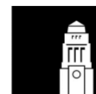

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Howat, A, Masterson C, Darwin, Z.

Title: Non-birthing mothers' experiences of perinatal anxiety and depression: understanding the perspectives of the non-birthing mothers in female same-sex parented families

Abstract

Objective: Partners of birthing mothers can themselves experience perinatal mental health (PMH) difficulties. Despite birth rates increasing amongst LGBTQIA+ communities and the significant impact of PMH difficulties, this area is under-researched. This study aimed to examine the experiences of perinatal depression and anxiety of non-birthing mothers in female same-sex parented families.

Design: Interpretative Phenomenological Analysis (IPA) was used to explore the experiences of non-birthing mothers who self-identified as having experienced perinatal anxiety and/or depression.

Setting and Participants: Seven women were recruited from online and local voluntary and support networks for LGBTQIA+ communities and for PMH. Interviews were in-person, online or via telephone.

Measurements and Findings: Six themes were generated. Distress was characterised by feelings of "Failure and Inadequacy in Role" (i.e., parent, partner and individual) and "Powerlessness and Intolerable Uncertainty" in their parenting journey. These feelings were reciprocally influenced by women's perceptions of the "Legitimacy of (Di)stress as a Non-birthing Parent", which impacted help-seeking. Stressors that contributed to these experiences were: "Parenting Without" a parental role template, social recognition and safety, and parental connectedness; and "Changed Relationship Dynamics" with their partner. Finally, women spoke about "Moving Forward" in their lives.

Key Conclusions: Some findings are consistent with the literature on paternal mental health, including parents' emphasis on protecting their family and experiencing services as focusing on the birthing

parent. Others appeared distinct or amplified for LGBTQIA+ parents, including the lack of a defined and socially recognised role; stigma concerning both mental health and homophobia; exclusion from heteronormative healthcare systems; and the importance placed on biological connectedness.

Implications for Practice: Culturally competent care is needed to tackle minority stress and recognise diverse family forms.

Keywords: perinatal mental health; motherhood; transition to parenthood; LGBTQIA+; interpretive phenomenological analysis

Introduction

Mental health difficulties are common in the perinatal period, i.e., during pregnancy and the first year following birth. International evidence indicates that approximately one in five mothers in high-resource Westernised countries are affected by perinatal mental health (PMH) difficulties; rates are higher in low- and middle-income countries (Fisher et al., 2012). Consequently, routine mental health assessment is incorporated into maternity and child health services in many countries, to facilitate timely identification and treatment. Although rarely explicit in evidence, policy or practice, this reported prevalence and health service response does not refer to all women: it concerns the maternal mental health of women who are gestational (birthing) parents, while non-birthing mothers remain invisible in policy and practice (Darwin and Greenfield, 2019).

Any parent or person pursuing parenthood can experience difficulties in this time of transition. There is now high-quality international evidence that the most common PMH difficulties, depression and anxiety, affect approximately one in ten fathers (Cameron et al., 2016; Leach et al., 2016; Paulson and Bazemore, 2010); referring here to cisgender fathers (i.e., gender identity corresponds with birth sex) in heterosexual relationships. Fathers are vulnerable to other PMH difficulties, including childbirth-related post-traumatic stress and perinatal obsessive-compulsive disorder (Fisher, 2017) but these are relatively newer areas for research, with prevalence not yet established. The prevalence rate for PMH difficulties in LGBTQIA+ non-birthing parents is currently unknown, with some inconsistent results and use of small sample sizes (Borneskog et al., 2013; Ross et al., 2007).

Unlike for maternal health (Bauer et al., 2014), the costs of paternal mental health have not yet been robustly estimated, however they are likely considerable given that mental health difficulties in either parent increases vulnerability to poorer child development outcomes (Aktar et al., 2019). There have, therefore, been calls in the research community and amongst campaigners for paternal mental health to be assessed in services that have existing provision for maternal mental health

(Fletcher et al., 2015; Ierardi et al., 2019), i.e., for gestational mothers. Tensions exist concerning acceptability, with challenges identified at the individual (i.e., parent), practitioner and service level (Darwin et al., 2021b). While some of these could relate to any non-birthing parent (e.g., remit of services, time available), they have commonly been approached as gendered, both concerning parent perspectives (including stigma, manifestation of mental health difficulties, barriers to help-seeking) and concerning practitioner perspectives (e.g., lack of training and confidence in working with men) (Darwin et al., 2021b).

Perinatal psychological distress in fathers is often underpinned by a sense of powerlessness and a loss of control arising from: discrepancies between expectations and the reality of parenthood; difficulties balancing individual needs with the competing demands of work and family; changes to the partner relationship; and conflicting messages about paternal role and involvement from both their partner and society (Domoney et al., 2017; Edhborg et al., 2016). Fathers report feeling excluded from maternity services, question the legitimacy of their experiences and entitlement to support, believing that services should prioritise the mother's needs (Baldwin et al., 2019; Darwin et al., 2017; Hambidge et al., 2021). Help-seeking is compromised by these influences and a lack of information about paternal mental health and available services (Baldwin et al., 2019).

