

Exploring non-birth mothers' experiences of perinatal anxiety and depression: understanding the perspectives of the non-carrying parent in same-sex parented families

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Abstract

Introduction: Research has demonstrated that partners of birth mothers can experience significant mental health difficulties, such as depression and anxiety, during the perinatal period. Whilst evidence is growing on the perinatal mental health (PMH) experiences of male non-birthing parents, parents from the LGBT+ community are under-represented. This is despite the growing number of births across LGBT+ communities and significant impact of PMH difficulties. Therefore, the aim of this study was to examine the experiences of perinatal depression and anxiety of non-birth parents in female same-sex families

Method: Interpretative Phenomenological Analysis (IPA) was used to explore the experiences of non-birth mothers whose partner was pregnant or had given birth and who self-identified as having experienced perinatal anxiety or depression. Seven women, recruited from online/local networks, were then interviewed in-person or online.

Results: Six superordinate themes were identified, including “Failure and Inadequacy in Role”, “Powerlessness and Intolerable Uncertainty”, “Legitimacy of (Di)stress as a Non-Birth Parent”, “Parenting Without”, “Changed Relationship Dynamics” and “Moving Forward”.

Discussion: Non-birth mothers’ experiences of perinatal depression and anxiety were underpinned by negative emotions, which were influenced by messages from services and wider society regarding the legitimacy of distress in non-birthing parents. Difficulties in the transition to parenthood and changes to relationship dynamics contributed to and were influenced by non-birth mothers’ experiences. However, non-birth mothers were able to move forward from their difficulties, through taking back control and drawing on their experiences to inform future family life. Whilst there is considerable overlap with perinatal depression and anxiety in other parents (lesbian mother and fathers), non-birth mothers report distinct experiences relating to sexual identity and their parental role. Given the current emphasis on fathers, the findings in this research warrant consideration and indicate the need to acknowledge non-birth mothers as parents as well as partners.

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1. Introduction

This chapter begins by defining the perinatal period and perinatal mental health. The chapter will then go on to provide an overview of the perinatal mental health literature in heterosexual couples, including both maternal and paternal mental health. This is then followed by a summary of the literature of perinatal mental health in the LGBT+ (Lesbian, Gay Bisexual and Transgender) community, especially focusing on lesbian biological/birth and non-birth parents. The final sections of this chapter will outline the rationale, aims and research question for this study. A glossary of terms relating to pregnancy, assisted conception and the LGBT+ community can be found in Appendix A.

1.1 The Perinatal Period and Perinatal Mental Health

The perinatal period typically spans pregnancy, birth and the first year of an infant's life, although recently some definitions of the perinatal period have covered the first 18 months postpartum. Mental health and wellbeing within this period are referred to as perinatal mental health (PMH). A significant proportion of parents develop PMH problems, ranging from depression and anxiety to psychosis, making this a growing area in relation to public health (National Institute for Health and Care Excellence [NICE], 2014; Bauer, Parsonage, Knapp, Lemmi & Adelaja, 2014). Furthermore, the significant repercussions on parents and the wider family of PMH issues emphasise the importance of well-timed and effective interventions to mitigate their impact (NICE, 2014).

Depression and anxiety are the most common mental health difficulties experienced in the perinatal period. Whilst the presentations of depression and anxiety in the perinatal period are the same as at any other time point, symptoms may specifically focus on parenting (Folliard, Crozier & Wadnerkar Kamble, 2020). For example, parents might experience difficulties bonding with their baby or have persistent doubts regarding their care-giving abilities (National Institute of Mental Health, 2020). Due to the frequent occurrence of depression and anxiety in the perinatal period, the following review will primarily focus on these two areas.

1.1.1 Maternal Perinatal Mental Health

Common PMH issues include depressions, anxiety, post-traumatic stress disorder, obsessive compulsive disorder and postpartum psychosis (Bauer et al., 2014). During pregnancy, approximately 12% of women experience depression and 13% experience anxiety, with many experiencing both (NICE, 2014). Furthermore, 15-20% of women experience anxiety and depression in the first-year post-birth (NICE, 2014; Bauer et al., 2014). In comparison to perinatal depression, there is less awareness of perinatal anxiety, and it is often insufficiently recognised (Hight, Gemmill & Milgrew, 2011). In adults, experiencing comorbid depression and anxiety is more common than either disorder alone, indicating that it is important to also consider anxiety when studying depression in the perinatal period (Lamers et al., 2011; Merikangas et al., 2003). However, while PMH problems affect a substantial proportion of women and national guidance recommends routine screening and timely access to treatment for PMH issues (Joint Commissioning Panel for Mental Health, 2012; NICE, 2014), approximately 24% of women in the UK do not have access to specialist PMH services as of 2018 (Maternal Mental Health Alliance, 2018). It should be noted that it is likely that this number has further reduced since this time, however more up to date figures for the UK are not available due to the Covid-19 pandemic (Maternal Mental Health Alliance, 2020). Whilst the continued lack of specialist services in some areas of UK is concerning, the growing emphasis on PMH has led to increased national investment in services with substantial improvements in the availability of specialist services being made over recent years.

PMH problems can have a number of potential adverse short- and long-term consequences at individual, familial and societal levels. At an individual level, mental health difficulties in expectant and new mothers have been associated with: poor physical health including poor nutrition and weight gain; increased risk of suicide; decreased social support; poor self-care; substance use; relationship difficulties and difficulties bonding or interacting with the infant due to reduced maternal sensitivity (Field, Diego, Hernandez-Reif, 2006; Joiner, Coyne & Blalock, 1999; Muzik & Borovska, 2010; Nicol-Harper, Harvey & Stein, 2007; Paris, Bolton & Weinberg, 2009). Research has also found that maternal PMH difficulties affect developmental outcomes for the child. Whilst the majority of research has focused on postnatal depression, both maternal perinatal depression and anxiety has been associated with increased risk of physiological, behavioural, cognitive, emotional and interpersonal

problems in children (Glasheen, Richardson & Fabio, 2009; Waters, Hay, Simmonds & van Goozen, 2014; Glynn et al., 2018; Rees, Channon & Water, 2019). A systematic review conducted by Sanger, Iles, Andrew and Ramchandi (2015) found conflicting evidence regarding the long-term implications of maternal postnatal depression on psychological outcomes in adolescent offspring. Whilst postnatal depression was consistently associated with impaired cognitive outcomes, the findings regarding internalising and externalising problems, overall psychopathology and psychosocial development were less consistent. However, the review did find that postnatal depression is a risk factor for concurrent/recurrent maternal depression, which in turn is a risk factor for internalising and externalising problems, psychopathology and adverse psychosocial development outcomes in adolescence (Sanger et al., 2015). At a societal level, PMH problems have long-term economic consequences including costs associated with preterm birth and cognitive impairment, health and social care, productivity losses, infant death, emotional and conduct problems, and special educational needs (Bauer et al., 2014). The total cost of PMH problems is approximately £8.1 billion per birth cohort in the UK (Bauer et al., 2014). On average, perinatal depression costs £74,000 and perinatal anxiety costs £35,000 per case (Bauer et al., 2014). Notably, the majority of these costs are associated with the adverse effects on the child, rather than the mother (Bauer et al., 2014).

A series of risk factors have been identified that may contribute to the development of PMH problems. Factors that may increase an individual's risk of perinatal depression and anxiety include: a history of mental health difficulties, a history of abuse or domestic violence, stressful life events, lack of social support, lack of partner support or poor relationship quality with their partner, unplanned pregnancy, young age, low socioeconomic status or poverty, and migration (Lancaster et al., 2010; O'Hara & Wisner, 2014; Howard et al., 2014; World Health Organisation [WHO], 2017). Other studies have identified protective factors that reduce the risk of developing perinatal mental illness, such as social support and resilience (Hain, Oddo-Sommerfeld, Bahlmann, Louwen & Schermelleh-Engel, 2016; Krasnoff, 2019). Whilst these factors increase and/or decrease an individual's vulnerability to perinatal depression and anxiety, it is important to recognise that any woman may develop mental health problems during the perinatal period.

A number of qualitative studies have described the experiences of women with PMH problems, factors contributing to it and help-seeking during the perinatal period.

Pressure to become the ‘perfect mother’ as constructed by society, in addition to feelings of incompetence and failure arising from discrepancies between the expectations and realities of motherhood and a perceived inability to meet cultural ideologies of ‘good mothers’, have all been highlighted as playing significant roles in experiences of perinatal distress (Beck, 2002; Knudson-Martin & Silverstein, 2009; Leslie, 2013). Additional contributing factors include perceived insufficient social support (Leahy-Warren, McCarthy & Corcoran, 2012), challenges in adapting their sense of identity (Furber, Garrod, Maloney, Lovell & McGowan, 2009), and maternal ambivalence arising from conflicts between motherhood’s perceived positive and negative features (Shelton & Johnson, 2006). In contrast to the focus of these previous studies, Hight, Stevenson, Purtell and Coo’s (2014) study of perinatal depression and anxiety provided insight into symptom presentation, factors contributing to symptoms and the context in which they develop. They identified an overall sense of loss and frustration that is contributed to by three main themes: pregnancy and motherhood-related changes, disappointment about the pregnancy and motherhood experience, and symptoms of anxiety and depression. The symptoms of perinatal anxiety and depression form a significant component of a broader experience of loss and frustration. This loss and frustration appear to develop in the context of numerous changes that occur in the perinatal period, such as in daily activities, social roles and physical appearance, and is reinforced by strong feelings of dissatisfaction with pregnancy and motherhood, including negative experiences of pregnancy, infant care difficulties and conflict with their partner. All these elements are closely related and reciprocally influence each other. Finally, qualitative research indicates that women often struggle to seek help in the perinatal period due a lack of awareness or knowledge from health professionals and stigma (Foulkes, 2011). This is frequently exacerbated by the fear that they will be perceived as failures as mothers by others, in addition to fears regarding being subject to child protection processes should they seek help (Foulkes, 2011; Boots Family Trust, 2013).

1.1.2 Paternal Perinatal Mental Health

Whilst there has been a considerable amount of research investigating maternal PMH, fathers’ mental health is less well studied. Similar to women, the perinatal period is a time of transition for men, with many psychological, social and physical changes occurring that need to be adjusted to (Finnbogadóttir, Svalenius &

Persson, 2003). These significant changes involve new roles and responsibilities; changes to social support networks; changes to the couple relationship, including feeling excluded from the mother-infant bond; and changes to sleep patterns (Goodman, 2005). Evidence has demonstrated that mental health issues, including depression and anxiety, are also common in fathers during this period (Singley & Edwards, 2015). The rates of perinatal depression and anxiety vary between 5-10% and 5-15%, respectively (Cameron, Sedov & Tomfohr-Madsen, 2016; Leach, Poyser, Cooklin & Gaillo, 2016; Paulson & Bazemore, 2010). However, men tend to present with less pronounced depressive and anxiety symptomatology than women (Figueiredo & Conde, 2011), potentially as a result of socialised gender roles (Simon, 2014). Due to this difference in the expression of psychological stress, the likelihood of men seeking or receiving help for their mental health problems is significantly reduced (Robertson, Bagnall & Walker, 2015). This issue is further exacerbated by potential stigma associated with PMH concerns, a lack of guidance and recommendations regarding father's mental health, and the limited number of services directly targeting fathers and their mental health; with the majority aimed at mothers (Darwin et al., 2017, Domoney, Iles & Ramchandani, 2017; Royal College of Psychiatrist, 2015; Schuppan, Roberts & Powrie, 2019).

As with maternal PMH problems, paternal distress has been linked to a range of adverse outcomes. Paternal depression and anxiety in the perinatal period can negatively impact the father's wellbeing, functioning and quality or supportiveness of relationships. This can result in an increased risk of maladaptive behaviours, such as substance misuse, and reduced couple co-operation and inter-parental conflict (Bronte-Tinkew, Moore, Matthews & Carrano, 2007; Fletcher, Garfield & Matthey, 2015; Ramchandani et al., 2011; Sweeney & Macbeth, 2016). Consequently, perinatal depression and anxiety in fathers may indirectly have an adverse influence on child developmental outcomes through impacting the emotional environment in which the child is developing (Domoney et al., 2017). Additionally, paternal mental health can also have a significant direct impact on offspring. Father involvement in parenting has been directly linked to more positive psychological and physical outcomes for children (Flouri & Buchanan, 2003; Wilson & Prior, 2011). Furthermore, positive father involvement protects against the potentially negative impact of maternal PMH problems, reducing the risk of emotional and behavioural difficulties in children (Goodman, 2004; Mezulis, Hyde & Clark, 2004; Chang, Halpern & Kaufman, 2009).

However, mental health problems can interfere with the father's ability to effectively engage with his child, for example fathers with depression are more withdrawn during interactions with their infants (Sethna, Murray, Netsi, Psychogiou, & Ramchandani 2015), and these children are at an increased the risk of later emotional, behavioural and cognitive problems regardless of maternal mental health (Ramchandani, Stein, Evans & O'Connor, 2005; Ramchandani et al., 2008; Lewis, Fletcher, Feeman, Garfield & Vimpani, 2011; Paulson, Keefe & Leiferman, 2009; Ramchandani et al., 2013). Additionally, poor paternal mental health can exacerbate the negative effect of maternal mental health problems on children's emotional and behavioural outcomes (Dierker, Merikangas & Szatmari, 1999; Kahn, Brandt & Whitaker, 2004). Whilst the economic cost of paternal mental health problems is unknown, it is likely to be significant considering the current total cost of perinatal depression and anxiety (Bauer et al., 2014).

A number of risk factors have been associated with the development of paternal PMH problems. Similar to the maternal literature, having a history of depression increased the risk of paternal perinatal depression, indicating that the transition to parenthood may act as a stressor for men with an existing vulnerability to mental health issues (Ramchandani et al., 2008). Studies have found that poor job quality; less secure attachment; low relationship satisfaction/quality and dissatisfaction with partner support; and financial burden are all significant risk factors for paternal perinatal psychological distress (Buist, Morse & Durkin, 2003; Giallo et al., 2013; Iles, Slade & Spiby, 2011). Additionally, there are certain experiences specific to the perinatal period that could potentially increase distress: poor mother and/or infant health; severe fatigue; witnessing birth trauma; low parental self-efficacy due to anxiety; and low parental confidence as a result of slower development of the father-infant bond (Bradley, Slade & Leviston, 2008; de Montigny, Lacharité & Devault, 2012; Giallo et al., 2013, Leach et al., 2016). Finally, maternal mental health is an important factor contributing to paternal mental health during the perinatal period. Research indicates a significant link between paternal and maternal PMH, with the risk of paternal perinatal depression or anxiety increasing if the mother is psychologically distressed (Goodman, 2004; Iles et al., 2011; Paulson & Bazemore, 2010). This association may be indirectly explained by the quality of the relationship between partners, for example maternal perinatal depression may decrease partner support and relationship satisfaction resulting in increased paternal

depression (Don & Mickleson, 2012). As in the maternal PMH literature, studies have indicated that social support, including partner support, is a protective factor for PMH issues (Avon Longitudinal Study of Parents and Children, 1998), although findings have been inconsistent (Matthey, Barnett, Ungerer & Waters, 2000).

There have been a limited number of qualitative studies that investigate fathers' experiences of PMH problems. Edhborg, Carlberg, Simon and Lindberg (2016) found that fathers with depressive symptoms in the perinatal period often felt a sense of powerlessness and a loss of control. These feelings arose from the stress arising from discrepancies between expectations and the reality of parenthood, difficulties balancing their individual needs with the competing demands of work and family, changes to the relationship with partners, and conflicting messages from both their partner and society. Fathers may also receive conflicting messages from society about their role and responsibilities as a father. In recent years, society has come to expect significant increases in paternal involvement and this change may mean that many men may lack a good role model and can be left unsure about what is expected of them (Domoney et al., 2017). Darwin and colleagues (2017) interviewed fathers about their PMH and found that psychological distress was mostly characterised by exhaustion, poor concentration and irritability. Whilst they often felt excluded from maternity services, fathers also questioned the legitimacy of their experiences and their entitlement to support, believing that services are under resourced and should prioritise the mother's needs. Consequently, fathers felt hesitant or unable to seek support because of their concerns that this may undermine their partner's needs. Many fathers felt that supporting their partner and protecting the relationship were fundamental to successfully navigating fatherhood which helped them manage their stress. Another study by Baldwin, Malone, Sandall & Bick (2019) indicated that the physical impact of fatherhood, for example exhaustion, and balancing conflicting demands, such as work and bonding time, may influence first-time fathers' experiences of mental health and well-being. However, despite willingness to engage in conversations and support regarding their mental health, many felt they were excluded by health professionals. Furthermore, several barriers prevented new fathers from accessing support during the perinatal period, including a lack of services or information about available services; a lack of information about mental health problems; exclusion by health professionals; inflexible working and self-imposed barriers, such as stigma. Fathers felt that support should be available to them in a

variety of formats, throughout the perinatal period. Finally, a recent qualitative study by Hambidge, Cowell, Arden-Close and Mayers (2021) found that fathers' experiences of PMH issues were influenced by unmet expectations; difficulties being a male in a female environment; stability of relationship with partner and a lack of support for fathers' mental health. They also found that experiencing PMH difficulties resulted in changes to fathers' behaviour and personality, and ambivalent feelings and emotions. Whilst fathers believed that the mother should be put first, they struggled to acknowledge and support their own mental health and felt the support for fathers was inadequate in comparison to mothers. Exclusion from and difficulty accessing services is important to consider within the context of fathers potentially not feeling able to access support from their partner for their mental health concerns due to the belief that their primary role in the perinatal period is to support their partner (Darwin et al., 2017; Schuppan et al., 2019; Redshaw & Henderson, 2013).

All four qualitative studies outlined above indicate that fathers have similar, yet qualitatively different, experiences of PMH issues to mothers which need to be considered by professionals. Additionally, there is a current lack of perinatal support for fathers and a need for tailored services or resources promoting psychological well-being during this time. However, it should be noted that over the last few years more services for men are now being developed, for example DadPad (2021) and Dad's in Mind (n.d.).

1.2 Perinatal Mental Health in the LGBT+ Community

The majority of research has been conducted in heterosexual couples. However, as of 2019, approximately 2.7% of the UK population over the age of 16 identify as lesbian, gay or bisexual (Office for National Statistics, 2021). The total proportion of the male and female populations the UK who self-identify as gay, lesbian, and bisexual is 2.9% and 2.5%, respectively (Office for National Statistics, 2021). The number of males and females who self-identify as gay or lesbian is 2.1% and 1.1%, respectively, whereas 0.8% of males and 1.4% of females self-identify as bisexual (Office for National Statistics, 2021). Over recent years, there have been a substantial increase of 53.2% from 152,000 to 232,000 in the number of same-sex couple families in the UK (Office of National Statistics, 2019). Whilst same-sex cohabiting couples remain the most common same-sex couple families (50.4%), the

numbers of same-sex marriage families have rapidly grown since the introduction of the Marriage Act (same-sex couples) in 2013, representing 29.4% of all same-sex couple families (Office of National Statistics, 2019). As of 2019, around 7.6% of individuals who identified as lesbian, gay and bisexual reported being in a same-sex marriage and 6% reported being in a civil partnership (Office for National Statistics, 2021). Consequently, more research is beginning to focus on Lesbian, Gay, Bisexual and Transgender (LGBT+) parenting. However, these studies have typically neglected to address PMH. This invisibility of non-heterosexual parents' mental health needs is also mirrored in government policies, such as the National Maternity Review in England (NHS England, 2016) and the NHS Long Term Plan (NHS, 2019). Despite the emphasis on the importance of addressing PMH within these policies, they also fail to recognise the diversity or complexity of family forms and therefore neglect the LGBT+ community (Darwin & Greenfield, 2019). Whilst acknowledging the need for research within the wider LGBT+ community, this review will focus specifically on the experiences of lesbian couples, as increases in access to reproductive technologies has led to a significant rise in the number of lesbian couples having children (Goldberg, 2006).

1.2.1 Perinatal Mental Health and Lesbian Birth Mothers

Lesbian birth mothers is a term for lesbian women who are biologically related to their child, or who carry and give birth to their child but may or may not be biologically related to them. The majority of the PMH research in LGBT+ groups is on birthing biological mothers. Of the limited studies available, evidence suggests that rates of PMH problems are similar or slightly higher in lesbian mothers in comparison to heterosexual mothers. Ross, Steele, Goldfinger and Strike (2007) found that lesbian and bisexual biological mothers experience higher levels of depressive symptoms relative to heterosexual mothers, indicating that perinatal depression may be more common in this population. Additionally, lesbian biological mothers conceiving with donated sperm reported higher levels of depression and anxiety than non-birth lesbian mothers on the Hospital Anxiety and Depression Scale (HADS), although on average levels remained within the 'normal' range (i.e., a score between 0-7 out of 21) (Borneskog, Sydsjö, Lampic, Bladh & Svanberg, 2013). Lesbian biological mothers also reported an increase in anxiety measured through the State Anxiety Scale of the State Trait Anxiety Inventory over the transition period to parenthood, but again these

findings are within the normal range (i.e., scores between 0-39 out of 80) (Goldberg & Smith, 2008). In a study assessing the role of an online forum in postnatal depression for lesbian birth mothers, Alang and Fomotar (2015) suggested that frequent use of the forum to discuss PMH issues supported previous research indicating an increased risk of PMH problems, including depression and anxiety, in lesbian mothers. Whilst not the sole focus of Alang and Fomotar's (2015) study, using engagement with online forum to draw conclusions about risk of PMH difficulties could be questioned. Potential bias within samples (i.e., the focus of the forum being specifically postnatal depression in same-sex families and participants either having confirmed diagnosis or self-identified symptoms to be postnatal depression) and not accounting for the same participants posing multiple times on a forum, could artificially inflate levels of use and subsequently perceptions of risk. Additionally, studies that use online forums do not account for lesbian birth mothers with PMH difficulties who either do not or are not able to use online forums or may not perceive their symptoms as postnatal depression and therefore conclusions regarding levels of risk may not be generalisable. Consequently, the conclusions of this study regarding risk should be treated with caution and only be considered in conjunction with findings from other studies. Finally, Steele, Ross, Epstein, Strike and Goldfinger (2008) found that 27.8% of non-heterosexual biological mothers had accessed mental health services in the previous year. Whilst the reason for seeking treatment was not clear, these figures are undeniably high. Therefore, these findings indicate that PMH issues, such as depression and anxiety, are equally, if not potentially more, common in lesbian birth mothers.

Whilst lesbian and heterosexual mothers share many of the same determinants of PMH, the context in which these variables create or buffer distress in lesbian, gay and bisexual women differs from that of heterosexual women. Research indicates differences in certain variables relevant to PMH in addition to specific sexual orientation-related factors (Ross, 2005; Ross, Steel & Shapiro, 2005). Rates of mental health difficulties, including major depression, anxiety disorders, substance use disorders and self-harm, are much higher in the LGBT+ community (Cochran, 2001; Cochran, Sullivan & Mays, 2003; Meyer, 2003). This is potentially due to high levels of minority stress generated by anti-gay discrimination (Frisell, Lichtenstein, Rahman & Långström, 2010). Therefore, the current research suggests that lesbian women are more likely than heterosexual women to report a past history of mental health

difficulties, and therefore a substantial proportion may be at elevated risk for perinatal depression or anxiety. However, it should be noted that the current research is limited and so caution should be used when drawing conclusions from these findings.

