of formalized treatments and support networks. Not everyone is comfortable with, or able to find, a known donor, nor to use at-home insemination successfully. The data from this study captured only the accounts of trans men who'd successfully had a gestational pregnancy. In our broader study, from which this data were taken, there were additional accounts from trans men who were not granted access to fertility services and who were then unsuccessful using informal means, causing a great sense of loss for these participants. Thus, our research illustrates that some trans men experiencing exclusion from pursing gestational pregnancies through structural or potentially discriminatory. Every staff member of these organizations, from those administrators on the front desk, to the nurses, pathologists and doctors who treat patients, need to be educated on how to negotiate an inclusive and supportive provision of their service to those in the community.

For many trans men, hormone therapy is experienced as essential to combating gender dysphoria and bringing one's gender into alignment (Nelson, 2016). The results from our

study indicate that ceasing hormone therapy during the preconception period can trigger distressing dysphoric episodes and, as evidenced in the above accounts, can set a troubling pattern for the subsequent pregnancy. Pregnancy-related dysphoria was a huge issue for participants and one that is currently an unknown quantity for many HCPs (MacDonald et al., 2016; Obedin-Maliver & Makadon, 2016; Veale et al., 2016). The preconception, prenatal and perinatal periods pose many challenges for trans men, and they must navigate these experiences without, what is for many, a key treatment, testosterone. As such, HCPs and trans men alike need to develop a better understanding of how to manage gender dysphoria when hormonal therapies are not an option during the pre- and perinatal periods.

The "breasts" project has many cues associated with femininity and for pregnant trans men the growing pregnant chest is experienced as extremely troubling. The majority of the trans men in our study had not undergone subcutaneous mastectomy, or top surgery, and still retained their original chest tissue during their pregnancies. As such, their growing chest triggered intense dysphoria. This had a number of implications, such as poor parental mental health, but also impacted on whether participants' chest fed their babies. Whilst one study found trans men are comfortable chest feeding (MacDonald et al., 2016), the majority of men in our study found it too confronting and either chose not to, or only chest fed for a matter of weeks. The decision of how to feed one's baby is a very personal one for all new parents, but for trans men this choice must be balanced between the well-established health benefits of chest feeding and the challenges that such a practice might sustain (Obedin-Maliver & Makadon, 2016). Specialized resources need to be developed to support trans men in relation to pregnancy-related chest changes and lactation specialists and community nurses need to be trained in supporting trans men and their babies in the postnatal period.

Ellis et al. (2015) wrote, of their study into the conception, pregnancy and birth experiences of gender variant parents: "loneliness was the overarching theme that permeated all participants' experiences, social interactions, and emotional responses through every stage of achieving gestational parenthood" (p. 63). This statement could be made from our own findings as experiences of profound isolation and loneliness overarched our own participants' accounts. A large body of research illustrates the connection between these experiences and an increased risk for postnatal depression, which could have serious implications for parental health and the health of their babies, both in the immediate postnatal period and into the future (Bonari et al., 2004; Wisner, 2009). Additionally, as baseline depression, self-harm, and suicide rates are higher amongst trans individuals than the broader population, particular attention to postnatal depression is certainly warranted (Obedin-Maliver & Makadon, 2016). However, there is currently negligible research on trans men's experiences of peri- and postnatal depression. To fully explore this area and aid in the development of resources that are more trans inclusive, more research is warranted.

This research demonstrates that trans men are having babies and are doing so without the formal support and resources that they not only need but have a right to. This leaves many feeling isolated, excluded, and vulnerable during a time when support is most required. Whilst there may be specialized HCPs who are knowledgeable about trans men's reproductive and obstetric health, it is unlikely that there are enough to support this population. Additionally, given the prevalence of discrimination experienced by trans people within the healthcare system (Grant et al., 2011; Mulé et al., 2009; Scheim et al., 2017) work needs to be done by HCPs and others in the community to make reproductive health more inclusive of trans bodies and identities. Education of HCPs in regards to transgender issues and reproductive health is also necessary in order to counteract the lack of knowledge in this

area and to stem the discrimination that prevails. Further, the current study illuminated an area of research that requires urgent attention, and that is the experiences of transgender men when accessing assisted fertility services. Future enquiries must also include trans men who have not been able to conceive, which may be associated with access to services, in order to provide a more inclusive picture of trans men's experiences of their fertility and pregnancy. Additionally, it may provide further insight into ways in which the provision of fertility services and information can be improved for trans men, and the broader trans community, who remain largely underrepresented in reproductive health research.

For the pregnant trans man, the materiality of the pregnant body is at odds with their identities as men and the subject position "father." Whilst transitioning can bring one's gender and embodied experience into alignment, the requirements of pursuing pregnancy serve to disrupt this alignment at a vulnerable time for any prospective parent. It is telling, perhaps that most of the participants in our study are yet to pursue a second pregnancy. This research also troubles static notions of "fatherhood" and "motherhood," suggesting that subject positions can be negotiated by individuals, even if this is at odds with their embodied experience, or how their body is viewed by others. The findings of this study are important insofar as they provide insight into how trans men experience and construct gestational parenthood and pregnancy. We hope that the body of research into trans men's experiences of pregnancy and parenthood can continue to be explored, and that appropriate services and resources for this population can be developed and delivered.

Chapter Four

Transgender Parents: Negotiating 'Coming Out' and Gender Affirmation with Children and Co-Parents

This chapter contains the journal article *Transgender Parents: Negotiating 'Coming Out' and Gender Affirmation with Children and Co-Parents*. This article has been accepted for publication and is currently in press, see Appendix G.

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Abstract

This study investigated how transgender parents negotiate 'coming out' and pursuit of gender affirmation (GA) with their children and co-parents. Sixty-six open-ended survey responses and 38 one-on-one interviews conducted with Australian trans parents, aged 24–67 years, were analysed using thematic analysis. The main themes were: (i) Anticipating their Response: 'Coming Out' to co-parents and children; (ii) "Having that talk" – Negotiating disclosure of trans identity with co-parents and children; and (iii) Negotiating Gender Affirmation alongside Parenting. 'Coming out' was experienced as both vital and a point of vulnerability, with GA necessitating communication and negotiation alongside parenting. Many participants reported significant anxiety before 'coming out' to co-parents and children. Children's age was an influential factor in reaction to changes in parental gender identity, with younger and adult children reportedly being the most receptive. Results are discussed in terms of the reported benefits of pursuing GA for trans parents.

Introduction and Background

A transgender (trans) person may identify with the opposite gender to which they were assigned at birth, with both genders, with neither, or they may experience gender in a different way altogether (The World Professional Association for Transgender Health, 2011). For trans people, the term 'coming out' is generally used to describe the act of informing others of their trans identity (National Center for Transgender Equality, 2014). Whilst it is sometimes considered as a discrete act, such as an announcement or conversation with family or friends (Brumbaugh-Johnson & Hull, 2019), 'coming out' can be also a multifaceted process that may begin with the individual recognising, acknowledging and accepting their trans identity, which can happen in stages and over time (Gagne, Tewksbury, & McGaughey, 1997). 'Coming out' can be an important part of a persons' journey towards affirming their gender identity, however, as a concept it is not without its criticisms. Some researchers have noted that when 'coming out' is positioned as compulsory, or crucial to living 'authentically', it promotes the notion that there is only one way to be, when, in fact, there are many (Mayeza, 2021; McCormick, 2013).

Trans people may mediate internal feelings of incongruity and their external gender expression in a number of ways (Burnes & Chen, 2012). For some, this is achieved through pursuing gender affirmation, which is the sequence of aligning ones external gender expression with the internal sense of gender identity (Fein et al., 2017). Gender affirmation is often colloquially referred to as 'transitioning' however, in line with the most current guidelines on terminology within trans research, the term 'gender affirmation' is preferred as it better reflects the breadth of actions and possibilities that can be involved (ACON, 2019). GA is a highly individual process that can follow, or occur in conjunction with 'coming out', and can be pursued in a variety of ways, depending on the person, their wishes and what is

available to them physically, socially and financially. A person may affirm their gender physically by using hormonal or surgical treatments to align their bodies with their gender identity; they may change their appearance, their name and their gender pronoun to align socially; and they may pursue recognition of their gender identity legally (Biblarz & Stacey, 2010; Weiner & Zinner, 2015).

Many trans people are also parents (Charter, Ussher, Perz, & Robinson, 2018; Riggs et al., 2016). Parenthood is reported by up to 50 per cent of trans people in some studies (Grant et al., 2011), and up to 80% of those who affirm their gender later in life (Pyne, 2012; Stotzer et al., 2014). Many trans parents negotiate coming out and pursuing GA whilst navigating their role as a parent, as well as, in many cases, their role as a partner or co-parent. Although there is a flourishing body of research on aspects of trans lives, such as physical and mental health care, housing, employment and other social inequities (Morris & Galupo, 2019; Ussher et al., 2020; Valentine & Shipherd, 2018), the family context, in which a multitude of these experiences are situated, is often overlooked (Charter, Ussher, Perz, & Robinson, 2021). There is still much to be explored and understood in terms of how trans parents negotiate, experience and communicate 'coming out' and pursuit of GA in conjunction with raising children (Dierckx et al., 2016; Hines, 2006), the aim of the present study.

Even in the most supportive families, 'coming out' and pursuing GA can be experienced by other family members as the loss of the mother, father as well as the husband, wife or partner that they previously knew (Haines et al., 2014). There is little research on how trans parents experience the negotiation and or re-establishment of relationships with their children whilst balancing changes in relationships, work and the rest of their lives following GA (von Doussa et al., 2015). There is some evidence that 'coming out' is not only a

significant part of identity development for trans people, but can lead, in time, to improved relationships between trans parents and their children (Church, O'Shea, & Lucey, 2014). Conversely, some trans people report negative or mixed relationships with their children post GA (Veldorale-Griffin, 2014), with pre-teen and adolescent children in particular reporting increased conflict with their trans parent around the time of GA (White & Ettner, 2006). Additionally, studies have found that children whose parents separated or divorced post a parent 'coming out' or pursuing GA, struggled more with the breakdown of their parents relationship than with changes to parental gender identity itself (Green, 2006). As Pyne (2012) asserts: "transitioning can be a time of high conflict, and if family break-down occurs, it often coincides with a number of other losses for trans parents" (p. 6).

Trans visibility in the broader community has grown exponentially over the last decade (Taylor, Lewis, & Haider-Markel, 2018), accompanied by many legal rights and protections (Bowers & Whitley, 2020). However, previous research indicates that trans parents can still be vulnerable to discrimination from co-parents, former partners or spouses (Pyne et al., 2015), as well as being subjected to discrimination from the broader community (Ussher et al., 2020). For those who must navigate these experiences whilst also raising children, there are added stresses. Many trans parents have reported feeling that their parenting is under intense scrutiny, from ex partners, the court system, and from the wider community, making it difficult to reach out for help, or access support services, for fear of having the care of their children brought into question (Pyne et al., 2015; Riggs et al., 2016). Additionally, many trans parents report fearing that their children will be bullied or excluded by their peers and the broader community, due to the gender identity of the parent (Biblarz & Stacey, 2010; Grant et al., 2011). This stigma has also been reported by children of trans parents, who assert that support is virtually non-existent (Dierckx et al., 2016; Imrie et al.,

2020). It has been concluded that these acts of discrimination and exclusion result from a social model that considers a cisgender heterosexual married couple with children who are biologically related to both parents as the only 'normal' family structure (Lasio, Congiargiu, De Simone, & Serri, 2018).

In previous decades, parents who 'came out' as trans were often advised, even by those closest to them, to sever all ties with their children and their former lives (Green, 2006). However, as trans rights have gained visibility and support, people are increasingly pursuing GA 'in situ', with the aim of preserving their families and relationships (Haines et al., 2014). As a result, it is recognised that "gender transition is often reflexively negotiated alongside commitments to family" (Hines, 2006, p. 354). However, there is still much to be known about how trans parents navigate these experiences. Therefore, our study aimed to address gaps in the research literature, by exploring the following research question: how do trans parents negotiate 'coming out' and pursuing gender affirmation in the context of their relationship with children and co-parents.

Method

Participants and Recruitment

Data presented in this article comes from a larger project examining experiences of parenthood amongst trans parents. A qualitative research design utilising online survey data and one-on-one interviews was used to explore the parenting experiences of 66 participants, 36 trans men and 30 trans women, aged 24 to 67 years old (M =38.3, SD =*11.04*). The children of participants ranged in age from 18 months to 39 years old, with the majority being aged 6- to 16 years old. Participants had between 1 and 5 children (M =2.36, SD= 1.00). Of the 62 participants who answered the survey question, 59 reported currently living full-time in their trans identity, two reported being 'out' in the home and with certain family and

friends, the other reported being 'out' only to their partner and a small group of trans peers. All participants had become a parent whilst in a relationship with their co-parent. Approximately 40% of survey participants reported that their co-parent was unaware of the participant's trans identity before having children. Approximately 35% of participants had 'come out' and commenced GA before becoming a parent. The remaining 25% described themselves as being at various stages of gender expression, and of being 'out'. Participants were recruited through online trans support groups and through targeted social media. Participants were directed to information on the study which contained a link to an online survey. At the end of the online survey, participants could indicate whether they would like to participant in a one-on-one interview. Thirty-eight of the survey participants consented to take part in interviews to further discuss their parenting experiences. Data presented in this article is taken from both the 66 surveys and 38 interviews. The Western Sydney University Human Research Ethics Committee granted ethical approval for this study, and all participants gave informed consent at both survey and interview.

Measures and Procedure

Survey items consisted of closed- and open-ended questions covering the following areas: demographics; information on participants trans identities; experiences of parenthood; and support systems and relationships. Participants were also given space to give further information on issues and experiences that were important to them. Responses from survey items were used to inform and guide individual interviews. All interviewees were reimbursed for their time with a $25 AUD supermarket gift card. One-on-one interviews were conducted via telephone and recorded with participant consent. Interviews were delivered as conversational in style and explored participant's subjective experiences around parenthood; relationships; mental health and wellbeing; support systems; and experiences around gender

expression and gender affirmation. Whilst we use the term 'gender affirmation' participants predominately used the term 'transitioning'.

Analysis

All data was professionally transcribed verbatim and integrity-checked for errors in transcription. Data were analysed using thematic analysis, which identifies and describes meaningful patterns across data by searching for implicit and explicit themes related to the research question (Braun & Clarke, 2006). Data were coded using the NVivo software program. Through discussion within the research team, coded data were then subjected to close analysis, discussion and interrogation, and coding summaries developed. The coded data were then read through to identify commonalities, differences, and patterns. Alongside this process, developing themes were discussed, reviewed and extracted. Through consultation within the research team, themes were then further reviewed and titled. Individual themes were reflected upon and titled not only on their own but also how they were situated in the context of the larger 'story' told within the data, as well as the research field more broadly (Fielden et al., 2011).

This study was grounded within a social constructionist epistemology, which "locates meaning in an understanding of how ideas and attitudes are developed over time within a social, community context" (Dickerson & Zimmerman, 1996, p. 80). Social constructionism acknowledges that whilst multiple stories and realities co-exist, not all are treated with equal validity; the lived experiences of those outside normative gender, sexuality or culture are often marginalised and their stories erased in favour of hegemonic discourses (Berkowitz et al., 2010; Rapmund & Moore, 2000). From a qualitative perspective, researcher reflexivity is vital for understanding how one's own personal assumptions and experiences influence the way research is conducted. The researchers conducting this study have diverse gender

identities and sexualities. The first author, a cisgender researcher, conducted all interviews. As a cisgender researcher working with a gender-diverse population it is imperative that one understands one's own impact and position within the research process. In keeping with the writing of Galupo (2017) we believe that our work is shaped by our own backgrounds and perspectives, and it is vital to acknowledge that these differences may impact on our scholarship.

Results

Three main themes were identified that were related to 'coming out' and negotiation of gender affirmation with co-parents and children, under which a number of subthemes were clustered. The main themes were: (i) Anticipating their Response: 'Coming Out' to co-parents and children; (ii) "Having that talk" – Negotiating disclosure of trans identity with co-parents and children; and (iii) Negotiating Gender Affirmation alongside Parenting. In the presentation of results, participant details are provided for longer quotes, including pseudonym, age bracket, as well as number and age range of children. The first sub-theme addresses experiences of those participants who became parents prior to 'coming out'. A coding summary is included in Table 1.

Anticipating their Response: 'Coming Out' to Co-Parents and Children

"Kids, partner...whole life just gone" – Fear and Anxiety about 'Coming Out' as Trans

For many of our participants, 'fear' was the most salient and commonly reported experience in regards to 'coming out' as trans within the family. Suzette (40's), a parent to three children under 15 years of age, stated: "I possessed a deep, deep fear of how everyone (in the immediate family) was going to react…it kept me awake at night and sat in my belly like a stone during the day". Many others agreed, describing the period before coming out as

"terrifying", "deeply worrying" and "a very scary time". When asked what aspects they were most concerned about, the majority of participants stated that losing their children and, if they were in a relationship, potentially losing their partner, was "by far the greatest fear" (Lyndall, 30's, parent to two primary school-aged children). One participant stated:

> There are so many stories etched into your brain of trans people coming out and just losing like absolutely everything. Their kids, their partner, their whole life just gone… I can't live without them (my family)…those thoughts, it was very, very difficult. Very fraught. I felt frightened (Krissy, 40's, five teenage children).

The fear of "the children being taken away from you" (Noni, 30's, two primary school-aged children), either formally through a legal custody situation, or informally by co-parents or other family members, were concerns echoed by many participants. Ty (40's, parent to one primary school-aged child) stated: "So much rested on how (my partner) was going to feel. I know she knew something was going on…but it's different to say it and do it and be it…a lot rested on her good graces (laughs)." Participants who had "deep uncertainty" (Damon, 20's, one infant and one primary school-aged child) around how their partner or co-parent would respond to their coming-out reported the most concern about these outcomes, leading some to delay coming out. Roger (30's, step parent to two teenage children) commented, "I absolutely could not tell (my partner)…for years actually, I knew it would probably end us and I really desperately wanted to avoid that".

Fear was expressed in relation to the responses of children, or the potential impact of having a trans parent on children, as one participant explains:

> Truly my greatest fear was how (me coming out) would affect (my children)…that they would be bullied and excluded and traumatised…that they would be damaged by

> me being me and never forgive me. (Jessie, 30's, parent to two primary school-aged children)

Other participants echoed this concern, making statements such as, "I was so frightened that (my children) would hate me" (Maury, 40's, two adult children); or, as Connie (40's, two teenage children) described "…terrified of how the kids would be…as a parent, to do something that hurts your kids goes against everything inside you".

Anticipating and attempting to manage potential responses of children was pivotal to how participants visualised and navigated their coming out process. Many participants discussed how the age of their children was central to this. Those with very young children reported feeling less anxious or stressed about the disclosure. As Damon (20's, one infant and one primary school-aged child) explains: "To be honest, I wasn't that concerned, …(my child) was at a stage where I didn't think the process would really affect her that much". Participants with older children, in particular those with teenagers, were more likely to report anxiety, fear and stress related to coming out. As Maury, (40's, two adult children) who came out almost two decades ago, describes:

> I was especially worried about (my teenage daughter)…I knew she was going to be devastated…it just seemed like the worst possible time…(being a teenager is) already such a hard time for them.

Other participants concurred that older children and teenagers presented a "much more complicated situation" (Leoni, 50's, two adult children) that needed to be carefully managed. However, many of these participants reported "feeling at a loss", "woefully unprepared" or "unsure" of how to communicate these experiences with their children: "It's not like there's a handbook (laughs), or at least there wasn't back then…It was hard to know how to express myself to (the kids)" (Leoni, 50's, two adult children).