Whilst the move towards recognising paternal mental health is important in addressing the needs of families, continued focus on gendered perspectives risks further marginalisation of already marginalised parents (Darwin et al., 2021b). In addition, by continuing to adopt a cisgendered, heteronormative approach (assuming heterosexuality to be the only preferred or 'normal' sexual orientation) through unquestioning use of terms such as maternal and paternal mental health, we "risk conflating gender and role" and our understanding of PMH difficulties in non-heterosexual couples will remain inadequate (Darwin and Greenfield, 2019). For example, despite an increase in the number of studies exploring (cisgender) fathers' experiences of PMH, we lack similar studies specifically focusing on the experiences of other non-birthing parents Existing qualitative research indicates that experiences of homophobia and discrimination from health professionals and lack of

appropriate and inclusive services contributing to negative mental health outcomes in non-birthing mothers (Abelsohn et al., 2013; Alang and Fomotar, 2015; Ben-Ari and Livni, 2006; Goldberg and Smith, 2008). As there may be differences in the dynamics of lesbian co-parent relationships (Dunne, 2000; Goldberg and Perry-Jenkins, 2007; Ross et al., 2007), it is unknown how these may relate to the mental health experiences for non-birthing mothers.

Access to reproductive technologies has led to a significant rise in the number of lesbian couples having children (Goldberg, 2006), therefore it is likely that midwives and other practitioners will increasingly work with non-birthing mothers affected by PMH difficulties. Research is needed to inform clinical practice and service provision, ensuring supportive, inclusive, and appropriate care. Whilst acknowledging the continuing need for research within the wider LGBTQIA+ community, this study aimed to explore non-birthing mothers' experiences of perinatal anxiety and depression in female same-sex parented families.

Methods

Design

A qualitative approach, Interpretative Phenomenological Analysis (IPA) was used to explore these experiences.

Recruitment

The study was advertised on social media sites, voluntary and support organisations for LGBTQIA+ communities and for PMH. Potential participants were screened using eligibility criteria (Table 1). Non-birthing mothers whose partner gave birth over five years previously were excluded due to potential difficulties recalling perinatal experiences. Parents who had experienced a late loss in the perinatal period (e.g., stillbirth or neonatal death) were also excluded to maintain the homogeneity of the sample.

[TABLE 1]

Eleven individuals expressed interest in the study and received the Participant Information Sheet. Four did not respond to further contact; the remaining seven took part and this is considered to be sufficient for IPA studies (Larkin et al., 2021).

Data collection

The semi-structured interviews focused on: previous mental health history, personal experiences of having perinatal depression and/or anxiety, how these experiences have affected them and their family, and their experiences of perinatal mental health support. Topic guide questions were not exhaustive and were used flexibly, allowing the interviewer to adapt to the participant's responses to explore their experiences in detail (Larkin et al., 2021). Due to the Covid-19 pandemic, a choice of interview formats was offered. One participant opted for face-to-face, four for online videocall and two for telephone interviews. All interviews were audio-recorded and around one hour in length.

Data Analysis

IPA provides a framework for collecting and analysing data regarding individuals' lived experiences (Larkin et al., 2021). The aim is to offer insight into how a given person, in a given context, makes sense of a specific phenomenon (McLeod, 2011). IPA is underpinned by a combination of three main theoretical concepts: phenomenology (focus on a person's experiences and meaning-making), hermeneutics (researchers' attempts to make sense of participants' sense-making), and idiography (commitment to the detailed experiences of an individual prior to making more general claims) (Larkin et al., 2021).

Interviews were transcribed verbatim. Analysis followed IPA guidelines (Larkin et al., 2021). The primary researcher read and re-read transcripts before coding line-by-line by adding descriptive

(e.g., key words, phrase, descriptions), linguistic (e.g., metaphors, pauses, repetition) and conceptual comments. All seven interviews were discussed in research supervision, resulting in an in-depth understanding of the data before the next stage of analysis. Emergent themes were developed by mapping connections between the initial codes. Guided by the research question, connections across emergent themes for each transcript were explored. Processes of abstraction, subsumption, numeration, polarization, and contextualisation were used to visually map connected themes for each participant. Groupings of emergent themes were discussed between authors and alternative ideas considered. Once complete for each transcript, an iterative, comparative analysis was conducted to draw out patterns within the group-level data, reviewing and refining thematic clusters in supervision. The themes were then organised into a framework (Figure 1).

Ethics and consent

Ethical approval was granted by the University's Research and Ethics Committee (*identifier removed for peer review*). Informed consent was gained from each participant prior to interview. No participants withdrew during the study. All identifiable information was removed from the transcripts and participants were assigned pseudonyms to protect anonymity.

Quality Checks and Reflexive Accounting

We were guided by seven criteria to evaluate the quality of qualitative research (Elliott et al., 1999). In addition to the thorough analysis steps as described above, the primary researcher attended a group facilitated by an expert qualitative researcher, completed a comparison of coding with a peer, and maintained a reflective diary throughout the research process.