Social support has been associated with PMH in heterosexual women (Robertson, Grace, Wallington & Stewart, 2004). While Bos, Van Balen and Van Den Boom (2004) found no significant difference in the use of social support or satisfaction with available support between lesbian and heterosexual women, support systems for lesbian women during pregnancy may vary. Research has identified three primary sources of support for lesbian couples having children, including friends in the gay and lesbian community, heterosexual friends, and families of origin (Ross, 2005), with many lesbian women highlighting friends as the most frequent providers of social support (Kurdeck, 1998). Lesbian women who experienced a lack of support reported that this frequently stems from discriminatory attitudes from their families of origin (Ross, 2005; Ross et al., 2005; Maccio & Pangburn, 2012). Therefore, poor quality relationships and lower levels of support, particularly from the family of origin, during the perinatal period may be an important determinant of mental health for lesbian mothers.

A series of potential factors influencing PMH which are unique to lesbian mothers have been identified in the literature. Despite sharing the experience of motherhood with heterosexual mothers, lesbian mothers are frequently marginalised because of their sexual identity and are likely to experience stigmatisation, discrimination and homophobia (Ben-Ari & Livni, 2006; Goldberg & Smith, 2008; Weber, 2010). Lesbian mothers have reported experiences of homophobia and discrimination from medical professionals or services (Ross, 2005; Chabot & Ames, 2004). Experiences of heterosexism in services can isolate many individuals and act as barriers to lesbian women receiving appropriate healthcare (Trettin, Moses-Kolko & Wisner, 2006). Lesbian women also may have the internalised homophobia they have experienced in their lives, resulting in many questioning their right to have children and feelings of inadequacy (Touroni & Coyle, 2002). Furthermore, stigma and discrimination has meant that parenting in sexual minority families is often subject to additional scrutiny. Despite evidence indicating no disadvantages to being raised by same-sex parents (Bos, Van Balen, Van Den Boom & Sandfort, 2004), same-sex parents' parenting behaviours are rated more negatively by heterosexual

undergraduate university students than similar behaviours by heterosexual parents (Massey, Merriwether & Garcia, 2013). Whilst the participants in this study were undergraduate students, these findings may be generalisable to the general population. Lesbian mothers report being anxious that their parenting will be judged more harshly by others and feel under greater pressure to justify their parenting skills due to their sexual identity, which has been linked to experiences of high levels of minority stress (Alang & Fomotar, 2015; Bos et al., 2004; Van Dam, 2004). This pressure may lead to lesbian mothers perceiving PMH issues being indicative of poor parenting and having concerns that this may have legal implications, such as having children removed (Alang & Fomotar, 2015). Whilst these fears are akin to those seen in heterosexual mothers, it could be argued that they cause more anxiety for same-sex parents due to the vulnerability resulting from additional scrutiny associated with their minority status (Alang & Fomotar, 2015). Therefore, discrimination regarding sexual identity and internalised homophobia may exacerbate stigma associated with mental illness among sexual minority women leading to increased reluctance in seeking help for PMH concerns, more debilitating conditions and poorer quality of life (Alang & Fomotar, 2015). Building on the factors outlined above, legal and policy issues surrounding parenthood, such as second-parent adoption or custody issues with donors, are often further barriers lesbians have to overcome to become parents and represent a significant and potentially unique source of stress for these parents (Ross et al., 2005).

A heteronormative narrative in healthcare can also influence PMH in lesbian women. Evidence suggests that healthcare professionals frequently fail to consider information on sexual orientation and lack knowledge of the social context of sexual minority mothers, meaning that healthcare providers may not discuss important contextual factors that could potentially increase the risk of PMH issues with this population (Alang & Fomotar, 2015; Røndahl, Bruhner, & Lindhe, 2009). Consequently, heteronormative communication in perinatal services might create barriers to discussing issues influencing PMH and to lesbian mothers seeking or accessing support. Therefore, it has been suggested that the stresses of pregnancy and of identifying as lesbian combine to form additional stress not experienced by heterosexual pregnant women (Trettin et al., 2006).

1.2.2 Perinatal Mental Health and Non-Birth Mothers

Whilst there has been a slight increase in research exploring PMH in lesbian birth mothers, studies focusing on the PMH of partners in the LGBT+ community are still lacking (Darwin & Greenfield, 2019). The prevalence rate for PMH issues in LGBT+ partners is currently not known. However, the growing evidence base indicating significant rates of perinatal depression and anxiety in fathers and its potential implications emphasises the importance of studying this area for partners in other types of relationships.

Although progress is being made in relation to paternal PMH in heterosexual couples, research has only just begun to address PMH experiences of partners in same-sex female relationships. Typically referred to as non-birth mothers, co-mothers, other mothers, non-carrying, or non-biological mothers, these parents do not carry the child during the pregnancy, although they may be biologically related to the child depending on the method of assisted conception. Whilst individuals may identify with any or none of the aforementioned terms, for consistency and clarity the term non-birth mother will be used in this thesis.

Studies specifically examining the prevalence rates of PMH depression and anxiety in non-birth mothers are limited and present conflicting evidence, meaning exact figures are currently unknown. During the perinatal period, Steele et al.'s (2008) study found that approximately 13.3% of non-birth mothers in lesbian partnerships had accessed mental health services in the past year, although the reasons were not stated. However, concerns regarding experiencing stigma relating to sexual identity, in addition to mental health stigma more generally, have been reported to act as barriers to non-birth mothers seeking help for perinatal mental health problems (Alang & Fomotar, 2015) and consequently, evidence drawn from reported figures of mental health service use may not be an accurate representation of the prevalence of perinatal mental health issues in non-birth mother. Evidence indicates that some non-birth mothers experience perinatal depression (Maccio & Pangburn, 2011; 2012), however levels of depressive symptomatology do not significantly differ between non-birth and heterosexual mothers (Ross et al., 2007). Similar to biological mothers, average anxiety levels increase for non-birth mothers during the perinatal period, although it is important to note that different women have different patterns of change during the transition to parenthood (Goldberg & Smith, 2008). Another study found that the

majority of non-birth mothers in lesbian couples undergoing donor insemination reported no symptoms of anxiety or depression and those that did typically reported less symptoms than birth mothers (Borneskog, Sydsjö, Lampic, Bladh & Svanberg, 2013). Finally, similar to studies involving fathers, findings from one study suggest that non-birth mothers may be more likely to experience depressive symptoms if their partners also experience depressive symptoms (Maccio & Pangburn, 2012).

Whilst non-birth mothers experience many of the same stresses contributing to PMH as birth mothers (outlined in the previous section), it is possible that non-birth mothers experience stressors unique to their parental role. Literature suggests that, as only one partner carries the child, partners within a lesbian couple may have different experiences of the transition to parenthood, resulting in differing role-related perceptions, expectations, adjustments and stresses (Goldberg & Perry-Jenkins, 2007). These differences may have distinctive influences on PMH. So far, several possible predictors of mental health and wellbeing specific to non-birth mothers have been identified in the literature, many of which appear to link or interact with each other.

Abelsohn, Epstein and Ross's (2013) qualitative study highlighted biology, connectedness and relatedness as one important factor contributing to PMH in expecting non-birth mothers. In western society, biological connection typically forms the foundations of family. Consequently, many lesbian couples express concern about biological relatedness when having children (Pelka, 2009). Non-birth mothers' feelings about biological connectedness are often dependent on personal desire to biologically conceive and experiences of infertility, both of which have also been linked to maternal jealousy and parenting identity (Pelka, 2009; Goldberg, 2010; Abelsohn et al., 2013).

Another important issue encountered by non-birth mothers is negotiating their role and identity as parents. Identity Theory proposes that interactions with society lead to the development of identities from the socially constructed shared meanings and expectations of the roles to which they are attached (Stryker & Burke, 2000). However, non-birth mothers face several barriers when constructing and negotiating a maternal identity, contributing to their PMH. In contrast to heterosexual fathers, there is a distinct lack of role models for lesbian non-birth mothers to aid them in navigating their parenting role and resources for partners often fail to capture the

complexity of their position (Vanfraussen, Ponjaert-Kristoffersen, & Brewaeys, 2003; Wojnar & Katzenmeyer, 2014). Consequently, many non-birth mothers experience a lack of control, role confusion and isolation but struggle to share these feelings with their partner due to anxieties about causing issues within the relationship or for their partner (Wojnar & Katzenmeyer, 2014). Walker (2017) highlights the struggle non-birth mothers experience with their identity as they do not fit in with the traditional societal norms of either mother or father and the language to describe their role beyond the mother/father binary is inadequate. Furthermore, whilst many lesbian relationships are built on equality (Clarke, Burgoyne & Burns, 2005), this may change to a more hierarchical structure after the birth of a child (Ben-Ari & Livni, 2006). From an identity theory perspective, role incongruence between parents, for example taking on roles that do not fit with their idea of parenthood, may affect their ability to verify their identities as parent, increasing the likelihood of a decline in individual well-being (Cast, 2004). Whilst this has only been hypothesised in relation to heterosexual parents, the same may be applied to lesbian mothers, particularly the non-birth mothers who may struggle with their parental role. Therefore, the lack of well-defined parenting roles may contribute to feelings of invisibility and non-birth mothers may struggle to embrace their maternal role and identity (Gabb, 2005; Walker, 2017).

Building on the stresses outlined above, a lack of social recognition as a 'real' parent by others, including family, friends and healthcare professionals, can be a significant challenge faced by non-birth mothers (Abelsohn et al., 2013; Dalton & Bielby, 2000; Wilson, 2000). This lack of social recognition links to Gender Theory which posits that society and the systems within society are instrumental in the development of parental identities (Goldberg & Perry-Jenkins, 2007). In Hayman, Wilkes, Halcomb and Jackson's (2013) qualitative study, non-birth mothers reported feeling excluded by maternity services who often failed to recognise non-birth mothers as legitimate parents, preventing them from participating in health-related procedures, and frequently used heteronormative language on forms or information leaflets. This exclusion often led to feelings of anger and sadness and the need to legitimise the non-birth mother's role as a parent (Hayman et al., 2013). When compared to heterosexual fathers, studies report that non-birth mothers feel they need to defend the quality of their parenthood significantly more frequently (Bos et al., 2004). Furthermore, they may also face institutionalised non-recognition or

discrimination, for example lacking automatic legal rights as parents, causing feelings of invisibility and vulnerability to increase (Goldberg & Perry-Jenkins, 2007). Conversely, non-birth parents who are recognised as legal parents experience a greater sense of legitimacy in their parental role which may have implications for feelings of connectedness with the child and improved mental health (Goldberg & Perry-Jenkins, 2007).

Other issues experienced by non-birth mothers related to parental identity are somewhat akin to those reported by heterosexual fathers, including bonding, breastfeeding, infant temperament and instrumental support. In McCandlish's (1987) qualitative study, lesbian mothers expressed concerns about the closeness of the child's bond with the non-birth mother in comparison to the birth mother. Breastfeeding is typically connected to developing maternal identity and enhanced bonding (Zizzo, 2009; Uauy & de Andraca, 1995). Non-birth mothers have reported feelings of maternal jealousy and exclusion towards the birth mother during the breastfeeding period (Gartrell et al., 1999; Pelka, 2009). Furthermore, non-birth mothers may not have the option of taking paid parental leave from work during the perinatal period and so may feel they lack opportunity to bond with their child in the same way as the birth mother (Epstein, 2002). However, these concerns regarding bonding lessen over time, with the majority of lesbian families reporting that they were equally bonded with the child by the age of five years (Gartrell et al., 2000). Similar to findings in heterosexual fathers, a quantitative study by Goldberg and Smith (2008) found that challenging infant temperament and low instrumental support were both strong predictors of increases in perinatal anxiety for non-birth mothers, but not birth mothers. Non-birth mothers typically retain financial responsibility through continuing to work, meaning they may adapt to their child's characteristics more slowly than birth mothers (Goldberg & Smith, 2008). Their role as primary provider may also mean that some non-birth mothers are not able to equally contribute to childcare, making them more sensitive to the availability and quality of external instrumental support that could supplement their own contribution to childcare (Goldberg & Smith, 2008). Furthermore, instrumental support may be significant for non-birth mothers because it represents tangible validation of their parental role (Goldberg & Smith, 2008).

Access to appropriate support and healthcare services during the perinatal period that meet their distinctive needs can be difficult for non-birth mothers (Abelsohn et al., 2013; Ross, 2005; Goldberg, 2010). Research reported a lack of acknowledgement of non-birth mothers in clinical settings and prenatal classes (Ross, Steel & Epstein, 2006; Goldberg, 2006). Furthermore, current available support for parents does not acknowledge the unique experiences of becoming a parent or intersecting mother and LGB identities of non-birth mothers and there is a lack of informational resources for this population (Abelsohn et al., 2013).

Finally, changes associated with pregnancy have been identified as a potential factor contributing to non-birth mother's PMH. Whilst many of the changes experienced are similar to that of heterosexual couples, Abelsohn et al.'s (2013) qualitative interview study, which used an intersectional framework, found that lesbian non-birth mothers reported unique physical and emotional changes associated with pregnancy, for example pregnancy-related symptoms and emotional/hormonal changes, which may potentially increase the risk of PMH problems. There is little research investigating the physiological impact of pregnancy on non-birth mothers, which is concerning considering evidence of physiological influences such as the synchronisation of menstrual cycles amongst lesbian couples (Weller & Weller, 1992). Given the potential correlation between the couple's mental health during the perinatal period (Maccio & Pangburn, 2012; Paulson & Bazemore, 2012), more studies are needed exploring physiological changes and the risk of PMH problems.

It is evident from the literature discussed above that there are a number of both general and specific factors that determine PMH for lesbian birth and non-birth mothers. However, evidence has also identified protective factors associated with lesbian families. Studies of heterosexual couples indicate that dissatisfaction with the division of labour is associated with perinatal distress (Des Rivières-Pigeon, Saurel-Cubizolles, & Romito, 2002). However, evidence suggests that this division is often more negotiable and therefore relatively equal between lesbian parents (Dunne, 2000; Ross et al., 2007; Goldberg & Perry-Jenkins, 2007). Preparation for parenthood is an additional protective factor. Unplanned pregnancy is weakly associated with perinatal depression in heterosexual women (Beck, 2001). However, in contrast to many heterosexual pregnancies, lesbians have to plan and prepare to become parents. Becoming a lesbian mother often involves in-depth discussion of roles and

responsibilities, which may be advantageous in adjusting to parenthood (Ross, 2005; Perlesz & McNair, 2004).

Whilst there have been an slight increase of studies investigating PMH issues in lesbian couples, they have mainly focused on the potential determinants of these issues. In contrast to the PMH literature in heterosexual couples, there are currently no studies exploring the experiences of perinatal mental health issues in either birth mothers or non-birth mothers.

1.3 Rationale and Aims for Study

Whilst research is slowly beginning to examine the prevalence and determinants of PMH in lesbian mothers and their experiences of maternity services, the use of a heteronormative framework when conducting research in this area means that our understanding of PMH issues in this population is still limited (Charter, Ussher, Perz & Robinson, 2018; Darwin & Greenfield, 2019). Furthermore, PMH research has previously neglected the experiences of partners. Although studies in heterosexual couples exploring experiences of fathers of PMH issues have started to increase, there is a distinct lack of similar studies specifically focusing on non-birth mothers' experiences. This is particularly concerning considering evidence highlighting the negative impact of parental PMH on individual and child developmental outcomes, in addition to increased risk of PMH problems in this population, the reported experiences of homophobia and discrimination from medical professionals and the current lack of appropriate and inclusive services. Differences in the dynamics of lesbian relationships and how this may affect the experiences and stresses of transitioning to parenthood for non-birth mothers further emphasises the importance conducting research specifically for this population. By continuing to use a heteronormative approach to PMH research, we risk conflating gender and role and our understanding of PMH issues in non-heterosexual couples will remain inadequate (Darwin & Greenfield, 2019). Therefore, research into this area is needed to develop our knowledge of non-birth mothers' experiences of PMH issues which can then be used to inform the future clinical practice of healthcare professionals and service provision, ensuring that they are supportive, inclusive and appropriate.

The overall aim of this study was to explore and understand the views and personal experiences of anxiety and depression in the perinatal period of non-birth mothers in same-sex relationships, where their partner has carried the child.

1.4 Research Question

How do non-birth mothers in same-sex parented families experience depression and anxiety during the perinatal period?

2. Qualitative Methodological Approach

In this chapter, I will outline Interpretative Phenomenological Analysis (IPA), the qualitative methodological approach chosen for this study, and discuss potential data collection methods used within this approach. I will then introduce the concept of reflexivity, its role within IPA and how I have used it in this study.

2.1 Qualitative Methodological Approach

Qualitative research involves a series of methodologies that take an interpretive and naturalistic approach to generating knowledge within the context of human experience (Denzin & Lincoln, 1994; Sandelowski, 2004). The focus of this type of research is to investigate meaning by eliciting and examining detailed accounts from participants regarding how they make sense of the world and the meaning they attribute to particular events, phenomena or situations (Denzin & Lincoln, 1994; Willig, 2008). Focusing on meaning is vital in trying to develop a comprehensive understanding of complex experiences (Willig, 2008). Data collection in qualitative research typically takes the form of interviews, focus groups, observational methods and document analysis. Interviews are especially useful to explore participants' experiences, views and opinions in-depth (Kvale, 1996). Given that this research is intended to explore the lived experiences of perinatal depression and anxiety of non-birth mothers in same-sex relationships, it was decided that a qualitative approach using semi-structured interviews to collect data was suitable.

2.1.1 Interpretative Phenomenological Analysis

IPA is a qualitative approach which provides a framework for collecting and analysing data regarding individuals' lived experiences and social cognitions (Smith, 1996; Smith, Flowers & Larkin, 2009). The aim of IPA is to offer insight into how a given person, in a given context, makes sense of a specific phenomenon, for example a major life event (McLeod, 2011). IPA is underpinned by a combination of three main theoretical concepts: phenomenology, hermeneutics and idiography (Smith et al., 2009).

First described by Husserl (1927/1971), phenomenological inquiry is a philosophical approach that gives primacy to experience and its perception. It aims to examine and describe lived experiences in the way they occur and by using their own terms rather than pre-existing theoretical categories and preconceptions (Smith et al., 2009; Smith & Osborn, 2015). In this way, the focus of IPA is not the structure of specific phenomena, but a person's experience of it and how they make sense of their experience (Eatough & Smith, 2008).

Hermeneutics is the theory of interpretation and is used as an approach to understanding or meaning-making (Eatough & Smith, 2008). Hermeneutics has been linked to phenomenology through the suggestion that phenomenological inquiry is an interpretative process (Smith et al., 2009). IPA is an approach which emphasises the significance of the meaning ascribed to lived experience by an individual, but also recognises that these meanings are only accessible through interpretative processes. IPA researchers engage with a double hermeneutic process by attempting to make sense of the participant's attempts to make sense of their experience (Smith & Osborn, 2003).

Finally, IPA is idiographic and so is concerned with the particular whilst preserving the integrity of the individual (Smith & Osborn, 2015). IPA begins with a detailed exploration of an individual's experience before moving towards generalisations about the experience (Smith & Osborn, 2015). Typically, IPA uses a small, homogenous sample which allows for the experience of each individual to be captured in depth whilst also enabling comparative analysis between cases (Eatough & Smith, 2008; Smith et al., 2009). Furthermore, the idiographic approach situates the individual within their particular context so that experiences are viewed in relation to the world, rather than separate from it (Smith et al., 2009).

In IPA studies, analysis is typically described as 'bottom-up' cycle which is both iterative and inductive in nature (Smith, 2007) and is normally guided by the flexible, non-linear strategies outlined in Table 1.

Table 1. IPA strategies (adapted from Smith et al., 2009)

Strategy	Description
1	Immersion in transcripts with close line-by-line analysis (descriptive, linguistic and conceptual comments) of experiences and understanding of participants.
2	Identification of emergent themes, starting with individuals and then moving across participants.
3	Beginning of interpretative account through development of a 'dialogue' between the researchers, their coded data and their psychological knowledge.
4	Development of framework to explain the relationships between themes.
5	Organisation of the data to clarify process of analysis.
6	Testing and development coherence and credibility of themes through supervision or collaboration.
7	Development of a narrative of results (supported by use of extracts and a visual guide e.g., diagram or table) and personal reflections (e.g. perceptions, conceptions and processes.)

An IPA approach was chosen for this study because of its focus on in-depth exploration of individuals' lived experiences and the meaning they ascribe to this, which is pertinent to this study's research question. Additionally, the effectiveness of IPA as a methodology for exploring complex and emotive topics (Smith & Osborn, 2015) fits well with the current topic, particularly considering the potential social, political and legal factors that are likely to be involved.

2.1.2 Alternative Qualitative Methods

Other qualitative approaches were considered, and these are briefly outlined below.

2.1.2.1 Thematic Analysis

Thematic analysis (TA) was considered. TA is one of the most commonly used qualitative research methodologies and focuses on identifying, analysing, organising and interpreting patterns of shared meaning, both explicit and implicit, within qualitative data (Braun & Clarke, 2006; Guest, MacQueen & Namey, 2011). In contrast to other forms of qualitative methods, TA is not a theoretically informed framework for research (Nowell, Norris, White & Moules, 2017). This theoretical freedom means that TA is highly flexible, so can be used within different theoretical frameworks, and is more accessible as it requires less theoretical knowledge in comparison to other approaches (Braun & Clarke, 2006; King, 2004). Furthermore, the highly structured approach to handling data in TA is useful with summarising key features of large sets of data (King, 2004). Whilst TA can be used within a phenomenological framework meaning that TA and IPA may produce similar findings, TA was considered not to be an appropriate method here due to this study's emphasis on idiographic lived experiences and the high probability of a small sample size.

2.1.2.2 Grounded Theory

Another common qualitative method that is usually considered as an alternative to IPA is Grounded Theory (GT) (Glaser & Strauss, 1967). GT was developed to provide systematic guidelines for gathering, synthesising and analysing qualitative data in order to construct new theories which explain social processes and their consequences (Glaser & Strauss, 1967; Willig, 2008). Codes, concepts and categories within the data are identified until the researcher is unable to create any new categories (Willig, 2008). This typically means that sample sizes tend to be larger in GT in order to ensure data saturation. Categories are then linked so as to generate a new theoretical account of a phenomena (Willig, 2008). As the research question is concerned with the exploration of individual lived experiences, rather than the explanation of social

processes or the generation of theories, it was decided that GT would not be an appropriate fit here.

In conclusion, the focus of this study on making sense of the lived experiences of perinatal anxiety and depression of non-birth mothers in same-sex families requires an Interpretative Phenomenological Analysis (IPA) approach.