"I've got to come clean" – The Burden of Keeping Secrets

For many participants, the "burden of keeping secrets" (Marilena, 40's, two teenagers and one adult child) prior to coming out reportedly impacted on their experiences of parenting, and their relationship with their partner. As one participant explained:

> I just felt totally distant and distracted…with (my child) I couldn't focus like be present with him at all…and with (my partner) I was so distant (Ty, 40's, one primary school-aged child).

Another participant spoke about how "exhausting and draining it is keeping secrets from (your partner and children)…living under the same roof, it's quite unbearable" (Raina, 40's, two high school-aged children). For Sonia (40's, three adult children and one primary school-aged child) the burden of keeping secrets led to her divorce:

> I always thought I was a cross-dresser…I didn't think I was trans enough to be transgender (at the time)...my ex-wife had no idea...I kept (my wardrobe) hidden away in the garage…and that was one of the underlying reasons for our divorce and our split.

Some participants reported leaving the family home for a period of time due to the pressure of secrecy. Sally (30's, one teenager and two primary school-aged children) stated, "the pressure of keeping so much from them… all became too much". Some participants reported moving back into their childhood home with parents, or with other friends or family members during GA. Lyndall (30's, two primary school-aged children) asserts: "I needed time to work out what was going on and how I was, sort of, going to tackle (coming out) to (my partner) and the kids…My mum surprised me, she was amazing and helped me get my head right".

For many, the build-up of pressure transformed into the drive to open up to their family. As Lynette (40's, one adult and one teenaged child) describes: "I'd just had it. I thought, I've gotta come clean and if she throws me out of the house, I'll be done with this, at least it'll be

out in the open (laughs)." Other participants echoed this account, agreeing that "something had to be done…that it was time to rip the band-aid off" (Nadia, 30's, two primary school-aged children). Other participants reiterated this experience of a "build-up to breaking point" (Noni, 30's, two primary school-aged children) in coming out to children and partners. Sally (30's, one teenager and two primary school-aged children) commented: "Once I reached that, kind of, tipping point it all just happened and came together".

"Having that talk" – Negotiating Disclosure of Trans Identity with Co-Parents and Children

The participants in our study who were still living in the gender assigned to them at birth when they first had children, reported a range of responses to 'coming out' to their co-parent and children. For some, 'coming out' was a sudden admission or disclosure, for others it was part of an existing, on-going dialogue within the family. However, all participants expressed observing the differing needs of co-parents in comparison to their children.

'Coming out' to Co-Parents: Support or the Final Straw in the Relationship

Approximately a quarter of participants had partners who knew they were "gender questioning", "gender experimenting", or as Tina (20's, parent to a toddler and another baby on the way) described: "on the spectrum, gender wise". Many of these participants, most commonly trans women or those assigned male at birth, anticipated support by partners and children in public GA, as they had been supported in expressing themselves in gender con-conforming ways in the home or in other private settings. As Nadia (30's, two primary school-aged children) describes:

> I'd always liked to wear, you know, dresses and skirts and sarong-type things at home, especially in the summer, I mean who wouldn't? (laughs) but, it was something that (the family) was used to...my hair was always quite long. There wasn't like a big, dramatic

change, I think (my partner) especially was just waiting for me to kind of, articulate, what she already knew…then it was just a matter of taking what was happening inside, outside.

Other participants described the 'coming out' process as "more of a gradual reveal" (Regina, 60's, three adult children and two grandchildren) rather than a sudden shift. Regina continues:

> I guess I'd always had that, you know, (feminine) element, so it wasn't really such a huge stretch for everyone when the time came…in that sense I felt supported to come out in my own time. No one made me feel any different really so I could really feel my way through it individually.

For Sonia (40's, three adult children and one primary school-aged child), it was the actions of her new partner, who supported what Sonia described as her "cross dressing" that pushed her to have the confidence to identify as trans. Sonia explains: "(My partner) sat on the end of the bed and said 'for fucks sake, can you just go and find out?'...And so from that I went to (trans support service) and was given a whole list of doctors names."

For participant's whose co-parent was unaware of their gender questioning or desire to engage in GA, disclosure was both a vital and vulnerable part of the process. As Frank (30's, one primary school aged child) explains:

> In my head, it was all I could think about...I had all these plans about how I was going to broach the issue and then one day I just blurted it out...I just said to (my co-parent) 'I think I'm a man, I think I'm trans' and my stomach just dropped...She was like, 'right' and then was pretty quiet for a while, then she was just like, 'ok, what's next, what do we do now? And then we talked through a couple of things and I made an appointment with my doctor to get some referrals...the relief was indescribable.

Other participants described 'coming out' to co-parents as "quite natural" (Nadia, 30's, two primary school-aged children), with many stating that their co-parents were "supportive and understanding" (Sally, 30's, one teenager and two primary school-aged children), "my biggest cheerleader" (Del, 40's, two children under 15) or "on board straight away" (Clay, 20's, toddler). Others described their co-parents, after the initial disclosure, "taking some time before continuing the conversation, which I encouraged" (Stellan, 20's, step-parent to three primary school-aged children). Similarly, Tina (20's, parent to a toddler and another baby on the way) told us "my partner-she took the time to go and learn about what it is and research what being transgender was". Whereas Raina (40's, two high school-aged children) explains:

> (my partner) was just like 'look, are you ok?' and I was like 'no, this is what's going on' and she was initially really shocked or taken aback...It was equal parts hugely stressful and a huge relief, the combination made me feel like I was going to have a bloody heart attack (laughs).

However, for other participants the response of their co-parent was less positive. For some it signified the beginning of a very difficult period in their relationship, for others it signified the end: "...out of the blue when we were driving my wife turns to me and goes, "Are you a girl?... are you trans?" and I couldn't lie to her...And the first words out of her mouth (after that) were "we are done"" (Marilena, 40's, two teenagers and one adult child). For Suzette (40's, a parent to three children under 15 years of age), 'coming out' to her partner was "the final straw for us as a couple". Suzette continues:

> I think after so many years of secrets and that, you know, tension of keeping secrets really took its toll on us...I reckon I was probably pretty distant for a lot of (the marriage)... she caught me looking up things on the computer and confronted me one night. I couldn't

deny it and that was that, really...We get on ok now and co-parent pretty well but that's taken time.

Participants who experienced a breakdown in their co-parent relationship after 'coming out', echoed aspects of Suzette's account, asserting that it was the "years of tension and build-up of secrets" (Connie, 40's, two teenagers) rather than 'coming out' itself that damaged the relationship.

Across the board, whilst participants acknowledged that changes to parental gender expression may be "obviously challenging for the kids" (Tilda, two children under 12 years old), many asserted that they felt it was difficulties with co-parents or challenges in relation to the break-down of co-parent relationships that impacted on how children experienced parental trans identities. As Marilena (40's, two teenaged and one adult child) describes: 'I think it had a lot to do with my ex-wife...she was really in my daughters' ear, all the time...I understood she was hurt but dragging the kids into it like that, it's so vicious and serves nobody in the end". Participants who experienced breakdowns in their co-parent relationships echoed this account, with some making comments that their co-parent "did a huge amount of damage to my relationship with the kids" (Connie, 40's, two teenagers) after 'coming out'. These accounts illustrate how disclosure to co-parents was experienced as both vital and vulnerable, due to co-parents' significant influence within the family unit, and their ability to impact on participant-child relationships.

'Coming out' to Children – The Intricacies of Age

"Do they understand?": Disclosing to Younger Children.

Experiences around 'coming out' to children were reported to be influenced by the age of children at the time of disclosure. Participants who had children under 10 years old when they first 'came out' asserted that the process was "very simple and straightforward" (20's, parent

to a toddler and another baby on the way. Nadia (30's, two primary school-aged children) said: "there wasn't like a grand reveal or anything, to them I don't think they really noticed any difference, they were so young". Others agreed that young children did not require extensive communication or explanations in regards to trans status. As Damon (20's, one infant and one primary school-aged child) describes:

> I just said (to my oldest child) that daddy was really a girl and that I had been stuck in the wrong body and now I was going to be a girl like I was supposed to be... (my child) were so not bothered to be honest...they just loved me the same and I think that that actually helped my partner come around as well...we were lucky in that respect, or I was rather.

Whilst the majority of participants shared similar experiences, there were contrary accounts. Tilda (20's, two children under 12 years old) states:

(My youngest child) took it very hard, he was just so confused and actually really angry...he started acting out and we did a lot of work and went to counselling, ... (my oldest) on the other hand has been amazing, she's so supportive and I feel like it's actually really improved our relationship...she seems really proud that I'm her parent. Some participants wondered if their young children wouldn't remember the disclosure, or that they may respond differently in time, as Frank (30's, one primary school aged child) describes:

> The real issue was everything was so easy (in regards to 'coming out') in that sense, it felt amazing and was a huge relief...as time went on though, then I started to worry that maybe in time, would I have to re-explain? Or that their feelings about me being trans would change and I'd re-traumatise them down the track or something.

Many participants who had 'come out' and affirmed their gender before having children expressed similar concerns. Bailey (20's, one preschool-aged child) commented:

> It's difficult because right now (my child) doesn't really understand but I do worry what will happen down the track...I'm hoping that we will normalise everything over time so it will never be a big deal but there is a part of me that is concerned about how they could react down the track, you know?

Participants who lived 'stealth' in their daily lives, meaning that their trans identity was not known to those in the wider community (Pfeffer, 2016), also grappled with the ramifications of 'coming-out' to children. Zak (29, one primary school-aged child) explains:

> This is a massive concern for me actually, if I tell (my child) too early it's so risky...he could 'out' me to anyone, on the street, at school, his friends and so on, not maliciously obviously but that's what little kids are like you know? If I leave it until he's older well, will it be a huge shock or like I've deceived him his whole life, or will he be unaffected by it all due to the way we are raising him? It is just so hard to know.

Being 'outed' in public was a common concern for many participants in regards to 'coming out' to their younger children. As Lyndall (30's, two primary school-aged children) states:

> My youngest went through so many phases (after I 'came out') ... like she would tell people in shops 'my daddy is a girl, she has a penis' things like that...or I would pick her up from daycare and she'd yell out 'daddy!' and, you know, I'm wearing a dress or what not and all the other kids would just be so confused, bless (laughs). You know, you've gotta laugh about these things but at the time it was challenging to say the least.

Many other participants with young children re-iterated this type of account, with some saying that "it's the price you pay for being free" (Damon, 20's, one infant and one primary school-aged child).

"She took the whole thing really hard": Negative Responses to Disclosure from Older Children.

Participants reported that 'coming out' to children who were aged approximately 10 to 16 years old was the most challenging, as changes to parental gender identity and expression were difficult for children of this age to understand. As Marilena (40's, two teenaged and one adult child) explains: "My youngest one, she won't talk to me except if she wants something, which is what you kind of expect at that age...she took the whole thing really hard...I feel like I've really hurt her and she's ashamed of me, like she won't let any friends see me." Other parents with children in this age group agreed, expressing variously: "They are already dealing with so much at school, their friends and are so sensitive to that, like, threat to their image and how they are perceived" (Lynette, 50's, one adult and one teenaged child); "the schoolyard can be so merciless with this kind of stuff" (Maury, 40's, two adult children); and "other kids can be the absolute worst" (Sonia, 40's, three adult children and one primary school-aged child). Roger (30's, step parent to two teenage children) pointed out:

> You know those tweeny, teeny years, they're already trying to figure out so much, about themselves and the world and how it works...it can be a lot to add to the situation and it is so important to understand that and be respectful of that, I think.

Many participants agreed being "respectful" of children in this age range was vital, in regards to how they negotiated 'coming out', such as what and how much information they shared at various times, which is the same approach many participants utilised with younger children. Participants also spoke about giving children in this age group "a lot of space...as long as they knew they could come back and talk about things when they were ready...maybe they could go away and do their own research" (Krissy, 40's, five teenaged children). Being sensitive to the needs of children and 'centering' them were seen as vital for this age group,

with many participants acknowledging that giving their child time was important, as pointed out by Sandy (50's, two adult children):

> It took me a while but I realised that I had to let (my child) be angry with me, or freeze me out, for a while...I had to put her in the centre and let her come back when she was ready...it's so hard at first because when you first 'come out' you can get a bit self-obsessed, with this freedom and you can want everything to happen now, now, now...I had to realise it wasn't all about me, which was a little bit hard, I'm ashamed to admit. That is, was about the whole family.

'As long as you're happy that's all I care about': Acceptance and Support from Adult Children.

In contrast, the majority of participants who 'came out' to their adult children reported feeling "the most understood" (Maury, 40's, two adult children) and "supported" (Regina, 60's, three adult children, two grandchildren), with many stating that they felt their adult children were already aware; as Marilena (40's, two teenaged and one adult child) states, "that something was going on". She continues:

> When I finally told my oldest he was just like, 'I know Dad'. He was well aware how unhappy I had been, for a long time, he must've put two and two together...it took me aback a bit, I honestly thought he'd be the hardest one to talk to because we'd always really bonded over guy-stuff, like sports and working on the car, you know, he really looked up to me...he just said 'as long as you're happy that's all I care about' and I don't think I've ever been prouder.

Other participants with adult children affirmed their experience of this age group being the most supportive. As Sonia (40's, three adult children and one primary school-aged child) articulated:

I think at that stage (of their lives) they have their own thing going on, they aren't so dependent on you...but also I think they remember the bad times, when I wasn't happy, or when I was so distracted all the time...(my second oldest) told me, 'you seem so different now, so much lighter' and he was right. I felt like the hugest weight had been lifted off my shoulders. There were a small number of contrary accounts. For example, Regina (60's, three adult children and two grandchildren) reported experiencing difficulties with one of her adult children, who was in their 30's when Regina 'came out': "He was just horrified, there's no other way to describe it...there was a long period where I wasn't allowed to see (my grandchild)".

Negotiating Gender Affirmation alongside Parenting

Slow Down and Communicate – Balancing Gender Euphoria with the Needs of the Family

For many participants, 'coming out' to co-parents and children was accompanied by contemplation of affirmation of gender identity in a broader social context. For many, contemplating and commencing the pursuit of GA whilst parenting was reported as "incredibly exciting" (Del, 40's), as well as "very complicated" (Connie, 40's, two teenage children). This was attributed to the wish to realise desired changes in gender expression whilst also being respectful of the needs and feelings of children and, in many cases, co-parents. As Sonia (40's, three adult children and one primary school-aged child) explains:

I think the biggest difficulty, or maybe regret I have, is that when you first, sort of, 'come out', it can be very intoxicating. It's very, very easy to get swept up in everything, you are excited and want to do all these things and sometimes the family can get lost in that a bit. My partner really had to be like 'woah, you need to slow down a bit and you need to talk

to us about what's happening'...At the time I was a bit annoyed (laughs) but I did come to realise that bringing them in was really important.

This account was reiterated by other participants, who also expressed the need to: "slow things down and really communicate (to children) about how I was feeling and what I needed to do...but also like asking them like 'what do you need from me?" (Marco, 30's, two children under 12 years old). For these participants, acknowledging the needs of their children and keeping communication open was key to navigating GA with immediate family. This could involve discussing what changing appearances meant to the participant and creating an age-appropriate dialogue with children around gender and what being trans meant to the participant, as well as more specific conversations around new names or alternative terms in place of 'mum' or 'dad' or deciding to keep certain things. As Tony (30's, one primary school aged child) stated:

> I started the discussion by explaining to (my child) that something had gone amiss with me before I was born and that my chromosomes had turned out a bit wrong. I tried to keep it simple and medical...it seemed important that (my child) understand it's a health condition that can be managed by certain things, like my medication...that seemed to work for us.

Those with older or adult children who already had an understanding of trans identities reported more broad conversations around gender, as Regina (60's, three adult children and two grandchildren) explains: "I talked to them a lot about gender being a social construct...I guess I took a more philosophical-type tangent with them".

Some participants described difficult experiences around the need to slow down or temporarily stop pursuing GA following 'coming out', in order to support children who were having difficulties adjusting to the changes in the gender identity of their parent. This was

perceived as challenging, with some parents stating: “slowing down transitioning for (my sons) sake was pretty brutal, it definitely took a toll” (Ty, 40’s, one primary school-aged child); and “to stop altogether...going back to dressing like a man was heart breaking, but I didn’t feel like I had a choice at the time...I felt like I had to do it for (one of my children)” (Krissy, 40’s, five teenage children). This disruption to pursuing GA reportedly had a detrimental impact on participant mental health, as Lynette (40’s, one teen and one adult child) explains:

> There were a lot of times when felt I had to revert (back to dressing male) and it honestly just messed with my head so much...that depression came back, started breaking down again...I truly thought at the time that’s what (the kids) needed from me, but actually what they needed was a bloody functioning parent (laughs).

A “better parent”: The Value of Pursuing Gender Affirmation

For all participants, balancing their own needs against those of their children was central to the way they approached pursuing GA. Many participants asserted that the most important thing for children is a functioning parent, whilst at the same time, pursuing some form of GA was vital to participants’ mental health. Finding a balance to meet both of these needs was a challenge.

The participants in our study were essentially unanimous that pursuing GA made them feel like a “better parent” and “a much better person”. As Sandy (50’s, two adult children) reported:

> To me and (the kids) the difference was really night and day...I was much more present, much more relaxed and much happier. Transitioning definitely made me a much better parent and (the kids) absolutely saw that...it’s something we talked about a lot, or used to anyway. It’s old news now (laughs).”

Accounts of being “more relaxed” and “more present” were echoed by the vast majority of participants in relation to parenting experiences after commencing GA. Many participants attributed these changes to factors such as, “finally living authentically” (Sonia, 40’s, three adult children and one primary school-aged child); “being able to be my true self” (Lyndall, 30’s, two primary school-aged children); and having “a huge weight lifted off my shoulders” (Jonnie, 20’s, two primary-school aged children). Additionally, participants were unequivocal in asserting that pursuing GA significantly improved their mental health and, as a result, their relationship with children and, in many cases, with co-parents:

> To go from not coping...unable to really ‘be there’ for the kids, and now I am thriving. Obviously, there’s a lot to it, a lot of moving parts, but our family is stronger, what I have with the kids is stronger and they feel it.” (Del, 40’s, two children under 10).

For the participants in our study, being able to pursue GA offered “immense freedom and joy” (Wyn, 40’s, one primary school-aged child), and many asserted variations of a comment made by Jonnie (20’s, one primary-school aged child) that: “transitioning absolutely saved my life, I would not be alive and I would never be able to be the happy, loving father and partner I am otherwise”. These accounts illustrate the significance that GA, holds for our participants. For those in our study, GA and the ability to parent were very much interlinked. Pursuing GA, and its association with mental health and wellness, are well established in these accounts, giving us a valuable insight into the profound impact GA has in the family context.

Discussion

This study examined trans parents’ experiences of ‘coming out’ and pursuing GA in the context of their relationship with children and co-parents. Our findings illustrate that changes around parental gender identity have a profound impact on the lives of parents, co-

parents and their children and that navigating these changes requires ongoing, consideration and negotiation. Pursuing GA was reported to be vital to the mental health and well-being of trans parents. Family can be both a source of great strength, as well as vulnerability, for trans parents, and finding a balance between parental gender-related needs, as well as protecting relationships with children, is of fundamental importance.