Reflexivity refers to the examination of researchers' values, assumptions, and experiences and how they may influence the qualitative research being conducted. The researchers' presuppositions are fundamental to IPA's hermeneutic cycle, and we recognise our relationships to this topic span our values, assumptions, and experiences relating to parenting, sexuality, mental health and professional backgrounds.

Results

Participants

Seven participants were interviewed, all of whom identified as either lesbian or bisexual mothers and were describing experiences as first-time parents. For participant demographics see Table 2.

[TABLE 2]

Group Analysis

Non-birthing mothers' experiences of perinatal depression and anxiety are presented as six themes, described below, with temporal and reciprocal connections demonstrated in Figure 1. Bold text is used in the narrative to indicate sub-themes.

[FIGURE 1]

Parenting Without

Non-birthing mothers experienced **a lack of inclusion, social recognition, and safety**, which contributed to their mental health difficulties. They described exclusion by professionals and significant others from parenting decisions and support: "*It got to a point where I felt completely pushed out of my family"* (Laura). Participants expressed mixed views on whether this exclusion related primarily to being the non-birthing parent or to their sexual identity. High levels of minority stress were acknowledged: *"How I was treated was probably the same as all other partners, but I went into that situation feeling like I wasn't supposed to be there!"* (Sarah). Some described attempting to legitimise their parental identity by getting married before embarking on assisted conception, to simplify legal aspects concerning parental responsibility. Nearly all participants

described invalidation of their maternal role by social networks, in services and in wider society. Many reported incidences of heteronormative care: *"The bit I had to sign, it was something like 'husband/male partner' … that kind of structural heterosexism was just quite upsetting"* (Natalie). Many of these incidents were perceived to result from ignorance or lack of training, although participants also experienced homophobia and discrimination from professionals and people within their personal network. One described intrusive questions that we understood as microaggressions (acts of discrimination against members of marginalised groups): "*My manager said I know he's both your kid like, but who's the Mum?"* (Alice). Visibility as same-sex parents increased hypervigilance to discrimination regarding parental identity and legitimacy of their family: Natalie reported "*No one's been horrible but you can just sort of see them going "oh I didn't expect that"…that just makes me feel a bit uncomfortable."* These experiences of discrimination and threats to role legitimacy contributed to internalised homophobia and feelings of inadequacy: *"My wife's brother sent this message all about how terrible it was we were having children. I was just like maybe he's right? Maybe we shouldn't be having the child?"* (Sarah).

All participants experienced difficulties adapting to a new parental identity. For many, these difficulties were exacerbated by uncertainty about their role, in contrast to binary-gendered parental roles they experienced a **lack of a template for their parental identity**: "*What is the other mother supposed to do? What is your role?"* (Sarah). Difficulties in trying to fit into established parental roles resulted in identity dissonance and role incongruence, contributing to distress. However, over time, participants carved out a role or accepted existing roles: *"I'm even more of [child's] parent because I'm not biologically related to [child] so there's like extra effort going in there."* (Andrea); "*I probably have settled into a bit more of a dad role"* (Sarah).

Some participants reported lacking **parental connectedness** with their child in the early months, leading to bonding difficulties. Some related this to biological connection or not having carried their child: "*I think it's about having that experience with [child] and like [child] being inside [partner]. It was almost like they already knew each other." (*Andrea). Furthermore, some experienced feelings of rejection, maternal jealousy, and resentment over the bond between their partner and their baby, especially when breast-feeding. One participant said: *"I got a bit jealous like I wish I had that kind of*

bond with him" (Alice). However, participants developed strategies to facilitate bonding, and all participants spoke of developing a bond over time.

Changed Relationship Dynamics

Becoming parents and experiencing PMH difficulties led to **changes to the couple relationship***,* which were sometimes unexpected. New parental identities often resulted in anxiety-provoking changes to roles and responsibilities, including spending less quality-time with their partners and "*just co-existing in the same house"* (Laura). This occasionally led to role resentment for both partners (*"She had quite a lot of resentment towards me! I got to get up every day, leave the house and go to work."* - Laura) and for some, resulted in feeling neglected by their partner ("*I struggled with the fact that my baby was now all that she could ever focus on! I felt really excluded"* - Sarah). However, some participants felt that negotiating parenthood brought the couple closer and *"stronger in the long run"* (Alice). Non-birthing mothers' mental health experiences could also impact the relationship between the couple and lead to disconnection or conflict. One participant commented: *"I saw these sides of her that I hadn't necessarily known were there. We couldn't understand each other. So we argued loads…it would just make me feel worse"* (Sarah). However, for others, working through mental health difficulties together strengthened their relationship: *"When I got very anxious she started supporting me more and I think that maybe helped her"* (Natalie).