2.2 Semi-Structured Interviews

In IPA studies, data is collected using methods which allow the participant to tell their stories and share their thoughts and feeling about an experience (Smith et al., 2009). A variety of data collection methods can be used to elicit these detailed accounts, including in-depth interviews, diaries, focus groups and observational methods (Smith et al., 2009).

Semi-structured, individual interviews have several benefits over the other data collection methods. Not only are they easily managed, but they also allow for a rapport to be developed between the researcher and participant, providing participants with the space and time to speak freely and reflectively, which may be more difficult in other methods such as focus groups (Smith et al., 2009). Additionally, the use of open-ended questions within semi-structure interviews results in data collection being participant led through facilitating an in-depth exploration of experiences. In contrast to structured interviews, semi-structured interviews also provides the interviewer with more flexibility to adapt follow-up questions to participants' responses, allowing participants to guide the interview into areas of discussion significant to their experience and which may not have been considered pre-interview. Semi-structured interviews were the most suitable data collection method for the current study because they should facilitate conversations which would elicit "rich and detailed, first person accounts" (Smith et al., 2009, p.56) of participants' experiences.

2.3 Quality Checks

Assessing the validity and quality of research is essential to establishing the appropriateness of the methods used and the credibility of findings. Qualitative research has received criticism for lacking the same scientific rigor as quantitative research (Rolfe, 2006; Sandelowski, 1993). Consequently, general guidelines have

been proposed to assess the quality of qualitative research. Elliot, Fischer and Rennie (1999) proposed a set of evolving guidelines which contain seven criteria which can be used to evaluate the quality of qualitative research, including: owning one's perspective, situating the sample, grounding in examples, providing quality check, coherence, accomplishing general versus specific research tasks and resonating with the reader. Similarly, Yardley (2000) also developed four principles for establishing quality in qualitative research, including: sensitivity to context, commitment and rigor, transparency and coherence and impact and importance. In line with these criteria, the following strategies were used to ensure the quality of the current research:

- During data analysis, I shared and discussed transcripts without initial coding, in addition to discussing and reviewing sections of coded transcripts, interpretations, emerging themes with illustrative extracts from the data and pen portraits with my research supervisors to check the credibility of my work and receive constructive feedback, including alternative conceptualisations.
- I had regular discussions with my research supervisors regarding the individual and group emergent themes to ensure they were grounded in the data.
- I attended peer supervision and training sessions with other trainees using an IPA approach in which we discussed the interpretation of the data and the development of codes and emergent themes during analysis process.
- A fully anonymised transcript was audited by a peer to check the credibility of my coding and themes.
- Finally, I kept a reflective diary throughout the research process, including reflecting on each interview during data collection and analysis, to provide an audit trail, increase transparency and own my own perspective.

2.4 Reflexivity

Reflexivity refers to the examination of the researcher's own values, assumptions and experiences and how they may influence the qualitative research being conducted. The researcher's presuppositions are fundamental to IPA's hermeneutic cycle and therefore it is imperative for researchers to be aware of them by adopting a reflexive

stance through the research, particularly during the interpretative stage of analysis. I have outlined my own fore-structures in a positionality statement below.

2.4.1 Positionality Statement

I am a white, 29-year-old cis-gendered, heterosexual female who currently does not have any children. Consequently, I have only a limited understanding of the possible experiences of the LGBT+ community and specifically non-birth mothers in same-sex parented families during the perinatal period. However, I am an ally of the LGBT+ community and there are many people within my social circle who identify as LGBT+ (although none of them currently have children). This personal connection has meant that I have developed a high level of empathy for this community and has influenced me to become invested in supporting and promoting issues relevant to this community, particularly through conducting and disseminating research. I also have a keen interest in the changes in identity that occur within transitions, particularly the transition to parenthood, as well as the influence of sociocultural and political factors on the experiences of mental health.

Despite my motivation and curiosity to explore this particular research topic further, I recognise that my personal characteristics may have influenced the data collection. Unlike certain other characteristics, such as gender and race, my sexual identity may not have been as visible. However, participants could of potentially viewed me as a representative of heteronormative society and felt that I was unable to empathise with their experiences, preventing them from being fully honest with me. Conversely, my open, curious and non-judgmental stance, my position as an ally and the important opportunity to share their experiences may have helped them to feel more relaxed and encouraged participants to be more open with me.

Whilst my current understanding of the personal experiences of PMH in non-birth mothers in same-sex relationship is limited, my review of the literature influenced my assumptions about the potential experiences of this population. I expected issues such as biological connectedness, social recognition and identity to play an important role in shaping non-birth mothers' experiences of perinatal depression and anxiety. However, I also recognised that I should not let these assumptions shape the research and I was open to having these assumptions challenged.

3. Method

In this chapter, I will give a detailed outline the study design, conduction of data analysis and ethical considerations.

3.1 Design

Due to the exploratory nature of this study, a qualitative design was used based on IPA to explore the personal experiences of perinatal depression and anxiety of non-birth mothers in same-sex parented families. Data was collected via semi-structured interviews with non-birth mothers, transcribed verbatim and analysed using IPA.

3.2 Participants

3.2.1 Sampling

The sample for this study was non-birth mothers who are currently in or have previously been in same-sex female relationships where their partner is pregnant or has given birth within the five years prior to recruitment and where the participant has experienced depression and/or anxiety (either diagnosed or self-reported) in the perinatal period.

A sample size of between six and ten participants is typically cited as being adequate for IPA studies (Smith et al., 2009), therefore this was the target sample for this study.

3.2.2 Inclusion and Exclusion Criteria

Following an in-depth discussion with the research supervisors, the following inclusion and exclusion criteria were developed to allow for the identification of a homogenous sample required for IPA.

Participants were eligible for the study if they were:

- Biologically female.
- A non-birth mother who had been or was currently in a same-sex relationship where their partner was either pregnant (i.e., women whose children had not been born yet) or had given birth within the last five years, regardless of which

parent is biologically linked to the child. Participants were eligible regardless of whether they had also been pregnant or given birth either prior or since the target perinatal period.

- Had depression and/or anxiety in the perinatal period, either diagnosed or self-reported.

Whilst the perinatal period typically only covers up to the end of the first year of the infant's life, a five-year period was chosen because:

1. It represented a significant parenting transition period (e.g., up to child starting school).
2. It covered the time period since the introduction of laws (e.g., the Human Fertilisation and Embryology Act 2008 and the Marriage Act 2013) and guidelines (e.g., Fertility problems: assessment and treatment, NICE 2013) which have had significant implications for same-sex couples, particularly for those wanting children.
3. Restricting the criteria to a shorter period of time would have reduced the size of the potential participant pool which may have caused difficulties in recruitment.

It was decided to also exclude non-birth mothers whose partner gave birth over five years previously due to potential inaccuracies in recalling perinatal experiences and because of the significant changes at a societal level which may have weakened the homogeneity of the sample. Additionally, parents who had experienced a late loss in the target perinatal period (e.g., stillbirth or neonatal death), non-binary individuals and women whose gender was assigned male at birth were also excluded to maintain the homogeneity of the sample.

Due to the significant impact of the Covid-19 pandemic on maternity care, a cut off of the 28th of February 2019 was initially included in the inclusion criteria in attempt to mitigate the effects of the pandemic on the study, i.e., by only including women whose perinatal period ended prior to the Covid-19 pandemic in the UK (pre-March 2020). Furthermore, women were also only eligible to participate if neither they or their partner were currently pregnant, and they had not had a baby during the Covid-19 pandemic. However, due to difficulties with recruitment and informal

feedback highlighting that these restrictions were preventing some potential participants from taking part in the study, these pandemic-related criteria were removed to reduce barriers to participating (see 'Ethical Considerations' section).

3.2.2 Recruitment

Participants were recruited primarily through advertising via social media sites (e.g., Facebook, Twitter and Instagram), voluntary and charitable organisations/groups for LGBT communities (e.g. LGBT Foundation) and PMH (e.g. PND and Me), and the LGBT networks at the University of Leeds and other higher education institutions. Eleven voluntary and charitable organisations were contacted and four agreed to advertise the study. An electronic flyer with details of the study (see Appendix B) was posted on the researcher's professional Twitter, Facebook and Instagram accounts.

Potential participants who expressed interest in the study were contacted by email or telephone to discuss the research, ensure they were eligible to participate and answer any questions. The Participant Information Sheet (PIS) (see Appendix C) was emailed to eligible potential participants, who were then contacted one week later and a time and date for an interview was arranged if they wished to participate. It was assumed that potential participants who had not responded within four weeks of the information sheet being sent out did not want to participate. An email was sent them thanking them for their interest and no further contact was made.

Eleven potential participants made contact via email to express their interest in taking part in the study. Four women ceased contact after being sent the PIS. The remaining seven women were eligible and opted to participate in the study, forming the final sample. All interested eligible participants took part in the study.

Provisions were also made for if more eligible potential participants had expressed interest in taking part in the study than the target sample size. Participants were selected on a 'first-come, first-served' basis. All individuals who expressed interest received a holding email to acknowledge their interest in the study. If too many individuals had expressed interest, then an apology email would have been sent to those that fall outside of the sample number once recruitment/data collection has been completed, thanking them for their interest.

3.3 Data collection

Due to government restrictions during the Covid-19 pandemic, participants were given the option of having the interview remotely, either over the telephone or online video conferencing software (e.g., Microsoft Teams, Zoom or Skype), depending on the participant's preference and access to these platforms. During the periods when restrictions were lifted, participants were also offered the option of face-to-face interviews, either in their home or a private location of their preference. One participant opted for a face-to-face interview, four opted for online interviews and two opted for telephone interviews.

A topic guide was developed following discussions with the supervisory team, who have experience of conducting other research with LGBT+ communities and as a gay parent, and attending IPA training hosted by the Doctorate in Clinical Psychology Programme to assist the interview process (see Appendix D). The expertise within the supervisory team helped inform some of the language used in the development of the guide. The guide focused on the following areas: previous mental health history, personal experiences of having perinatal depression and/or anxiety, how have these experiences have affected them individually, their relationship and the family, and their experiences of support regarding their mental health during this time. In accordance with an IPA approach, the questions on the guide were not exhaustive and were used flexibly, allowing me to adapt questions to the participant's responses to explore their experiences in detail. The topic guide was informally piloted through conducting an interview with a peer who was currently pregnant. Whilst the peer identified as heterosexual, she was able to draw on her perinatal experiences to role play the data potentially generated by questions and provide feedback on the questions and prompts. Following this, the topic guide was deemed appropriate for data collection and no changes were made

In addition to the one-to-one interview, participants were also asked to provide basic demographic data prior to the interview via a self-completed questionnaire, including age, sexual orientation, ethnicity, employment (e.g., full-time, part-time, self-employed etc.), length of time with partner, and family formation including number and age of children. The language used in the questionnaire was informed by organisations with expertise in the area (e.g., the LGBT Foundation). The information gathered via the questionnaire was used to personalise interviews and to provide pen

portraits to contextualise the interview data (Silverman, 2013). See Figure 1 for flow chart of participant progression through study.

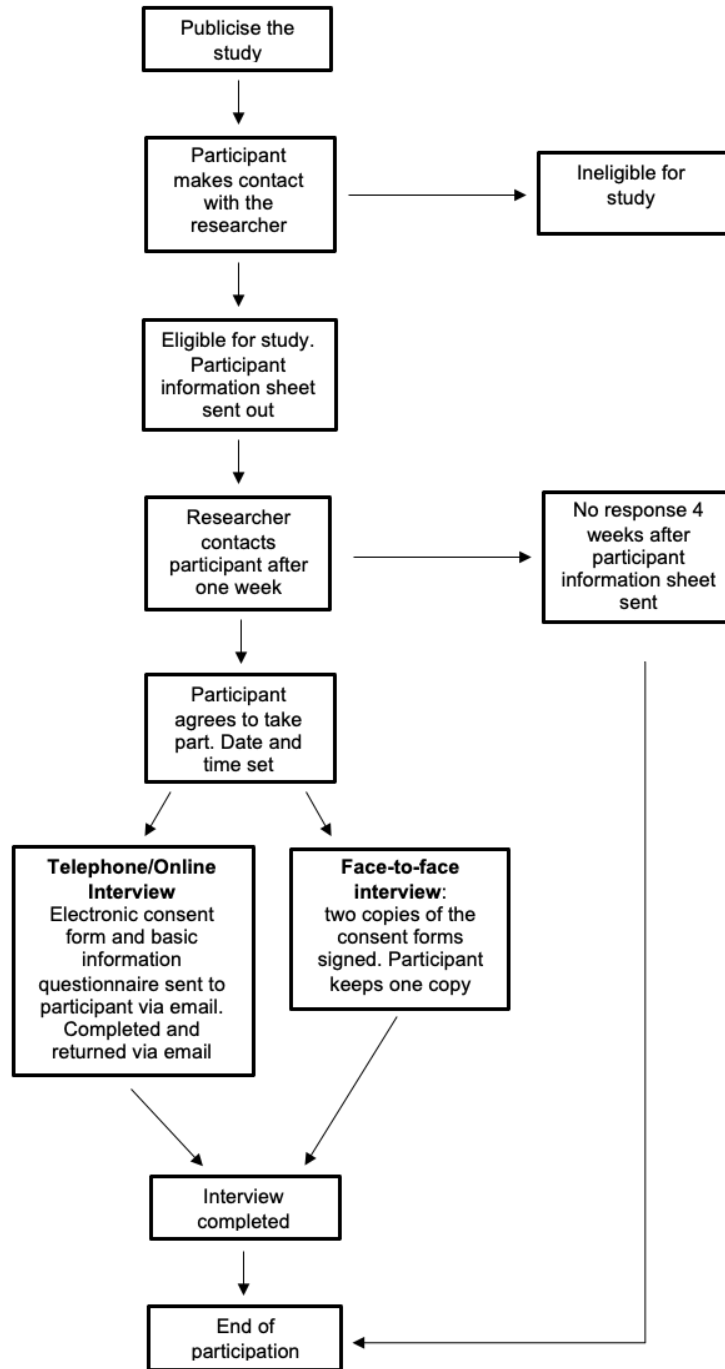


Figure 1. Flow chart of participant’s progression through the study

3.4 Transcription

All interviews were audio-recorded and then transcribed. Three interviews were transcribed by myself to gain an understanding of the transcription process and

due to concerns about maintaining the anonymity of these participants (see 'Ethical Considerations' section). The remaining four interviews were transcribed by a professional transcriber at the University of Leeds. The professional transcriber signed a Transcription Confidentiality Agreement prior to beginning transcription.

3.5 Data Analysis

Interviews were analysed as they became available. After each interview, I would listen back to the recording a few days later and note down my thoughts and feelings about the interview and the participant in my reflective diary. On receipt of the completed transcripts, the stages of analysis followed the guidelines provided by Smith et al. (2009). Analysis included the following steps:

Step 1 – 'Reading and Re-reading'

I initially read the transcript in-depth whilst listening to the recordings without making any annotations to fully re-familiarise and immerse myself in the data. Then I would re-read the transcript, accompanied by the audio, noted down any initial thoughts or potential comments on the transcript that may be helpful in the next stage (see Appendix E).

Step 2 – 'Initial Noting'

During this stage, I went line-by-line through a copy of the transcript initially coding the data by adding descriptive (e.g., key words, phrase, descriptions, etc.), linguistic (e.g. metaphors, pauses, repetition) and conceptual comments to the margins as suggested by Smith et al. (2009). For the first transcript, this was done on a paper copy of the transcript but for the following transcripts, this was done electronically as comments were easier to organise and edit using this method. I would then read through the transcript several more times refining these comments. An example of a transcript with this initial annotation can be found in Appendix F. Each transcript with initial notes were discussed with the supervisory team, who had also previously read the transcripts. This led to a deeper discussion of the data before step 3 was formally embarked upon.

Step 3 - 'Developing Emergent Themes'

Following the completion of initial noting, I developed emergent themes that were recorded in a separate column on the electronic transcript. These were developed by mapping connections between the notes generated during stage 2. Then I went through the transcript again, refining these emergent themes.

Step 4 - 'Searching for Connections Across Emergent Themes'

In this stage, I explored the connections across the emergent themes for each transcript. Emergent themes were either printed out, cut up and placed on a table or written on coloured post-it notes which were then stuck on the wall. Guided by the research question and interesting aspects of the participant's account, connections and links between themes were tentatively identified by physically grouping them together. This allowed for a visual representation of the themes emerging for each participant. Photographs of this process can be found in Appendix G. Processes of Abstraction, Subsumption, Numeration, Polarization and Contextualisation were used to guide my understanding and grouping of emergent themes that appeared related to similar core experiences (Smith et al., 2009). Groupings of emergent themes were discussed in meetings with my research supervisors to consider alternative explanations and to ensure that groupings were agreed upon. Once the groupings had been finalised, they were then named.

Step 5 - 'Moving to the Next Case'

Step 3 and 4 were repeated for each transcript before moving on to the final step.

Step 6 - 'Looking for Patterns Across Cases'

Also referred to as the 'group analysis' stage, a comparative analysis between the themes for all participants was conducted in which they were compared, clustered and re-clustered to draw out patterns within the data, making sense of it on a group level. Again, this was done physically through the use of post-it notes (see Appendix H). This was an iterative process involving re-visiting individual transcripts, re-

examining relationships between themes and re-considering interpretations. As with the emergent themes, thematic clusters were discussed in supervision with my research supervisors. Once it was felt that the resultant thematic clusters appropriately reflected the experiences of the participants, each one was assigned a name summarising this experience. The themes were then organised into a framework to illustrate the relationships between them.

3.6 Ethical Considerations

3.6.1 Informed Consent and Withdrawal

Informed consent was obtained from participants (see Appendix I) prior to the interview after they had had the opportunity to read the PIS and ask the researcher any questions. For the face-to-face interview, the participant completed a paper of the consent form at the beginning. For the remote interviews, participants were sent electronic copies of the consent form and electronic signatures were accepted. Consent was then verbally re-established at the beginning of the interviews.

Participants were informed that they could withdraw from the study at any point, but that their contributions may be retained unless they specifically withdrew consent for this. Participants could also withdraw their data from the study up until three weeks after the interview, after which point the interview data would be analysed. No participants withdrew during the study.

3.6.2 Confidentiality and Anonymity

Only non-identifiable demographic information was collected from participants and all identifiable information was removed or changed from the interview transcripts and pen portraits. All participants were assigned pseudonyms to protect their anonymity.

Participants were also informed via the PIS that in the unlikely event that there were concerns of an immediate risk of harm to the participant or someone else, I would have a duty of care to waive confidentiality and share this information with relevant others. This was not necessary for any of the interviews.

3.6.3 Sensitive Topics and Participant Distress

This study explored personal experiences of depression and anxiety which could have been distressing for some participants, especially if they were currently struggling with these issues, and could potentially trigger negative emotions associated with the topic, such as shame or guilt.

Participants were reminded of the potential of distress arising from the interview via the PIS. Participants were informed that they could take break during the interview or could stop the interview at any point if they were becoming distressed. Participants were also informed that I would discontinue the interview if I felt that the participant was experiencing extreme levels of distress. There were no instances of interviews needing to be paused or discontinued for these reasons, although one did need to be paused to attend to the baby. At times where participants expressed some distress, I drew on my clinical experiences as a Clinical Psychologist in Training to manage this. Participants were given a list of supportive resources and organisations for them to access should they have wanted additional support following the interview.

3.6.5 Data storage

All the interviews were audio recorded on a password-protected audio-recording device for telephone/face-to-face interviews and on OneNote for online interviews. The audio recordings were then transferred to my University of Leeds drive which was only accessible to myself. Following data analysis, all audio files were permanently deleted. All the interview transcripts were fully anonymised.

Demographic data and consent forms were scanned and/or uploaded to my secure University of Leeds drives and the original documents permanently deleted.

Following the completion of the research, all data, including electronic copies of demographic data, consent forms and anonymised interview transcripts, will be transferred to a secure drive administered by the Doctorate in Clinical Psychology research coordinator. The files will be deleted three years after completion of the project.

3.6.7 Ethical Clearance

Ethical approval for this study was granted by the University of Leeds School of Medicine Research and Ethics Committee (SoMREC) on the 5th June 2020 (see Appendix J).

Following initial difficulties with recruitment, an amendment was submitted to SoMREC requesting permission to remove the following inclusion criteria:

- “Partner must have given birth to their child within the five-year period between 1st March 2014 and the 28th February 2019.”
- “Neither they nor their partner are currently pregnant and if they have not had a baby during the Covid-19 pandemic”

Additionally, the amendment requested permission to advertise the research at other LGBT networks at the University of Leeds and other higher education institutions in recruitment procedure. Approval for this amendment was granted on the 18th September 2020 (see Appendix K).

4. Results

In this chapter I will present the research findings. I will begin by presenting pen portraits for each of the participants, including my reflection of their interviews, to contextualise the data. Following this, the overall group analysis will be presented with illustrative quotes from the interviews indicated with italics.

4.1 Pen portraits

This section provides an introduction to each of the participants, including information about their previous mental health experiences, their journey to becoming a parent and their PMH experiences. Each pen portrait also includes some reflections on the content and experience of the interview. To provide clarity regarding participants' family structures, each pen portrait is accompanied by a genogram. Figure 2 provides a key for the symbols used in the genograms. The symbols were informed by McGoldrick, Gerson and Petry (2008).

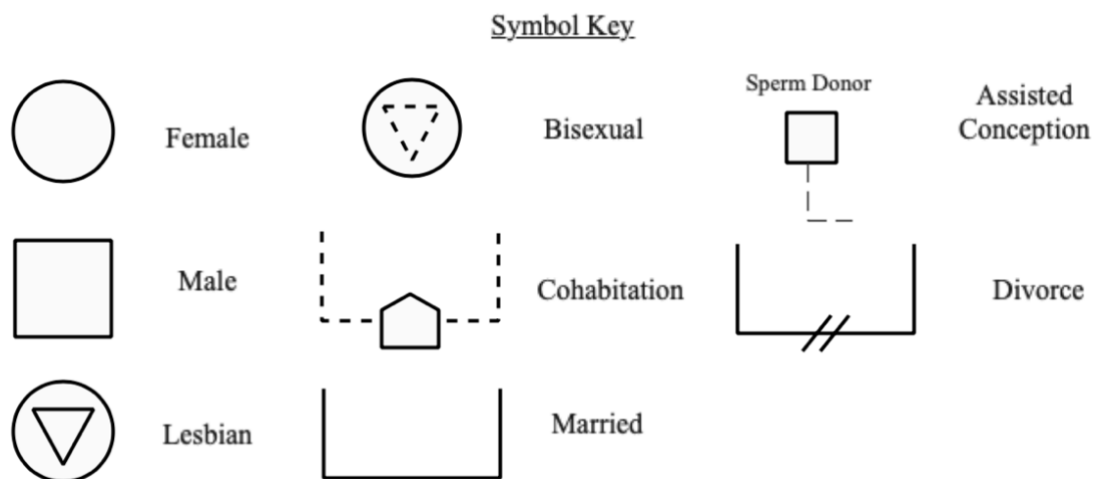


Figure 2. Key for symbols used in genogram

4.1.1 Simone

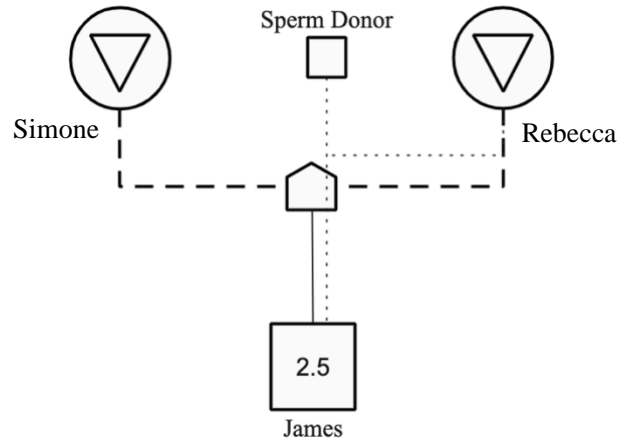


Figure 3. Simone's genogram

Simone is a white British woman in her 40s who identifies as a lesbian. She lives with her partner, Rebecca, and their two-and-a-half-year-old son, James. James was conceived through IVF after several unsuccessful IUI attempts. All attempts were with Rebecca as the one undergoing treatment (see Figure 3 for genogram). Simone was initially reluctant to have children due to her own poor relationship with her parents, in addition to not wanting to conform to societal heteronormative norms. However, she was persuaded and became more committed over the process of becoming pregnant after witnessing how much Rebecca was invested.