Fear and anxiety around relationships with children and co-parents withstanding parental gender identity changes are evident in participant accounts. If a co-parent relationship is already experiencing issues, one parent 'coming out' as trans can cause a significant breakdown in the co-parent dynamic. Research by White and Ettner (2006) has indicated that one of the primary factors that predicted a healthy trans parent-child relationship was a positive relationship between co-parents, regardless of their relationship status. This held true for the participants in our study. Children can be significantly impacted by the management of a parent's pursuance of GA (Hafford Letchfield et al., 2019). Our study illustrates the benefits of trans parents being informed and empowered to approach gender-based concepts with their children and co-parents or partners, as early as is feasible. However, this vital dialogue may put pressure on the trans parent at a time of already heightened emotions. If, as Haines et al. (2014) claim, co-parents, partners and children 'transition' with the trans parent whilst the family dynamic is renegotiated, then we would argue that all family members may benefit from an independent support system, outside solely of each other, in order to give space to each members 'transition', vicarious or actual. Our study shows this could be through channels such as peer support or informal groups catering to family members of trans individuals, as well as more formal channels such as health professionals like counsellors or psychologists. Unfortunately, skilled and specialised trans services are rare, especially outside major metropolitan areas (Petit et al., 2018). There

is a serious dearth of support for the families of trans people, especially in regards to children with trans parents. The absence of formal literature is significant however, what may be the greatest loss is the absence of peer-informed and -led support systems, particularly in the online realm (Gender Identity Research and Education Society, 2016).

Whilst the knowledge and skills to support trans parents and their families should be embedded within healthcare education, practice and policy, this is still not necessarily the case (Hafford-Letchfield et al., 2019; Riggs et al., 2014). Extensive research around trans health and well-being indicates that many health services are often ill-equipped and not always proficient in delivering trans-appropriate support (Bradford, Reisner, Honnold, & Xavier, 2013; Ho & Mussap, 2017; Riggs et al., 2014; Robinson et al., 2020). Healthcare providers working with trans parents need to be able to situate and support the family context in which their client is positioned (Petit et al., 2018). Additionally, healthcare providers working with trans people and their families need to be informed of, and understand, the challenges they face and be knowledgeable of best practice in supporting them throughout the different stages of family life (American Psychological Association, 2015). To this end, a vital avenue for future research would be longitudinal explorations on trans people and their families in order to understand the needs of trans parents, their children and co-parents over the life span, children's developing maturity, co-parent relationships, the gender affirmation journey, amongst other milestones and experiences.

Our findings also illustrated that age of children is a key factor in how they comprehended and approached changes to parental gender identity, a finding that has been established in previous studies (Church et al., 2014; Veldorale-Griffin, 2014). Although a trans parent cannot always predict or control if or when they may 'come out' and pursue GA, understanding that the age of their children can be influential on how the trans journey is

experienced within the family, has enormous value. If trans parents, and their co-parents or partners, are informed and can put appropriate, pre-emptive, support frameworks in place, children may be better placed to manage these changes. Hines (2006) has illustrated that open dialogue with children about gender, gender identity and changes to parental gender identity, assisted in preserving close parent-child relationships. Our study illustrates how vital communication is between trans parents and their children. When children have an insight in to what being trans means, and why 'coming out' and pursuing GA are important aspects of being trans, for many people, then that child is able to approach this aspect of life, and of their own family life, with a deeper and empowered understanding.

Veldorale-Griffin (2014) found that children who understood that it was necessary for parents to be able to live in their authentic gendered self, employed a variety of adaptive coping skills and independently sought out to inform themselves. In contrast, children who positioned changes to their parent's gender identity as a betrayal, experienced significant, and often long-term, difficulties adjusting. This is in keeping with the pedagogical design of programs such as the national Safe Schools initiative, which was a public school-based program in Australia, which sought to educate school-aged children on sexuality, gender concepts and inclusivity (Safe Schools Coalition, 2013). This national initiative was decimated largely due to conservative politicians and media, which has left a significant educational chasm for these young people and their communities (McKinnon et al., 2017). Participants in our study reported that GA was hugely beneficial for their mental health and their experience of parenthood. For the vast majority, the question was not 'if' they would 'come out' and pursue GA, but when. These findings are supported by numerous other studies which illustrate the importance of transitioning and GA for the mental health of trans people (Dierckx et al., 2016; Jellestad, 2018; Motmans J., 2012; Strauss, 2017). As such,

fostering affirming and supportive social networks for trans parented families is vital, however, this can be difficult given the significant discrimination and stigmatisation of trans people who are subjected to the dominant cultural narrative around parenthood and family (Downing, 2013). Trans parents are chronically excluded from both conventional and same-sex discourses around parenting, as well as an almost complete lack of representation in parenting resources and exclusion from community-based support networks (Hafford Letchfield et al., 2019; Ryan & Martin, 2000). It is important to reveal the challenges that may occur for trans parents as they navigate integrating their trans identities with their identities as parents. Although the parenting role is viewed as culturally normalising, trans parents face unique challenges as their trans identity is often positioned as their overriding identity, and they can become socially disadvantaged as a result (Burnes & Chen, 2012; Haines et al., 2014; Meyer, 2012).

There were some limitations to this study. As the data came from a larger project examining trans parenthood more broadly, 'coming out' and pursuing GA were not the main focus and, as such, there is still much so more to explore and understand around these experiences. The majority of participants were white, had completed higher education and were living in their affirmed gender, as such there are implications for the transferability of results. A further limitation is that the experiences of children and co-parents were only expressed through the perspectives of participants; an important direction for future research would be to also interview children and co-parents to more fully and accurately understand their experiences.

Conclusion

Understanding the family dynamics in which trans parents are situated is essential, as pursuing GA has a profound impact on the lives of all family members. When support and

communication exists, this journey can be navigated with confidence and cohesiveness. Living authentically whilst also protecting relationships with children and maintaining a positive relationship with co-parents is of fundamental importance to trans parents. Support for both the individual and the family unit is imperative to this process.

Chapter Five

Negotiating Mental Health amongst Transgender Parents in Australia

This chapter contains the journal article *Negotiating Mental Health amongst Transgender Parents in Australia*. This article is also included in Appendix H.

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Abstract

Background: Many transgender (trans) parents experience challenges related to their mental health, which can affect and impact on their experiences of parenting, however there is scant research on how Australian trans parents contextualize and experience their mental health, the support they receive for it, and impacts within the family context.

Aims: The present study aims to address these gaps in the literature, through examining how Australian trans parents contextualize and experience issues around their mental health, and their experience of formal and informal support for their mental health?

Methods: This study aimed to explore these experiences, through a qualitative research design using online open-ended survey data and one-on-one interviews, with 66 trans parents, aged 24–67 years old. Data was analyzed using thematic analysis.

Results: Many participants reported significant challenges in relation to their mental health: such as depression, anxiety, and suicidal ideation, which reportedly made parenting challenging. However, participants reported that gender affirmation as well as family and social support had a positive impact on their mental health. The majority of participants reported feeling they had to educate their therapist, that they were pigeon-holed by their

gender identity or, had concerns about confidentiality. However, some participants expressed positive interactions with therapists, particularly therapists specializing in, or knowledgeable of, trans health.

Conclusion: The results reinforced the need for mental health professionals and associated services to be competent in treating trans parents and reiterated the positive impact of family and social support, as well as support for gender affirmation, on the mental health of trans parents and their ability to parent.

Introduction

Many transgender (trans) people are parents. A meta-analysis by Stotzer et al. (2014) indicated that 25% to 50% of trans people report being parents, with trans women and those who affirm their gender later in life more likely to be a parent (Grant et al., 2011; Pyne, 2012). The lives of trans parents and their families are significantly impacted by the societal context in which they live. Currently, Australian society is shaped by heteronormative ideals that overlooks families in which the parents are of the same gender, or where the parent or parents are trans (Haines et al., 2014) (Riggs et al., 2016; Short, Riggs, Perlesz, Brown, & Kane, 2007). As a result, families shaped outside the heteronormative, cisgender family framework, such as trans families, are at risk of marginalization (Veldorale-Griffin, 2014), with parents who came out as trans previously advised to sever all ties with their children and former lives (Green, 2006). However, over the last decade as trans rights have gained visibility and support, trans people are increasingly pursuing gender affirmation (GA) whilst also pursuing and preserving families, relationships and careers (Haines et al., 2014). As a result, experiences around GA and the ability to live authentically are increasingly negotiated in tandem with commitments to family and mental health and wellbeing (Hines, 2006). As

part of this process, trans parents negotiate normative cultural scripts about gender and parenthood, varying from appropriation to resistance (von Doussa et al., 2015).

Trans people experience significantly poorer mental health compared to their cisgender counterparts (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Leonard, Lyons, & Bariola, 2015), attributed to the psychological impact of discrimination and systematic oppression of trans people (Hatchel, Valido, De Pedro, Huang, & Espelage, 2018). For trans parents, issues around parenting and mental health may be complicated by a history of discrimination and pathologization by the medical community and the family court system (Bockting et al., 2013; Charter et al., 2018; Puckett, Matsuno, Dyar, Mustanski, & Newcomb, 2019; Rodriguez, Agardh, & Asamoah, 2018). Much like the broader population, trans people may seek support for issues around their mental health. When trans people have access to social support their overall mental health and self-esteem is improved (Lefevor, Sprague, Boyd-Rogers, & Smack, 2019; Nemoto, Bödeker, & Iwamoto, 2011). However, due to concerns around judgment, trans parents may feel apprehensive about seeking such support (Green, 2006; Hafford Letchfield et al., 2019).

There is evidence that formal health services are often ill-equipped to serve the trans community and mental health professionals (MHPs) are not always proficient in delivering trans-appropriate support (Bradford et al., 2013; Riggs et al., 2014). There continues to be a gap with regard to mental health research with trans people, particularly from an experiential perspective, resulting in trans-identified needs often lost in the provision of care (Benson, 2013; Bockting, Knudson, & Goldberg, 2006; Charter et al., 2018). Equally, there is minimal research on the perspectives of trans parents who have experienced mental health issues in response to the support received (Riggs et al., 2015). A greater understanding of such issues is needed to help expand the inclusivity and visibility of trans people in broader health

literature (Eaton, Ohan, Stritzke, & Corrigan, 2016; Hunstman, 2008; Maybery & Reupert, 2009).

The present study aims to address these gaps in the literature, through addressing the following research questions: How do Australian trans parents contextualize and experience issues around their mental health? What is their experience of formal and informal support for their mental health?

Method

Participants and recruitment

This data is part of a larger study examining the experiences of parenthood amongst trans parents. This larger study was open to any trans person living in Australia who is also a parent. A research design utilizing online survey data and one-on-one interviews was used to explore the parenting experiences of 66 trans individuals, aged 24 to 67 years old. The children of participants ranged in age from 18 months to 39 years old, with the majority being aged 6- to 16 years old. Participants had between 1 and 5 children. Fifty-five parents (83%) had children that were biologically related to them, including 25 gestational parents (38%), whilst a number of these participants also co-parented children in blended families. Eleven participants (17%) parented children through co-parenting with partners, for example step-parents or other blended family arrangements. Further demographic details are presented in Table 1 (p.59).

Participants were recruited through an information sheet sent to a number of trans support groups, as well postings on social media. Participants were directed to an online survey collecting demographic information as well as open-ended questions related to their family history, experiences of support, and any other information about parenthood that they choose to express. Survey participants indicated whether they would like to take part in a one-on-one

interview to further discuss their experiences as a parent. Thirty-eight (58%) of the survey participants consented to being interviewed. Data used in this article is taken from the qualitative component of the 66 surveys and 38 interview responses. Demographic data did not indicate a discernible difference between those who were surveyed and those who volunteered to be interviewed. To protect privacy, participant geographical location was not included in the demographic questionnaire however, approximately 65% of participants who took part in the one-on-one interview verbally indicated that they currently resided in a regional or rural setting. To contextualize, approximately 31.5% of the Australian population reside in regional and remote areas of the country (Australian Bureau of Statistics, 2016). The Western Sydney University Human Research Ethics Committee granted ethical approval for this study, and all participants gave informed consent.

Measures and procedure

Online survey items consisted of closed and open-ended questions covering the following areas: demographics; experiences around gender identity; parenting experiences; and support systems. Participants were also given space to write on issues and experiences that were important to them. Individual semi-structured telephone interviews were conducted to examine the subjective experiences of parenting; personal relationships; wellbeing; support systems; gender identity; and gender affirmation within the family context. Interviews opened with participants being asked, *Think back to when you first had children, what was life like for you then?*. Participant responses from online survey items were used to inform and guide individual interviews. Interviewees were reimbursed for their time with a modestly valued supermarket gift card.

Analysis

All open-ended survey and interview data were professionally transcribed verbatim and integrity-checked for errors in transcription. Open-ended survey data and interview data were analyzed using thematic analysis, a method which identifies and describes meaningful patterns across data by searching for implicit and explicit themes related to the research question (Braun & Clarke, 2006). The thematic analysis followed a linear, six-stage method (Fereday & Muir-Cochrane, 2006; Nowell et al., 2017), described as follows: data was subjected to multiple close readings to identify commonalities, differences, and patterns. From these readings, an initial coding framework was developed. Data were then coded using the NVivo software program. In consultation with the research team, coded data was subjected to close analysis, discussion and interrogation, and coding summaries developed. Alongside this process, themes were developed, extracted, discussed, reviewed and refined. Themes were then further reviewed and named. Individual themes were considered and named not only on their own merit but also in the context of the larger 'story' told within the research (Fielden et al., 2011).

Results

Three main themes were identified that were related to mental health, under which a number of subthemes were clustered. These were (i) *Parental Experiences of Mental Health*, which consisted of two subthemes: "Everything was a struggle" – Experiences of poor mental health, and "Parenting under a dark cloud" – parenting when mentally unwell; (ii) *Subjective Experiences around Informal Mental Health Support*, which consisted of two subthemes: Relationships with family and friends, and Gender affirmation: From absent to present parenting; and (iii) *Subjective Experiences around Formal Mental Health Suppor*t, which consisted of four subthemes: "My psych was a lifesaver": "Invaluable" support from mental

health professionals, “Educating the therapist” – experiences of being heard by MHPs, “I am not just my gender” – mental health concerns are related to a range of issues, and “Confidentiality is my primary concern” – geographical challenges in accessing mental health support. In the presentation of results, participant details are provided, including pseudonym, and age bracket. For longer quotes the age range and number of children is attached to participants first mention.

Parental Experiences of Mental Health

“Everything was a struggle” – experiences of poor mental health

All of the trans parents who took part in our study discussed experiencing mental health issues at some point in their lives. Many reported periods of “feeling very depressed” (Trent, 30’s), “so down and low” (Jason, 20’s) as well as “anxiety (that) was through the roof…recurrent panic attacks” (Zak, 20’s). Tina, a parent of one toddler with a second child on the way, (20’s) said:

> (before affirmation) my dysphoria was completely out of control… it became very, very distressing and almost impossible to function. The worse it got, the worse my depression got and the worse my dark thoughts got. I became frightened of myself.

Instances of self-harm, suicidal ideation and gestures were also reported, as Trent (30’s, parent to one primary school aged child), who gave birth to his now primary-school aged child after commencing gender affirmation, describes “(the pregnancy related dysphoria) got so bad that I started to feel like I didn’t have a choice (but to self-harm)”. Additionally, many participants, specifically trans women, reported disordered eating. As Noni, a parent to two primary school-aged children, (30’s) describes:

> I’d go days without eating…I just couldn’t eat because every single morsel of food that I put into my mouth would go onto my body in a male pattern. So, if I eat some

chips, that was going to my belly and that would make me look more male and I would've rather died. In fact, I wanted to die…I very nearly starved myself to death.

Others discussed being diagnosed with eating disorders and the distress and concern amongst family members at their "sudden deterioration" and "skeletal, gaunt and frightening" appearance (Nadia, 30's, parent to two primary-school aged children). Some parents spoke of using alcohol to "cope", as Colin (40's), a father to one preschool-aged child and step parent to a primary-school aged child, told us: "My drinking really started to escalate. I was needing more and needing it earlier every day. I thought it was helping me cope with all the stress and anxiety but it was making it much, much worse." Tommy (20's), a gestational parent to one preschool-aged child, described: "For me (the drinking) put a huge wall up around me, kept everything at a bit of a distance, made me feel like I had some control over how I was feeling." These accounts illustrate how profoundly participants experienced distress around their mental health. For many, these experiences were deeply embodied and had significant consequences in their ability to function and make meaning of their lives.

"Parenting under a dark cloud" – parenting when mentally unwell

Participants were unequivocal in the assertion that their mental health directly impacted on their experiences of parenting, described as becoming "very overwhelming" or "stressful" or like "parenting under a dark cloud" (Del, 40's, a gestational parent who gave birth to two children before and during coming out) as a result of mental health issues. For many participants, self-positioning as a "bad" or "terrible" parent was described as inescapable. This was associated with feelings of guilt which exacerbated depression and anxiety, creating "a vicious cycle" Leoni (50's, parent to two adult children):

I was depressed for about five or six years, which I only really started to recognise with the birth of my second child. (During that time), I found it so hard to be a good

> (parent). I probably seemed ok on the outside but I was dying inside and just desperately detached.

Other participants talked about feelings of "shame" as Krissy (40's), parent to four teenage children, explains:

> I was drinking more and more and becoming more and more difficult to live with… I wasn't thinking anything of it but it was making me into a pretty narky-nasty sort of person…One night when I've had too many to drink and I've been an asshole… my oldest son actually had a chat with (my partner) and said, "Can you say something to Dad? Can you do something? That just broke my heart when I found out, the shame of it.

Tommy (20's) described being "ashamed of myself as a dad" due to his depression, whilst Colin (40's) states: "I wasn't a dad, I was a ghost…it was shameful…The more I withdrew myself from (the family) the worst I felt. It was very much a vicious cycle".

Absence was another common experience in regards to parenting when mentally unwell, and some participants spoke of their "inability to be present" when caring for their children. For example, Connie (40's, parent to two teenage children) told us, "I honestly felt like an absent parent when I wasn't well. I just couldn't focus on the kids at all"; and Clay (20's, parent to a toddler) described his "inability to connect with (his child) when I was sick…I was checked out and totally absent". Del (40's) echoed these accounts: "When I think back to those early years (of parenting) I just think of absence. I just wasn't able to be present with (my kids), I was not coping at all".

These stories illustrate how much mental health can impact on experiences of parenting, and how serious this can be for trans parents. Participants in this study were very candid in sharing these deeply personal accounts, which many acknowledged were their

"lowest moments" (Damon, 20 s, parent to an infant and a primary school-aged child). As stated previously, there is significant societal stigma for parents around admitting that they are struggling with parenting and their mental health (Maybery & Reupert, 2009), and the parents in our study have exhibited great resilience in surviving these challenges. Whilst these accounts make for difficult reading it is vital to understand the actual lived experiences of trans parents rather than just the statistics so often cited, in relation to their mental health.

Subjective Experiences Around Informal Mental Health Support

Relationships with family and friends

Participants raised the importance of supportive familial and social relationships to their mental health. As described by Tina (20's):

> Knowing that you've got people to prop you up when that is very important. If you don't have that support, then you're gonna fall and you're gonna fall hard and it takes a long time to get yourself back off the ground.

Many participants cited their relationship with their children as being fundamental to their wish to "be better" (Leoni, 50 s) and to their "sense of self worth" (Tommy 20's). Marilena (40 s) states: "My (20 year old) son looked at me and said, I just want you to be happy Dad, that's all I want, and he has been my biggest supporter ever since". Other participants concurred, citing their children's encouragement of them, and their "unconditional love" (Colin, 40's) as being stabilizing forces within their lives. As Nadia (30's) describes her relationship with her children:

> "(they) have always loved me the same…but as I have gotten more comfortable in my skin it definitely has had a knock on effect, I am happier which has made them happier and visa versa…I see how much they have cared for me and, for me, the act of caring for them kept me grounded."