Some participants reflected on the impact of their **partner's (mental) health** on their own mental health. This sometimes led to an unanticipated *"role reversal"* (Andrea) in their relationship and parenting role: *"I became doubly a carer because my partner was able to do very little physically… I was pushed into a situation where I was probably caring for him [child] more on my own than I thought I would be."* (Simone). Some felt underappreciated in this carer role, with one participant feeling like a *"maid"* (Alice). Most participants reported connections between their own mental health and their partner's: *"I could also tell that she was at such a low place, I was worried for both of them! Like her and the baby!"* (Annie).

The following three themes describe the core experiences of perinatal depression and anxiety (depicted centrally in Figure 1). These underpinned many of their reported symptoms of depression and anxiety and were reciprocally linked to the two previous themes.

Failure and Inadequacy in Role

Non-birthing mothers spoke of a sense of failure and inadequacy in their **parental role,** feeling like *"a 'second-rate' parent"* (Sarah). For some this stemmed from regret regarding their decision to become parents, heightened by their active decision to pursue parenthood and significant investment in assisted conception. Most participants compared themselves negatively to other parents, whilst others reported feeling or behaving like a father, with associated negative societal narratives: *"I'm the one who doesn't know what they're doing! That does stupid stuff and messes up"* (Sarah). These feelings were compounded by difficulties with bonding ("*It'd [mood] dip and I'd feel a bit numb towards [child]"- Alice)* which left participants feeling like *"a terrible parent"* (Annie). Participants also reflected on the impact of their mental health difficulties: *"the biggest impact it has on me being more short-tempered…I wish I was like a wonderful, calm parent"* (Simone), and on the impact of being criticised by others: "*It was all these people telling us "oh you shouldn't do that, you should do this!"* (Laura).

Participants also felt inadequate in their **partner role** due to feeling unable to protect their partner, particularly where there had been a traumatic birth. One commented on their attempts to be *'pragmatic'* following the traumatic birth: "*It didn't stop me from feeling helpless though, and sometimes not good enough"* (Simone). Choices made regarding who would be the carrying parent could also exacerbate feelings of inadequacy: *"I did feel a bit guilty that it had been her going through it and not me"* (Natalie). Some felt unsure how best to help their partner and additional stress came from struggle to balance all their commitments: "*It makes me feel pretty crap when she's crying in the morning and I've got to go to work*" (Alice).

Participants described feeling inadequate in their **individual roles** too, including their personal and professional identities, which arose from the multiple demands: *"It felt like I was never giving my*

family enough of my time! But equally not giving my work...I felt like I was letting everybody down" (Sarah). Some reflected on the impact of mental health difficulties on their work: *"My work definitely suffered. I was very distracted"* (Simone).

These feelings of failure were exacerbated by stigma associated with mental health difficulties (*"I do have this kind of prejudice, this like self-internal prejudice about my mental health."* - Andrea) and being a same-sex parent (*"It was like this fear that if I admitted I was feeling these things, that people would just be like well we've told you that's why it should be a man and a woman having a baby!"* - Sarah).

Some participants employed coping strategies such as normalising their experience, practising gratitude, self-compassion, and acceptance. For example, Laura's gratitude diary helped manage the criticism she faced: *"It made me look at myself and think well do you know actually I am a good parent!"*

Powerlessness and Intolerable Uncertainty

Participants described a **lack of control** contributing to feelings of powerlessness and intolerable uncertainty. They located their lack of familiarity with pregnancy and parenting as contributing to their fears. These were compounded by experiencing traumatic events, discrepancies between expectations and reality of becoming a parent, and being excluded from their partner's/child's care: "*I felt completely useless. And like I wasn't needed. Wasn't wanted"* (Laura). Fear of experiencing discrimination was also expressed: "*On and off I do get worried about how people will treat us as a family"* (Natalie). For some, feeling a lack of control was intensified by personal need for control, the physical strain of being a new parent and additional stressors, such as work difficulties or moving house. One participant said, *"One of the things for me was so much about being in control!...When you become a parent, the first thing you learn is you can't be in control all the time!"* (Sarah).

To cope with lack of control, most entered **survival mode and hidden struggles**. Driven by a sense of duty to their family, participants used avoidance-oriented coping strategies and consciously

tried to disconnect from their emotions and needs. One said: *"Because I had a child to look after and a partner to support, I think I just kind of powered through it"* (Simone). Participants hid their feelings from others to *"keep up appearances"* (Sarah), due to not wanting to be a burden, or fearing stigma and dismissal from others. However, survival mode was emotionally exhausting and sometimes worsened mental health difficulties.

For all participants, experiencing mental health issues was **familiar territory** and this familiarity helped to make sense of and manage their current experiences. Whereas some participants viewed their previous struggles as increasing their vulnerability to PMH difficulties, others viewed them as protective: *"It's become a lot easier to know, when I'm feeling anxious and to put things in place to reduce the impact of that"* (Natalie). Understanding their difficulties in this way also helped reduce feelings of failure and inadequacy.