Simone had previously experienced episodes of depression triggered by significant life events, including family rejection due to her sexual orientation, and had been prescribed medication and referred for counselling, which she found helpful. In the past, Simone typically coped with her depression through using alcohol and through problem-based coping (e.g., trying to change the situation). Simone experienced depression after the traumatic birth of James which involved experiences of medical negligence and had long-term physical and emotional implications for Rebecca. Rebecca experienced post-traumatic stress symptoms following the birth but had not received any support for this. The family have recently received compensation after filing a court case against the Trust and are planning to use this money to access private therapy for both parents.

During the interview, Simone focused more on the impact of the traumatic birth on her partner. I frequently had to prompt her to think about questions in relation to her own experiences of PMH. This mirrored Simone's narrative within the

interview that the impact on her was not a priority as this traumatic birth did not happen directly to her. Simone had some difficulty in opening up and expanding on answers during the interview. When talking about emotional events, Simone's body language became closed (e.g., crossing her arms and avoiding eye contact) and her tone of voice became noticeably flat.

This was my first interview and therefore I was anxious about how it would go; combined with this, the previous room booking had overrun meaning that our time together was pressured, and Simone seemed anxious about this delay due to other commitments. Consequently, I sometimes stuck more to the interview schedule and prompts rather than using open questions based on the issues Simone raised. At times, I found it difficult to connect with Simone, particularly when it felt like she might be minimising her experiences and struggling to open up about the emotional impact they had had on her, making the interview feel stilted and surface level at points. This left me frustrated with myself and wondering what I could have done to help her open up more. I found the story of the traumatic birth difficult and upsetting to listen to and it made me reflect about my own decision to have children in the future. Additionally, a colleague of mine had recently had a traumatic birth and the interview made me reflect on the potential impact of this on her mental health and the importance of reaching out to her.

4.1.2 Andrea

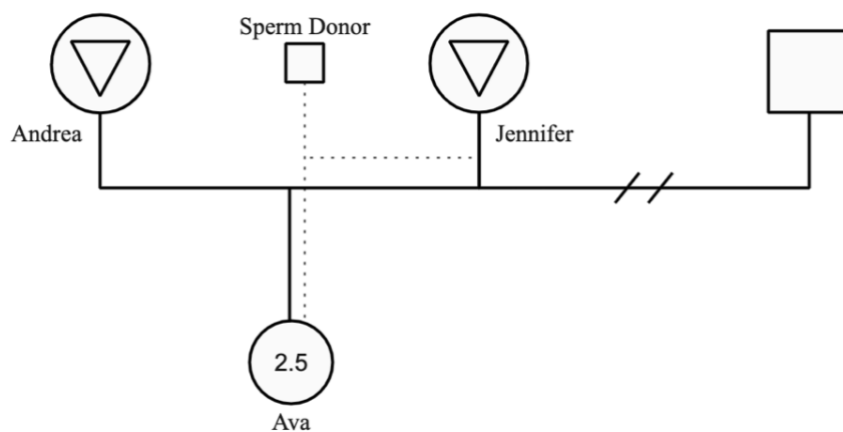


Figure 4. Andrea's genogram

Andrea is a white British woman in her 30s who identifies as a lesbian. Andrea has been with her wife, Jennifer, nearly 10 years and they have a two-and-a-half-year-old daughter, Ava, together. Ava was conceived on the second IUI attempt and carried by Jennifer (see Figure 4 for genogram). Unlike Jennifer, Andrea had not previously wanted children, but together they decided to pursue parenthood.

Andrea describes herself as an anxious person and has previously struggled with cannabis use. Andrea takes medication to manage her anxiety and has previously had CBT, which was helpful. Andrea identified help-seeking as a strength of hers, attributing this to the resources and knowledge her experiences of working in mental health have given her. Following the traumatic birth of Ava, Andrea experienced significant anxiety, including intrusive thoughts. Additionally, Jennifer became depressed after the birth, experiencing suicidal ideation, which Andrea supported her through. Both Andrea and Jennifer received support from their GP and health visitors concerning their PMH, which has had a positive lasting impact on them.

During the interview, Andrea spoke in detail about the process of becoming pregnant, including political undertones of the decision, choosing the sperm donor and experiences of heteronormative care. The depth in which Andrea spoke about these topics left me wondering how these experiences had subsequently influenced her sense of parental identity and mental health experiences. Andrea also spoke at length about the traumatic birth, becoming emotional at times, indicating the significant impact this had had on her. When speaking about her PMH experiences, Andrea reflected on her difficulties bonding with Ava, strong feelings of inadequacy as a parent in comparison to her wife, and confusion about her parental identity. Additionally, she spoke of fear of judgement from others and internalised mental health stigma, compounded by being a mental health professional, and using protective strategies to lessen the risk of experiencing homophobia. Andrea would frequently question the relevance of her responses to the research and would seek reassurance from me, reflecting her concerns about other's judging her.

This was the first interview done remotely via Microsoft Teams. I was less concerned about the logistics of the interview due to my familiarity with the platform and therefore the interview felt less stressful. However, at times the internet connection became unstable, interrupting the flow. Andrea was very open and articulate about her experiences, which contributed to me feeling relaxed in this

interview. I felt a connection with Andrea because of her communication style and role as a mental health professional that enabled me to ask open questions to explore her experiences. At times, Andrea struggled to stay focused on the question which made me wonder whether the questions were too open. I found it difficult to bring her back to the questions because Andrea was clearly anxious about the relevance of what she was discussing, and I did not want her to feel that what she was saying was not important or interrupt her flow. Consequently, the interview was longer than anticipated but I think this helped put her at ease and provided context for Andrea's experiences.

4.1.3 Natalie

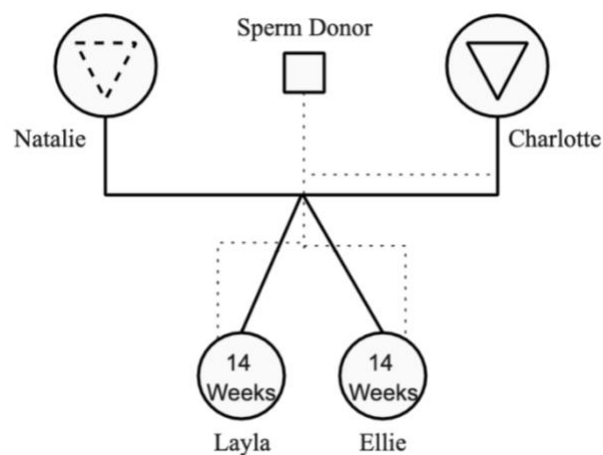


Figure 5. Natalie's genogram

Natalie is a white British woman in her 30s living in England who identifies as bisexual. Natalie has been with her wife, Charlotte, for more than 10 years and they have 14-week-old twin daughters, Layla and Ellie. Layla and Ellie were conceived on the first attempt through unmedicated IUI, carried by Charlotte and born during the Covid-19 pandemic (see Figure 5 for genogram). Both Natalie and Charlotte wanted children, although neither wanted to carry. For practical reasons, it was decided that Charlotte would be the birth mother.

Natalie describes experiencing depression when she was younger, and on-going experiences of anxiety. She has previously accessed psychological therapies, including CBT and counselling, and takes medication to manage her anxiety. Natalie reported using emotional coping strategies Through her previous experiences, Natalie

reported increased emotional intelligence such as socialising, exercising, speaking with others about her emotions and externalising her feelings through writing. Natalie experienced anxiety during Charlotte's pregnancy citing environmental stressors, concerns about Charlotte's depression during the perinatal period, and fears of experiencing homophobia and discrimination as a same-sex family. This resulted in Natalie taking time off, although she then drew on resources from her previous therapy to cope with her anxiety and to proactively address her fears of homophobia whilst at work.

Natalie spoke in-depth about their journey to becoming pregnant, including anxieties related to fertility decisions, negotiating and challenging heteronormative systems in primary care and during assisted conception. The time spent on this in the interview and the anger and frustration evident in her language and tone of voice indicated the importance of these issues in providing context for her perinatal anxiety, specifically in terms of increased minority stress. Additionally, when Natalie talked about speaking out against heteronormative/heterosexist care and becoming a 'special case' in funding for fertility treatment, I wondered how the sense of responsibility and pressure associated with challenging discriminatory practices had impacted her PMH. Natalie also spoke feeling like she had failed as a partner. Natalie reflected on the differences between the experiences of fathers and non-birth mothers and the need for tailored support.

Natalie approached her responses in a logical way, for example seeming to catalogue her anxieties into a hierarchy, which helped me negotiate the interview. In contrast to other participants, Natalie seemed positive about her mental health experiences. This surprised me a little, perhaps indicating my own bias in believing that participants would have a more negative experience, and, at the time, I worried a little about how her experiences would fit into a wider group analysis. I found her passionate anger about heteronormative/heterosexist care contagious, sharing her irritation concerning her negative experiences with the healthcare system which stayed with me sometime after the interview. Additionally, it was upsetting to hear about her distress regarding discrimination and it made me acutely aware of my own privilege as a cis, heterosexual female.

4.1.4 Sarah

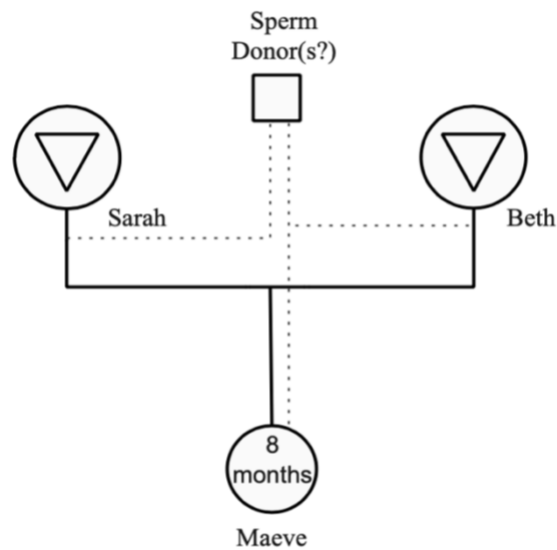


Figure 6. Sarah's genogram

Sarah is a white British woman in her 30s living in England who identifies as a lesbian. Sarah has been with her wife, Beth, for more than 10 years and they have an 8-month-old daughter, Maeve, together. Maeve was conceived through the third attempt (all IUI) and was carried by Beth (see Figure 6 for genogram). Both Sarah and Beth had wanted children and it was initially planned that Sarah would carry, but this changed due to her poor mental health at the time.

Sarah's mental health problems started as a teenager, including self-harm, suicidal behaviour and an eating disorder, and she struggled significantly with coming to terms with her sexual identity. Sarah has engaged with various psychological therapies and whilst she found CBT useful, she ultimately felt let down by services. Sarah views her mental health difficulties as an integral part of her identity. Sarah identifies as Christian and identifies her faith as acting as both a protective factor and contributor to her distress about her sexuality. Sarah became depressed during Beth's pregnancy following vocalised homophobia from Beth's family, triggering internalised homophobia and leading her to question their decision to have children and her parental identity. Sarah felt unsupported by Beth during this time leading to conflict in their relationship. Sarah also felt ignored and invalidated by professionals in her role as non-birth parent and that there was no support available to her. This was her motivation for participating in the study. Sarah is currently going through fertility treatment herself with the aim of carrying their second child.

Sarah spoke extensively about issues relating to minority stress, including her experiences of homophobia, the internalised homophobia stemming from her religious background, and her increased sensitivity to feelings of exclusion as the non-birth parent. This seemed to be fundamental to her questioning her legitimacy as a parent and the feelings of isolation underlying her PMH experiences. Additionally, Sarah repeatedly voiced confusion and dissonance about her role, desperately wanting to be a mum but lacking a motherly bond and often feeling like 'second rate' parent or dad, resulting in feelings of inadequacy. Throughout the interview, there was a strong sense of powerlessness and inevitability in relation to Sarah's experiences of mental health, viewing her 'illnesses' as part of her identity, having control over her life and something from which she could never completely escape. At times, Sarah struggled to articulate how she had been feeling, which seemed to relate to how chaotic she felt during this time.

Sarah seemed quite anxious about opening up and would often jump between different topics and time periods which I found at times hard to follow. However, I was struck by how open Sarah was about her struggles with internalised homophobia and how this contrasted with the pride in their sexuality expressed by previous participants but reflected challenges about multiple parts of identity i.e., the role of faith. I felt sadness about the feelings of powerlessness and inevitability she felt about experiencing PMH during her own pregnancy, in addition to her relief that she would finally be able to access support as a birth mum. As a professional, I felt a pull towards engaging in a therapeutic relationship with her which was difficult to put aside both during and after the interview.

4.1.5 Laura

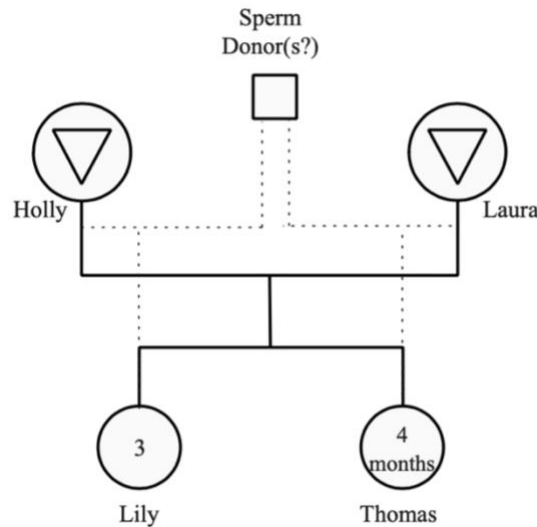


Figure 7. Laura's genogram

Laura is a white British woman in her 30s living in England who identifies as a lesbian. Laura has been with her wife, Holly, for 6 years and they have a 3-year-old daughter, Lily, and a 4-month-old son, Thomas. Lily was conceived through IVF and was carried by Holly, which suited Laura due to her own fear of childbirth (see Figure 7 for genogram).

Laura has previous experiences of depression following her mother's death and situations where she does not feel in control or valued. Laura has previously attended counselling but found this to be an unhelpful experience involving the "dragging up" of emotional difficulties. Laura became depressed during Holly's pregnancy due in part to conflict with her mother-in-law in which she felt criticised and excluded from parenting decisions. These feelings continued after the birth, exacerbated by feeling she was missing out on time with their child due to work. Laura began to experience suicidal feelings, which she coped with by suppressing and hiding her emotions until she broke down at work. Following this, Laura privately accessed support through a holistic life coach who worked with her on developing proactive coping strategies. Holly also experienced postnatal depression, although this was not recognised at the time. Both Laura and Holly's mental health experiences caused conflict and disconnection in their relationship.

Laura's need to feel in control and valued was clear throughout the interview, as she expressed the importance of having her opinions listened to and having a sense

of purpose. She often spoke about wanting to prepare and research the area and there was a clear preference for practical approaches to difficulties. Whilst Laura had some experiences of heteronormative care and having her role invalidated by others outside of her immediate network, she appeared to have been more affected by the criticism she received from her mother-in-law. In contrast to the other interviews, Laura drew a lot of comparisons between her experiences as non-birth mum and birth mum, viewing that biological motherhood afforded her different privilege in terms of having control over her decisions and her opinions being valued. Laura also spoke passionately and at length about maternity care as a birthing parent, including power imbalances, informed consent and heteronormative care.

Laura had her son with her at the interview for childcare reason. At times, I found this a little distracting and meant that I could not hear some of the recording due to the baby crying. I also wondered how this impacted on Laura's engagement in the interview. I noticed I felt dismissive of Laura's use of a holistic life coach during the interview and struggled to keep an open mind about this. I also reflected that I struggled to move away from my professional self as I kept mentally trying to formulate her avoidance of emotion. At times Laura spoke about topics not directly related to the interview, such as power and consent in maternity care and I found it difficult to bring her back to her own experiences because I was interested in what she was discussing. Whilst the comparisons she drew between her experiences of non-birth and birth mum added an alternative interpretation of her experiences, I worried that at times we were spending too much time discussing her current experiences in detail and the experiences are not fully separable.

4.1.6 Alice

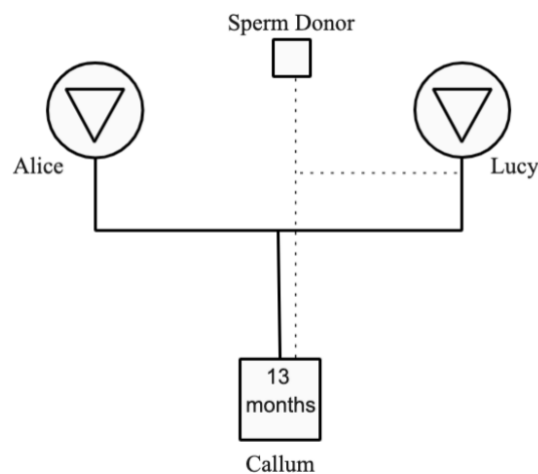


Figure 8. Alice's genogram

Alice is a white British woman in her 20s living in England who identifies as a lesbian. Alice has been with her wife, Lucy, for nearly 4 years and they have a 13-month-old son, Callum. Callum was conceived through IVF and was carried by Lucy (see Figure 8 for genogram). In contrast to the other participants, Alice has always wanted children; however, she reported that Lucy was less sure due to her mother's experience of postpartum psychosis. Lucy ended up "going with the flow", although Alice did not explain why it had been Lucy who had carried.

Alice struggled with poor mental health since her teens, and she was diagnosed with autism when she was 24. Whilst she engaged in the limited therapy she was offered and tried to develop coping strategies such as exercise, Alice attributes her recovery to meeting her wife who is her main source of support. Alice began to feel anxious during Lucy's pregnancy due to Lucy struggling with her mental health. These feelings increased after the birth when Alice began to feel overwhelmed as a new parent, as well as feeling excluded and underappreciated in her role as non-birth mum. Neither Alice nor Lucy received any mental health support, despite requesting it for Lucy, and feel let down by services.

Similar to some of the other participants, Alice spent large portions of the interview focusing on Lucy's mental health. Perhaps this demonstrates the significant role Lucy plays in Alice's life and the importance of Lucy's mental health in relation to her own. It also mirrors the focus on birth mums and the exclusion or neglect of partners' needs by services. When asked to reflect on her own experiences, Alice offered quite limited descriptions of her feelings and generally there seemed to be less emotional depth to this interview than in comparison to the others, potentially linked to her neurodiversity. During the interview, it appeared that Alice's mental health experiences were often influenced by her own parental desire, such as feelings of being excluded from the mother-infant bond due to not being able to breastfeed. I wondered how this made her feel as a mother, particularly as her desire to be a parent had been much stronger than her wife's, and I questioned how that contributed to her feelings towards Lucy.

This was the first telephone interview that I conducted, and I speculated whether Alice chose this type of interview due to difficulties with social communication. I found this interview much more difficult than the others as I could not read Alice's

body language to take cues from her or gauge how she was finding the interview. I also initially struggled to get into the interview, sometimes talking over Alice. Over time I felt like we built up a connection as Alice was starting to open up more and offer information freely. However, halfway through the interview, Alice needed a break in the interview for childcare reason and when the interview resumed, I noticed that the interruption from Alice's home life made it difficult for both of us to get back into the flow. Consequently, the second half of the interview was much shorter, and I felt less able to explore Alice's responses further.

4.1.7 Annie

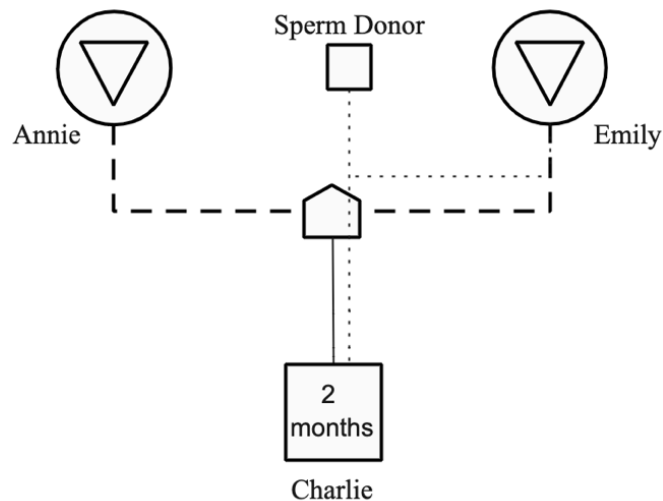


Figure 9. Annie's genogram

Annie is a white woman in her 30s living in England who identifies as a lesbian. Annie has been with her partner, Emily, more than 10 years and they have a 2-month-old son, Charlie. Charlie was conceived through IVF after unsuccessful IUI attempts, was carried by Emily and was born during the early stages of the Covid-19 Pandemic (see Figure 9 for genogram). Both Annie and Emily were initially uncertain about having children, fearing they might regret their choice.

Annie had experienced mild depression whilst a teenager and as an adult following a trauma, for which she took antidepressants and attended counselling. Annie reported not finding counselling helpful at the time, which she linked to her familial tendency to suppress emotions. Annie began to feel anxious during the pregnancy due to Emily's mental health deteriorating significantly as a result of the

physical impact of fertility treatment and pregnancy. Emily's mental health deteriorated to the point where she was considering terminating the pregnancy but improved after receiving support from her GP and a mental health team. Following Charlie's birth, Annie became very depressed so sought help from her GP who recommended a counselling service. Annie is currently engaging with an online course provided by the counselling service.