Raina (40's), parent to two high-school aged children, states: "Support from your immediate family is definitely something that's very important 'cause they're the ones you can turn to that you know can't run away (laughs)".

However, in regards to extended family, many participants in our study reported mixed experiences. Multiple participants reported currently having no current relationship with their parents or other extended family members. Some attributed this to their family being unable to accept them coming out as trans or taking steps toward gender affirmation, whilst others stated that their relationship had always been problematic. For some, the loss they associated with family estrangement was not their own, but rather the loss for their children in not having grandparents or other family who cared for them. For example, Melinda (40's), a mother of one teenage daughter, said, "I don't give a hoot what my father thinks of me…but he's not there for his granddaughter and that kills me". Other participants spoke of having strong relationships with some family members but not others. Jessie (30's), parent to two primary school-aged children, explains:

> One sister thinks I'm the biggest sin against God ever and she's disowned me, but I have other family members that are supportive…My younger sister is fantastic and she really helps share her parenting journey with me, which is great.

Many participants agreed that a positive relationship with family was invaluable, particularly in regard to support for their own parenting. As Sam (30's), a gestational parent to one primary-school aged child and a step parent to another, told us, "my dad has spoken to me about all sorts of stuff to do with discipline and just building a relationship with (my son). He has been helpful". Tommy (20's) said, "I really looked to my Dad for advice in raising a son, being a man he can look up to…I don't want him missing out on anything". Other participants discussed how their relationship with their family had "deepened" (Melinda,

40's) since they had children of their own and that they derived a lot of support from them; "everyone gives me positive feedback about the person that I've become…They can see I'm a lot happier now" (Darla, 40's, parent to two teenage children).

Additionally, many participants reported positive support from friends and social circles: "I have a lot of friends that I consider family and they have really helped me get through it all. They make it worthwhile (Tina, 20's). Others discussed how "humbling" (Sonia, 40's) it was that their friendships had grown closer, or "deepened to another level" (Tommy, 20's). Others spoke about support from friends in the lesbian, gay, bisexual and trans (LGBT) community as being particularly valuable: "they really understood the complications of transitioning" (Steve, 20's). Tina (20's) agreed, stating that: "speaking to friends (in the LGBT community) that have been in similar situations" is especially helpful, she continues: "It certainly makes you remember you're not the only one". However, some participants noted that many of their friends in the trans community didn't have children, which sometimes impacted on their ability to "fully share experiences" (Steve, 20's).

Gender affirmation: from absent to present parenting

The majority of participants in our study reported that gender affirmation had a significant positive impact on their mental health, as Ty, a father of one primary school-aged child, ad two high-school aged children (40's) describes:

> (Before) I was really, really struggling. I was getting to the point of not functioning and I was breaking down constantly every day, starting to break down in front of the children, which was very difficult…For me, transitioning was such a powerful force and had a huge impact on my mental health.

This account was echoed by many other participants, who reported gender affirmation was "the beginning of healing for our family" (Damon, 20's), or as Sandy (50's) explains "when

the kids were young I wasn't present. Now that I've transitioned, from their point of view, the only change is that it's better and our family is better." Gender affirmation was also reported to have had a significant impact on the ability to parent. As Del (40's) describes, "I relaxed more and I was able to start being more present with (my children). I am a way better parent now, than I ever could have been before."

When asked to describe the ways gender affirmation improved mental health, participants gave a range of responses, such as, "(it) brought everything into alignment" (Justin, 30's), the positive impact of "finally living authentically" (Tina, 20's) and hormone therapy "finally made me feel like a normal person" (Del, 40's). Marilena (40's) explains: "From the first dose (of hormones) I just felt something click inside me…I felt like I finally unclenched (laughs)". Other participants gave similar accounts, with Tommy (20's) telling us: "I definitely relaxed more after transitioning, and it also had a weird side effect in that I completely stopped drinking. The desire just wasn't there anymore". More specifically, many of the trans men in our study spoke about how top surgery (breast removal) improved not only their mental health, but also their experience of parenting. As Steve (20's), parent to one preschool-aged child, explains:

> (top surgery) made me an infinitely better parent. I was able to be more present in my own skin and from that comes so much more interaction and just being able to do simple things like go to the beach with my son.

Across these accounts, participants expressed a shift from experiencing parenting as 'absent' toward being 'present' following gender affirmation. Participants reported that they felt this created a more positive and relaxed home environment as well as a subjectively improved relationship with their children. Participant accounts illustrate that the improvement to mental health and wellbeing that gender affirmation allowed also made space for a deeper parental

connection with their children. It is vital to add, however, that pursuing GA is not without its own set of challenges. Aspects of GA can be prohibitively expensive, putting it out of reach for many trans people. For our participants, significant costs were associated with "vital treatments" (Steve, 20's) such as top surgery and face feminizing procedures. There was often significant guilt attached to spending large sums of money on pursuing GA whilst also being a parent and providing for children.

Subjective Experiences Around Formal Mental Health Support

The majority of participants cited the desire to be a better parent as their primary reason for seeking formal support. As Krissy (40's) explains: "(the kids) were the main reason…I realized I had to get better and do better, for them." Participants had a range of experiences of formal support services, from positive interactions with specialists, to challenges being heard, feeling that they were boxed in by perceptions around their gender identity and concerns about confidentiality. The vast majority, approximately 80% of participants, reported mixed experiences with formal mental health support, with approximately 10% reporting solely positive or negative experiences, respectively. Every participant in our study had accessed formal mental health support at some point in their lives, with the majority of participants engaged in one-on-one counselling at the time of the study.

"My psych was a lifesaver": "invaluable" support from mental health professionals

Whilst participants reporting primarily positive experiences with their MHPs were in the minority, those who did described them as "invaluable" (Zak, 20's), or as Ty (40's) explains: "My psych was a lifesaver, I was not in a good place…she really turned things around for me and I am a far better off for it now…the family is far better off." Other participants expressed how "nourishing" (Clay 20s) and "deeply beneficial" (Trent, 30s) a solid relationship with a

MHP could be. The main aspects noted were 'being heard' and 'being listened to'. As Damon (20's) describes: "I felt that (my MHP) really listened to me and to what I needed from him and I respected that". Other participants reiterated that a MHP who was "present and engaged" (Zak, 20's), as well as "empathetic, (my MHP) treated me like a person rather than a cluster of needs" (Ty, 40s) and "knowledgeable" (Tilda, 20's) made the therapeutic experience more beneficial.

Additionally, participants who were able to see a MHP who specialized in trans health spoke very positively of the support they received, as Tilda (20's) told us: "My psych in (capital city) has been amazing. She was referred to me by (a trans health service) and has been really brilliant, actually." Zak (20's) reiterated this, saying:

> "I was extremely lucky (the first MHP I saw) was recommended to me by (trans support service) and was brilliant. He just made everything very normal and easy. I felt like we were both on the same page, which meant we could focus our energy on me and my treatment. There was very little need for basic explaining, on my part.

For these participants, who were geographically able to access MHPs who have experience or specialist training when treating trans clients, the experience was overwhelmingly positive. By interacting with a professional who is already informed and up-to-date with nomenclature, treatment and communicative competency, participants are able to immerse themselves in the therapeutic process and derive fuller benefits.

"Educating the therapist": experiences of being heard by MHPs

Some participants spoke about efforts MHPs went to in order to educate themselves, as evident in Lyndall's (30's) account:

> My therapist was great. She went away after our sessions and did lots of research…any time I introduced something new she worked it out herself and it took a lot of the pressure off me. I really appreciated that.

However, the majority of participants described challenging experiences in "being heard" (Sam, 30's) and "being understood" (Darla, 40's) by MHPs:

> I have honestly had very few positive experiences with (MHPs), and I've seen quite a few over the years (laughs). I've seen some who just don't seem to understand (being trans), and don't seem to want to…You feel like you have to educate them about absolutely bloody everything. (Leoni, 50's)

This experience of "educating the therapist" (Maury, 40's) was a common refrain in this study, as is evident in Leoni's account, above. As Stellan (20's, step parent to three primary-school aged children) describes: "I just felt like I was constantly having to explain everything. It wasn't very enjoyable and I didn't really get much from the sessions". Others spoke of having to "constantly teach the right terminology" as well as, in more serious examples, being "repeatedly misgendered", or MHPs "using my old name" when discussing earlier life events. As Sam (30's) explains:

> He (the MHP) kept saying things like, "when you used to be a woman this or when you used to be a woman that" even though I had repeatedly explained to him that I didn't like him doing this…I would tell him' "listen, I have always been trans ok? I was never a woman". But he just couldn't understand…it made sessions very uncomfortable for me.

"I am not just my gender": mental health concerns are related to a range of issues

Much like the broader population, trans people wanted support for a variety of issues. However, many participants spoke of a perceived misconception amongst MHPs that they

sought mental health support only for issues surrounding their trans identity or gender affirmation. As Colin (40's) told us:

> My mother died about a couple of years ago and it was a very, very difficult time…The grief was very overwhelming…I was very distracted with (caring for my children). My GP put me in touch with a counsellor and it was a mess (laughs)… They were just so fixated on my transition (which had occurred many years previously) and, you know, my being trans I suppose. It totally overshadowed the way they approached and talked to me. Like actually, I am not just my gender (laughs). I have a whole life going on.

Other participants echoed Colin's account of MHPs lack of "recognition that I need help with other issues" (Darla, 40's). Participants said they often reached out to MHPs for work-related stress, grief and loss, as well as relationship issues, depression and anxiety. If MHPs focused on gender affirmation, it negated the impact of other experiences, and implicitly defined participants by the trans aspect of their identity, rather than the totality of their experience.

> *"Confidentiality is my primary concern": geographical challenges in accessing mental health support*

A number of our participants lived outside major metropolitan areas, with many living in regional and rural areas. For these participants, finding appropriate professional mental health support was described variously as "impossible", "a total no go" or "extremely difficult" (Steve, 20's). Colin (40's) shares his experience:

> Confidentiality is my primary concern, for my family's safety. I don't feel like I can get that (in rural town). There's only one counsellor (in the area), that I'm aware of …I sometimes see a psychologist when I go to Melbourne but it's very few and far between…it's made things very difficult at times.

This account was echoed by Tommy (20's), who stated: "There is just literally no-one in (our town). I'd have to drive over two hours, which is just totally impractical, especially with the kids." Other participants reiterated that there was a lack of MHPs in their community, as well as fears around confidentiality in small communities, as Raina (40's), who is not "out" in her rural community explains:

> My wife actually works at the local hospital and we go to events where all the doctors and such are there and you know, they blabber. They're shocking. I know for a fact that the local psychiatrist goes around telling people about others, I've heard it myself. How am I supposed to trust these people with something so private?

Steve (20's), who lives 'stealth', meaning that no one in his community knows he was assigned female at birth, reiterated this account:

> I don't feel that the confidentiality within (my town) is adequate. I've experienced that on a firsthand basis a few times…there's a lot of anecdotal information shared between (MHPs) during conversations and (the town) might not be an environment that is confidential.

For these participants, the benefit of professional mental health support had to be weighed against the social risk of being outed in their small communities. For many, the risk was perceived as too great and they were compelled to forgo assistance.

Discussion

This study examined how Australian trans parents contextualize and experience issues associated with their mental health, as well as their experience of support for mental health concerns. Our findings showed that mental health issues were a significant concern for the majority of trans parents who took part in this study. For many, experiences of gender dysphoria generated depression, anxiety, suicidal ideation, alcohol abuse and disordered

eating. Whilst these outcomes have been recognized to have high prevalence in the trans community (Pitts et al., 2009; Riggs et al., 2014) there is a dearth of research exploring how this is experienced subjectively on an individual level (Morris & Galupo, 2019). Our participant accounts illustrate how poor mental health impacted upon subjective wellbeing as well as on experiences of parenthood. Many of our key findings align with the work of Riggs et al. (2015), who established that experiences of discrimination, the ability to access gender affirming treatments, as well social connectedness were key factors in determining trans mental health.

Dominant cultural discourses inform us what behaviours, attitudes and identities are appropriate for 'good' and 'bad' parents (Ussher, Charter, Parton, & Perz, 2016) and many of the participants in our study viewed themselves as 'bad', 'absent' and 'detached' when they were unwell. These perceptions were accompanied by significant feelings of shame, as has been reported in previous research with parents who experience physical or mental health concerns (Mauthner, 1999; Parton, Katz, & Ussher, 2019; Price-Robertson, Reupert, & Maybery, 2015). For many of the participants in the present study, these negative appraisals created a vicious cycle that further solidified self-positioning around poor parenting and deficiency. Given the stigma already associated with being trans, in a world designed to exclude (Hughto et al., 2015; Valentine & Shipherd, 2018), those who are both trans and parents exist at a vulnerable social intersection, particularly in regards to mental health (Charter et al., 2018). In the broader literature, parental mental health is consistently positioned as a liability in regards to raising children, however parenthood can also be a source of strength. For many of our participants, parenthood was the primary source of motivation in seeking support for their mental health. They cited seeking mental health support, as well as building stronger family and social bonds, not just for their own benefit

but for the benefit of their children. Trans people can exhibit great resilience in the face of discrimination and marginalization (Graham et al., 2014; Pinto, 2008; Ussher et al., 2020; von Doussa, Power, & Riggs, 2017) and that resilience is also displayed in their approach to parenthood.

Participants in our study reported that gender affirmation was a significantly beneficial experience for their mental health. These findings are supported by numerous other studies which illustrate the importance of transitioning and gender affirmation for the mental health of trans people (Dierckx et al., 2016; Jellestad, 2018; Motmans J., 2012; Riggs et al., 2015; Strauss et al., 2017). For our participants, bringing their gender into alignment was reported to have alleviated dysphoria and allowed them to become more present and relaxed in regards to their experiences of parenthood. It is important to note, however, that gender affirmation means different things to different people and there is no singular way for it to be expressed (Fein et al., 2017). For some participant's, surgical interventions such as top surgery were vital, whilst others found hormone therapy, or dressing certain ways, equally beneficial. However, it is important to recognize that the financial costs associated with gender affirmation can dictate significantly what is accessible to each individual, additionally social situations may also contribute constraints on how affirmation is expressed (Jellestad, 2018). Like myriad aspects of being trans, subjective accounts of the experiences and perceived benefits of gender affirmation are often overlooked within the research sphere (Fein et al., 2017; Ho & Mussap, 2017). As gender affirmation appears to be central to the mental health and wellbeing of many trans people, we believe it is vital for more research to be done that explores the actual lived experiences of those going though these processes. Additionally, research that explores strengths and wellness of trans people, rather than

focusing on vulnerability, is vital for developing interventions (Glynn, 2016; Hendricks & Testa, 2012; Ussher et al., 2020).

Participants in our study identified the importance of supportive family and social circles in addressing mental health concerns and bolstering their parenting. Family and social support were experienced through a parental lens, with participant relationships with children, and support for and around their parenting being positioned as, for many, central to their experiences of mental health and wellbeing. Social support and relationships are fundamental determinants of mental health and wellbeing (Stephens, 2008) and in the trans community these kinds of connection may be particularly vital (Puckett et al., 2019). Previous research has found that, in addition to gender affirmation, when trans people receive social and emotional support they experience significantly improved mental health and wellbeing, and negative outcomes (Robinson, 2014), such as suicidality, depression and anxiety are significantly decreased (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Gorin-Lazard et al., 2013).

Our findings illustrate that experiences with MHPs are often challenging and as such, many of our participants may be receiving inadequate support. Given that trans people already experience significantly higher rates of mental health concerns, being unable to fully access and utilize mental health services may intensify these risks (Riggs et al., 2014). Timely, appropriate and informed mental health support is vital, for trans parents and beneficial for their children (Hunstman, 2008; M. Jones et al., 2016; Maybery & Reupert, 2009). However, our findings suggest that many trans parents feel they are not receiving this support. In line with previous research (Grant et al., 2011; Xavier, Hannold, Bradford, & Simmons, 2007) we found that trans people feel they have to educate their MHPs on trans issues which suggests that many MHPs are still not fully informed. MHPs often do not

receive significant or specialized training on gender identity or working with gender diverse communities outside of a diagnostic framework (Vance, Halpern-Felsher, & Rosenthal, 2015). Additionally, many MHPs have not received training that challenges their own assumptions about sex and gender (Benson, 2013). The inclusion of gender theory in clinical training is vital in preparing therapists to work with this cohort in order to assist MHPs to explore and deconstruct their own understandings and potential biases when working with this population; as Hendricks and Testa state: "cultural competence must surpass mere acceptance of trans people" (2012). Further, trans-informed training in the development of strategies to work with gender diverse people and their families is vital. Culturally competent and trans informed care is key for building resilience amongst these families and individuals (Bockting et al., 2006; Hendricks & Testa, 2012; Pinto, 2008). Mental health education must encompass multifaceted understandings of gender diversity that move past binary notions of gender, in addition to being grounded in clinical frameworks, that are also relevant for working with trans communities.

Our findings demonstrate that trans people experience a range of mental health concerns related to issues in their lives, as is the case with the broader community. Additionally, our study also illustrated the significant difficulties trans people in rural settings have in accessing appropriate mental health services. One positive outcome of the COVID-19 pandemic is the developing availability of specialist telehealth consultations. Whilst it is still in its early stages, initial surveying of specialists indicates their support for it becoming a permanent feature of their practices (Royal Australasian College of Physicians, 2020) which has significant potential to increase equity to rural trans populations, as well as many others.

There were both limitations and strengths to this study. The data came from a larger project exploring parenthood amongst TDG parents, where mental health was not the main

focus. This may have avoided a selection bias in attracting participants who have mental health concerns, and demonstrates the commonality of mental health concerns in this population. The use of a qualitative research method is a strength, allowing us to ask trans parents directly about their experiences around mental health and the support they receive. This gives trans parents the space to inform those with an interest in mental research what this population identifies as important and where support is needed. The limitations are that the study was cross sectional, so could not examine mental health across time, with all accounts being retrospective. Additionally, the data for this article came from a larger study looking more broadly at experiences around trans parenthood. As such, there may be gaps in our knowledge of specific participant experiences in relation to their mental health and experiences of support.

It is vital to de-stigmatise both parental and trans mental health. Ill-informed treatment effects the wellbeing of people who come to MHPs for support, and is antithetical to the central tenets of mental health care. There is a burgeoning movement to more fully acknowledge and understand the complexity of identities amongst people receiving support for their mental health. Knowledge, understanding, and appreciation of diverse identities are a fundamental component of this movement.

Chapter Six

Experiences of Transgender Parents in Navigating Transphobia

This chapter contains the journal article *Experiences of Transgender Parents in Navigating Transphobia*. This article has been accepted for review by the journal Family Relations. Peer review comments have been addressed and we are just waiting for official confirmation of publication, see Appendix I.

Article citation: Charter, R., Ussher, J.M., Perz, J. & Robinson, K. (2021). *Family Relations,* (Under Final Review)

Abstract

Objective -The current study explored transgender parent's experiences of transphobia, and how they support their children in dealing with transphobia.

Background - Transphobia has a significant impact on transgender parents, impacting mental health, and well-being. Secondary stigma may impact their children.

Method - Data taken from open-ended survey responses (N = 66) and one-on-one interviews (N = 38), with Australian transgender parents aged 24-67 years, was analysed using thematic analysis.

Results - Transphobic verbal abuse and physical harassment wasn't uncommon when transgender parents where in the broader community, alone or with their children. Transphobic discrimination also occurred in healthcare practitioner interactions.