Legitimacy of (Di)stress as a Non-birthing Parent

Participants viewed birthing mothers as the priority when accessing support for mental health: *"It didn't affect me in the same way. It's not my body that's been ravaged."* (Simone) **(prioritising others and neglecting self)**. However, there was conflict between prioritising others' needs and feeling neglected and sometimes resentful. Most participants acknowledged that prioritising family whilst neglecting themselves was unhelpful but continued to do this. Furthermore, maternity services and PMH support typically prioritised the birthing mother, perpetuating narratives that non-birthing parents should be able to cope: *"It's such an overwhelming experience for the person that didn't give birth. It's never acknowledged, how overwhelming it can be"* (Alice).

Participants felt further unsupported through **exclusion from partner support** groups (targeted at fathers) and a lack of support for LGBTQIA+ parents. One participant reflected, "*where am I supposed to go and what am I supposed to do? Because em I can't go and rock up to a group for Dads!"* (Sarah). Participants felt a need for inclusive, tailored support for non-birthing mothers in female same-sex parented families so that their *"specific concerns and stressors are recognised"* (Natalie). One participant wished-for: *"like the [local mental health group for fathers] thing but for*

people like me? That's what I really could have benefited from at that point" (Sarah). Some participants did receive support from services, and many described good quality professional interactions: *"The GP was really, really good… she just said there's nothing wrong with me. It's very, very normal to feel like that"* (Annie).

Most participants were able to utilise **informal support systems**, mainly from friends rather than family. Barriers to accessing support networks included feeling judged, fearing burdening or *"intruding"* (Laura) on others. One identified that her own discomfort regarding her sexuality prevented her using LGBTQIA+ support networks.

Moving Forward

Participants described **taking back control** through help-seeking (both informal and professional) and previously developed coping strategies to *"pull myself out of how I was feeling"* (Natalie). Whilst participants experienced on-going mental health difficulties, most felt able to cope: *"I still have that a little bit now kind of imagining horrible things that might happen. I'm better able now to dismiss them as intrusive thoughts"* (Andrea). Some participants found positives in their mental health struggles, such as accepting them as part of their identity or strengthening their relationship. One participant commented, *"I guess it's shown me that I can be strong in a crisis"* (Simone).

Participants described the influence of PMH difficulties on **our family moving forward**. All participants spoke of love for their families and hope for the future, referring to *"a new chapter in our lives"* (Annie). Some participants believed their PMH experiences had improved their parenting: *"It's made me more concerned about making sure that they understand emotion and just trying to help them to not feel as anxious and depressed as I can"* (Natalie). Some found the risk of experiencing similar difficulties in the future intolerable, deterring them from more children (either as a birthing or non-birthing mother): *"You can have a second one and it can be a completely different journey to how the first one was. But I just think I couldn't even risk how it was the first time!"* (Annie). Conversely, some participants experienced a positive impact on parental desire due to overcoming their fear of

childbirth and the joys of being a parent: two participants had or were currently pursuing gestational parenthood.

Discussion

This study provides the first in-depth exploration of non-birthing mothers' experiences of perinatal depression and anxiety in female same-sex parented families. Here, we consider commonality with existing paternal mental health literature and discuss those areas that appear amplified or distinct for non-birthing mothers. This discussion elaborates the key findings: non-birthing mothers' feelings of failure and inadequacy; the ways in which distress is viewed problematic; and aspects that contribute to their distress, including the impact of maternity and health services. Finally, we outline how these could be addressed through changes in practice (Table 3).

Consistent with the paternal mental health literature, non-birthing mothers reported feelings of failure and inadequacy in their multiple roles. This included a perceived inability to meet cultural and personal expectations of being a 'good' parent and partner, together with feeling unable to perform either at work or home (Darwin et al., 2017; Edhborg et al., 2016). Alike paternal mental health research, participants emphasised their experienced (in)ability to 'protect' their partner (particularly if their partner was experiencing perinatal distress or had experienced a traumatic birth), and difficulties in bonding with their child, both of which they experienced as failing in role.

For the non-birthing mothers in this study, PMH difficulties were worsened by: a lack of role models or socially identified role, relationship dynamics (with partner and with baby), and feeling excluded by services. Whilst all of these have been evidenced in paternal mental health literature (Baldwin et al., 2018), differences exist. Difficulties common to all first-time parents in adjusting to a new parental identity were exacerbated for participants by lacking a well-defined socially agreed role, role models and flexible language, as evidenced previously (Brown and Perlesz, 2008; Wojnar and Katzenmeyer, 2014). Whilst there are similarities, in that fathers receive conflicting messages about what is expected of them (Domoney et al., 2017), there is a notable absence of any template to guide non-birthing mothers. Therefore, in becoming first-time parents, non-birthing mothers experienced difficulties embracing their parental identity, perceived invisibility, and a sense of isolation that other

parents may not experience; findings that cohere with wider literature on LGBTQIA+ parenting experiences (Padavic and Butterfield, 2011; Walker, 2017; Wojnar and Katzenmeyer, 2014).