As in the other interviews, the focus was often on her partner's mental health. Annie struggled to reflect in the interview on her antenatal anxiety during the pregnancy, possibly because focusing so much on Emily's needs had led her to disconnect from her own emotions. A lack of control and uncertainty seemed to underlie much of Annie's antenatal anxiety, particularly in relation to the decision of whether to continue with the pregnancy. In relation to her depression, Annie spoke about moving from survival to recovery mode and its impact on her bond with Charlie and relationship with Emily, resulting in her questioning and criticising her parental efficacy. Annie also reported previously believing that she would be immune from PMH difficulties, reflecting perhaps the stigma around these issues, and I wondered how this had influenced her subsequent experiences of depression. Notably, Annie frequently used metaphors relating to being on a journey, and a rollercoaster.

I felt more comfortable with this second telephone interview and Annie was very articulate. I noticed that it was easier to ask open questions exploring her experiences in depth due to how open and candid she was being. This was my final interview and I noticed I was much more confident conducting the interview in comparison to the first in-person interview and was less hesitant when exploring Annie's experiences. I felt it was a strong interview, providing rich data, and I felt a sense of accomplishment once it had finished.

4.2 Group Analysis

As described in the methodology chapter, a group analysis was conducted to identify overarching themes representing experiences shared by some or all the participants. Within this section, the superordinate and subordinate themes developed from the group analysis will be briefly outlined and evidenced by supporting quotes and extracts from the interviews. Six superordinate themes were identified, including: **'Failure and Inadequacy in Role'**, **'Powerlessness and Intolerable Uncertainty'**,

‘Legitimacy of (Di)stress as a Non-Birth Parent’, ‘Parenting Without’, ‘Changed Relationship Dynamics’, and ‘Moving Forward’. The first four superordinate themes are comprised of three subordinate themes each whereas the final two superordinate themes are comprised of two subordinate themes each. Figure 10 depicts a thematic map to assist the reader in conceptualising the themes and relationships between them.

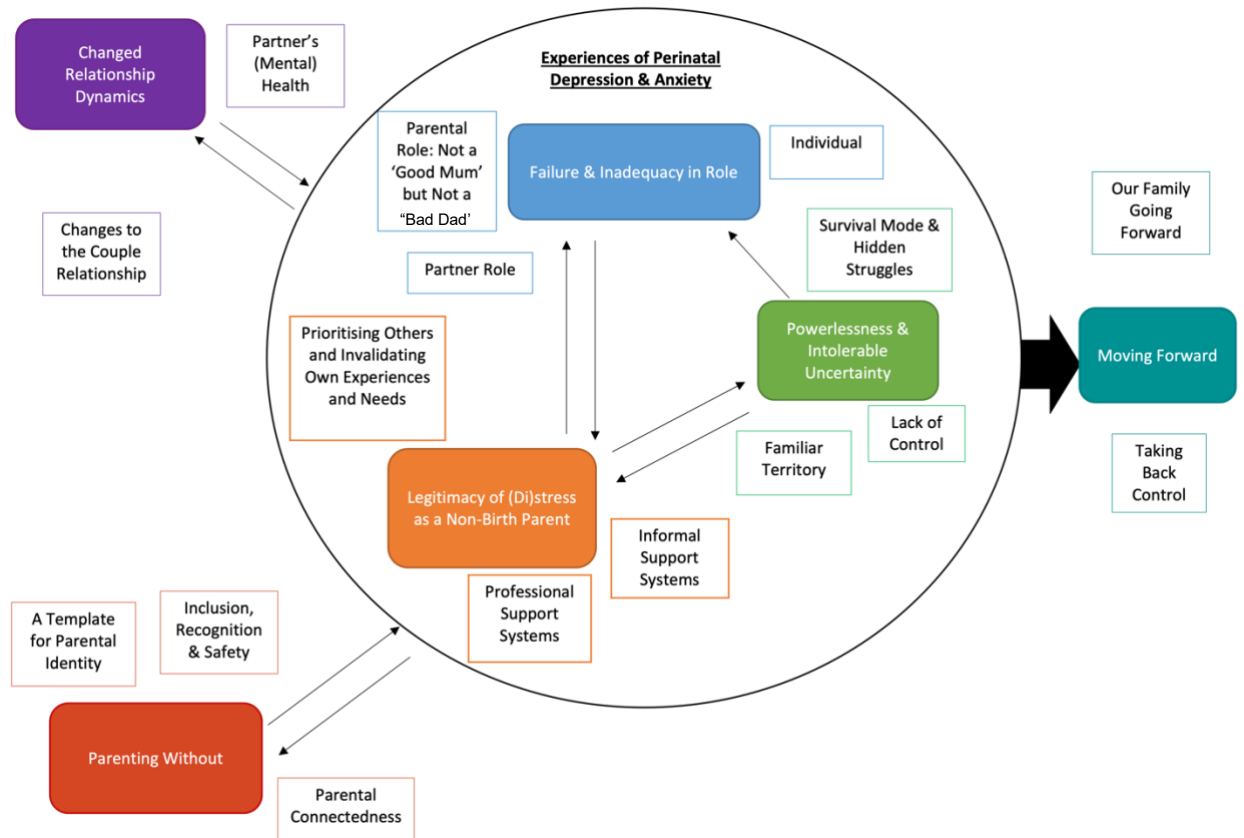


Figure 10. Thematic Map

4.3 Failure and Inadequacy in Role

This superordinate theme represents the sense of failure and inadequacy participants expressed in their different roles which seemed to epitomise the pinnacle of their perinatal psychological distress. This theme comprised of three subordinate themes: ‘Parental Role: Not a ‘Good Mum’ but Not a ‘Bad Dad’’, ‘Partner Role’ and ‘Individual Role’.

4.3.1 Parental Role: Not a ‘Good Mum’ but Not a ‘Bad Dad’

All participants spoke of feeling that they were failing or inadequate as a parent which contributed to experiences of perinatal depression and anxiety. At times, feelings of failure or inadequacy were shared with their partner, and at other times these feelings were more individual. These feelings were indicated by internal and external perceptions of failure.

Internally, some of the women reported experiencing regret over their decision to have a child, especially when they were struggling to adapt to the physical demands of having a new-born, such as managing a lack of sleep, and when the reality of parenthood did not match their expectations. Andrea talked about the extreme disparity between her expectations and reality after the birth of their daughter leading to intense disappointment and inescapable regret: *“I suppose I wasn’t expecting it to be like easy or even really really happy but like, I mean literally there was no joy.”* Frequently, feelings of regret were accompanied by guilt that contributed to feelings of failure and hopelessness, as Andrea described: *“I know that we both had this feeling of like we’ve done the wrong thing, and that was really difficult because that we couldn’t reverse it.”* The guilt experienced by some of the women appeared to be heightened by their active decision to pursue parenthood and the significant financial, emotional and practical investment in assisted conception building expectations higher.

A couple of the women compared their capabilities as a parent to their partners’, viewing their partner as a more ‘natural mum’ and leading to them feeling like an inferior or second-rate parent. Alice referred feeling less able than her wife at soothing their son: *“So Lucy goes shopping. He’d be screaming and I’m like “Ooh!” [Laughs]...And I just had to wait for her to get back.”* Similarly, Andrea frequently compared herself to her wife during the interview, contributing to her anxiety about her own ability to keep her daughter safe: *“I definitely had a sense of like I am much less good at this than her [Jennifer], and would avoid...like taking her out.”*

Participants also expressed not feeling good enough and questioning their adequacy as parents, particularly within the context of deviating from societal norms of ‘good parenting’ and potentially being judged by others. Natalie spoke about both her and her wife questioning their adequacy as parents when they had to start bottle-

feeding their children: “...we did have a sort of oh are we being really bad giving them formula?”

Andrea and her wife felt intensely guilty when comparing their struggles with parenthood to other parents who they perceived as ‘worse off’, including those with less instrumental support or resources to draw on and parents with children who were not sleeping; these comparisons intensified feelings of shared failure: “*Erm I remember Jennifer once said to me like... “what do single mothers do?” and we just both like [laughter] burst into tears because like, we could barely we felt like we could barely manage, you know, ...but we have all this support and we have each other.*”

Some of the participants felt their behaviour and actions were more in line with those expected of fathers, creating identity dissonance and adding to their sense of failure given their negative perceptions of fathers, which appeared shaped by societal narratives. This was summed up by Sarah when talking about an incident where she had placed her child on a chair and they had fallen, expressing feelings of wanting to be better than a father: “*And then that made me feel like a ... second rate parent! Made me feel more like a Dad! Like, you know, I’m the one who doesn’t know what they’re doing! That does stupid stuff and messes up and makes it like ... em and that was really hard because I wanted to be the Mum! And I’m like the perfectionist! I wanted to be the best Mum! And then I was like totally like messing it up!*”

Some participants shared that they felt they lacked a parental bond towards their child which led to feelings of guilt and shame. Annie spoke about sounding like “*a terrible parent already*” when her partner became upset after she admitted to her that “*I really didn’t feel like I did miss him [son] today*” following her returning to work and questioned “*what’s wrong with me*” over her lack of bond. Own concerns about bonding contributed to low parental efficacy amongst some of the women. For example, Andrea felt inadequate as a parent for providing adequate physical caregiving but not feeling the emotional aspects: “*I remember Ava couldn’t er, she wouldn’t stop crying...and I was just like holding her going like “I don’t know I don’t know who you are, erm I don’t know what to do to make you feel better” ... so I think if you’d seen me with her, you would have thought what a loving mum.*” The feelings of being a ‘terrible’ parent arising from a lack of parental bond were often exacerbated by a disparity between expectations and reality of bonding and messages from society that parents should feel ‘amazing love’ towards their child(ren), which Annie summed

up as: *“Everyone wants to be with their baby all the time when they’ve just been born.”* Similarly, Sarah referred to feeling *“really bad, really guilty”* due to her lack of connection and resentment towards her son because: *“I was just like, you know, everyone was saying that you’re supposed to feel like this massive rush of love and, you know ... want to jump in front of a train for your child. But I was there like you need to stop crying or I’m going to like send you back to the shop.”* Whilst all the women understood that parents may struggle with bonding to their child, for some there was a sense of shock and lack of compassion toward themselves when they did struggle:

“Objectively I can look at it and say oh there’s nothing wrong with you because, just some people... take time to bond...But when it’s you yourself! You just think oh God! That sounds terrible!” (Annie.)

Some of the women felt their experiences of mental health difficulties impacted on their ability to live up to being the ‘ideal’ parents they aspired to be. Simone spoke about the lasting impacting on her mood following the traumatic birth of her son, including irritability: *“I think that the biggest impact it has on me being more I guess short tempered...I wish I was like a wonderful, calm parent, but I mean sometimes I am, sometimes I can roll with it and other times it’s just [pause] yeah.”* Whilst some of the women had reconciled the impact of their mental health, some were continuing to struggle to adjust to this unexpectedly different version of parenthood:

“I just don’t feel that I am the parent that I want to be! Like I think in my head, I knew what kind of parent I’d be based on the kind of person that I am. And I don’t feel now that that’s the case...Erm but ... I feel like I’d probably be a better Mum if I was being myself in terms of, you know, not wobbling! And just be able to like be, you know, stick with being who I was in terms of being very, like efficient.” (Sarah)

Additionally, some participants’ experiences of specific mental health symptoms, such as intrusive thoughts of harming their baby or not being able to protect their baby, increased feelings of being a ‘terrible’ parent. This was summed up by Sarah: *“The first problem I was having with these intrusive thoughts, which were horrible! Just you know, things like chucking my baby out of the window type of things!”* Similarly, Andrea spoke about how her intrusive thoughts and anxiety lowered her parental efficacy as she feared that she would be unable to keep her child

safe: *“So this sense that I didn’t want to be out out with her because something bad would happen or [yeah]. And I kind of didn’t trust myself.”*

Some attributed their feelings of failing to external messages regarding their ability as a parent. Participants referred to the anticipated and experienced criticism and judgement of parenting from others. Laura spoke about the criticism she faced from relatives regarding her parenting decisions: *“It was all these people telling us “oh you shouldn’t do that, you should do this! And, and you can’t do that, you should do this. And you mustn’t do that!”* Over time, this criticism left Laura feeling worthless and inadequate in her parental role, contributing to suicidal feelings.

This sense of failure and inadequacy in their parental role was exacerbated by stigma relating to mental health, both generally and as a parent, and stigma relating to sexual identity. For a couple of the participants, there was fear that admitting their mental health struggles would be met with judgment of their parenting by others or that they would be dismissed or judged, which subsequently impacted on their help-seeking. Sarah spoke about her fear of sharing her intrusive thoughts, saying: *“But I didn’t really feel like I could do much about that because I think it’s like that standard fear that if you say you’re thinking certain things, and people will be like questioning your ability to be a parent and all that side.”* Sarah went on to comment about the potential negative implications of sharing her feelings: *“And I definitely wouldn’t have spoken to anyone about it! Cos I was like, they’ll take my baby away!”* Andrea expressed feeling torn about wanting to provide a healthy view of emotions and being seen as a ‘mad mum’ due to her own internal prejudice about her mental health:

“And I want her to have a healthy view of emotions and I want her to know that it’s okay to cry...But I also do have this like prejudice against myself...I don’t want her to have stories about her mum, like crying a lot when she was a baby and [yeah], you know like or her mum being sad all the time or, you know like [yeah] or being mad or being unusual.”

For the participants that had shared their mental health difficulties with others, there was hypervigilance to being perceived negatively by others as a family. Following her diagnosis of postnatal depression, Andrea expressed feeling *“sort of paranoid”* about whether other people thought she was abusive parent after seeing a domestic violence prompt on her health record during an appointment with her GP, explaining her anxiety as: *“That that something had, been seen or [yeah] that an*

assumption had been made...the health visitor had come round and she'd made an assumption about something, and then that was on my record."

Most participants reported that PMH difficulties were not spoken about openly in maternity services or antenatal classes and are viewed as 'taboo', which meant that some of the women were confused or scared about what was happening and internalised these feelings as failure. Laura commented that the taboo nature of PMH difficulties had been a barrier to her accessing support: *"Nobody talks about the fourth trimester or em birth trauma, recovery, postnatal depression. It's like oh it's taboo! You mustn't talk about these things....and it's because nobody's talking about it, it's not then really acknowledged. And people just kind of squirrel themselves away and try their best to deal with it on their own, like what we did."*

For some participants there was an added layer of stress due to homophobia and expectations of failure as a same-sex parent, increasing the pressure to be a 'successful' parent. Consequently, there was a fear that by admitting they were struggling, this would confirm other people's homophobia and their own internalised homophobia, intensifying the feelings of failure. Sarah spoke of the intersection between her faith and sexual identity and her increased anxiety about experiencing homophobia from the church: *"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! That's why, and it was almost like in my head I was already confirming my fears about it!"* This stigma and fear of being perceived by others as failing acted as a barrier to help-seeking for Sarah: *"Which made me not want to talk to people because ..I was worried that deep down everyone would just be thinking like, you shouldn't be having children cos you're 2 women. And if you were a man and a woman you wouldn't be feeling so em ... like worried about it."*

Some participants employed coping strategies such as normalising their experience, gratitude, self-compassion and acceptance to increase their levels of internal validation to buffer against these feelings of failure and inadequacy as a parent. Laura reflected on her use of a gratitude diary to help manage the criticism she faced from others, commenting: *"And over time it ... did make me feel better about myself. Because it made me look at myself and think well do you know actually I am a good parent!... and just constant positive reinforcement but making me do it rather than get that recognition from somebody else!"* Whilst some participants used these

strategies, others did not as they potentially felt like they did not need to and some participants reported continuing to struggle with these feelings. Additionally, several participants spoke about a shared feeling of failure or inadequacy with their partner, as highlighted above, which appeared to help diffuse some of the personal feelings of failure.

4.3.2 Partner Role

Some participants felt a sense of failure or inadequacy as a partner arising from feeling powerless to protect or support their partner during pregnancy or birth, particularly if there had been a traumatic event. For example, Simone commented on her attempts to be “*pragmatic*” in her support of her partner following her son’s traumatic birth: “*I mean, it didn’t stop me from feeling helpless though, and sometimes not good enough.*”

Additionally, some participants felt they were not able to support their partner in their parental role or their mental health difficulties, despite wanting to help. Participants identified several barriers here. Some participants reported not knowing what to do to support their partner. For example, Simone felt distressed about not knowing what to do to help support her partner more: “*Even though I don’t really know what else I could have done.*”

Alice struggled to balance returning to work and supporting her partner, resulting in acute feelings of guilt and failure: “*It makes me feel pretty crap when she’s crying in the morning and I’ve got to go to work and stuff! And then it affects my mood for the day because [Yeah] that it, you know, she, she’s been crying and I’ve had to leave her or we’ve argued in the morning.*” This was echoed by Simone, who said: “*I found it really hard when I went back to work because of how much she was struggling at home. So yeah, that was awful.*”

Mental health experiences impacted both Laura’s and Andrea’s ability to be present for their partners emotionally and physically. Laura reflected on how her mental health difficulties resulted in her disconnecting from her relationship, meaning she was not emotionally present to support her wife in her struggles: “*But I mean I was in my slump and my bad place so I wasn’t really picking up on a huge amount.*” Andrea spoke of her embarrassment and frustration when she experienced a panic attack when her partner was given an epidural, expressing high levels of criticism for herself and her role as a partner: “*I felt really shit for that happening...I wasn’t able*

to be, the supportive partner I wanted to be in that moment [yeah] and, you know, it felt a bit pathetic.”

Finally, Natalie spoke about how not being able to go back into the hospital and provide emotional support to her wife after the birth due to Covid-19 restrictions and the negative impact this had on her feelings of supportiveness as a partner: *“Erm so then I was very very worried erm and sad because I knew that Charlotte wasn’t coping I couldn’t care give to her, she was trying to care seek from me it didn’t work.”* However, Covid restrictions also acted as a facilitator to being a supportive partner for some participants as they were at home more and so could provide both mental health and parental support. For example, Annie was able to provide more support to her partner who was struggling with her mental health during the antenatal period due to being furloughed: *“She [Emily] has said to me that if it wasn’t for that, me being here with her when she was feeling so low, those few months, she probably wouldn’t have been able to keep the baby because she would have just been here, by herself, with her thoughts.”*

This sense of failure and inadequacy in their partner role was exacerbated by having actively decided that the other partner would carry the pregnancy, leading to further feelings of guilt:

“I helped as much as I could do, but I did feel a bit guilty that it had erm been her going through it and not me because it’s just-- being pregnant and giving birth is such a horrible experience I think.” (Natalie)

4.3.3 Individual Role

This theme relates to the feelings of failure and inadequacy participants experienced in relation to their role as an individual, particularly in relation to their professional and personal identity, and the contribution of these feelings to perinatal anxiety and depression

Becoming a parent had left some participants struggling to balance work and family demands. By focusing on either, they felt they were letting people down. Sarah struggled to compromise between work and family life before and after the birth of her daughter, saying: *“I was trying to work from home but ... there was so many demands on me from a family perspective and [Yes] it just didn’t work because I was trying to divide my attention between two things and it felt like I was never giving my*

family enough of my time! But equally not giving my work and I just felt I couldn't commit to both well enough." This led Sarah to feel she was failing everyone, contributing further to her distress: *"I felt like I was letting everybody down. So I was letting my family down by working, but letting my work down by being with my family and I, I've always taken like a lot of pride in my work and took it very seriously. So I didn't like the fact that I was then em having to put that to one side. Then I'd feel really guilty for putting work above family."*

Additionally, for some participants their mental health experiences had a significant impact on their work identity, with them feeling that they had become less effective at work. Simone spoke about how her low mood and anxiety and her wife's coping impacted her work: *"My work definitely suffered [laughter]. I was very distracted, very distracted when I was at work erm yeah. Spent most of my day checking how Rebecca was."* Similarly, Sarah commented how difficulties with anxiety and depression became an obstacle in delivering her work ethic: *"I feel like a different person at work now...My work can be a bit shoddy because I just don't have the capacity for it in the same way. And so that does bother me because...the kind of values that I hold really strongly, I've had to kind of put to one side."*

Finally, some participants criticised their ability to cope with their mental health experiences, even in the face of praise, and would seek out assurance from others that their struggle to cope was valid. Simone appeared to doubt how well she coped with the trauma of her son's birth, even when her wife *"reckons I've done really well."* When Natalie was experiencing acute anxiety, she sought a counsellor to provide her validation that she needed to take time off: *"And I went to see erm, the counsellor who I was seeing at the [workplace] and said "I'm really worried about how I am" and she was like "just to go home, do not be here, take some time off you're not okay."*

These feelings of failure and inadequacy were exacerbated by stigma surrounding mental health difficulties. For example, Andrea expressed a sense of failure and self-criticism arising internalised stigma relating to experiencing mental health despite being a mental health professional: *"Even though, so I do have this kind of prejudice, this like self erm internal prejudice about my mental health I think."*

4.4 Powerlessness and Intolerable Uncertainty

This theme depicts the feelings of powerlessness and intolerable uncertainty that underpinned participants' experiences of perinatal anxiety and depression, which in turn contributed to the first theme, 'Failure and Inadequacy in Role'. Whilst these two elements overlap, powerlessness is predominately related to recognition and inclusion by others and intolerable uncertainty predominately related to lack of clarity about their role (both of which are explored further in the theme 'Parenting Without', see Section 3.6). This theme consists of three subordinate themes: 'Lack of control', 'Survival Mode and Hidden Feelings', and 'Familiar territory'.

4.4.1 Lack of Control

All participants described experiencing a lack of control contributing to the feelings to powerlessness and intolerable uncertainty underlying their perinatal mental health issues.

For some, becoming a new first-time parent and their lack of familiarity with the process of assisted conception and parenting contributed to a lack of control which led to intolerable uncertainty. Annie spoke about feeling *"this is real now"* after discovering her partner was pregnant which was accompanied by anxiety about what could go wrong during the pregnancy, leading to her catastrophising: *"So as soon as we found out she was pregnant and I was already thinking oh God what, we have to be really careful so we don't lose, you know so we don't lose. What happens if we have a miscarriage? What happens if this happens?"* Similarly, Andrea spoke about *"dawning realisations"* of the additional responsibilities of being a parent and her subsequent fear about keeping her daughter safe, with this perceived lack of control contributing to intrusive thoughts about her daughter coming to harm: *"I was just terrified, and-- that something would happen and I was having, sort of intrusive thoughts about like a car so for example not stopping at a red like and just mowing us down...the kind of world felt unsafe.... Erm so lots and lots of risks all the time."* This fear about potential negative events and participants' inability to avoid or control them overwhelmed them emotionally, as summed up by Natalie: *"Erm so I think, exceptionally overwhelmed by everything that was going on."* Sarah spoke about not knowing what to do as a new parent, contributing to her anxiety: *"I don't know. It was just like I, I had this massive like 'help'! I don't know like ... this whole parenting thing, I was like I don't know what I'm doing!"* Whilst the previous examples related

to becoming a new parent more generally, others spoke about their lack of control and subsequent intolerable uncertainty about their parental identity as a non-birth mother due to a lack of a clearly defined template for their role, which led to Sarah having a “*massive freak out*”. This is discussed in more detail in the subtheme ‘A Template for Parental Identity’ (see Section 4.6.1).