Conclusion - Participants 'stayed safe' by isolating, or avoidance, as well as fostering social connections and support. Discussing transphobia with children was challenging, eliciting concern and anxiety however, parental- and peer-support is vital.

Implications - Trans-parent families continue to thrive, in spite of transphobia, supporting and educating one another whilst fostering strength and mutual care.

Introduction

Many transgender (trans) people, just like their cisgender counterparts, are parents (Imrie et al., 2020). One meta-analysis reported that between 25%-50% of trans people have children (Stotzer et al., 2014), including over 50% of trans women, 17% of trans men and 20% of gender-diverse people (Grant et al., 2011). Additionally, Grant et al. found that 82% of survey respondents over 55 years old reported being a parent. Trans men and women may have biologically-related children, parent step-children or other blended family situations (Charter et al., 2018). Trans parents, and their children's lives are fundamentally affected by the societal context in which they live and families living outside the heteronormative, cisgender framework are vulnerable to significant risk of marginalisation (Veldorale-Griffin, 2014). It is well established in previous literature that trans people can experience significant transphobia in their lifetimes (Charter et al., 2021; Lombardi, 2009; Riggs, 2014; Rood et al., 2017). Transphobia has been defined as acts of "prejudice, discrimination, and gender-related violence due to negative beliefs, attitudes, irrational fear, and aversion to transgender people" (Mizock & Lewis, 2008, p. 336).

In Australia, data collected by multiple national organisations found that transphobia is frequently directed at trans people, with 64.8% of participants reporting at least one occurrence, ranging from being socially isolated, to verbal abuse and physical violence (Hyde, 2014). A 2015 U.S. study found that 46% of trans people reported experiencing verbal abuse and harassment, and 47% reported experiencing at least one sexual assault (James et al., 2016). Additionally, a 2017 report into violence against LGBTQI+ (lesbian, gay, bisexual, transgender, queer) people in the United States found that over 50% of LGBTQI+ people murdered in hate-related crimes were trans women, even though the entire trans and gender diverse population make up only 12% of all LGBTQI+ people (Gates, 2011). These

findings highlight the very vulnerable position trans people are put in by society at large, and intimates at the significant, and compounding trauma that transphobic acts perpetrate on the individual (Mizock & Lewis, 2008; Ussher et al., 2020). Additionally, this trauma has the potential to impact those close to them, this is known as secondary or 'associative' stigma (Stangl et al., 2019) and children can be particularly affected when their parent is harassed and discriminated against (Salter et al., 2010). Given the significance of the parent-child relationship, parental distress related to personal transphobic experiences may also be internalised by their children (LeBlanc, Frost, & Wight, 2015). Previous research has found that some children of trans parents do report experiencing transphobic-related bullying and social exclusion (Dierckx et al., 2016; Veldorale-Griffin, 2014). Open communication and positive parent-child relationships may ameliorate some of these effects (Haines et al., 2014), however specific strategies and lived experiences are not as well researched compared to other aspects of trans parenthood.

Transphobia is linked to significant mental health disparities in the trans community (Charter et al., 2021; Mizock & Mueser, 2014). When compared to the broader population, trans people experience triple the rate of major depressive episodes, triple the rate of anxiety disorders and are 25 times more likely to make at least one suicide attempt (Bouman et al., 2017; Nuttbrock et al., 2010), as such, competent healthcare is particularly consequential (Charter et al., 2021). Appropriate and timely medical care is a recognised human right in Australia and is undeniably vital for the ongoing health of trans parents, and their children (Anti-Discrimination Board of New South Wales, 2011). However, extensive literature indicates that many healthcare services and providers are not proficient in or, in some cases, willing to provide appropriate care to this community (Bradford et al., 2013; Charter et al., 2018; Riggs et al., 2014). This is experienced by trans people in behaviours such as

healthcare practitioners exhibiting a lack of understanding of gender diversity, engaging in persistent misgendering, refusing to acknowledge changed names, 'gatekeeping', refusal of treatment and, in some accounts, abuse (Alpert, Cichoski, Eileen, & Fox, 2017; Bartholomaeus & Riggs, 2020). It has also been proposed that secondary stigma may extend to the children of trans parents when they too interact in the healthcare domain, compromising trust and inhibiting support-seeking in healthcare settings, both of which having the potential to impact long term health and well-being (Johnson & Benson, 2014). A solution for this is unclear, Stroumsa et al. (2019) found that increased trans-specific education and sensitivity training does not improve competency of care, rather, transphobic attitudes exert a strong, stable influence. These findings suggest that addressing the healthcare barrier is a complex issue and requires a willingness for the individual to examine their own biases as much as any institutional change (McPhail, Rountree James, & Whetter, 2016).

Thus, transphobia can run the gamut, from subtle acts of discrimination, daily micro aggressions and exclusion, all the way to physical or sexual violence and abuse (Miller & Grollman, 2015; Mizock & Lewis, 2008; Ussher et al., 2020) and as long as the systematic nature of transphobia goes unchecked, trans parents and their children will continue to be made vulnerable. However, it is important to acknowledge that, when taken at face-value, the presentation of statistics, such as those above, can contribute to a stereotypically 'bleak' view of the lives of trans people, which can further marginalise (Lytle, Vaughan, Rodriguez, & Shmerler, 2014). It is vital to be unambiguous in acknowledging that, whilst systematic societal oppression enacts and perpetuates victimisation, trans people are not victims. There are many alternative experiences outside the dominant discourse of trans-psychosocial

distress which require acknowledgment and inclusion (Bowling, 2019; Riggle, Rostosky, McCants, & Pascale-Hague, 2011).

Therefore, there is still much to explore in regard to transphobia in the lives of trans parents and their children. The present study aims to explore this by asking the following research questions: How do trans parents experience and navigate transphobia in their daily lives? And how do they discuss and support their children's experiences of transphobia?

Method

Participants and Recruitment

A qualitative research design utilising an open-ended online survey responses and individual interviews collected data from 66 participants made up of 36 trans men and 30 trans women. Participants were aged between 24 to 67 years old (M =38.3, SD =*11.04*). Participants had between 1 and 5 children (M =2.36, SD= 1.00). Ages ranged between 18 months to 39 years old, with the majority of children being 6- to 16 years old. Participants were recruited through targeted social media and study information distributed by trans health organisations and online support groups. Participants were given information about the study and research consent, after which they could select to take the online survey. After the survey, participants could indicate whether they would like to also take part in an individual interview. Thirty-eight participants consented and their contact details were collected. Data presented in the results section of this paper is taken from the 38 interviews, demographic information is taken from the online survey. Data presented in this paper is part of a larger study, looking more broadly at trans parent's experiences around parenthood. Ethical approval for this study was evaluated and granted by The Western Sydney University Human Research Ethics Committee. Written consent was required to commence the online survey and verbal consent was given before individual interviews commenced.

Measures and Procedure

The online survey consisted of a series of closed- and open-ended questions covering demographics; information on children; relationship status; and support systems. Participants were also given open-ended sections where they could elaborate on responses, as well as any other issues and experiences that they thought were important to add. All interviewees were offered reimbursement for their time in the form of a $25 AUD supermarket gift card. Individual interviews took place over telephone at a day and time chosen by participants. Interviews were unstructured and delivered in an informal style, commencing with the question: “Think back to when you first had children, what was life like for you then?”. Responses from the online survey were used to guide individual interviews, eliciting prompts about growing up, friendships and relationships, subsequent children, experiences with their parents and siblings, mental health and well-being, employment, and experiences around gender expression and gender affirmation. All interview data was then transcribed, and integrity checked.

Analysis

Data for this study was analysed using thematic analysis (TA), a set of techniques which seeks to identify and describe meaningful patterns across data by searching for themes, the underlying meaning embedded in subjective understanding (Vaismoradi, Jones, Turunen, & Snelgrove, 2016), and how they relate to the research question . Transcribed data was uploaded into the NVivo software program and systematically evaluated to identify commonalities, differences, and patterns in participant accounts, resulting in the iterative development of initial codes. The research team reread data and re-examined codes to identify developing themes, which were questioned, discussed, and reviewed. In consultation with the research team, themes were finalised and named.

The results are presented in three main themes. The first is 'Trans Parents Experiences of Transphobia' under which three subthemes were identified: 1) '"It's not safe for me out here" – Transphobic abuse in the community'; 2)'"I don't understand…are you a woman or a man?" – Transphobic abuse and discrimination in medical settings' and 3) 'Complicating Care – Implications for Parents'. The second theme is 'Strategies to Stay Safe – Finding the "Comfort Zone"', under which two subthemes were identified: 1) 'Home – Safety and Isolation' and 'Social Support – Confidence and Connection'. The third theme is 'Discussing and Navigating Transphobia with Children' under which a single subtheme was identified, 1) 'Different ages, different stages – Balancing care and knowledge'. In the presentation of results, participant accounts are attributed a pseudonym and age bracket. Longer quotes also reference the number and age range of children.

Results

Trans Parents Experiences of Transphobia

The majority of participants in our study reported significant experiences of transphobic abuse in the community and when dealing with medical professionals.

"It's not safe for me out here" – Transphobic Abuse in the Broader Community.

For many participants, experiences of transphobic abuse, harassment and threats whilst out in the broader community were not uncommon. These included experiences of verbal abuse such as "people screaming out 'freak', or 'faggot'" (Lynette, 40's), or "people shouting 'it' or 'fucking freak' when I've been out" (Krissy, 40's). There were also reports of physical intimidation in public settings. Such as Sally's (30's) experience of a stranger "menacing me when I was trying to set up my nieces birthday party", even though she was with her family she states: "I had to hide in the public toilets until he went away". Noni

(30's, two primary school-aged children) also reported an aggressive experience whilst she was out with her children:

> To have people scream terrible things at you when you've got your kids with you. It's pretty awful...There was one time, a man shouted something and threw a half full drink at me from his car when I was putting (my daughter) in her car seat. He threw it really hard, and it just missed me and I just, kind of, ignored it for her sake but I was really shaky afterwards...I mean, what if it had hit (my daughter)? Or me, or it had been something worse? I avoided the shops for quite a while after that.

For participants such as these, being out of the home could be, at times, "anxiety inducing" (Roy, 20's), and having their children with them added an extra layer of vulnerability and caution as Nadia describes: (30's, two primary school-aged children): "It's just that thought sometimes of 'it's not safe for me out here'. That feeling of, like, hyper vigilance...When I have the kids there can be like an even extra edge or feeling of caution, especially in new places." Participant Lyndall (30's, two primary school aged children concurred saying: "I do take caution, or care rather, especially when I'm out with (my child). There's definitely been times that things have felt not particularly safe or at least a bit uncomfortable, you know?". This kind of social uncertainty was particularly common amongst parents with younger children:

> I definitely felt more exposed when I was out with (my first child) when she was little…obviously, there's that normal parental protective feeling but, for me, it was with an edge, I didn't want her to be subjected to anything…I just couldn't know what might happen, it was so difficult. (Noni, 30s, two primary school-aged children).

Multiple participants also noted avoiding public transport, saying things such as "I don't catch the train with kids anymore, we've been approached too many times it's really hard to

move out of a situation in that kind of space" (Sonia, 40's, one primary school-aged child, one teen and two adult children), as well as buses and taxis being mentioned as vulnerable spaces. Busy public spaces could also be a point of vulnerability, as Nadia (30's, two primary school-aged children) describes when first taking her youngest child to a new day care:

> We were walking down the escalator and this woman coming up the other way, she was staring right at me and then spat. Right at me. I couldn't believe it. It didn't hit me or anything but Jesus, I'm there holding my kids hand and she spat at me, at us….I have never in my life had to work so hard at holding it together…I hardly remember the whole process of dropping (my child) off but once it was done I practically ran to the car, locked the doors and just fucking wept. It makes me want to cry now just thinking about it…I didn't do the drop offs or the pick-ups for a long time after that, which obviously created a lot of logistical issues, but I just couldn't.

These accounts illustrate just some of the hostility transgender parents may be subjected to whilst engaging in broader community settings. In all the cases participants reported, they were simply attempting to undertake routine and commonplace tasks such as shopping, catching public transport, celebrating with family, or taking their children to school. Tasks that are essential to everyday family life.

> *"I don't understand…are you a woman or a man?" – Transphobic Abuse and Discrimination in Medical Settings*

Multiple participants relayed experiences of transphobic abuse, inappropriate comments or refusal of service from medical professionals and support staff in a number of fields. However, interactions with physicians were the most troubling. Jessie (30's, one toddler) described the following encounter with a new physician:

> I had one doctor who was extremely inappropriate and extremely rude…I went to have a special health check and needed to make sure that everything was ok. And he said – I told him I was a transsexual person so that the test would be relevant to my birth sex I guess. And he said "What, what do you mean, you take dick up the front?"…He was completely unprofessional and absolutely out of control. I said "Have you never had a transsexual patient before? Because that's extremely inappropriate". He said, "I don't understand what you're saying…are you a woman or a man?"…and so I left."

Jessie described this experience as "extremely humiliating". In addition to this experience, when trying to engage a different physician in the regional town to which his family had just moved, Jessie was told by this new physician that he was "deeply uncomfortable" filling Jessie's hormone prescriptions, as directed by his specialist endocrinologist, and refused to do so. The ramifications of this meant that Jessie had to forgo local medical care and liaise with a GP over 250km away, travelling every 6 weeks just to have his prescriptions filled. Another participant Melinda (40's, one teen) described her experience, when attending a new physician to have some blood tests done:

> (The doctor) sat there staring at my form going "Testosterone. Testosterone. Testosterone." And then looked at me and went "Testosterone. Testosterone"…Every time she said it I just cringed and winced and she just kept saying it over and over. Then she spent ten minutes tapping away on her computer without talking to me and then a new form came out of the computer and she stapled that to the back of the other one…and said "You can go and get your bloods done by the nurse outside"…And I looked at the form and she had changed my name back to my male name and had changed my gender back to the male gender and underlined

> ‘testosterone’…(Afterwards) I walked outside and got into the car, and started crying and ripped up the form and just drove home.

This encounter had a profound and long-lasting impact on Melinda, as she explains: “(it) really damaged my self-confidence” making her no longer feel “comfortable taking the kids to the doctor” or attending by herself, experiences which, subsequent accounts will show, are not uncommon.

Transphobic discrimination was also evident for those trying to access assisted reproductive care. This is exemplified in the account of Marco (30’s, two primary school-aged children), who wished to expand his family, with his wife carrying his egg, and using donor sperm, a procedure both legal and practiced widely in Australia. As Marco explains: “(The first clinic) defined it as a surrogacy arrangement and were clearly very uncomfortable…they said they needed to refer it to an ethics committee which was something we weren’t a party to”. The next IVF clinic stated they “weren’t prepared to treat us”. At a third clinic, the clinician explicitly stated that “if we were a lesbian couple, he would be doing exactly what we asked but he wasn’t comfortable because I was trans”. Marco went on to describe that he and his partner were rejected by three more IVF clinics due to specific staff “not being comfortable treating me”, as well as the assertion that his presence in the waiting room might concern other clients, with one clinic manager stating: “what will other people in the waiting room might think?”. When eventually Marco and his partner found the clinic that would eventually see them through treatment, he had to have an egg extraction rescheduled for a different date as the anaesthetist on duty that day “isn’t happy to treat you”. Although they were eventually successful in having a child, Marco stated later in his interview that he believed the strain of those experiences contributed to the end of his relationship.

Complicating Care – Implications for Parents

Transphobic barriers to healthcare can have a significant impact on, not only the individual, but the whole family. As touched on previously, children's medical appointments are made complicated when the parent has experienced mistreatment. As Tilda (20's, two primary school-aged children) describes: "it's a bit full on when you gotta then take (the kids) somewhere where you, personally, haven't had a great experience." Melinda (40's) also reported feeling "anxious" and "uncomfortable" having to take her children to the same local medical centre where she had been repeatedly and intentionally misgendered. Tommy describes it thusly:

> "there's got to be a level of trust when you take your kids to the doctor, that they'll do everything in their best interests (of the child), you know? But when you've been and seen that (negative) side of them it becomes a really different thing. It's a strange position to be in."

Participants who were able to access doctors and other healthcare practitioners experienced in working with transgender clients, providers who "educated themselves" (Tilda, 20's) or were "just accepting and non-judgemental" (Zak, 20's) reported having positive experiences. Stellan (20's, three primary school-aged children) reported being "lucky enough" to access a trans-specific medical practice, saying:

> they were awesome and put a whole team together, basically; psych, endo, my (practitioner), the whole thing…there was obviously still a process to it, but they really made me like everything was going to be ok…it's not always easy but when you have that around you, to support? Really awesome."

Non-specialised GPs could also offer affirming care as Krissy (40's, five teens) describes: "(My GP) hadn't actually treated a trans patient before, but you wouldn't have known

it…She was just ultra-professional…she just got it and she never made me feel anything but taken seriously, but not too seriously (laughs), nah she was great". Participants who had positive and affirming interactions with their healthcare providers reportedly felt more confident accessing care for their families, as Tina (20's) states: "Once I started seeing (my current doctor) it just made things a lot easier…I felt comfortable going there, they looked after me…when (my partner) got pregnant, you know, there's so many appointments…they made us feel pretty well looked after, no dramas (laughs) so I went to most of (the appointments) with her".

Strategies to Stay Safe and Negotiate Transphobia - Finding the "Comfort Zone"

Home – Safety and Isolation

To navigate experiences of transphobia in everyday life, participants reported employing various strategies. For some, 'staying close to home' was important, as Bailey (20's, one pre-school aged child) describes:

> It was really daunting to be out in public where there were other people around...It put me off leaving the house for a while...so I didn't like even going to the shops...I just sorta stayed home, for a year (laughs).

Another participant Sam (30's) also described "playing it very safe at first", with home being the "comfort zone" particularly when his children were still young. Some expressed finding enjoyment in this, as Suzette (40's, two primary school-aged children and one teen) expresses:

> I found that period really special, actually. Yes, it was a bit isolating but having that time, just be with the kids and, you know, garden and take care of the house so that (my partner) could relax…I guess I became a housewife (laughs)

Some participants also expressed concerns about how their children may be impacted by 'staying close to home':

> I'm sure (the kids) were ultimately fine but there were so many things I would've loved to do with them that I just didn't feel safe at the time...the park, the beach, the pool...it just felt so unfair and also I had so much guilt because I was the one choosing to avoid things but also had no choice, you know?" (Stellan, 20's, three primary school-aged children).

Others concurred, also expressing concern for the impact on their partner:

> not being ok to take your kid to the park or nip up the shops...I absolutely felt like a failure...then there's the tension with your partner, (she) understood but on some level, there was still a lot of guilt and she had to take on a lot more for a while. It made me feel pretty bad (Mickie, 30's, one primary school-aged child).

Similar experiences of "feeling like a shit partner...not being able to contribute in that way" (Justin, 30's) were reported. However, most participants acknowledged that their partners were supportive and understanding. As Tina (20's) states: "(your partner) obviously sees better than anyone the reality of that kind of harassment…They don't want you to have to be subjected to that either…they want you safe and happy."

In contrast, a different perspective was taken by some, pushing themselves to "get out there" (Noni, 30's, two primary school-aged children) in the broader community in spite of past experiences. Noni (30'), who described harassment in an earlier account, explains:

> I just thought 'stuff it', you know? I wasn't about to let those assholes win (laughs). I just really pushed myself to get out there. I also didn't want the kids to get, you know, a complex. I didn't want them to feel like I was ashamed of who I am…I went out of my way and joined as many local groups, the canteen, you know, and all the things as

> I could. It's easy for people to talk about 'that weird trans girl' but it's another thing when you're right in front of them and they get to know you.