Changes, both expected and unexpected, that occurred in their relationship over the course of the perinatal period significantly contributed to participants' experiences of perinatal depression and anxiety, as described in paternal PMH literature (Edhborg et al., 2016). Furthermore, participants in this study shared role resentment, feelings of being neglected and jealousy; these have been highlighted elsewhere as an often-unexpected challenge for fathers and non-birthing mothers (Goodman, 2005; Paldron, 2014; Tammentie et al., 2004). However, this study offers new insight into these difficulties by framing them in the context of PMH. Despite these tensions, some participants felt their parental roles became more equal over time and some established their own parental identity moving beyond the heteronormative binary, echoing previous research conducted with lesbian couples (Goldberg et al., 2008; Padavic and Butterfield, 2011). In addition, some of the participants reflected on how these experiences may impact on their future reproductive choices, individually and as a couple, including future decisions about carrying.

Participants' perinatal distress was exacerbated by their own concerns about lack of parental connectedness and difficulties bonding. Salient here appeared to be not having carried the pregnancy and, for some, a lack of biological connectedness. It is plausible that the potential to become gestational mothers themselves may make these issues more difficult to negotiate for non-birthing mothers. Echoing the experiences of fathers, some non-birthing mothers linked their bonding difficulties to exclusion from the (birth) mother-infant bond, especially during breastfeeding (where applicable), accompanied by feelings of jealousy, uncertainty, and inadequacy (Goodman, 2005). In this study, the participants who struggled with their parental bond took steps to address these feelings by doing more 'mothering duties' (Bower-Brown, 2022; Goldberg and Perry-Jenkins, 2007), and concerns regarding bonding lessened over time.

Perinatal distress was experienced as challenging/problematic both by non-birthing mothers in this study and by fathers in the wider literature. Stigma in relation to men's mental health has been repeatedly cited as inhibiting help-seeking (Baldwin et al., 2019). Here, stigma concerning mental health was linked to stigma as an LGBTQIA+ parent and 'letting the side down', indicating that

barriers to help-seeking may be no less than for male parents but may be qualitatively different. With both groups, stigma also relates to perceiving that, as a non-birthing parent, their needs are not as 'legitimate' or important as their partner's. Further, both groups' beliefs appear to be reinforced by messages received from maternity and other services' focus on the birth parent, creating barriers to seeking or accepting help (Baldwin et al., 2019; Darwin et al., 2017; Lever Taylor et al., 2019). Such similarities concerning legitimacy of distress amongst non-birthing parents may imply that there are culturally-embedded expectations that non-birthing parents must be 'strong' and that these expectations to connect to role (as partner and co-parent) rather than gender. As with fathers, some non-birthing mothers voiced wanting professionals to ask about their emotional well-being (Lever Taylor et al., 2019). This is included in the NHS Long Term Plan's (NHS, 2019) proposals of evidence-based assessment and signposting for partners of birthing mothers for mental health support. In the current study, there were examples of participants' needs being considered or included within their partner's support provision. Their positive experiences further reinforce the importance of including all partners within PMH services (Darwin et al., 2021a) and warrants further attention in maternity and other services.

In most interactions, echoing paternal literature, non-birthing mothers felt excluded by maternity and other services (Darwin et al., 2017; Edhborg et al., 2016). Here, exclusion was further compounded by services being heteronormative. Though some fathers struggle with lack of recognition of their parental role, they are typically recognised as a partner. Conversely, non-birthing mothers may face non-recognition in both their partner and parent roles due to a lack of cultural competence within systems. Participants reflected on an implicit hierarchy of parental roles that influence the support available to different types of parents, which fits with the fathers' literature where men report feeling like a 'second-class' parent in the eyes of society (Hambidge et al., 2021). Parents who do not fall within a typical role, such as non-birthing mothers in female same-sex parented families, may be seen as third-class parents, contributing to their feeling overlooked. For example, non-birthing mothers reported exclusion from and invisibility in partner-specific support in clinical and non-clinical settings (i.e., groups, information, etc.). Consequently, non-birthing mothers may experience a double disenfranchisement (i.e., chronic invalidation of their relationship to the

baby that further ostracises them and prolongs their difficulties) (Cacciatore and Raffo, 2011; Doka, 1999), which is likely to be exacerbating mental health difficulties and acting as a barrier to support, in line with previous findings (Abelsohn et al., 2013; Kirubarajan et al., 2021). Some participants also felt a lack of individual and familial safety, leading to increased threat associated with becoming a same-sex parent, due to experienced or anticipated homophobia (or biphobia), prejudice, and discrimination. For some, experiences of discrimination from professional and personal systems deepened feelings of internalised homophobia and inadequacy. This has been reported elsewhere and connected to parents' own doubts about their right to have children (Touroni and Coyle, 2002). Whilst our participants reported examples of microaggressions, for many it was the anticipation of discrimination that contributed to their PMH difficulties (Padavic and Butterfield, 2011). In addition to contributing to perinatal depression and anxiety, the discomfort and distress caused by these experiences may inhibit help-seeking.