For other participants, there was a lack of control in relation to issues associated with minority stress. In addition to fears about experiencing discrimination as a family in the future (“*And then, on and off I do get worried about erm, about how people will treat us as a family... I do worry about how erm Layla and Ellie, the girls will be treated at school and will they be bullied*”), Natalie spoke about a lack of control over the political context in which she was having a family which she described as “*very right wing*” and her subsequent feelings of powerlessness. She also voiced intolerable uncertainty over how they would be treated in the future, reflecting on the impact of the Gender Recognition Act on the Transgenders community: “*So that made me feel angry and upset for the broader LGBT community and I thought well if that’s happening to trans people what’s going to happen to us potentially.*” For Natalie, this lack of control and subsequent difficult feelings had both an emotional and physical impact on her:

“I was very very tired a lot of the time. Erm I was crying loads at work...I tend to feel quite light-headed and a bit kind of light in my body...So I had those kind of physical symptoms [yeah]. Erm and just kind of the not being able to stop worrying about what was going on at that point in time.”

Experiencing a lack of control frequently accompanied traumatic events during pregnancy and/or birth. For several participants, being unable to predict or influenced what was happening either in the moment and/or in the future lessened their feelings of control and increased feelings of intolerable uncertainty. For Annie, the lack of control and subsequent intolerable uncertainty over her partner’s decision to continue with the pregnancy contributed to her feeling “*highly anxious*”: “*It was just so weird because it just felt like we were on a, like this tiny line where it was, her decision could have gone either way you know? [Yeah.] She was like right in the middle and em, and so I just felt really on edge because I knew it was on this point, fine point where she could decide, you know ... one way.*” Echoing this, Simone described feeling helpless and intolerably uncertain about the future and the impact

of the traumatic birth on their lives: *"Erm, just not knowing how things were going to pan out really. Kind of not seeing an end in sight."* The lack of control and intolerable uncertainty associated with traumatic events also contributed to some participants experiencing a sense of powerlessness. Simone spoke about feeling *"very helpless a lot of the time"* in response to the physical and emotional impact of trauma on her family.

Other participants described a lack of control arising from being excluded from their partner's pregnancy/birth/care and exclusion from decisions about their child's care, resulting in feelings of powerlessness. Laura spoke about the lack of control and subsequent powerlessness she felt when she was excluded from parenting decisions by her mother-in-law, leaving her questioning her worth as a parent and contributing to suicidal feelings: *"It just got to a point where I was like I felt completely useless. And like I wasn't needed. Wasn't wanted. And it was like oh what's the point of me being here?... It's very much like you know there's no point, no purpose anymore."*

Some participants viewed the difficult feelings and experiences outlined as unavoidable and inescapable. For example, Simone describing feeling *"trapped"* which resulted in her becoming *"more withdrawn"*. This feeling of being trapped by their situation resulted in a helplessness about their situation and a hopelessness for the future for some: *"what I felt then was that it wasn't going to end and that was terrifying."* (Andrea). Furthermore, participants felt unable to help or change what was happening and felt constrained to behave in ways they found distressing, resorting to a position of powerlessness summed up by Simone who said: *"it is what it is."*

Additionally, participants felt a lack of control and subsequent powerlessness in relation to their PMH experiences, expressing an inevitability regarding their poor mental health, an inability or futility regarding changing how they felt and that their mental health had a strong control over them, potentially contributing to the maintenance of problems. For example, when reflecting on her PMH experiences Sarah said: *"It feels like almost inevitable [laughs]! Like there was no way that we were going to be in that situation and have a baby and just be like "yay!""*

Lack of control and subsequent intolerable uncertainty and powerlessness contrasted with the significant amounts of planning and investment put into embarking on parenthood and the formal systems used to pursue assisted conception. Participants spoke about the stress arising from the discrepancies between expectation

and reality of becoming a parent, including disappointment, anger and loss, which increased lack of control. Simone spoke about the expectations of being in a “cocoon” with her wife and baby following the birth but the loss and anger of having this “*taken away from us*” following her wife’s traumatic birth: “*We just didn’t have the chance to just be the three of us...exploring him being in our lives, kind of, at home in the first couple weeks.*”

For some participants, this lack of control and following powerlessness and intolerable uncertainty was heightened by their personal need for control in their lives and was linked to feelings of failure and inadequacy as an individual and a parent. For example, Sarah spoke about the clash between her personal values and parenthood which contributed to her intolerable uncertainty about her role and feelings of inadequacy as a parent: “*One of the things for me was so much about being in control! Everything being perfect! And obviously when you become a parent, the first thing you learn is like you can’t be in control all the time! You can’t be perfect!*”

Participants would seek out familiar and predictable situations, such as returning to work or spending time with friends and family, to help increase feelings of control and reduce uncertainty: “*I think maybe once I started my shared parental leave I think that was a bit better because... it created more of a sense of normality within the family because she went back to work....*” (Simone).

Participants’ feelings of lack of control contributing to powerlessness and intolerable uncertainty were often exacerbated by the physical strain of being a new parent, specifically in relation to exhaustion and lack of sleep. Annie compared the lack of sleep she experienced to “*torture*”. Additionally, nearly all participants spoke about the existence of additional stressors outside of parenthood, which appeared to add to experiencing a general lack of control in their lives and exacerbate the feelings of powerlessness and intolerable uncertainty related to becoming a parent:

“*I lost my grandmother and ... for at least 6 to 8 months after we were, it’s like we just finalised dealing with ... selling her house and dealing with all that. And some of my family made that quite a hellish experience! So I had all that going on while we were pregnant. And then ... when baby was 5 weeks old ... we moved house ourselves... it was just too much going on.*” (Laura).

4.4.2 Survival Mode and Hidden Struggles

This theme represents the strategies participants used to manage their feelings of powerlessness and intolerable uncertainty.

As a result of experiencing a lack of control, the majority of participants would go into survival mode, coping “*just each hour...or each day*” (Andrea) and ‘just getting on with it’ due to their perceived inability to change their situation. This was summed up by Laura as: “*I just shut myself off and thought right, this is my life now! Great! Just, just get on with it.*” This survival mode was typically driven by the sense of duty participants felt to continue to look after their family regardless of their emotional distress. Simone’s strong sense of duty allowed her to continue to look after her family, explaining: “*I wasn’t in a situation where I could allow it to drag me down as much as it possibly would have done under other circumstances.*”

Most of the participants described using what would be defined as avoidance-oriented coping strategies to prevent themselves becoming overwhelmed by negative emotions, for example avoiding situations in which they felt out of control that contributed to feelings of inadequacy. For example, Laura would frequently delay going home to avoid feeling “*pushed out*”, saying: “*Certain days of the week, we’d always have people round. And it was, that’d be the day I’d try and take, you know I, I’ve got stuck at work! So I was deliberately on a slightly later train in the hope that I’d get home when all these people had already left!*” Whilst this felt helpful in managing difficult feelings in the moment, the use of avoidance could have quite a limiting impact on participants’ lives. For example, Andrea’s fear of being unable to protect her daughter and her subsequent avoidance of being alone with her meant that she spent less time together with her daughter building a bond.

Several participants expressed a desire of wanting to escape their situation. For Annie, her “*feeling of wanting to run away*” manifesting in suicidal feelings: “*I actually felt like I just want to die!*” However, participants felt trapped as they were unable to escape from their situation due to their sense of duty (“*Frustrated sometimes I just wanted to be out of the situation. Just I want to flee, run away. [Sigh] And obviously I didn’t.*” - Simone) or their lack of other viable options due to Covid restrictions (“*And then we ended up being locked down. So I was locked in this house, not able to see anybody else. Stuck with my wife who I thought hated me at this point!*” - Sarah).

Some participants would also disconnect from their emotions and needs to continue to function in day-to-day life and carry out their roles as carers more effectively in their eyes. Simone spoke about not being aware of how her depressive symptoms were affecting her at the time: *“Because I had a child to look after and a partner to support, I think I just kind of powered through it.”* Some participants used their responsibilities to distract themselves from their own difficulties. For example, Simone used her carer role as a way to distract herself from becoming overwhelmed by her own emotions: *“Yeah taking on the carer role and throwing myself into it and yeah.”* Conversely, Laura used work as a distraction: *“So that[work] kept me quite pre-occupied. So I had, I had another avenue to focus on. I had another reason to kind of get up and get my brain in gear rather than get up and think oh what battle am I going to have today?”*

Nearly all participants put on a ‘mask of coping’, hiding their feelings from others including their partner, to *“keep up appearances”* (Sarah). This was summed up by Laura as: *“And the, the fake face just to get through it until these people left! [Yeah, yeah] Em so yes, lots of faking it.”* Some participants hid their feelings due to not wanting to burden others. For example, Annie hid her distress from her own mother: *“Cos she’s a bit of a worrier! [Yeah.] I thought [laughs] she doesn’t need anything else to worry about!”* Similarly, Alice hid her feelings from her partner so as not to add to her mental health difficulties: *“I was worried for her and her, her mental health. But I never actually told her that!”* Some participants hid their struggles due to fears of stigma or being dismissed by others. Sarah spoke about talking with other people in a way that was *“quite matter of fact”* and *“making light of it a little bit”* due to her fear that other people would dismiss her: *“I feel like people would just be like oh yes it’s Sarah, be like obviously she’s going to like have some kind of drama going on!...which probably isn’t how people think at all! But that’s how in my head they’re thinking.”* However, this mask of coping was a fragile façade, with Simone explaining that *“...if I had been under scrutiny I think I would have crumbled.”* For most participants, the suppressed emotions eventually became so overwhelming that the mask would slip. Sarah spoke of breaking down at work, saying: *“Like I’m not really one to like cry a lot. But I was like almost crying on my colleague. Cos it was just like I can’t deal with all this and process it!”* This would further exacerbate feelings of a lack of control.

Being in survival mode was emotionally exhausting for participants and for some women, contributed to further mental health difficulties. For example, Annie made sense of her depression following the birth of her baby in the following way:

“I think for me it does make sense that the pregnancy was so low for my partner [Yeah] that I was worried about her so much that I ... was on a sort of constant state of trying to keep things going. Keep things positive and ticking over for her. [Yeah.] But then when I realised sort of that she'd instantly bonded with the baby, it was like my body just sort of shut down then? [Yeah.] And em did what it needed to do... to ... to recover from that I guess?”

Whilst some participants did access emotional support (see ‘Taking Back Control’ subtheme), most participants prioritised instrumental support over emotional support, as summed up by Natalie: *“Erm getting help from other people when we could [yeah]. And when we couldn't, talking to other people on the phone or video chat or whatever”*. There was a perception that more practical support reduced pressure on them as a caregiver, enabling them to reduce the impact of physical strain on their mental health and leave survival mode: *“But then we got some help in so my parents and other people came to help and they helped do the night-time things and that go a lot easier.”* (Natalie).

4.4.3 Familiar territory

This theme depicts participants’ previous experiences of mental health and how they used these to make sense of and manage their PMH experiences.

Contrasting with the uncertainty that accompanied birth/early parenting, familiarity came in relation to their own mental health. All participants had previous experiences of mental health issues, although these varied in severity and chronicity. Whilst the triggers for these experiences did vary, they typically seemed to centre around events or situations where people felt a lack of control, uncertainty and rejection or undervalued. For example, Laura’s depression was typically triggered by situations where she was *“not in control”* or where she is *“not listened to, my opinions aren't being valued or, you know, even acknowledge”*: *“I get to a point where I, I don't matter! It doesn't matter if I'm here! If I'm not here! What's the point?”* For a couple of participants, minority stress relating to their sexual identity appeared to significantly contribute to their mental health struggles. For Sarah, difficulties coming to terms with her sexual identity contributed to her taking an overdose in her twenties:

“Em and had a really difficult time coming out. Em and lots of resistance and everything which obviously made everything a lot worse.”

The participants had previously used a range of coping strategies, including emotional suppression and avoidance, substance use and more emotion based coping strategies, to help manage their difficulties: *“I don’t know, my family is quite sort of, you know, keep your feelings all inside and [laughs] don’t talk about them.” (Annie).* It is notable that all participants had sought help for their previous mental health issues, including use of medications and/or accessing psychological therapies. For some, the experiences of help-seeking and therapy had an influence on their current help seeking behaviours, including speaking to professionals and the type of therapy they subsequently access for support with their PMH experiences. For example, Laura’s previous negative experiences of counselling was highly influential in the type of support she sought out for her PMH difficulties: *“I started googling for local counsellors. But I was, instantly put off because of the previous experience that I had with the counsellor at college.”*

Some of the participants felt that as individuals they were more vulnerable to poor mental health and interpreted their mental health experiences as a significant part of their identity. As Sarah put it: *“I think having, having, struggled for so long it’s just kind of, just see it as being just part of the way things are really.”* Consequently, this illness identity and previous experiences of mental health increased their risk to PMH difficulties. Simone commented that she was *“definitely prone to experiencing depression”*, saying: *“Definitely certain things will make me spiral and and trigger it.”* This was echoed by Andrea who described herself as *“quite a naturally anxious person anyway”*: *“my baseline is probably higher than most [uh huh] people’s. Erm and I’m kind of okay with that, that’s part of who I am and stuff and that’s okay with me, you know.”*

Additionally, some participants viewed their previous experiences of mental health as protective in that they were able to draw on them to understand their current experiences and had developed coping strategies/emotional intelligence which allowed them to manage current difficulties. For example, Sarah was able to use her previous experiences of mental health difficulties to manage her intrusive thoughts: *“...because of my history of mental health like I think, I was able to be just like that’s an intrusive thought! Stop it. End of! I think if I hadn’t had all that it would have been*

much harder." Natalie spoke about *"developing coping strategies in my early twenties"* and her experiences of psychological therapies, such as CBT, helping her identify and manage distress: *"It's become a lot easier to know, when I'm feeling anxious [yeah] and to put things in place to kind of, reduce the impact of that."* Being able to understand their PMH difficulties in this way may have also helped reduced feelings of failure and inadequacy.

4.5 Legitimacy of (Di)stress as a Non-Birth Parent

This superordinate theme refers to the recognition of, and accessing support for, perinatal depression and anxiety. It is comprised of three subthemes including: 'Prioritising Others and Invalidating Own Experiences and Needs', 'Professional Support Systems' and 'Informal Support Systems'.

4.5.1. Prioritising Others and Invalidating Own Experiences and Needs

This theme depicts participants' recognition of their own PMH difficulties and accessing support.

Some participants viewed themselves as low(er) priority when it came to accessing support for their mental health difficulties due to their role as a non-birth parent, mirroring messages that they received from services and wider society. Annie spoke about neglecting her own well-being due to prioritising her partner's mental health: *"I think it was at that point I wasn't really even thinking about my one to be honest! [Yeah.] Because it was just so important for me that ... that she felt ... em you know okay?"* Some participants spoke of an expectation within society that the non-birth parent's needs were less of a priority. For example, Andrea spoke about the *"unacceptable"* lack of spaces for partners to sleep on the maternity ward and noted *"there are all these dads around, you know, who were sitting in these chairs, you know."* Furthermore, some participants would invalidate or minimise their own mental health experiences in comparison to their partner due to their role being a non-birth mother, potentially seeing their struggles to cope as further failure and inadequacy: *"it didn't affect me in the same way. It's not my body, it's not my body that's been ravaged."* (Simone).

Several participants felt they had a sense of duty to prioritise their family's needs over their own and to ensure their partner got the support they needed without taking

away from this. Simone turned down offers of support from the health visitor because “*I was just trying to ensure that Rebecca got the right support*”, going on to say: “*I didn’t think that it would make me better able to support her I guess, I didn’t feel like it was having too much of a negative effect on that.*” However, accompanying this was internal conflict between prioritising others’ needs and not having their own needs met, which left them feeling neglected, uncared for and sometimes resentful, feeding into feelings of powerlessness, intolerable uncertainty and failure. Annie spoke about the difficulties of negotiating the internal conflict she felt around her partner’s decision to keep their baby: “*You know when she’s having a proper breakdown and she’s feeling suicidal! I’m thinking well what should I be thinking here? Cos ... I want her to keep [the pregnancy] but [laughs] [Yeah] ... I don’t want her to feel that bad! [Yeah.] So I’m not sure what the right decision or what I should be encouraging her to do?*” Most participants acknowledged that prioritising the family whilst they neglected themselves was unhelpful but seemed unable to break away from this, possibly because by doing so reduced feelings of failure and inadequacy as a partner. For example, Simone recognised that by accessing support “*I probably would have been able to cope with things slightly better*”, but felt unable to do so: “*I dunno probably just don’t want to acknowledge these things.*”

4.5.2 Professional Support Systems

This theme considers the availability and accessibility of mental health support within professional systems for non-birth mothers.

Some participants spoke about feeling uncared for and their mental health experiences being invalidated by professionals due to the focus of maternity services and PMH support on the birth mother and neglecting non-birthing parents. Alice described services being “*all about the birth mum*” and feeling “*ignored*” by professionals due to lack of recognition of the experiences of non-birth parents within services, saying: “*it’s such an overwhelming experience for the person that didn’t give birth [Yeah]. It’s never acknowledged [Yeah] how, how overwhelming it can be.*” This was echoed by Sarah who spoke feeling as though her distressed was ignored during midwife appointments: “*I didn’t say a thing through the whole thing [appointment]! And usually I’m quite chatty!...but she [midwife] didn’t say like are you okay? Or you know what, is there anything worrying you? There was nothing!*”

Some participants were either not present or were excluded from maternity appointments (worsened by Covid restrictions) and therefore were less visible to professionals and did not have the opportunity to be asked about their mental health experiences. Natalie spoke about not being able to attend appointments due to Covid restrictions meaning: *“No one was asking how I was feeling.”* This was echoed by Laura who was not asked by the health visitor how she was feeling because: *“I was out at work anyway! I wasn’t here!”* However, even when they were able to attend appointments and were asked about their mental well-being, some felt silenced by their partner’s presence due to fear of causing conflict with them. For example, Sarah spoke about visits from the health visitor, saying: *“Cos they come round and they, they ask how you are. Em but you had your sessions together. And obviously like I said, my wife’s just like, it’s fine! If I’d, if I’d suddenly gone in one of those sessions like “no! Everything feels terrible!” She would have just been like “what were you doing? Shut up!” Like it just wouldn’t have been the right forum.”* Interestingly, Covid restrictions increased visibility of partners to professionals as participants were more likely to be present in appointments or be included in appointments through remote methods, and therefore could be asked about their well-being. There were examples where individual professionals acknowledge women, facilitating feelings of being cared for and the legitimacy of their struggles: *“I sent Charlotte with a whole list of questions, [yeah] about the birth, and they said that I could do a zoom chat with her and a midwife.”* (Natalie).

Alice spoke about an unsaid expectation within services that partners should be able to cope: *“I don’t know if they expect you to be a bit like, a bit like a father? A bit like a typical bloke of ... you know just shut up and put up and get on with it!”* However, Alice felt that there was a physiological impact of pregnancy and birth on the mental health experiences of female partners that was neglected: *“It, it messes, it messes with your head and your hormones when they’re born as well! Which wouldn’t happen to a bloke like but your menstrual cycles all over the place! And everything! So you’re all over the place too!”* The neglect of non-birth parents and narratives around coping may reinforce the beliefs of some participants that they should neglect their own needs and prioritise the birth mother.

Natalie spoke about the lack of PMH support for the non-birthing parent, in contrast to the support available for birth mothers: *“But that [PMH service] wasn’t open to me, so I think basically all that was open to me was IAPT [yeah]. And I*

suppose talking to the mental health midwife.” Sarah expressed shock regarding the lack of specialist perinatal support for partners, comparing it to her previous experiences of help-seeking: *“Considering the number of times that I’ve ... sought help for stuff before, and it’s always been, not easy to get support but like, you can always find advice around your particular issue... I was just like how is nothing existing here?”* Additionally, there was a general lack of awareness amongst participants of PMH issues, particularly in partners, which acted as a barrier for some to accessing specialist support: *“I was just kind of looking for sort of ... em ... for counsellors who could help with depression. [Yeah] It wasn’t until much later that ... we actually could put a label on it, that it was em paternal or perinatal.”* (Laura). For some participants, this lack of support exacerbated PMH difficulties and contributed to feelings of isolation, as described by Sarah: *“The fact that there was no support and that was kind of pushing everything.”*

Some birthing parents received PMH care from services and therefore some participants also received support in the context of their partner accessing support. For example, Annie described the offers of support she received from the mental health team working with her partner: *“So part of her care team and the people that would come round, when I was there with her, they would speak to her and then also speak to me and ask me how I’m doing? [Good.] If I needed support...which was nice.”* Participants who were included in support felt cared for as a family by services, as summed up by Andrea: *“What’s clear to me through this whole process is like how much care there is...how much people that work in that area care like [yeah] about you and your baby, you know.”* Whilst some did not access support, having the safety net of being aware that they could access support was reassuring: *“I guess knowing that there was support available was useful, because it was there and on offer.”*(Simone).

There was a sense of the increasing professional awareness of partners’ PMH and those professionals were both normalising, supportive and non-judgemental of their struggles, helping ease feelings of failure and lack of control. Annie described a positive experience of talking to her GP about her mental health difficulties, saying: *“The GP was really, really good. Really helpful ... she just said there’s nothing wrong with me. It’s very, very normal...to feel like that and that it makes sense because she knew a, sort of journey we’d come on during the pregnancy and how hard it had been.”* Laura compared her wife’s (more recent) experiences as a non-birth parent to

her own saying things “*must have changed*” as: “*The health visitor, she said to my other half, she’s like “if you have any issues, you know, we’re here for you too. We’re not just here for new Mums, we’re here for Dads and partners. We’re here for you.” [Yeah]. And it’s like “Wow! Okay!” Whereas ... I don’t think we had any of that when the health visitor came and saw us?*” Some participants highlighted the significant impact of good quality professional support/interactions on mental health outcomes. Annie summed this up in the following statement: “*It just goes to show that one, one person who ... is really helpful and understanding can just change em such a big decision like that!*” However, there was a sense that participants who had been supported by a professional system that they were lucky in the support they had been offered/received: “*I feel quite lucky everyone I spoke to was really nice and helpful. [Good, good.] I know that’s not everybody’s experience though so I do feel lucky!*” (Annie).