A number of other participants made similar assertions, such as "there's a real importance in just putting yourself out there and making life as normal as possible, for (the whole family)" (Tina, 20's) and "working really hard to not let fear get in the way of the basic things I needed to do" (Ty, 40's). For these participants, the desire for normalcy compelled them to override social anxieties. Noni (30's) stated, "life must go on regardless", and calculated risk was taken, balancing legitimate concerns for safety with the responsibilities of being a parent.

Social Support – Confidence and Connection

Some participants created or drew upon networks of friends with whom they felt safe in order to venture out of the home. Damon (20's, an infant and a primary school-aged child) describes her experiences after joining a trans-friendly parent's group:

> I was super lucky, I had made some really great friends (in the group), and we had, like, regular park and shopping dates...they were awesome and really understood where I was coming from...it was a definite lifesaver and really kept me connected and helped me build up a lot of confidence going out.

Similar strategies were reported other participants, such as Regina (60's) "for a good while I only went anywhere with people that made me feel safe and, as Clay, (20's, one toddler) describes:

> I had a core group...so we'd go shopping, out for a coffee and so on, all together, I felt a lot more confident that way, plus some of them had kids the same age too so it was nice ...Although there were still some situations I totally avoided like pubs or other mixed situations where alcohol was involved, it just felt too risky.

In relation to interacting with healthcare practitioners, isolating and forgoing medical care for children was not an option, so many participants relied on their social networks as a "buffer" (Tommy, 20's), to access those spaces, utilising as Marilena (40's) jokingly referred to it a "chaperone", a friend or family member to accompany them to appointments or attend in their place, depending on the circumstances:

> My wife just ended up doing most of the appointments (with the children), she didn't mind rather, but it was still more pressure on her…and, you know, there were things I would've liked to go to but it was uncomfortable" (Connie, 40's, two teens).

Clarence (40's) had his mother-in-law take his young child to specialist appointments for a congenital condition that needed regular treatment, he says:

> (My mother-in-law) was an absolute godsend, she took (him) to every appointment and was just brilliant, really proactive with the doctor…(the reception staff) treated me so atrociously (at the beginning) I couldn't go back, but (my mother-in-law) really stepped up for us…Funnily, it actually made us a lot closer (as a family) so something very special came out of a pretty crappy situation.

For many years Marilena (40's) reported taking her close friend to medical appointments for both herself and her children: "I just found people were better behaved when I wasn't alone (laughs)…so I had my chaperone…we turned it into something fun when we could." However, she continues, "there's absolutely an element of the ridiculous to (having to take someone with you), I shouldn't need to do that, or be put in that position. No one should". Participants who were able to access formal or informal LGBTQI+ family support groups, were unanimous that they were highly beneficial for themselves and their children, as Damon (20's, an infant and a primary school-aged child) reports:

> (My partner) and I decided real early to make an effort to find other families like us, so we reached out to the 'Rainbow Families' organisation…we went to lots of, like, organised picnics and meet up type things… holiday camps…we felt it really helped (our oldest child) to feel 'normal'…she saw lots of families that were like us…I feel like it helped her build, like, strength and a, maybe, pride in our family.

'Normalising' family was a benefit many participants associated with these family support groups, as well as valuable connections for children: "We just built such a lovely little community around us at group and I saw how much the kids flourished when they were together…really great connections and really great for the kids to support each other" (Jonnie, 20's, two primary school-aged children).

These strong social networks were vital for many participants in reclaiming their ability to engage in the broader community with confidence and, in some cases, heal from genuinely traumatic experiences. However, not everyone had the opportunity to access or foster these types of support systems. Some participants were estranged from family, or had relatives that lived long distances away, others had moved to regional areas where the prevailing culture was perceived as "still very much stuck in the past" with regards to trans people (Raina, 40's). For this group, early parenthood was experienced as "very isolating" (Bill, 30's) with support coming solely from partners.

Discussing and Navigating Transphobia with Children

Participants in our study were almost unanimous in discussing the challenges associated with helping and supporting their children understand transphobia and the discrimination it elicits. As Marco (30's, two primary school-aged children) describes:

> It is a very, very difficult conversation to have with your kids...that some people won't like you, or that some people might even want to hurt you...And then how it

> could affect them, especially at school, it's really difficult…You want them to understand but not be frightened…there's a lot of nuance to it, and it can be a little complicated.

Some participants began the conversation after their children witnessed or experienced transphobic abuse that was directed towards them. Suzette (40's, two primary school-aged children and one teen) describes being abused in public with her oldest child:

> (We came home) I was really rattled and just trying to keep it together…he just asked me "What did that man want? Why was he so angry?" And I didn't really know what to say at first…I sat him down and I just laid it out for him, I told him (about transphobia), I guess, properly…I tried to explain that some people didn't 'believe' in people like me, that it upset them because they couldn't understand it, and that it made them angry sometimes… He actually understood it a lot better than I expected.

After that initial discussion Suzette and her children had ongoing conversations about transphobia and "made a big effort to make space for their feelings and questions…it's an ongoing process now". Helping children understand that the balance between safety and disclosure was important for many participants, as Ty (40's, one primary school-aged child) describes:

> I always framed them (the conversations) in terms of saying that there are some people who didn't like trans people or who could get angry or upset or that they didn't understand those issues and that – we talked about his safety, I think, him being mindful about with whom he chooses to share that information, and at what points he shares that information, and that sometimes he might make mistakes. I was very conscious about not wanting to create secrets.

This issue of centring their children in discussions, and raising issues about child safety was reported by other participants, such as Damon (20's, one baby and a primary school-aged child):

> (My partner and I) just really tried to convey to (our child) that whilst there was nothing to be ashamed of, that people might react to certain information in unexpected ways and that that was never her fault…we still wanted her to feel like she had the right to discuss things how she liked with people but with an understanding that there might be consequences to that.

The issue of "consequences" to disclosing parental trans status was reiterated by multiple participants and was described variously as their children experiencing "bullying" (Sally, 30's), "being left out by their friends" (Melinda, 40's), as well as the fear that "they might get abused or worse" (Stellan, 20's). Tina (20's, one toddler and a pregnant partner) describes her fear of, "my trans-ness being weaponised to hurt (my child)", a concern echoed by a number of participants and reported, as "anxiety inducing" (Krissy, 40's). One participant furthered this by expressing "a huge anxiety that (my child) might end up holding it against me, because of the way other people have talked and behaved" (Del, 40's, one primary school-aged child and one teen). Protecting one's children is a fundamental aspect of parenthood however, protecting children from secondary stigma related to parental trans status makes for a complex situation which parents often cannot address alone.

Over time, peer support was viewed by many participants increasingly vital for their children's adjustment and well-being, as Krissy (40's, five teens) describes it: "supportive friendships make a huge, huge difference, especially in high school". Krissy furthered:

> so much of how they respond to things can become really effected by their friendships rather than just what you say or do…my oldest had a great group of friends and, the

> way he handled everything (around my transition), through high school, they were so lovely…my daughter, on the other hand…I felt like some of her issues and resentments (towards me) were from feeling a bit shaky with her friends, which made our relationship more tricky as I transitioned.

Many participants with older children concurred that, during certain phases, the quality of the parent-child became increasingly influenced by the quality of their friendships. "when things were good with her friends at school, things were good between us…(when I was transitioning) those solid friends, that she could rely on, made a big difference " (Melinda, 40's).

Different Ages, Different Stages – Balancing Care and Knowledge

Participants were almost unanimous that the age of children had a significant impact on how their children understood transphobia and how parents approached associated conversations with them, as Sonia (40's, one primary school-aged child, one teen and two adult children) describes:

> There are very different approaches as they grow up…when they are really little you don't want to overload them so it's really more them slowly understanding your personal story…as they get older it develops more into how (my) story fits into the world, how it fits with other people…it's very different because it's not just about the family anymore and, at a point, it's not even completely about your relationship anymore and that can be weird.

Other participants reported a similar experience, of watching their child develop "an awareness of how trans people are viewed and treated by society and, over time, how that might possibly also affect them." However, "overloading them with information" too young (Tilda, 20's) was an issue, but in contrast "there can be a risk of not telling them enough…it's

really tricky to get it right" (Roger, 30's). Melinda (40's) stated: "Keeping up with the different ages and different stages can be a bit of a rollercoaster (laughs)…sometimes they know more than you think and sometimes I assume she knows things and am really surprised she doesn't because we haven't talked about it…so there's a lot of subtle checking in".

Many participants noted that experiences at school played a vital role in many of their children's developing personal understanding of transphobia, as Sally (30's, two primary school-aged children and one teen) describes:

> (Before children start school) You're in this little bubble, family, friends, it's all they kind of know. They have an understanding of things and, I always felt, (my kids) were solid in that, but once they enter that school environment then they are really at the mercy of so many other things, influences…Me and (my partner) worked really hard to prepare them for that and really try build up a resiliency and a solid friendship group from the outset.

The majority of participants reported, as Noni (30's) states, "The school itself was nothing but supportive" however it was children's experiences with peers and their families that were reportedly the most challenging. As Marco (30's, two primary school-aged children) describes:

> Once they're in there (school) you have no real control anymore around their social lives and what people might say or do…you really just have to be super supportive because, regardless of what has come before, this is a journey that they essentially have to go through alone.

For many parents, supporting their children through new and challenging social environments was an opportunity for increased connection and care. Roger (30's) describes his sons experience and how they approached it:

> "(My partner and I) just felt like the bullying just came out of nowhere when (our child) hit high school…He was teased pretty badly (and) really withdrew and it was honestly horrible…we did all the 'things', we went to the school, spoke to teachers, etcetera…What ended up working for us was really nurturing his existing friendships and his interests outside of school… a counsellor and they got him hooked up with an online group for kids with trans and queer parents…we noticed a real difference (after taking those steps)."

However, whilst transphobic related-bullying and associated social stresses occurred, there was a lot of pride in parental accounts of their children, as Roger (30's) states: "what genuinely wonderful humans (my children) are, emotionally intelligent and real advocates for social justice, I couldn't be more proud". Sonia (40's, one primary school-aged child, one teen and two adult children) describes her experience:

> I feel like in a lot of ways, (my transition) brought us closer together…there had to be a lot of honesty and care, going both ways, a lot of support…many times there were difficult conversations where I really just had to shut up and listen….but we all really took care of each other, even when those tough times came, we really pulled together and I am incredibly honoured to be their dad.

Due to the society in which we live, transphobia will almost certainly affect the children of trans parents at various points throughout their lives. Given that there are virtually no resources or exemplars to follow, trans parents must intuit their response to these situations.

Discussion

This study examined how trans parents' experience and navigate transphobia, as well as how they discuss and navigate transphobia with their children. Our findings illustrate that transphobic harassment, discrimination and abuse is pervasive, and has a profound impact on

this population and navigating these experiences requires much determination for parents, and an ongoing, supportive dialogue with children.

Confirming previous findings (Riggs, 2014; Valentine & Shipherd, 2018), many of our participants reported considerable abuse when out in the broader community. Trans parents were routinely made to feel unsafe and vulnerable, denying them the confidence to perform routine daily tasks and limiting their access to social resources (Lombardi, 2009). Whilst all transphobic behaviour is unacceptable, some of these encounters displayed significant aggression, and, adding an extra layer of vulnerability, occurred whilst parents were with their children. This can be deeply traumatic for both parent and child (Valentine & Shipherd, 2018), compounding stress (Valentine & Shipherd, 2018) and augmenting parental guilt and shame (Pyne et al., 2015). The strain of constant vigilance places an undue burden on this population, and it is a harsh indictment on the broader community that some trans parents must forgo basic needs or simple activities with their children, such as swimming or catching public transport, out of fear of harassment and to protect their physical and mental health.

Our findings confirmed that some trans people report experiencing discrimination from medical professionals, and barriers in accessing medical and reproductive care (Charter et al., 2021; Riggs et al., 2014), which, in turn, impacts their ability to confidently engage for their families. In a number of accounts, participants were subjected to highly inappropriate transphobic behaviour from the professionals entrusted with their care. Withholding or refusing necessary medical treatment is a form of institutional abuse which can drastically impact the physical and mental health of the individual and their family (Ho & Mussap, 2017; Riggs et al., 2014). Whether it is intentional or unintentional, the medical system is failing, and significant change is required to improve this. Addressing the dearth of trans-competent

education amongst medical practitioners is not enough, a more fundamental shift addressing transphobia in health is what is required. Marginalisation is interconnected, and each circumstance: whether it be social isolation, violence, or health discrimination, reinforces and energises the other (Divan et al., 2016). Transphobic discrimination is a product of an environment in which "covert if not overt permission is given to "punish" people for gender transgressions" (Lombardi, Wilchins, Priesing, & Malouf, 2002, p. 91) impacting not only the individual but those closest to them as well. As long as transphobia goes unchallenged, then discrimination and marginalisation will continue to proliferate. A broader societal shift is required to change this, one that starts from the ground up, necessitating significant changes in the way we educate our young people on gender identity and equality (Pyne et al., 2015; Robinson, 2013).

Given the prevalence of transphobia in the community, research around how parents discuss and navigate it with their children it is still relatively limited (Pyne, 2012; Riggs, 2014). However, our findings established that trans parents demonstrate great care when approaching these issues with their children. Discussions need to be balanced in a way that helped children understand, whilst assuaging fear and anxiety. This was identified as particularly important if the child themselves had witnessed a transphobic incident or abuse directed towards their parent. As a child, the notion that people may want to harm your parent must be distressing, but to witness harassment or abuse directed towards them may be experienced as considerably traumatic (LeBlanc et al., 2015; Richters & Martinez, 1993). Whilst substantial research has found that supportive parent/child relationships, as well as open and ongoing communication go a long way to buffer these negative experiences, (Dierckx, 2017; Petronio, Jones, & Morr, 2003; Pyne, 2012) professional support may also be

beneficial. However, considering the complicated reality of trans issues in some healthcare settings, work still needs to be done to build trust (Charter et al., 2021).

Transphobic bullying of children was evident in some participant accounts. Whilst bullying can occur for any child, transphobia adds an extra layer of vulnerability (Hatchel et al., 2018). As has been established (Cowie, 2011; Veldorale-Griffin & Darling, 2016), peer support was reportedly invaluable for children during this time, particularly the normalising influence of peers within the LGBTQI+ family community (Russell, McGuire, Lee, Larriva, & Laub, 2008), but also supportive friendships more broadly. Coupled with parental support, these networks serve as significant protective factors and in the development of resilience for children (Dierckx, 2017; Roe, 2015). As bullying occurs predominantly in school (Hatchel et al., 2018; Hughto et al., 2015) this suggests a need to address the educational environment in which children, are positioned (Thompson, 2019). Programs such as Safe Schools Australia, an anti-bullying initiative that aimed to teach students about sexuality and gender, had shown to be significantly beneficial in educating this population (Cross et al., 2011; McKinnon et al., 2017; Safe Schools Coalition, 2013). Robinson (2012) asserts that education and open discussion around gender and sexuality are vital for children's ongoing health and well-being, into adulthood. Additionally, comprehensive education may go a long way to destigmatising gender diversity and reducing transphobic bullying (Robinson, 2013; Robinson, 2014).

The main limitation of our study was that children's experiences were assessed through parental accounts, rather than accounts with children themselves. Future research would benefit from interviewing the children of trans parents directly about their needs and experiences of transphobia. Additionally, the data for this study was taken from a larger research project focusing on parenting more broadly, as such, transphobia was not the key

focus. Given its significant impact on the lives of trans parents and their children it deserves further, more in-depth exploration.

It is often assumed that a trans parents gender identity impacts their children's health and well-being whilst overlooking the real, material and potentially severe consequences that transphobia has on families (James, 2020). Trans people should not have to fight for their existence, and their children should not have to bear the brunt of this marginalisation. However, in spite of this, our findings show that these families continue to thrive, finding ways to support and educate one another whilst fostering strength and mutual care.

Chapter Seven

Discussion and Conclusion. Understanding Experiences around Parenthood for Trans Parents

I began this thesis by exploring the meaning of trans parenthood and the ways in which our society is shaped by heterocisnormativity. In my review of existing literature on trans parents and their families I noted how heterocisnormativity has shaped our societal understanding of parenthood and how family is 'done'. The literature I reviewed showed the ways in which trans people are excluded from parenthood narratives and how transphobic discrimination directly impacts not only their health and well-being but that of their families. The review of the literature identified the need for further research into trans parents' lived experiences and how they can be supported, leading me to use a social constructionist epistemology and queer theory to examine empowerment and vulnerability in accounts of trans parenthood. The review also identified intersectionality as a theory which would allow for a consideration of how intersecting identities shape trans parents' experiences of parenthood. This led me to pose two research questions: "What are trans parents' subjective experiences of parenthood?"; and "What implications does heterocisnormativity have on their experiences of parenthood?". To answer these questions, I conducted a two-stage qualitative research study with Australian trans parents aged 24 to 67 years. I analysed 66 surveys and 38 one-on-one interviews, using thematic analysis, intersectionality and queer theory, and my findings were reported in four peer-reviewed journal articles. In this chapter I discuss my findings in relation to the two research questions, examine the strengths and limitations of the research, make suggestions for future research and implications for future practice, return to the issue of reflexivity, and conclude the thesis.

What are Trans Parents' Subjective Experiences of Parenthood?

The overall findings from this thesis demonstrate that parenthood is a source of great joy for trans parents. Whilst the 'trans' aspect of their identity is often what society focuses on, trans parents are primarily concerned with the particulars of parenthood. They are parents first; parenthood is parenthood irrespective of gender identity. For the most part, the parents in this study have been subjected to myriad obstacles to becoming the people, and the parents, that they are. Yet they persevere and demonstrate strong connections and love for their children that transcends these normatively imposed barriers. There are many experiences that trans parents share with other parents: negotiating the desire to have children with the realities of how and when; navigating the changes that parenthood can bring; wanting their children to grow up safe, healthy and happy; managing relationships with co-parents, and the requisite parental hopes and fears. However, the findings presented in this thesis illustrate that trans parents are subjected to many unique challenges which have a profound material impact on their experiences of parenthood. However, in spite of this, the parents in this study exhibited great courage and perseverance.

Although 'parenthood' is traditionally a culturally normalising role, the 'trans' aspect of identity often overshadows how trans parents are perceived, and as a result they can experience disadvantage (Haines et al., 2014). The lack of cultural scripts for trans parenthood can make it challenging for trans parents, and their families, to reconcile heterocisnormative cultural norms around parenthood with trans identities, leading to a need to create alternative discourses around parenthood (Goddard & Wierzbicka, 2004; von Doussa et al., 2017). Trans parents are also excluded from both normative parenting resources and support, leaving them and their families even more isolated (Ryan & Martin, 2000).

Gender Affirmation as a Vital Aspect of Parental Wellbeing

The findings in this thesis illustrate just how vital gender affirmation is to the mental health and well-being of many trans parents, and how it influences their experiences of parenthood. Again, it is important to acknowledge when discussing gender affirmation that it means different things to different people and there is no specific way for it to be expressed (Fein et al., 2017). However, throughout this thesis I demonstrated how central affirmation of gender is to trans parents, to their wellbeing and, by extension, their ability to parent and their relationships with their children. This study illustrates just how integral communication about gender affirmation is between trans parents, co-parents and their children. When children are able to understand trans identity, and why 'coming out' and pursuing gender affirmation may be important to their parent, then that child is able to approach these experiences with a deeper knowledge and understanding (Veldorale-Griffin, 2014). Additionally, my findings illuminate the value of trans parents being informed and empowered to approach gender-based concepts with their children and co-parents or partners, as early as is feasible. Children can be significantly impacted by a parent 'coming out' and pursuing gender affirmation, with their age at the time being a highly influential factor (Hafford Letchfield et al., 2019), as I found in my research.