This study's findings support the clinical recommendations listed in Table 3.

[TABLE 3]

Strengths and Limitations

A key strength is the rigorous approach to analysis, which allowed for the generation of rich, detailed phenomenological data and valuable contribution to the understanding of non-birthing mothers' experiences of perinatal depression and anxiety in female same-sex parented families, an area previously neglected. Early dissemination through webinars and workshops with parents and practitioners has informally demonstrated that the findings resonate with other same-sex parents, indicating credibility.

A limitation in data collection within the study is that gender identity was not established directly with participants. All participants identified with the criterion of being in a female-same sex relationship and self-identified as lesbian or bisexual mothers. With hindsight, however, we recognise that not explicitly establishing participants' gender identity was an oversight.

Homogeneous samples are valued within IPA (Larkin et al., 2021). With this we must acknowledge the implications for transferability. In addition, the sample's diversity was limited in ways that were not planned. All participants were discussing their experiences as first-time parents (although some were currently pursuing subsequent parenthood) and they all were recovering from their PMH difficulties, reporting that their distress was less acute. We lacked intersectionality within the sample (e.g., all were white, and appeared to have high education and health literacy). The need for intersectional approaches is indicated by recent survey findings relating to experiences of maternity services amongst LGBTQIA+ people which demonstrate the intersection of racism and transphobia (LGBT Foundation, 2022). This study may not have captured the experiences of individuals who feel less able to participate in this type of research due to current PMH symptoms, or feelings of shame and stigma. We also recognise the sociolegal context in which this study was undertaken and that safety to speak freely may be compromised in some countries, or indeed regions within countries.

Future Research

Future research should focus on evaluating culturally competent care provided by maternity services and whether this adequately addresses the needs of LGBTQIA+ parents. The lack of intersectionality within this study in addition to previous findings from heterosexual ethnic minorities (Watson et al., 2019) indicate the importance of studying the non-birthing mothers' experiences of PMH in female same-sex parented families who identify with other minority statuses.

Research has demonstrated that fathers may have increased vulnerability to PMH difficulties in subsequent pregnancies based on previous traumatic pregnancy or birth experiences and that they may face different challenges in meeting the needs of multiple children (Darwin et al., 2017). Therefore, research should be conducted to explore the PMH experiences in non-birthing mothers in subsequent pregnancies, and with families where co-parents have held different roles with different pregnancies.

Finally, this study focused on non-birthing mothers in female same-sex relationships. LGBTQIA+ people are not a homogenous group. There would likely be significant difference

between the experiences of these populations, for example, transgender parents may experience or fear experiencing transphobia within services. Further research is needed to explore distinct PMH experiences with individuals with differing gender and sexual identities.

Conclusion

This study explored the experiences of perinatal depression and anxiety of non-birthing mothers in female same-sex parented families. Many experiences of non-birthing mothers were similar to those previously identified by heterosexual fathers, however, there also appear to be additional difficult experiences including those relating to interactions with heteronormative health services. Whilst more research is needed with non-birthing parents with other identities (i.e., transgender and non-binary non-birthing parents) to explore their potentially unique experiences, improving cultural competence in perinatal services has the potential to benefit the mental health and relationship outcomes of LGBTQIA+ parents.

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Table 1. Eligibility criteria for participation in the study

Eligibility Criteria
1) A non-birthing mother who had been or was currently in a female same-sex relationship where their partner was either pregnant or had given birth within the last five years (regardless of which parent is genetically linked to the child)
2) Depression and/or anxiety in the perinatal period, either diagnosed or self-reported.

Table 2. Participant demographics

Age (years), *Mdn* (range)	35 (27-40)
Ethnicity, *n*	
White British	6
White Other	1
Sexual identity, *n*	
Lesbian	6
Bisexual	1
Child's age at time of interview (months), *Mdn* (range)	13 (2-36)
Assisted conception method for index birth, *n*	
Intrauterine Insemination (IUI)	3
In Vitro Fertilisation (IVF)	4
Employment status, *n*	
Full-Time	5
Part-Time	2
Relationship status	
Married/Civil Partnership	5
Co-habiting	2
Relationship length (years), *Mdn* (range)	12 (3-15)