In relation to being a same-sex partner, most participants expressed additional feelings of difference and unimportance through feeling excluded by partner support groups and a lack of specialist support for LGBT parents. Sarah spoke about feeling uncared for and confused where she could access support when she saw a regional support organisation for fathers being advertised: “*I just remember thinking well that’s not going to help me is it? So what am I supposed to, 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 also spoke the lack of inclusive resources, with the majority of support available being heteronormative and “*never quite right*”: “*It was like articles telling Dads how to do things. I’d be like well I’ll just read it and read it as Mum instead of Dad, but it wouldn’t quite fit. [Yes] Or like you know that kind of, just try and like make stuff work. Like perinatal mental health stuff for Mums, I’d be like okay. And then I’d be trying to get support there and it wouldn’t quite be right cos then it would be like, you know, to come to terms with the birth. And I’d be like, wasn’t me.*” Sarah summed up the support available to her as a same-sex parent, saying: “*I felt that, you know, there wasn’t much for me ... out there.*”

Additionally, there appeared to be a parental hierarchy in relation to support, beginning with birth mothers, and then fathers due to negative societal stereotypes about parental competence, and then other types of parents, contributing to feelings of unimportance, isolation and feeling like a third-class parent. Natalie described

challenging the hospital over the lack of inclusivity in a nationally available but locally commissioned app supporting new fathers with mental health difficulties:

“They did come back and say “well we’re doing this first because, of this whole list of reasons”, and it did seem sensible so apparently erm there’s a high incidence of domestic violence from men against women after birth and, erm there are all kinds of negative stereotypes which I know in the media etcetera about dads not being able to look after children, so I did get that [yeah]. And they did say they were then going to look at erm same-sex partners.”

All participants highlighted the need for increasing awareness and normalisation of PMH difficulties, particularly in non-birth parents, as summarised by Laura as: *“Making it more accessible. And, and a topic.”* Furthermore, participants identified a need for professionals to ask non-birth parents about their mental well-being. Sarah felt that as a non-birth parent having her own space to *“check in”* would have helped with: *“Just feeling...cared for in that kind of way....”* Some participants highlighted the importance of appropriately supporting birth mothers and perceived there would be a ‘trickle-down’ effect on their mental health as there was less pressure on them to provide support and eased some of the uncertainty they felt in relation to their partner’s mental health. For example, Alice spoke about her wife being *“let down by services”* and the impact that support would have had on her indirectly:

“If that mental health midwife had gotten in contact and things, then maybe...I would have felt even more excited and happy because there wasn’t that blip all the time of em you know Lucy’s not feeling particularly stable or, or she’s feeling quite anxious at the moment, if she got support from another source then maybe it wouldn’t have taken the excitement away.”

Nearly all participants spoke about the need for inclusive, tailored support for same-sex non-birth mothers: *“I think what I really, actually wanted ... was a proper like, dedicated, like a support from, 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). Natalie emphasised the importance of having separate support for non-birth mothers that recognised the nuances of their mental health experiences and how these differ from fathers: *“Maybe at the moment we do need something separate so that our our specific concerns and stressors in ways are recognised and built into the programme...I imagine it would just get ignored if it was all done together [yeah]*

at the moment.” Sarah echoed this in her reflections on current partner support, saying: *“I’ve found a lot of the stuff, it’ll be like ... stuff about Dads and then they’ll just change the wording to be like the Dads or em... second parents. It’s like, but it’s like you’re being lumped in a box with them!”* However, Sarah also felt that maternal mental health support should be inclusive of non-birth mothers and not be separated out, and that this would help validate her parental identity: *“Mums should mean me or my wife equally. [Yeah] Without any kind of distinction... anything that would count for my wife as Mum, should count for me as the Mum!”*

4.5.3 Informal Support Systems

This theme represents the recognition of and accessibility of support for PMH issues for non-birth within their own personal networks.

Most participants felt they were able to draw on their personal support networks to some degree, but the support mainly came from friends rather than family: *“When I feel like that I tend to draw on support networks and talk a lot to friends [yeah] and they were really supportive.”* (Natalie). These personal support network often involved other parents and other same-sex families, which allowed participants to normalise their experiences of distress. However, sometimes this could be perceived as dismissive and some felt a sense of betrayal they were not ‘warned’ by their support network of the stress of having children, as described by Andrea: *“I was kind of annoyed with people which is probably unfair. Erm I remember texting my friend H who has two sons...and she was like “oh yeah, I had that” kind of thing. So this sort of frustration that, no one was talking about [hm] this.”* Additionally, some participants felt less able to vocalise their distress to support networks. For example, at times Andrea felt unable to share her difficulties with friends due to the guilt over struggling whilst having an ‘easy baby’: *“So this sense that we were finding it difficult but then we couldn’t really talk to anyone we knew, because they all have normal kids who weren’t sleeping [laughter].”* Furthermore, whilst the majority of participants were able to draw on protective social networks with a shared social identity (i.e., sexuality), for Sarah her internalised homophobia prevented her from drawing on these networks, contributing to feelings of isolation and as though *“nobody understands”*: *“I don’t massively identify in that world. I feel like it massively identifies gay! I just, I kind of would say I am because I’m with my wife but I don’t, I’m not in that kind of*

culture. So even though I'm in the [LGBT] groups it's not like, I don't really feel part of it particularly."

Some participants felt supported by their families and felt legitimised in their distress as non-birth parents. However, others did not as their family were not around, unsupportive of them as LGBT parents or prioritised the birth parent, leaving them feeling left out or lacking in their own support. For example, Sarah spoke about feeling *"like I'd lost a bit of the support from the family"* when they did not condemn her brother-in-law's homophobic comments towards her and her wife. Similarly, Laura, who lacked a close family of her own, felt unable to draw on extended family due to feeling like she *"intruded"* on their lives: *"And for me to be sort of getting in touch all the time, you know and trying to initiate that sort of, that sort of relationship that I would have had with my own Mum, I always felt like I was intruding? So I didn't."* Conversely, Simone was relieved by the focus on her partner by their support network as this enabled her to cope: *"I don't think many people have been aware of how much it was affecting me, I think all focus was on Rebecca, I was there in the background really...if I had been under scrutiny I think I would have crumbled."*

Whilst the majority of participants felt supported by their partner, a couple of the women did not. Sarah spoke about the lack of support for her mental health difficulties from her wife due to her lack of understanding about mental health issues: *"When you said who supports you? And obviously I didn't say my wife cos she's terrible! She does not understand mental health at all! It's just not her bag!"* Furthermore, the mental health of the birth mother also limited the support received from their partner: *"There have been sometimes where I've felt like my needs have been ignored but I can understand why."* (Simone).

4.6 Parenting Without

Contributing to powerlessness and intolerable uncertainty and to a sense of failure was a superordinate theme 'Parenting Without'. This theme represents the absence of factors that facilitate the transition to parenthood which contributed to the PMH difficulties. This theme consists of three subthemes: 'A Template for Parental Identity', 'Inclusion, Recognition and Safety' and 'Parental Connectedness'

4.6.1 A Template for Parental Identity

This theme represents the difficulties of adjusting to parenthood due to lack of a defined role for non-birth mothers and its contribution to perinatal depression and anxiety.

All participants spoke about the difficulties associated with the identity transition to parenthood, described as a *“massive life change”* by several of the women, and adapting to a completely new identity, despite the significant amount of planning and effort that had gone in to becoming parents. Andrea spoke about the initial difficulties in adjusting parent as *“such a big thing to learn to do”*, going on to say: *“I guess I wouldn’t have thought of it in terms of like postnatal depression but I would of thought...something like “this is a normal reaction to a big life change.””* Additionally, most participants expressed difficulties in adjustment as a result of being the non-birthing partner. For example, Alice talked about her difficulties balancing work with adapting to her new parental role: *“You have to carry on with normal life and also get used to being a parent!”* However, for some participants these difficulties in this identity transition were exacerbated by confusion and uncertainty about their role as a non-birth mother. Some participants expressed confusion about where they fit within the parental identity binary of mother and father as a non-birth mother. For example, Sarah spoke about her confusion around gender roles, saying: *“Just before the baby was born I had like a total freak out about not being the Dad and not being the Mum and all that.”*

This confusion and uncertainty were often attributed to the lack of a well-defined socially agreed role for non-birth mothers, summed up in the following statement by Sarah: *“What is the other mother supposed to do? What is your role?”* This lack of a ‘clear template’ for non-birth contrasted participants’ perception of fathers and their role, with Andrea reflecting on her role confusion saying: *“I don’t know if dads have that. Erm but then I guess dads are dads so dads have their own defined role.”* The lack of a clear template for their role led to increased feelings of invisibility and struggles to embrace maternal identity. For example, for Andrea the title of mother felt more like an honorary title: *“so I’m Ava’s mum but I’m not her mum.”* Participants expressed wanting a clear indication of what they should be doing as a non-birth mother to help manage their uncertainty and role confusion, with Sarah

explaining: *“I just wanted something that was like, you know, you are the other mother. If you do these things, then the Mum can do those things!”*

Additionally, for some participants there were distinct lack of role models for their parental identity. This was related to being a minority group (e.g., being seen as ‘special’ or different due to a lack of representation of same-sex couples in services and society); becoming a parent without their own parents (e.g., bereavement or estrangement) or difficulties with their partner’s family meaning they had a lack of a mother role model; or the lack of a social network with a shared social identity to draw upon. This meant that some participants often felt they had no one to turn to for support or advice which increased feelings of isolation and uncertainty. For example, Sarah spoke about not being able to seek support regarding her role due to her lack of involvement within the LGBT+ community: *“I was asking people at work and they were just like well, em ... em I can put you in touch with my friend who’s gay and this would be someone who’s like had children 20 years ago or 30 years ago. And it just felt like there was nobody! I didn’t know anybody at that stage.”* Additionally, services made assumptions of competence based on gender in that there seemed to be an expectation that as women, they would know what to do as parents. However, this meant that they were often having to work out parenthood by themselves and there was a lack of support as mainly aimed at fathers: *“I think that people assume because you’re both women, you probably know what you’re doing! Like you know that whole thing about women can’t use the Dad Pad [resource that has been commissioned in several areas throughout the country] er cos it’s for Dads, but it’s like because people assume that Dads don’t know what they’re doing.”*(Sarah).

Participants struggled to carve out a parental identity of their own and often tried to fit within the binary, although many felt that these roles were not the right fit. Some participants felt unable to fit within the ‘mother’ role as they felt this belong to their partner: *“Like I’m not the Mum! She’s the Mum!”* (Sarah). Additionally, some also felt a sense of role incongruence and identity dissonance as they were being forced into an ‘father’ role that did not fit with their idea of parenthood and that was outside of their ‘comfort zone’, which contributed to powerlessness, intolerable uncertainty and feelings of failure. Sarah spoke about behaving in ways that *“made her feel more like a Dad”* and that that *“was really hard because I wanted to be the Mum!”*

Established relationship dynamics and physiological changes associated with pregnancy, such as hormonal changes, frequently added to the confusion and uncertainty around the non-birth mother's role. When talking about her relationship with her wife Sarah explained: *"And the whole like, the man's supposed to run around after the woman! I, my wife does all the running around!... I was doing all the parent, the Mum's stuff! So I didn't know like what I was supposed to do at the hospital and things."* For Alice, her confusion about her role stemmed from the hormonal impact on her of having a new baby and meant that she was drawn to taking responsibilities associated with the mother role, saying: *"It felt like there's this incessant need to like try and feed them and all sorts of stuff!"* However, she was unable to do this because she was in a *"supporting role"* rather than a 'mother role'.

Whilst there was a general sense of successful adjustment to being a parent, some participants still continued to struggle with their parental identity. Andrea talked about trying to disentangle her continued struggles with her role: *"That's really difficult to pick apart like how much of that is I'm Ava's mum, and Jennifer is also her mum, or is that to do with me as me, like is that something to do with me as a person and nothing to do with, you see what I mean? [yeah yeah] Nothing to do with me not being her biological mum."* However, most participants managed to carve out their own role somewhere between the parental binary, with some liberating themselves from the notion of a template and seeing their role as special. For example, Andrea explained: *"I think I am more Ava's parent than anyone else like in the world because I'm like, I'm even more of her parent because I'm not biologically related to her so like hm, so there's like extra effort [yeah] going there. So I'm I'm extra specially her mum. Because Jennifer's her mum by default, you know what I mean?"* Others had settled, albeit begrudgingly, into more of a 'father' role: *"As much as I've been saying I don't want to do the Dad thing, I probably have settled into a bit more of a Dad role... kind of like [laughs] okay with that now! It just is what it is."* (Sarah).

4.6.2 Inclusion, Recognition and Safety

This subtheme represents the exclusion, lack of social recognition and prejudice and discrimination faced by same-sex non-birth mothers and their contribution to their experiences of PMH difficulties.

Contributing to the powerlessness, intolerable uncertainty and feelings of failure underpinning participants' experiences of PMH were incidences of feeling excluded

by professionals and their support network. Sarah spoke about being dismissed during appointments for her daughter increasing her anxiety about her role: *"A lot of them [staff] just, you know, when you take her for injections and stuff, would just like pretend that I was completely invisible...I was really sensitive about it!"* This exclusion by others led to a perceived lack of control in their role which increased feelings of worthlessness and, for some, suicidal feelings: *"It got to a point where I felt completely pushed out of my marriage, my family...I was suicidal at one point."* (Laura). When participants did feel included by services and others, they felt a sense of belonging, more in control and less uncertain about their role which in turn reduced feelings of failure and inadequacy. The inclusion of Sarah in the decisions concerning assisted conception and fertility treatment meant that being the non-birth mother felt less distressing for her, despite her desire to carry: *"Right at that time we made the decision it didn't bother me that it was her. It felt like the right thing."*

Participants were divided whether the exclusion they experienced was related to being the non-birthing parent or whether it was related to sexual identity. Some participants linked their feelings of exclusion to their role as a non-birth parent, similar to fathers. Laura spoke about the lack of value given to the role of non-birth parents, contrasting this with her subsequent experiences of being a birth mother and her perceived privilege associated with this: *"I think not being the birth parent, I think it gave other people ... what they felt was the right to exclude me from conversations? [Hm hm] Whereas now, with this baby, it's been a case of my body, my baby, my choices and my decisions!"* Additionally, some participants spoke about feeling excluded from being a parent due to balancing competing demands of work and family life as a non-birth parent. For example, Laura spoke about feeling *"resentful"* and *"jealous"* that she was at work and *"all the people coming round to visit ... and spending time with my child that I couldn't have."* However, there were times when participants felt excluded due to being a same-sex parent. Annie described feeling excluded after reaching out to a local Dad Group about accessing parenting support: *"I picked up the leaflet and emailed them and said em, you know I'm not a Dad but can I join or will it be weird?...And I never heard back from that! [Mm] That was the only time that I felt a little bit like excluded!"* Some participants felt more sensitive to being excluded due to their high levels of minority stress and sometimes interpreted exclusion as discrimination: *"One of the problems I was having, was separating out what ... was potentially because I was a same-sex partner and what every other parent*

would have? I think em ... how I was treated was probably the same as all other partners. So I think men in a maternity unit tend to be put to one side! Like they're there just to run around after the woman and that's kind of their job! Em but I think because I was so heightened sensitivity, I went into that situation feeling like, you know, I wasn't supposed to be there!" (Sarah).

Nearly all women spoke about taking steps to legitimise their parental identity prior to embarking on assisted conception. For example, Andrea, like several other participants, explained that one reason her and her wife got married was so that she would be legally recognised as a parent: *"In order for me to be our daughter's mum [hm], we have to be married... like it wasn't the reason we got married but it was a helpful thing to do."* However, whilst for most of the women their role as a mother was recognised by others (*"Oh yeah they made a massive effort...they really did recognise me as a mum."* - Natalie), some women experienced a lack of social recognition and validation as a same-sex mother, which invalidated their parental identity, increased feelings of invisibility and difference, and added to their role confusion as their role is not recognised by wider systems. Participants reported experiences of heteronormative and heterosexist care by services, spanning from their decision to have children to the end of the perinatal period, which had a significant impact on their levels of distress. This included interactions with fertility services and individual professionals, heteronormative forms, protocols and assumptions, a lack of inclusive resources and culturally competent care. Midwives would *"lump together as a kind of pair"* Sarah and her wife as mothers due to being a same-sex couple, ignoring their individual roles. Natalie spoke about her *"awful"* experience discussing pursuing assisted conception with the GP: *"She just kind of looked at us as if she was really confused and it was a weird thing to be asking that we were saying we wanted to erm get pregnant [uh huh]. She kind of said "what you two?"* Natalie's experience negatively impacted her mental health at the time and was a *"kind of lingering stress"* contributing to her anxiety during the perinatal period: *"I was worried those [interactions] were going to continue with the NHS moving forwards."* Several participants spoke about the lack of inclusive language on forms increasing feelings of invisibility: *"The bit I had to sign, it was something like 'husband/male partner' [yeah]. Actually male partner... that kind of structural heterosexism was just quite upsetting"* (Natalie). Some participants had to repeatedly challenge professionals and heteronormative assumptions in order to be recognised as parents, causing additional

stress and increasing their visibility, and potentially vulnerability, as same-sex parents. Sarah described having to repeatedly remind midwives that she was also a mother: *“A lot of them were just em ... like really, really dismissive of me!...like they’d say like, “Oh I’ll give you back to your Mum now!” and just ignore me. So we had agreed that when we went to see them, we would say like, really deliberately just sit there and be like “which Mum?””* Additionally, participants also spoke about the lack of representation of same-sex couples increasing feelings of invisibility and difference and invalidating their role, as described by Sarah: *“There was nothing representative of same-sex couples to make me feel I wasn’t the...first same-sex couple to give birth in years, which is what it felt like!”*

Many of the incidents described by participants were perceived to be a result of ignorance or lack of training rather than malicious, and attempts at addressing social difference could be viewed clumsy and alienating to participants. Sarah described frustration with the lack of cultural competence amongst midwives, saying: *“The midwives make comments like oh we didn’t, we didn’t know if you were like a friend? Or if you were the other partner and no one wanted to come and ask you cos they thought that you might find it weird...It was like ... they, they should be more used to it by now!”* However, some were referred to as ‘special’ due to being a same-sex couple. Andrea spoke about her surprise at being perceived as a “novelty” by the ward staff following the birth of her daughter. Whilst this wasn’t necessarily a negative thing, it made the participants aware of their difference to heterosexual families: *“We were referred to as a special couple...I mean we are a special couple, but I think they meant that you’re a female couple.” (Andrea)*. Furthermore, sometimes beneficial gender stereotypes and parental hierarchies worked in their favour as a parent, potentially because it helped managed feelings of failure. For example, Natalie spoke about being allowed into the hospital following the birth despite the Covid pandemic because she was a “also a mum”: *“So in that way, erm it kind of worked in my favour because I think she was prioritising me being there over maybe a male partner.”*

Spending time alone with their baby helped development of confidence in parental identity, contrasting with triadic interactions where they defaulted to position of secondary parent/caregiver. Andrea explained this by saying: *“If I took Ava to the doctor on my own, I was like her mum then [yeah]. So people knew I was her mum [yeah]. Whereas if it’s me and Jennifer and Ava then, or if it’s Jennifer and Ava then Jennifer’s her mum [yeah], you see what I mean? [yeah] So I really enjoy those*

experiences where I'm on my own with her...when people people assume [yeah] she's my daughter."

Some participants also experienced invalidation of their role by their support network, including their partner. For example, Laura talked about her wife wanting to hide their relationship whilst on the ward following the birth to avoid intrusive questions that may have increased feeling of vulnerability: *"A lot of people thought I was her sister...And we just went along with it because I was then obviously going home and Holly was like ... "I don't want to deal with the questions! Let's just roll with it! Keep ourselves to ourselves.""*

A lack of safety, including experiencing homophobia, discrimination and prejudice from both professionals and people within their personal network, contributed to powerlessness, intolerable uncertainty and feelings of failure and inadequacy underlying PMH difficulties: *"I get a heck of a lot, cos I'm a teacher. So I get a heck of a lot from kids cos I refuse not to come out. And em I get "Eurgh! That's disgusting!""* (Alice). For some, this fed into internalised homophobia, resulting in questioning the legitimacy of parental role. For example, Sarah spoke about the homophobia she received from her brother-in-law as a significant trigger for her perinatal depression and anxiety: *"My wife's brother who em ... feels really strongly about us not being together, he'd sent this message all about, you know, how terrible it was we were having children."* Sarah explained that this experience reinforced the homophobia she had internalised from growing up within the Christian culture leading her to question the legitimacy of having family: *"I was just like maybe he's right? Maybe we shouldn't be having the child? I was questioning it. And ... I think a lot of like internalised homophobia [Laughs] was kind of like coming out where I was just like, yes, feeling like it, it, it, we shouldn't be doing it and stuff!"*

Some participants spoke about experiencing microaggressions in the form of questions which invaded their privacy as a same-sex family: *"There were a couple of people who did ask inappropriate questions. Like how did you make your baby and who was the donor [laughter] and stuff like that. It's like er yeah no, [laughter] don't ask questions like that."* (Simone). Whilst some tried to view these questions as curious and an opportunity to educate others (*"I was very happy to talk to people about it in fact, you know, I think it's really important to do that."* - Andrea), others found these more intrusive and threatening as they invalidated their parental and

family identity, and emphasised difference, increasing feelings of loss of control and failure: *“My manager said em ... “oh who em ... I, I, I know he’s bo-- I know he’s both your kid like, but who’s the Mum?” And I was like “we’re both the Mum!” “Yeah, yeah, I know that! I know that. But who’s, who’s the Mum? Who, because I’m trying to work out who is, whose he is?” (Alice).*

Underlying minority stress also increased hypervigilance to discrimination regarding parental identity and the legitimacy of their family. Some were concerned about experiencing prejudiced or homophobic events both as a same-sex couple and in the future as a family, questioning the legitimacy of their parental role and their family and their family’s safety. Natalie spoke about instances of homophobia and discrimination in society which *“raises stress levels [yeah] a bit more than it would do otherwise”* as subsequently increasing her vulnerability to perinatal anxiety: *“I think as we were trying to get pregnant there were all those horrible erm homophobic attacks on people you know on buses and stuff [yeah]. That was really awful. So that kind of heightened my anxiety around well are they or we gonna face homophobia.”*

Having children increased their visibility as a same-sex couple and whilst many people had not directly experienced discrimination or prejudice, there seemed to be an anxiety about the potential vulnerability associated with this. Natalie spoke about her experiences of having strangers approach them about their children, explaining: *“Some people when we say that we’re both mums perhaps don’t react and that’s great. But some older women especially do tend to react a little bit not in a horrib-- 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.”*

Participants frequently reported taking additional steps to reduce the likelihood of experiencing prejudice and manage their anxiety regarding discrimination, including impression management (*“I’ll do things like make people like me and stuff so they can’t be horrible to us...if someone’s being difficult I’ll be like deliberately charming and, you know, like, kill them with kindness sort of thing.” - Andrea*), have a support network with a shared social identity (*“Out of our closest friends and the people we spend most time with, with families, we’ve actually realised that we’ve only really got a couple that are heterosexual couples.” - Simone*), being involved in training and influencing work polices (*“What I did to try help, actually a key thing which haven’t said was organising... the erm LGBT parenting event...I got colleagues*

from HR, erm from Policy to come and listen [hm] because I wanted them to come and heard about our experiences...And erm they were really enthusiastic about coming to listen.” - Natalie).