Understanding how gender affirmation is experienced within the family has enormous value. If trans parents, and their co-parents or partners, are informed and can put appropriate, pre-emptive, support frameworks in place, these potential changes to the family dynamic may be better managed. A common fallacy is that, as a parent, pursuing gender affirmation is somehow a selfish or damaging act rather than a process that can not only be lifesaving but also life giving and life affirming (Pyne, 2012). It is not an act that is embarked upon casually. Gender affirmation brings the 'self' into alignment, and as such can benefit

everyone, including children (Glynn, 2016). In Australia, it is becoming increasingly common for trans people to 'come out' and pursue gender affirmation "with the goal of retaining their careers, families, and network of friends" (Hines, 2006, p. 362) meaning that gender affirmation is increasingly being negotiated alongside existing commitments (Hafford Letchfield et al., 2019). As demonstrated by the accounts in my study, co-parents, partners and children are also increasingly adjusting to these changes, or 'transitioning with' their parent (Hafford Letchfield et al., 2019; Haines et al., 2014). Previously, there was an expectation that trans people must relinquish the possibility of parenthood in order to pursue gender affirmation. This research illustrates that trans identities and parenthood are not mutually exclusive, indeed they are, and can be, mutually beneficial (von Doussa, 2020).

Parental Mental Health – Vulnerability and Strength

The findings of my study illustrate just how profound mental health concerns can be for trans parents; directly and significantly impacting both subjective wellbeing and experiences and self-evaluations of parenthood. Many parents experienced, at one time or another, intense gender dysphoria, depression, anxiety, and suicidal ideation. Additionally, accounts of transphobic stigma, discrimination and abuse were pervasive, including harassment when with their children, which was experienced as especially distressing. Trans-based discrimination directly impacts mental health (dickey & Budge, 2020; Levitt & Ippolito, 2014a; Valentine & Shipherd, 2018; Wilson, 2015), and has been found to be particularly traumatic when a person's immediate safety feels threatened (Drabish & Theeke, 2021). These experiences, and the anticipation of future victimisation, can be internalised, magnifying senses of stigma and shame (Hendricks & Testa, 2012; Scandurra et al., 2018). Parents' own experiences of transphobia engendered major concerns about the potential for transferring trauma or stigma to their children, as reported in previous research (Haines et al.,

2014; Pyne et al., 2015). My findings suggest that parents must reflexively negotiate external factors that are very much outside of their control, such as harassment and discrimination, within the context of their relationships with their children, balancing protection and honesty (Hines, 2006). There is both a wish to shield children whilst also keeping them informed and educated.

These findings illustrate that trans parents can exhibit both vulnerability *and* strength in regard to their mental health. By constructing themselves as both vulnerable *and* strong, the participants in this study took on a both/and position in relation to their experiences, an approached described as 'tight-rope talk' (McKenzie-Mohr & Lafrance, 2011). Tight-rope talk enables trans parents to reject the forced dichotomy of either/or, vulnerable *or* strong, in order to articulate a more complex account of their experiences, acknowledging both struggle and resilience. In this context, adopting more than one perspective reflects the complexity of subjective accounts, neither refuting or simplifying aspects of one's experience (Ussher et al., 2016). McKenzie-Mohr and Lafrance (2011) describe this adoption of a "both/and" position as enabling the construction of emancipatory counter-positions, which serve to challenge the oversimplification of "either/or" binaries, where people are "agent or patient", "powerful or powerless"; or in the case of trans parents, vulnerable or strong (p.66). In spite of personal and societally imposed challenges, and a significant dearth of trustworthy formal mental health, trans parents continue to persevere and thrive. Whilst acknowledging the challenges around experiences of mental health concerns, most participants also spoke of the affirming and life-changing joy around parenthood. The wellbeing of children was the major theme in parents' narratives throughout parental accounts, with particular implications in regard to improving parents' own health and wellbeing. The most salient wish of the parents in this

thesis was to live authentically whilst raising their children in safe and inclusive communities.

Although prior research has helped elucidate processes that negatively impact mental health in trans people, far less has focused on understanding what is protective and beneficial (Puckett et al., 2019). Taking the volume of deficit-based literature that exists into consideration, there is a clear need for further exploration into what factors may contribute to fulfilment and resilience. Affirmative or strengths-based perspectives provide a credible lens through which to investigate parental mental health, adopting the belief that there are many strengths and resources that a person, or community, possesses, which need to be fostered to benefit both the individual and society as a whole (Ross, Law, & Bell, 2016).

Affirmative and strengths-based perspectives acknowledge that, while trans parents may seek services when experiencing distress, they also have a wealth of ideas, skills, and resources that they can draw upon in their time of need (Munford & Sanders, 2005; Prendergast & MacPhee, 2018; Saleebey, 2009). Trans parents may have been victimised because of who they are, yet they are not victims (Baines, 2007). They are capable change-agents who have myriad experiences from which they can draw for coping and resilience (Ross et al., 2016; Ruff, Smoyer, & Breny, 2019; Veldorale-Griffin & Darling, 2016). Likewise, affirmative and strengths-based perspectives require that HCPs support, or act as allies, to trans people and communities. Trans affirmative practices and approaches celebrate diversity, promote cultural competency, and provide safe and non-judgemental spaces for their trans clients (Henderson et al., 2018). HCPs who use affirmative practice approaches recognise that, while some trans people have experienced challenges as a result of living in a heterocisnormative society, overall trans people are resilient and able to overcome these challenges (Byers, Vider, & Smith, 2019; Gates & Kelly, 2017). Trans identities are not

'deviations'; affirmative and strengths-based healthcare practice must support trans people while actively speaking out when others in their field, and more broadly, treat them with any less than the dignity they deserve (Gates & Kelly, 2017; Oswald et al., 2005).

What Implications does Heterocisnormativity Have on Trans Parents Experiences of Parenthood?

> Leaving (trans parents) out does the work of reinforcing anti-trans bigotry, whether that's the intention or not. It mirrors the illusion that trans people do not have kids—that we're somehow deviants rather than loving parents trying our best for our kids. (Clover, 2020)

The findings of my research highlight the rigidity of heterocisnormative discourses around parenthood and demonstrate just how pervasive and damaging these assumptions can be. As heterocisnormativity is committed to upholding hierarchical and binary systems of gender, dictating the acceptable ways in which family is 'done', there is little room for deviation from this normalised ideal (Gamson, 2000). As stated in Chapter One, challenges to heterocisnormative ideas of parenthood are positioned as not only 'dangerous to the child' but also a potential harbinger of the destabilisation and degradation of society itself (Riggs, 2006; Robinson, 2008). I assert that many of the challenges trans parents experience are due to this heterocisnormative privileging, leaving trans parents excluded, erased, and vulnerable to discrimination and transphobia.

Is Healthcare Failing Trans Parents and their Families?

The fundamental underpinning of my argument is a critique of the treatment trans parents receive when trying to access healthcare. Historically, the medical model has occupied a socially dominant position which has been responsible for much of the way trans people are viewed and treated within contemporary western society (ref). Whilst

contemporary medical approaches have moved to incorporate a more multifaceted and inclusive understanding of trans lives, I argue that serious issues remain in the positioning of trans lives within the healthcare paradigm.

The findings in this thesis confirm much of the previous research: trans people are being subjected to significant and pervasive discrimination from healthcare professionals and systems, as well as encountering barriers to accessing appropriate medical, mental health and reproductive care (Dolan, Strauss, Winter, & Lin, 2020; Johnson et al., 2020; Riggs et al., 2014). For trans parents, this impacts not only the ability to maintain or improve their own health, and to exercise their reproductive rights around pregnancy and assisted fertility but also, to confidently engage healthcare for their families. The trans parents who took part in this study relayed myriad experiences of being subjected to inappropriate transphobic behaviour from the professionals entrusted with their care; from being overtly or covertly denied care, to verbal abuse and harassment. To emphasise what has been demonstrated throughout this thesis, withholding or refusing healthcare is a form of institutional abuse (Ho & Mussap, 2017; Riggs et al., 2014). I would assert that the healthcare system is failing trans parents and their families, and significant change is required to improve this.

Findings from this study suggest one of the underlying causes for this failure is a fundamental lack of provider competency and education related to trans health care (Benson, 2013; McCann & Sharek, 2016; Riggs et al., 2015). Whilst the knowledge and skills to support trans people should be embedded within healthcare education, practice and policy, this is still not necessarily the case (Hafford-Letchfield et al., 2019; Riggs et al., 2014). As explored in Chapter One, many HCPs and institutions acknowledge that trans-specific education is sorely lacking in their curricula (Chatterjee et al., 2018; Hollenbach et al., 2014; Obedin-Maliver et al., 2011; White et al., 2015). Logic would dictate that increasing

education is the solution. However, I concur with research conducted by Stroumsa et al. (2019), simply increasing training hours is not enough to improve quality of care. A fundamental shift addressing transphobia and biases is what is truly required. HCPs, and institutions more broadly, must not only be educated on the clinical aspect of trans health, but also be educated around recognising and deconstructing their own heterocisnormative assumptions (Clabby, 2017; Poteat, Logie, & van der Merwe, 2021). Transphobia in healthcare is not merely an extension of societal transphobia (Stroumsa et al., 2019), rather, the psychiatric construction of trans identities as a "distinct, pathological and medicalised entity" has helped create the hegemonic power of heterocisnormativity (Stryker, 2008a, p. 38). Scientific authority has been used to both "empower and imprison populations over time", long contesting the "existential validity" of trans people (Pachankis, 2018, p. 1207). Therefore, addressing the foundation of transphobia as it relates to the healthcare domain requires rethinking the role medicine plays in the construction of gender and gender diversity (Fausto-Sterling, 2012; Stroumsa et al., 2019). It is possible by addressing the pathologisation and medicalisation of trans identities it also address broader societal transphobia (Stroumsa et al., 2019).

"Sometimes just existing feels like a radical act" – Transphobia and the Family

It is often assumed that a trans parent's gender identity impacts their children's health and well-being whilst overlooking the real, material and potentially severe consequences that transphobia enacts (James, 2020). Findings from this thesis help to illuminate an under explored area: how transphobic harassment, discrimination and abuse is experienced by trans parents, and, in turn, how it can be experienced within the family context. As I demonstrated in Chapter Five, transphobia is a product of an environment in which "covert if not overt permission is given to "punish" people for gender transgressions" (Lombardi et al., 2002, p.

91). It does not begin and end at the individual being victimised, but ripples through the people closest to them, and into the community. Marginalisation is interconnected, and each circumstance: whether it be street harassment, exclusion from parenting resources, or healthcare discrimination, reinforces and energises the other (Divan et al., 2016).

Many of the parents in this study were routinely made to feel unsafe, vulnerable, or unwelcome, when accessing public spaces; robbing them of the confidence to fulfil routine daily tasks, and limiting their access to social resources (Domínguez-Martínez & Robles, 2019; Lombardi, 2009). These findings which have been mirrored in other Australian based research on experiences of trans women of colour (Ussher et al., 2020). For some, this denial of safety was also extended to their basic healthcare needs. The strain of constant vigilance places an undue burden on this population, and it is a harsh indictment on the broader community that some trans parents must forgo basic needs or activities with their children, such as shopping or catching public transport, out of fear of harassment and to protect their physical and mental health, and that of their children. Additionally, it is yet another indicator that the healthcare system is failing trans people when they feel they must take a 'chaperone' to medical appointments to receive equitable care. As Pyne states (2012): 'creating safety' from transphobia is not the responsibility of trans parents, "but of the institutions charged with providing equal opportunities for all" (p.28). People cannot truly thrive when they must maintain a constant state of vigilance. As has been noted throughout this thesis, these experiences have a significantly deleterious effect on the mental health and wellbeing of trans people, and on their ability to parent (Bower-Brown & Zadeh, 2021; Bradford et al., 2013; Chess et al., 2019; Chodzen et al., 2019). However, in spite of this, the accounts that make up this thesis are not the voices of passive victims, rather they are parents who are resisting heterocisnormativity and exercising agency in the face of discrimination. As 'Clarence', a

gestational father in his 40's commented, as a trans person "sometimes just existing feels like a radical act". As we explored previously, queer theory involves disrupting what is known and taken for granted about families (Few-Demo et al., 2016). Queer theory offers us abundant opportunities to unpack, explore, and expand what is taken for granted about 'doing family', facilitating the "transgressive power of resisting" and the 'radical act', not just of trans existence, as noted by Clarence, but of trans parents' resilience and perseverance (Downing, 2013, p. 106).

Methodological Strengths and Limitations of the Thesis

The methodology utilised in this thesis has a number of strengths which merit acknowledgment and could have implications for future research. Firstly, the findings of this study benefited from the use of a qualitative approach. Qualitative methods allow for rich descriptions of complex human phenomena, by exploring underlying values, beliefs, and assumptions (Choy, 2014; Sofaer, 1999). This study utilised an open-ended method of enquiry that allowed trans parents to raise the issues that mattered most to them (Yauch & Steudel, 2003), an approach that can be particularly beneficial when researching with marginalised communities, as it provides the space for people to express themselves in a way that is authentic to them, and in their own words (Hesse, Glenna, Hinrichs, Chiles, & Sachs, 2019). Additionally, the findings of this study have been strengthened by a relatively large sample size for a qualitative project (van Rijnsoever, 2017).

Two types of triangulation were utilised to increase methodological vigour. Triangulation in qualitative research refers to the use of multiple methods or data sources to develop a comprehensive understanding of the phenomena under investigation (Patton, 1999). Firstly, method triangulation was adopted through the use of both online open ended surveys and one-on-one interviews. This resulted in a broader understanding of trans

parenthood as the nature of data yielded by these two methods of collection differs (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). Limiting data collection to a single method may result in the exclusion of eligible participants or lessen the breadth of results (Polit, 2017). Secondly, investigator triangulation was utilised by incorporating multiple investigator interpretations of the data during analysis. Variations in age, experiences of parenthood, sexuality, social status, and theoretical and disciplinary backgrounds between myself and my supervisors strengthened the analysis, as the data was able to be viewed from a range of perspectives (Moon, 2019).

There are several methodological limitations to consider. Firstly, 51 of the 66 participants identified as being from a Western cultural background and forty-two of the sixty-six participants had completed some form of higher education, which usually correlates with higher levels of employment, income and socioeconomic status (Battle & Ashley, 2008; Burnes & Chen, 2012; Quagliata, 2008). As such, there are implications for the transferability of findings. Additionally, although this study aimed to employ an intersectional perspective the majority of participants were white and well-educated. Intersectional research that does not fully engage with race or class has been referred to as 'depoliticised', and its "critical potential has been neutralised" (Bilge, 2013, p. 409). As such, this aspect of my analysis is theoretically incomplete in that it fails to fully attend to the interlocking systems of oppression that form a true intersectional analysis (Bower-Brown & Zadeh, 2021). Although this study still has value in its approach, engagement with more diverse participants is vital for future research to extend scholarly understandings of the experiences of trans parents. Encouraging more culturally diverse research participation is a longstanding issue within the health sciences (Passmore, Kisicki, Gilmore-Bykovskyi, Green-Harris, & Edwards, 2022). I believe that my recruitment process could have been optimised in order to reach a wider

cultural spectrum of the community by liaising with stakeholders in the trans community and specifically targeting more diverse trans and gender diverse healthcare and support groups. Snowballing is common a recruitment strategy with many benefits however, there is a risk of cultural or socioeconomic homogeneity within the sample due to the way in which many people socialise (Kirchherr & Charles, 2018).

The trans and gender diverse community are not monolith in their experiences; there is potential diversity in the unique experiences of, for example, trans mothers, compared to trans fathers or non-binary parents, and those who identity as heterosexual compared to those who identify as gay, lesbian, bisexual or queer. However, much previous research, including the research presented in this thesis, considered trans parents together as a single group. Future research would benefit from focusing on the intersecting identities of trans and gender diverse parents to more fully understand their experiences. Additionally, there were no direct comparisons made between the experiences of parents who had children before pursuing gender affirmation, and those who were at other stages of the affirmation process when having children, or perhaps more established in their gender identity. This was not wholly unintentional. For many of our participants, there was not a personal demarcation of 'before' and 'after' in regards to the journey towards affirming their gender, and parenthood. For many, it was very much not a linear process and took place over an extended period of time. Some participants initially became parents when they were still living in the sex assigned to them at birth, then had more children during the outward pursuit of affirmation, others had children when they were established in their affirmed gender, whilst some fluctuated for periods of time until they settled into a personal and private expression of gender that they were comfortable with. However, participants were very much unanimous that, regardless of their experiences of gender affirmation, they had, as Sam (30's) stated: "always been trans",

as such a choice was made to treat their experiences the same, regardless of the experience of gender affirmation.

A further limitation was the lack of inclusion of participants who identified as non-binary or gender diverse. I attribute this to my own short-sightedness when initially researching, designing and advertising the study. Much of the literature I consulted when developing the project was skewed towards research on the trans population, in particular older or more 'foundational' research on gender, and it wasn't until I had already started to recruit participants that I realised the language I was using was not inclusive of the gender diverse and non-binary population. I changed the language on all the online information and recruitment resources, as well as on the online survey and correspondence with participants. However, whilst recruitment stayed open for a number of months after this point, no more participants enrolled in the study. I believe this was because I had left it too late; the initial 'push' for recruitment had passed, information on the study had already been shared by networks, and the skew towards trans participants was established.

The findings from this research are limited to the Australian socio-cultural and historical context in which they have been produced. The study was initiated in 2015, with data collection completed in late 2016. The benefit of this was that I was able to capture trans parents' responses to protections such as the federal outlawing of discrimination based on gender identity in amendments to the Sex Discrimination Act (Australian Government, 2013). However, 2015 and 2016 also witnessed extensive and highly contentious debates in the media, and the government, around the legitimacy of trans lives and identities under the guise of concern around the school LGBTQI+ anti-bullying program 'Safe Schools' (Safe Schools Coalition, 2013). This program came under intense scrutiny by political and media conservatives, as well as religious groups, and instigated widely broadcast anti-trans rhetoric

throughout Australia (Domínguez-Martínez & Robles, 2019; Thompson, 2019). Since this time, other developments have occurred in relation to social, moral, and political discourses around trans lives, as well as the broader LGBTQI+ community. Such as the extensive debates around marriage equality for 'same sex' couples, culminating in the success of a national referendum in its support (Australian Government, 2017). This was significant as it removed the requirement of 'forced divorce' for married couples where a partner pursued gender affirmation and wanted to obtain official recognition of their gender 'change' (Inkpin, 2021). Whilst the data analysed in this thesis is situated within the cultural context of Australia, and the findings discussed have broader relevance for other countries with similar socio-cultural perspectives and protections for trans people, such as the United Kingdom, Canada, and the United States (Edelman, 2020). However, as I explored in Chapter One, trans human rights and protections vary enormously across the world and there is a significant need for further research exploring the experiences of trans parents in countries where there are different socio-cultural circumstances.

Given the pervasive discrimination trans parents, and their families, are subjected to, it behoves researchers to explore frameworks, such as minority stress models, that illuminate how trans parents develop coping mechanisms and resiliency in the face of multiple stressors (Bockting et al., 2013; LeBlanc et al., 2015; Winter et al., 2016). Taking a strengths-based perspective and focusing the strategies trans parents and their families used to manage their wellbeing in light of multiple, compounding stressors may be a particularly important avenue for future research (Dierckx, 2017; Veldorale-Griffin & Darling, 2016).