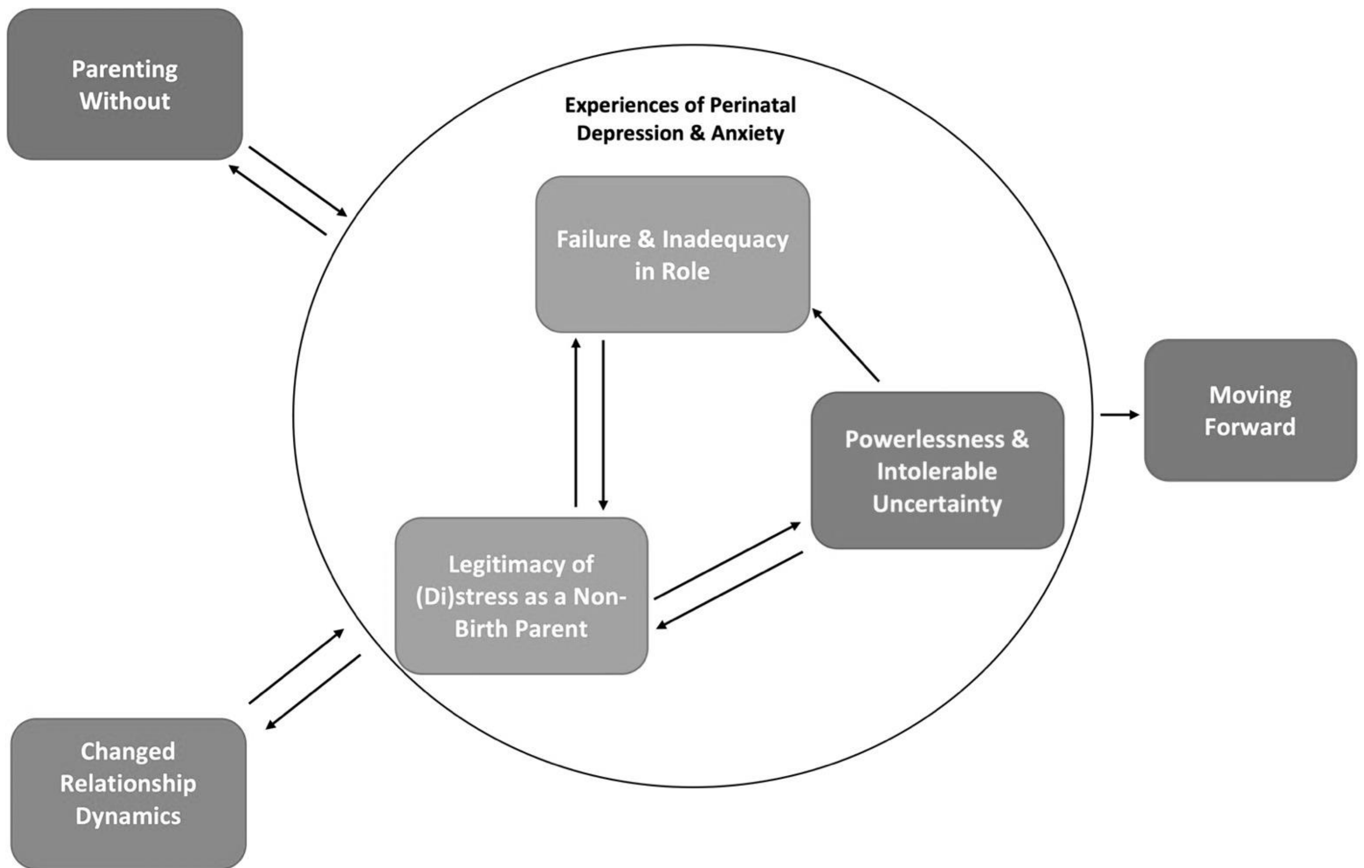

Figure 1. Thematic Map

(**Note:** figure to be printed in grayscale)

Table 3. Clinical Implications based on findings

Clinical Implications
1) Service managers and practitioners need to reflect on the ways in which they are cisgendered and heteronormative. Through being more inclusive of diverse family formations, it is likely possible to help reduce the contribution of minority stress to PMH difficulties in non-birthing (and indeed birthing) LGBTQIA+ parents. This can be achieved through working in partner-inclusive ways and ensuring interactions are individualised and person-centred.
2) Practitioners need to consider that parents may have contact with maternity services in multiple capacities in families where more than one person has the physical ability to be pregnant. Language concerning pregnancy history (e.g., gravidity and parity), whilst physically accurate, may not capture the psychological experiences for a family; including those relating to experiences with maternity care. For example, reproductive choices about gestational parenthood may be influenced by experiences in the context of non-gestational parenthood. There may also be consideration such as fear of childbirth which are likely to be relevant for midwives and other practitioners, given emerging evidence that this can be influenced in LGBTQIA+ people following a partner's traumatic birth.
3) Any routine assessment of partner's mental health within maternity and other universal services needs to ensure that non-male non-birthing parents are included.
4) Practitioners need to be aware of expectant and new parents' barriers to seeking and accepting support. For example, any LGBTQIA+ parents, including birthing parents, may experience stigma relating to sexuality and hold fears about increased scrutiny which may act as an additional barrier to help-seeking.

5) In signposting or referring people for support, it is necessary to consider the support that is available. For example, father-focused support may risk further marginalisation. Not all LGBTQIA+ parents may embrace a 'pride'-based identity and consequently services should not rely on LGBTQIA+ organisations to provide support. Instead, we need to ensure that support offered to non-birthing parents is not exclusive to fathers, whilst also recognising the research-informed value of tailoring support to fathers as men.

6) Education and training are needed for our student midwives and existing workforce to promote cultural competence concerning LGBTQIA+ families.