Reflections on my use of theory and analysing as an 'outsider'

> "All theories risk becoming hegemonic, normalized, or exclusive if they are not reflexively critiqued by the scholars who engage them" (Jones Jr., 2009, p. 42).

I have reflected on my use of theory to ground my doctoral research and it has revealed some strengths and weaknesses to my approach and application. As stated at the outset, the social constructionist epistemological basis for this research is the recognition of participants as the principal experts regarding their own lived experiences, as well as the research as a vehicle for social action. Both of which entreat us to reflect on the responsibility that accompanies writing about other people (Burr, 1995). Consequently, the preservation of participant experiences was imperative to me throughout the research process. When analysing participant accounts for this thesis I was very cognisant that understanding the 'answers' to the research questions was not mine to construct, but the participants to give. Adding to this my awareness of my position as an 'outsider', in some ways, to my participant group, I feel that I approached analysing and reporting participant accounts with an abundance of caution. As such, there is a realist slant to the presentation of data, which does contrast with constructionism. However, this epistemological basis informed so much of how I approached and analysed the literature used to inform, structure and develop my research. I used social constructionism to interrogate the institutional hegemony that trans parents reported impacting their lives and experiences.

It should perhaps not be surprising that the use of the term 'queer', in its theoretical form, is a somewhat challenged term within the social sciences (Jones Jr., 2009). There is some friction when queer theory is engaged with the idea of reportable and interpretable realities. 'Queer' is not an umbrella term for the LGBTQI community; many people within that community do not identify as, or refer to themselves as 'queer'. In its theoretical form, 'queer' takes on a more specific political and academic usage, as Gamson (2004) states: "Queer marks an identity that, defined as it is by a deviation from sex and gender norms either by the self inside or by specific behaviors, is always in flux" (p.349). In this sense,

'queer' refers to a critical view of identities and politics that opposes social and academic hegemonies, critiques assimilationist views of sexuality and identity, and denaturalises binary identity categories (Jones Jr., 2009). Many participants in this research, refer to themselves simply as male or female, with no need to qualify their experience of gender further. Many are 'straight' or heterosexual. So where do they fit within a 'queer' theoretical framework? Are their experiences rendered normative? Or do they become victims of 'coercive queering' (Ansara, 2010). I believe that many of our participants engage in 'tight-rope talk' (McKenzie-Mohr & Lafrance, 2011) when negotiating identities, with many adopting a "both/and" position in relation to their experiences of gender, sexuality and beyond; enabling them to challenge the oversimplification of "either/or binaries" (p.66). This study was specifically advertised as being open to trans and gender diverse parents, and many participants were 'straight' mothers and fathers however, there is still a of level of personal comfortability evident to engage in a trans or gender diverse cohort. Whilst demographics and participant 'identities' are an absolutely vital aspect of research, I would argue that we need to allow space for individuals to negotiate their own identities in an ongoing and mutable way.

Final Reflections

> The objectives of WHO… shall be the attainment by all peoples of the highest possible level of health...all human rights, including the right of recognition before the law, the right to the highest attainable standard of health, the right to body integrity, the right to found a family, and the right to be free from degrading treatment, among others, apply equally to all human beings, including those who may be trans or gender diverse.

The statement above is first article of the constitution of the World Health Organisation (2018). These are human rights that are universal, not a question for cultural interpretation.

They are the minimum that every human being must be granted, by virtue of the fact that they are human. (Castro-Peraza et al., 2019).

The purpose of this study was to give trans parents an opportunity to share their experiences, in their own words, and to give a voice to this group of people who are routinely silenced and excluded by heterocisnormative privileging. The findings reported in this thesis illustrate just how pervasive societal prejudice is towards trans people. There are barriers and obstacles at every turn. However, this thesis also illustrates the strength, and resilience trans parents exhibit by virtue of their 'existence as a radical act'; persevering through parenthood and loving their children in spite of trans parenthood being positioned as a subversive act.

Just as with other forms of discrimination, trans people cannot do the work to end transphobia. It is the responsibility of those existing outside of trans and gender diverse spaces, the cisgender community. Whilst trans people can 'exist as resistance', it is cis people who must do the actual work of actively dismantling heterocisnormativity.

In the preface of this thesis, I explored the personal experiences that led me to pursuing this research for my PhD. In the intervening time, I have watched my queer friends and loved one's grow their families; caring for their children, and themselves, with grace and bravery. I have also had the privilege of supporting, and celebrating with, some of my closest friends as their child has 'come out' and begun to explore what gender affirmation means to them. The time I have spent on this project, the awareness and resources I have accessed, has been helpful to my friends, and just for that I am truly grateful. Time marches on; as I have supported my own peers on their respective journeys, now the next generation is growing up and making their own way towards affirmation and authenticity. I am on the cusp of having my second child as my oldest child is on the cusp of adolescence, gaining an understanding of himself and his own relationship with, and place in, the world. And I wonder, how much

the struggles and the strength of those who have come before, including those who shared their stories in this research, have worked to pave a brighter way? When listening to the stories that trans parents have shared in this thesis, the deep love and support that exists within their families, I think so.

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Appendix A: Recruitment Materials - Flyer

University of Western Sydney
Bringing knowledge to life

What is the study about? At the University of Western Sydney we are researching transgender parents experiences of parenting and wellbeing.
Who are we looking for? Any transgender parent living in Australia, who is aged 18 years and over.
What is required? You will be asked to complete an online survey about your background and about some of your experiences as a transgender parent. At the end of the survey, you will be given an option of further participation in a one-on-one interview, at a time convenient to you.
You can find out more about the study and complete the survey online at:
www.westernsydney.edu.au/thri/research/hdr_research/experiences_of_transgender_parents_in_australia
www.facebook.com/transparentsresearch
If you want more information about the study or you prefer a paper copy of the survey, please contact us on:
0424035344
r.charter@uws.edu.au
This study has been approved by the University of Western Sydney Human Research Ethics Committee (Study ref: H11272).

Appendix B: Recruitment Materials - Webpage

Experiences of Transgender Parents in Australia

Are you a transgender parent?

This study is looking at the parenting experiences, subjective wellbeing and identity of transgender parents.

What is the purpose of the study?

The purpose of the study is to develop an understanding and awareness of the experiences of transgender parents, and how they foster their own wellbeing whilst caring for their families.

Who is invited?

Any transgender parent living in Australia, or from Australia, who is aged 18 years or over.

Please note: All gender diverse parents are welcome to participate. You do not have to identify specifically as transgender.

Do you have a choice?

Participation is totally voluntary. If you decide not to be involved, there will be no negative consequences. You can change your mind and quit the study at any time and you don't have to give any reasons if you don't want to.

What does this study involve?

You will be asked to complete an online survey about your background and about some of your experiences as a transgender parent. At the end of the survey, you will be given an option of further participation in a one-on-one interview, at a time convenient to you.

Who is conducting the study?

This study is conducted by Rosie Charter, a PhD candidate with the Centre for Health Research, at Western Sydney University. Rosie is under the Supervision of Professor Jane

Ussher, at Western Sydney University. The study is an unfunded project, conducted in fulfilment of the requirements of the Doctor of Philosophy degree.

What are the benefits/positives?

You may not receive any direct benefit from this study. However, you may find that discussing your experiences provides you with a greater understanding of yourself and your experiences. This study will also create greater community awareness of the unique experiences of transgender parents.

Are there any risks?

Sometimes answering questions or talking about certain experiences can be difficult, so if you decide to take part in the study, we will do whatever we can to make sure you feel safe and comfortable.

If you have some discomfort after completing the survey, and feel as though you would like to talk to someone, please feel free to contact the number below:

Qlife, an LGBTI service - 1800 184 527 - 5:30pm-10:30pm service

Confidentiality/Privacy

Everything you give or say to us will be confidential. No one will know you have taken part in this study except those you tell or the researcher involved in the study. We will make sure no one will find out that you have taken part. All your information will be stored safely and securely at Western Sydney University.

Will taking part in this study cost me anything, and will I be paid?

Participation in the survey will not cost you anything and there is no payment. However, if you choose to take part in the second stage of the study, a one-on-one interview, there is reimbursement in the form of a $25 gift card.

What will happen with the results?

The findings of the research will be disseminated as part of a doctoral thesis, and may also be submitted for publication in an academic journal. Additionally, a report of the results will be available to any participant or LGBTI group who wishes to view it.

*Please note that the minimum retention period for data collection is five years.

Complaints

This study has been approved by the Western Sydney University Human Research Ethics Committee. The Approval number is H11272

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email humanethics@westernsydney.edu.au

Contact details

If you have some questions and would like to know more about the study or experience any problems while on the study, please contact the researcher, Rosie Charter, on (02) 46203592 or r.charter@westernsydney.edu.au

Appendix C: Survey Questionnaire

Transgender Parents Experiences of Parenthood

Introduction

As part of the **Parenting Experiences of Transgender Parents Study** being conducted by the University of Western Sydney, we are interested in your experiences of parenthood. **Transgender parents** aged **over 18 years** are invited to take part in this study. The study has been approved by the University of Western Sydney Human Research Ethics Committee (Study ref: H11272).

Instructions:

- Taking part in the study is voluntary
- Information you provide is confidential
- The survey will take about 15 minutes to complete
- Use the **previous** and **next** buttons at the bottom of each page to move between pages.

If you have any questions, please contact us on: Tel: 0424035344 ; Email: r.charter@uws.edu.au

Your participation in this study is greatly appreciated.

Parenting Experiences of Transgender Parents

Questions about yourself

1. What is your current age?

2. How many children do you have and how old are they?

3. How would you describe your current relationship status? (e.g. single, partnered, not sure)

4. What was the sex assigned to you at birth?

- o Male
- o Female
- o Intersex
- o Unsure

5. How do you currently describe your sexual orientation?

6. How do you describe your cultural background?

7. What is the highest level of education you have completed?

- o Less than Year 10
- o Year 10 (School Certificate or equivalent)
- o Year 12 (Higher School Certificate or equivalent)
- o Tertiary diploma/trade certificate/TAFE
- o University degree or higher

8. How would you describe your gender identity?

9. Do you currently live full-time in your preferred gender?

- o yes
- o no
- o other

Questions about parenting

10. How are you related to your children? (e.g. biological parent, stepparent, foster)

11a. Do your children currently live with you full-time?

- o yes
- o no
- o other

11b. If your children do not live with you fulltime, how would you describe your custody or care arrangements? (e.g, I share custody, I have adult children, etc)

12a. Are you currently in a relationship with your co-parent?

- o yes
- o no
- o other

12b. If you are not currently in a relationship with your co-parent, how would you currently describe your relationship?

13. How would you describe your other support systems? (e.g. relationship with other family members?, formal support groups?, friendship groups?)

14. Are there other experiences related to parenthood you would like to share or that you feel is important?

Final comment and further contact

15. If you are interested in participating in an individual interview for this project, please provide us with the following contact information. All information you provide is confidential. There is a $25 reimbursement voucher for participation in the interview.

Name

Address

Phone (daytime)

Email

16. What are your preferred days and times for contacting you by phone?

17. Please provide any feedback or comments you wish to make in the comment box below.

You have completed the survey once you click on the **Done** button below.

If you have any further questions about the study, please contact us on Tel:

0424035344 or Email:

r.charter@uws.edu.au

If you have any discomfort after completing the survey, and feel as though you would like to talk to someone, please feel free to contact the number below:

Qlife, an LGBTI service - 1800 184 527 - 5:30pm-10:30pm service, or

Lifeline, crisis support – 13 11 14 – 24 hour service

Thank you for participating in this survey. It is much appreciated!

Appendix D: Ethics Approval

Locked Bag 1797
Penrith NSW 2751 Australia
Office of Research Services

ORS Reference: H11272

HUMAN RESEARCH ETHICS COMMITTEE

6 August 2015

Professor Jane Ussher
Centre for Health Research

Dear Jane,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H11272"The Constructions and Experiences of Parenthood amongst Transgender Australians", until 28 February 2018 with theprovision of a progress report annually if over 12 months and a final report on completion.

Conditions of Approval

1. A progress report will be due annually on the anniversary of the approval date.

2. A final report will be due at the expiration of the approval period.

3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to beingimplemented. Amendments must be requested using the HREC Amendment Request Form:
http://www.uws.edu.au/
data/assets/pdf_file/0018/491130/HREC_Amendment_Request_Form.pdf

4. Any serious or unexpected adverse events on participants must be reported to the Human Ethics Committee via theHuman Ethics Officer as a matter of priority.

5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to theCommittee as a matter of priority

6. Consent forms are to be retained within the archives of the School or Research Institute and made available to theCommittee upon request.

Please quote the registration number and title as indicated above in the subject line on all future correspondence relatedto this project. All correspondence should be sent to the email address humanethics@uws.edu.au.

This protocol covers the following researchers:
Jane Ussher, Janette Perz, Rosie Charter

Yours sincerely

Professor Elizabeth Deane

Presiding Member,
Human Researcher Ethics Committee

Appendix E: Participant Consent Form

Transgender Parenting Study: Consent to Participate in Research

1. I acknowledge that I have read, or have had read to me, the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by _____ ("the researcher") and I, being over the age of 18 acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

2. I acknowledge that I have been given time to consider the information and to seek other advice.

3. I acknowledge that refusal to take part in this study will not affect me in any way.

4. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

5. I acknowledge that this research has been approved by the University of Western Sydney Human Research Ethics Committee.

6. I acknowledge that I have received a copy of this form and the Participant Information Sheet.

7. I understand that the interviews will be digitally recorded and transcribed.

8. I understand that my identity will not be disclosed to anyone else or in publications, presentations or potential future research. Data collected from the three stages of the project, including the social networking site, will be used in the results. However, the data will be based on aggregates, patterns, and similarity of themes and will not reveal the identity of any specific individual.

Name of Participant: Name of Researcher:
Sign: Sign:
Date: Date:

Appendix F: Interview Schedule

Interview Schedule

(*Interview description for participant):* "You might remember from the survey you took that this research project is looking at the parenting experiences of transgender parents.

Before we get started, there's just a few things I'd like to let run through with you. Firstly, your participation is completely voluntary, you take a break or stop at any time and for any reason. You can also withdraw from the study at any time.

I just want to let you know that I will be recording our interview. The interview recording will then be transcribed, once it's transcribed any identifying information, such as your name or your children's names, or any other identifying information will be removed. Your interview transcription will be completely de-identified.

On the webpage where you first accessed the survey, you will find my contact details, the university ethics department contact information as well as the details for some support organisations should you need. There is also more information of

Do I have your permission to start the interview?"

- Interview questions are numbered 1-7
- Prompts are listed below each question.

I'd like to talk with you about your experience around parenthood:

1) "Think back to when you first had children, what was life like for you then?

a. How old were you?

b. Was your first child planned?

c. Were you in a relationship at the time?

d. What kind of support did you have around you when you first had children?

e. How did things change as you had any subsequent children?

2) How would you describe family life now?

a. How old are your children now? Are they at school, etc? What is that like?

b. How is your relationship with their co-parent?

3) When you were growing up did you always want to be a parent?

a. If not, how did you feel about parenthood?

b. If yes, what did you think about becoming a parent?

c. Can you tell me a little bit about your own parents and family when you were growing up?

4) Besides your co-parent or partner, where do you go to for support?

a. Do you spend much time with your extended family?

b. Friendship groups?

c. Formal support groups?

d. Healthcare professionals or services?

5) I'd like to talk with you about your experience with gender.

a. How do you identify and describe your gender?

b. What has it been like for you to develop an awareness of your gender?

c. Did you decide to transition? If so, what was it like for you?

c. Did you decide to transition? If so, what was it like for you to transition or affirm your gender?

d. Have you experienced much transphobia? How has this affected you and your family? How have you dealt with this?

e. Have you been subjected to prejudice, discrimination, and stereotypes related to being transgender? Have you encountered any stigma in your family? In your relationships?

f. Can you describe the coping strategies you have used to cope with these experiences?

g. Can you talk about if being transgender has or has not affected your experiences with work? Have you experienced stigma or transphobia at work? How have you dealt with this?

6) Next, I'd like to talk with you about your experiences with healthcare providers.

a. What has been your experiences when dealing with doctors, psychologists or other specialists?

b. Have you had any ongoing healthcare issues?

c. Did you or you partner/co-parent need any formal or informal reproductive assistance? What were your experiences?

d. Have you found yourself having any negative attitudes toward your health care? If so, how have they affected you? How have you dealt with this?

e. Have you faced any prejudice, discrimination, and stereotypes related to your healthcare?

f. Can you describe the coping strategies you have used to cope with stigma related to healthcare?

7) Is there anything that we didn't get to talk about today that you'd like to include?

a. Is there anything important that you think I have missed?

b. If any what do you think are the challenges related to being a trans parent? What are some of the special aspects?

c. Lastly, do you have any recommendations for formal support or health services and research related to the topics we've addressed today?

Appendix G: Journal Article 1

From: John P Elia <jpelia@sfsu.edu>
Sent: Friday, 15 October 2021 6:40 PM
To: Rosie Charter R.Charter@westernsydney.edu.au>
Cc: joheditor@gmail.com <joheditor@gmail.com>
Subject: Journal of Homosexuality - Decision on Manuscript ID MS# 051-21

15-OCT-2021

Dear Ms Charter:

Ref: Transgender Parents: Negotiating 'Coming out' and Gender Affirmation with Children and Co-Parents

Our reviewers have now considered your paper and have approved publication in *Journal of Homosexuality*. We are pleased to accept your paper in its current form which will now be forwarded to the publisher for copy editing and typesetting.
You will receive proofs for checking, and instructions for transfer of copyright in due course. Your manuscript will then be placed in the queue to be published in the *Journal of Homosexuality.* Please note that although your manuscript may not be published for several months, the publisher will place your article on the Taylor and Francis website with a DOI number so it can become preliminarily available to readers to read and cite your work, etc.

The publisher also requests that proofs are checked through the publisher's tracking system and returned within 48 hours of receipt.

Thank you for your contribution to Journal of Homosexuality and we look forward to receiving further submissions from you.

Sincerely,

John

John P. Elia, Ph.D.
Editor-in-Chief, *Journal of Homosexuality*

John P. Elia, Ph.D.
Associate Dean, College of Health & Social Sciences/
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(Published by the Taylor & Francis Group, LLC)

Phone (415) 338-2871 Fax: (415) 338-0570

Appendix H: Journal Article 2

This appendix has been removed as per Taylor & Francis publication agreement

Appendix I: Journal Article 3

FamilyRelations<onbehalfof@manuscriptcentral.com>
Thu 23/10/2021 6:44 PM

To:

- Rosie Charter

23-Sep-2021

Dear Ms. Charter:

Your manuscript entitled "Experiences of Transgender Parents in Navigating Transphobia" has been accepted online and is presently under final review for publication in the Family Relations.

Your manuscript ID is FR-0151-21.

Please mention the above manuscript ID in all future correspondence or when calling the office for questions. If there are any changes in your street address or e-mail address, please log in to Manuscript Central at https://mc.manuscriptcentral.com/fr and edit your user information as appropriate.

You can also view the status of your manuscript at any time by checking your Author Center after logging in to https://mc.manuscriptcentral.com/fr.

Thank you for submitting your manuscript to the Family Relations.

Warmest Regards,

Wendy Middlemiss, Editor
Lauren Eaton, Editorial Assistant
Family Relations: Interdisciplinary Journal of Applied Family Science,
familyrelations@unt.edu

Appendix J: Journal Article 4

This appendix has been removed as per Taylor & Francis publishing agreement.