Nearly all participants spoke about the need for staff training and an increase in culturally competent care in order to understand the needs of same-sex mothers and reduce the distress associated with lack of inclusion, social recognition and safety. Natalie explained: *“I think maybe our stress levels wouldn’t have been this high in the first place if, erm there was more training for NHS staff about, erm same-sex parents [hm], and we hadn’t experience some of the negative experiences that we had experienced.”* This was echoed by Sarah, who said: *“the staff need an understanding that people in same-sex relationships are coming in with all these layers of, like homophobia and things they have to deal with. So you do have to go the extra mile, I think, to try and make them feel more included.”*

4.6.3 Parental Connectedness

This theme represents the contribution of parental connectedness or lack thereof to participants’ experiences of perinatal depression and anxiety.

Some participants reported struggling with their parental bond towards their child in the early months, contributing to feelings of intolerable uncertainty and failure and inadequacy. Andrea spoke about providing the physical elements of caregiving but not feeling an emotional attachment to her daughter: *“Well like I say I think if you had seen me [uh huh], you would have been like “Andrea is being a good mum there” [yeah]. Erm but I just felt like nothing [yeah].”* This was echoed by Annie who described *“going through the motions”* whilst looking after her son.

Some participants linked their lack of a bond to aspects of their role as the non-birth parent. For Andrea, not being the parent who carried was important to understanding her lack of a parental bond: *“I didn’t give birth to her which I think is- - [yeah yeah] so it’s not even necessarily about the biology, I think it’s about having that [yeah yeah] experience with her and like her being being inside Jennifer and stuff. Erm it was almost like they already knew each other, do you know what I mean? [yeah yeah]. Erm, whereas I was just a bit like oh hello you know [laughter].”* Sarah spoke about *“biological factors at play”* influencing the differences in bonding between her and her wife: *“my wife would be, like her reactions to the baby were completely different to mine. And there was no way I was having those same*

biological, hormonal reactions.” For some, there was a sense of betrayal and frustration that they had not been warned about the difference in bonding as a non-birth mother by others: *“I felt no one had prepared me for that. No one had said ... you know once your baby’s born, like you have to actually work to bond with it because you’ve, you’ve got no biological connections. So I didn’t know what was going on.”* (Sarah).

Breastfeeding also appeared to play an important role in the lack of parental connection for several participants. Some felt a sense of rejection and exclusion due to their baby’s preference for the birth mother and the mother-infant bond, particularly during the breastfeeding period, leaving participants feeling like a secondary parent: *“Jennifer was erm breast feeding her and we were trying to get it so I could also feed her with a bottle [yeah]. And she just would not have that...it’s ridiculous looking back but I was taking that personally [yeah yeah]. [Laughter] You know? Like she didn’t like me and stuff.”* (Andrea). Additionally, some participants expressed feelings maternal jealousy and resentment towards the birth mother over their bond with the baby, as described by Alice: *“Sometimes I ... I got a bit jealous like I wish I had that kind of bond with him. And sometimes I think now like if I carried a baby would ... the bond be different? How would it be and stuff?...And I think you know ... if I carried he’d probably cling to me a bit more? [Yeah] Get a little bit, get a little bit like oh I wish it was me he was clinging to!”*

Other participants considered the link between their mental health difficulties and feelings of connectedness to their child. For example, when speaking about her mood, Alice said: *“It’d dip and I’d feel a bit numb towards him [son].”*

Some participants developed practical strategies to help facilitate the bond with their child. For example, Sarah began to get up with her baby more often: *“So I’d get some bonding time before work.”* For Annie, being furloughed during the Covid-19 pandemic had provided her more opportunity to develop a bond with her baby: *“I’ve actually had a lot of time with, with the baby... It’s good for me cos I can bond with the baby.”*

The participants who did not struggle with their sense of parental connectedness often held protective beliefs about bonding or used self-compassion and acceptance to make sense of bonding difficulties, lessening feelings of failure and uncertainty. Laura spoke about feeling *“very spiritually connected”* with her baby during the

pregnancy meaning that despite not feeling like a mother: *“I already felt a connection to the baby.”* Additionally, Natalie’s belief that parental bonds develop gradually, and acceptance of her feelings were protective against distress arising from an initial lack of bond: *“I think I understood and was very honest with myself with how I felt towards them through the entire time.”*

Despite initial struggles with a lack of parental connectedness contributing to the experiences of PMH difficulties for some participants, all of the women described a gradual development of bond overtime: *“Now she’s like a fully blown person like erm we definitely have our own relationship.”* (Andrea). However, some did note that they still struggled with feelings of exclusion and jealousy: *“They still have a very strong bond, which [Yeah] you know, is always difficult to kind of watch.”* (Sarah).

4.7 Changed Relationship Dynamics

This superordinate theme represents the changes to the couple’s relationship dynamics as a result of becoming parents and PMH difficulties. Changes to relationship dynamics and PMH difficulties influenced each other in a reciprocal relationship. This theme comprised of two subordinate themes: ‘Partner’s (Mental) Health’ and ‘Changes to the Couple Relationship’.

4.7.1 Partner’s (Mental) Health

This subordinate theme encapsulates the impact of participant’s partner’s health during the perinatal period, including both physical and mental health, on their own mental health.

Some participants had partners who struggled with either their own PMH difficulties and/or physical health issues, during pregnancy and following the birth. As a result, an unexpected *“role reversal”*, as described by Andrea, occurred for several participants where they had to take on more of a carer role than they had anticipated for both their partner and baby. This role reversal significantly contrasted with what many of the participants had expected their role to be following the birth, with this disparity between their expectations and reality contributing to feelings of powerlessness and intolerable uncertainty. Simone described taking on additional caring responsibility following the physical impact of a traumatic birth on her partner, saying: *“I became more a carer, I mean obviously I was going to be a carer anyway*

having a young child, but erm I guess I became doubly a carer because, erm you know my partner was able to do kind of very little physically and after the surgery that she had.” Alice described feeling underappreciated in this carer role by others, contributing to her distress: “My Mum turned up with flowers. And she said “Oh I gave the bigger bunch to Lucy because she did all the work!” And it’s like actually I’m running around to keep the house tidy, keep the baby safe and clean and fed. And keep Lucy happy, clean and fed! It was almost like looking after 2 babies!”

Some women also took on more of a primary caregiver role for their child than they had expected or wanted. For example, Simone said: *“I was kind of like very much pushed into the situation where I was probably caring for him more on my own than I thought I would be...I guess I can’t help feeling a slight resentment but the situation is what it is.”* This was exacerbated by participant’s parental desire and conscious decisions not carry. However, Simone went on to reflect that by taking on this primary caregiver role: *“In the long run it helped my relationship with him probably because I was still very present.”*

Their partner’s health led to changes the dynamics between couples for some participants. For example, Andrea felt distress over the changes in her wife due to her struggles with mental health difficulties after the birth and her anxiety and self-doubt of having to take on a stronger role than usual, saying: *“I supposed what’s significant about in our relationship is like Jennifer’s very much like...the one with her head screwed head and like erm, she’s kind of like [pause] like she’s very reliable like, you know I’m probably a bit less reliable like. Erm she’s very strong and, so it was very shocking to see her not being that [yeah]. And then like as a consequence me having to step up a bit more.”*

Additionally, for most participants, their mental health was typically correlated to their partner’s mental health, summed up by Alice as: *“if her’s is bad then mine is bad.”* This link between partners’ mental health experiences may be explained by concerns about their partner and being placed into a carer role without being able to access their own support. Annie described feelings of concern and uncertainty about both her partner and future child when her partner experience significant mental health difficulties during her pregnancy: *“I could also tell that she was at such a low place, I was worried for both of them! Like her and the baby.”* Interestingly, for Simone the impact of her partner’s distress on her was exacerbated by her physical empathy

woman: *"I guess being a woman...I could empathise so much with what she'd gone through and how damaged she felt, maybe I found it worse than if I'd been a man."*

4.7.2 Changes to the couple relationship

This theme relates to the changes to the relationships as a consequence of becoming a parent and experiencing PMH issues.

For all participants, becoming parents led to changes in the couple relationship. However, whilst for some these changes had been anticipated and managed, for others some of these changes had been unexpected and participants felt they had not been prepared for them. This disparity between their expectations and reality contributed to feelings of powerlessness, intolerable uncertainty and failure. Sarah spoke about her distress at being *"blindsided"* by unexpected changes in her relationship and the subsequent increased conflict with her wife, saying: *"I think like we've always had a really strong relationship. So I didn't expect, at all that ... that it, anything would shake that...I was kind of like [laughs] really shocked to find that, like basically just everything changed! And like I said, I felt like she hated me! I felt like I couldn't do anything right!"* For Sarah, this sense of being unprepared for these changes were accompanied by feelings of frustration and betrayal: *"You know if someone had said to me, you know your wife's going to see like, see you in a different way and treat you in a different way, I could have like prepared for that."*

Some participants noted changes in the roles they had previously assumed within the couple relationship due to their new parental identities. Sarah spoke about how her role as the non-birth parent meant that she was taking on roles and responsibilities that previously her wife had taken on, which contributed to her distress: *"In our relationship, like my wife's the one who goes out to the shop... she would always go out and do that kind of stuff. She would always drive everywhere and, cos all that stuff used to cause me so much anxiety. So I was then doing all that stuff which was making me anxious cos I don't like doing it!"*

The stress of adjusting to different parental roles and having different responsibilities meant that participants were spending less quality time with their partners. Alice explained that since the birth of their child: *"Me and Lucy haven't had any time together really. We've had about 11 hours!"* For Laura, there was a sense of her and her wife becoming strangers due to their different parental roles: *"I think, with, with my wife we just kind of got ourselves into our own little zones... And ... it*

was just like we were just co-existing in the same house!...It was just like we were just 2 people existing in the same place.” Adapting to different parental roles led to role resentment for both birth and non-birth mothers, contributing to couple conflict. Laura spoke about the guilt she felt after discovering her wife’s resentment of her being able to go out to work: *“She...had quite a lot of resentment towards me! I got to get up every day, leave the house and go to work.”* This role resentment appeared more pronounced for non-birth mothers if the participant had wanted to carry themselves and if they felt underappreciated in their role. Alice, who had previously hoped to carry but was not able to at that time, spoke about feeling like a *“maid”* as well as her desire to more spend time with her son, but being unable to due to her being the partner that worked fulltime: *“It was like a pull to come home and sometimes I get that, like last week, I snuck off from work early cos ... I just wanted to be with Callum...Lucy’s gone back part-time...I wish I was the one that was part-time.”*

Additionally, some parents felt neglected and uncared for by their partner due to perceptions that their main focus was now solely on the new baby. For Sarah, the unexpected shift of her wife’s attention to their new baby left her feeling abandoned and excluded: *“I struggled with the fact that, like my baby was now all that she could ever focus on! Still is! Still annoying!...that bond that they had, I felt really excluded because I just didn’t like, if the baby cried, I’d be like “please stop crying! Shut up!” Whereas my wife would be like “I can’t bear for her to cry!”*” Additionally, Sarah expressed feelings of jealousy towards the baby, relating her experience to those of fathers: *“So it changed the dynamic in the sense of like ... you know, I remember doing em, ages ago like some training on, em domestic violence...they were talking about like how like the Dad becomes really jealous when the Mum...em has the baby because there’s like that connection and that, and I could identify with that! Although like I said there was no, there’s no violence [Yes] but like I could identify with that feeling of jealousy and just like well hang on! How am I not the centre of your universe anymore?”* These feelings of stress arising from changes to the couple relationship outlined above were frequently compounded by the conscious decision regarding carrying made by the couples.

For some of the women, they were continuing to struggle with the changes in their relationships: *“It’s meant our marriage is now different and it will never be the same. But it’s quite difficult to kind of come to terms with that.”* (Sarah). However, for others negotiating the challenges and changes of parenthood brought them closer

together. Alice summarised this as: *“I think we were a good team [yeah]. I think, I think it’ll probably make us stronger in the long run.”*

Mental health experiences could also impact on the relationship between the couple. For Simone, her low mood impacted on her interactions with both her partner and son: *“Probably more irritable with her [partner]. Probably more irritable with James, maybe.”* Laura, on the other hand, spoke about the disconnection to the relationship both her and her wife experienced due to their mental health difficulties: *“For her it was looking back at, do you know what we were both in really bad places? We weren’t helping each other out!”* For some, struggling with mental health difficulties caused revelations about their relationship. Sarah spoke about her shock at discovering her wife’s lack of understanding and supportiveness whilst struggling with her questioning about her parental bond and role: *“Brought to the surface a lot of stuff that I’d never known about, our em relationship...I saw these sides of her that I hadn’t necessarily known were there? Like the fact that she just couldn’t try and understand how I was feeling! And I never knew that she could be quite so, like ... careless! And I think that was really difficult because em ... you know, it’s like you hope that the person’s going to be there when you need them.”* For Sarah, these revelations led to conflict and further distress: *“We couldn’t understand each other. So we argued loads at which point I’d just wanted to leave! But the problem was when we argued, it would just make me feel worse. Em and I self-harmed for the first time in years in that period cos I just couldn’t deal with it all!”* However, for other participants, working through mental health difficulties together strengthened their relationship. Having both experienced PMH difficulties, Natalie and her wife developed a strong, mutually supportive relationship: *“I think it was very positive...I was supporting her very well. But then I think well actually when I got very anxious she started supporting me more and I think that maybe helped her because she was having to, kind of go beyond her own feelings of erm depression to support me.”*

4.8 Moving Forward

This superordinate theme describes how the women came through and, to a varying extent, are currently working through their PMH difficulties and what the future holds for them and their families. It should be recognised that the participants

were at different stages of moving forward. There were two subthemes: 'Taking Back Control' and 'Our Family Moving Forward'.

4.8.1 Taking Back Control

This theme represents the steps taken by the participants to regain control over their mental health. Some participants took back control of their mental health through help-seeking, whether that was through talking with others or seeking professional help. Through talking to others, some participants were able to label their experiences of PMH difficulties, giving them a sense of control over and a foundation from which to seek help: *"It wasn't until somebody mentioned it in, in a conversation and, and it sort of ...don't want to say it normalised it but it, on the one hand it did and on the other hand it just kind of, kind of turned the light bulb on! Ah, okay! Now there's a label for it...I can work on figuring out how to get out of it."* (Laura).

For Laura, developing practical coping strategies through working with a holistic life coach helped provide her with a sense of control in uncontrollable situations: *"He basically sat down and was like, right these issues, they're not going to go away! They are your life! Let's go through situations, ways and then develop ways for you to ... manage and cope with these situations."* Laura was able to develop a repertoire of coping strategies to allow her flexibility in managing her emotions: *"Because every situation you're thrown in ... one technique ain't going to fit every situation! [Yeah] So let's look at all these different things [Yeah] So it was really beneficial."*

Other participants were able to draw on previously developed coping strategies to help them manage their experiences of perinatal depression and anxiety. Natalie used a psychological model she had been previously familiar with to make sense of her experiences by externalising and deconstructing her difficulties to identify areas which she could change: *"So I basically used that model [TOBIAS model], erm and worked through each of those different points to think about what had been happening in the lead up to me feeling quite anxious [uh huh]. Erm, and what I could change to kind of boost my internal environment so make-- help myself feel, er more, er confident I suppose and less fearful."* By utilising this model, Natalie was able to take back control of her mental health: *"I was able to put all that into practice and kind of pull myself out of how I was feeling."*

Most participants had come to manage their PMH difficulties through the use of acceptance and compassion towards themselves. Sarah expressed this as: *“I think a large part, for me, was just like almost like, just accepting it a little bit and being like actually, I’m not coping! [Laughs] and just feeling like I’m not bonded. And, and that’s okay and like normal. And I think that was what helped.”*

For all the participants, the process of taking back control was slow and some were still negotiating this. As summed up by Andrea who struggled postnatally: *“So that was like the immediate kind of aftermath and then I think that, if memory serves, that just like gradually got better.”* The majority of participants still experienced ongoing difficulties in terms of mental health, even outside the perinatal period. For Simone, continuing to live alongside the impact of a traumatic birth was challenging: *“I mean there’s still ongoing issues, which has an impact on our home and family life and the things we would like to do and... Erm so yeah it was it was difficult.”* However, most participants felt more able to manage their emotions and symptoms. For example, when speaking about her intrusive thoughts, Andrea said: *“I still have that a little bit now kind of imagining things that might-- horrible things that might happen. I’m better able now to, erm dismiss them as intrusive thoughts.”*

Some participants were able to find positives in their experiences of PMH which helped them come to terms with their experience. Andrea integrated her experience of perinatal anxiety into her identity, saying: *“I’m very much of the mind that like I try not to have any regrets and I try not to think yeah I’d change that or-- so I think every experience we have like that kind of makes me who I am right so, erm it can’t be that bad. It can only add to my life experience, you know?”* Others spoke of their experiences increasing their emotional intelligence, strengthening their relationship, motivating them to change elements of their life causing stress, and providing the opportunity learning about themselves, in addition to develop skills to help manage their mental health in the future:

“I guess it’s shown me that I can be strong in a crisis...there were a couple of times when we were at the hospital and I just had to be very direct and the one who talked the midwives about what was happening and the way we were being treated just wasn’t good enough really.” (Simone).

4.8.2 Our Family Going Forward

This subordinate theme represents the influence of PMH issues on the participant's family life in the future, including their feelings towards their families and view of the future, the type of parent they wanted to be and future reproductive choices.

All participants spoke of a general sense of love towards their families and hope for the future. Andrea's daughter had inspired overwhelming positive feelings of both love and pride: *"My sense of pride is like overwhelming about her, you know. To the point where I can't really distinguish it from like my love for her."* Similarly, Annie viewed having her son as a new beginning in her and her partner's life: *"The actual baby is great. So ... a new chapter, a new chapter in our lives."*

For some participants their experiences of PMH had informed the type of parent they wanted to be going forward. For Natalie, this involved being an emotional role model to her children to support them in their own mental well-being: *"I'm very concerned that we try and teach them about emotions...Erm so I think it's maybe made me more erm concerned than I might have been otherwise about making sure that they understand emotion [yeah] and that they-- just trying to help them to maybe not feel as anxious and depressed as I can."* Whilst Sarah's experiences also encouraged her to be an emotional role model, she also identified the additional pressure associated with this: *"I feel a lot of pressure to, like I said, stay well for my daughter and to be a good example. So I don't know whether I'd say that's positive or negative?"*

Whilst the majority of participants' parental desire had not been affected by their PMH experiences, for others the fear of history repeating itself and the risk of experiencing similar difficulties in the future felt intolerable, leading them to not want more children. For Annie, her experiences of becoming a parent were *"such a rollercoaster"* that *"I think for me, one's enough"*: *"You can have a second one and it can be a completely different journey to how the first one was. But I just think, couldn't even risk how it was the first time on everything!"* Others, such as Alice, spoke about wanting another child but voiced uncertainty about their ability to cope when they had struggled with their first child: *"We really want Callum to have a sibling but we know that obviously it's difficult now! So we know that it's going to be even more difficult with another child."*

However, some participants experienced an unexpected positive impact on parental desire due to the joys of being a parent and overcoming their fear of childbirth. Whilst also recognising the financial barriers to having more children, Natalie voiced a significant change in her view having children, saying: *“If we had enough money, erm the experience of having these two has made me think that I do actually really like babies and I’d like some more.”* For Laura, her role as the non-birth parent provided her the opportunity to overcome her fear of childbirth which ultimately helped her in her own journey to gestational parenthood: *“I think going through the pregnancy as the observer, or the partner...it did open my eyes to, do you know what pregnancy isn’t something to be that afraid of! It’s not a permanent state. It’s you know, it’s a temporary situation. It’s a means to an end.”*

Two participants had or were currently pursuing further gestational parenthood themselves, providing them with an opportunity for role reversal. Sarah described a lack of control regarding decision to pursue assisted conception due her mental health difficulties: *“It kind of almost feels like ... the decisions are being made by, like my illnesses not my, me or what I want!”* Sarah expressed anxiety about her decision to have a child due to the inevitability of struggling with her mental health, saying: *“I know if I have a baby, I will struggle”*, and her loss of trust in the supportiveness of her wife: *“One of the biggest problems for me, was...realising that I’m probably not going to get the support that I would want to have, from my partner... and knowing that that will potentially be like the same story again, in terms of having to kind of deal with that alone, I think is really difficult.”* However, Sarah felt comforted and reassured by the thought she would receive support from services due to her role as a birth mother, which she had not been able to do as the non-birth mother:

“But I’m hoping that if that’s, if there are any problems down the line, like I said that there’s probably more support that I can access as the Mum who’s pregnant. So I kind of feel a bit like it’ll be fine because if I do have a massive meltdown, at least there’s somewhere I can go with all of that which [Yeah] wasn’t the case before.”

5. Discussion

In this final chapter, the rationale and aim for this research are revisited before summarising the findings and situating them in the wider PMH literature. I will then discuss the study's strengths and limitations, followed by suggestions for future research and finally outline the dissemination plan for this research as well as implications for clinical practice.

5.1 Revisiting the Research Rationale and Aims

This study responds to the current lack of research exploring PMH difficulties, such as depression and anxiety, in the non-birth mother in same-sex parented families. Despite the increasing numbers of lesbian couples pursuing assisted conception, little research examines PMH in the LGBT+ population. Furthermore, whilst there is growing recognition of the prevalence and impact of fathers' perinatal anxiety and depression, alongside research exploring fathers' experiences of such difficulties, exploration of these issues in other non-birth parents, including same-sex non-birth mothers, is lacking. The well-documented negative impact of PMH issues, in addition to the risk of discrimination and lack of inclusive services for same-sex partners highlights a significant need for research into this area. Therefore, it was concluded that an in-depth, qualitative study could contribute to our understanding of same-sex non-birth mothers' experiences of perinatal depression and anxiety, and support future research and clinical practice.

The aim of this study was to explore and understand the views and personal experiences of anxiety and depression in the perinatal period of non-birth mothers in same-sex relationships, where their partner carried the child. To meet this aim, women who self-identified with the above were recruited via University organisations and online via social media. IPA was used to analyse these interviews, resulting in 6 superordinate themes and 16 subordinate themes. The following section will summarise and discuss these themes, locating them within the wider literature.

5.2 Summary and Discussion of Findings

Participants' experiences of perinatal depression and anxiety were mainly characterised by feelings of failure and inadequacy in their various roles, in addition to powerlessness and intolerable uncertainty, which further contributed to this sense

of failure. These feelings contributed to and were influenced by participants' perceptions of the legitimacy of their distress in their role as a non-birth parent within the wider support systems, which impacted subsequent help-seeking. Contributing to these experiences were the stresses of transitioning to parenthood. This included an absence of factors that could facilitate this transition (i.e. lack of a clearly defined template for their parental role, lack of inclusivity, recognition and safety, and lack of parental connectedness), and changes that occurred in their relationship with their partner (i.e. as a result of their partner's health and changes associated with parenthood). Finally, participants spoke about moving forward from their PMH difficulties, taking back control of their mental well-being and reflecting on the influence of their experiences on their family in the future e.g., future reproductive choices. Some of the themes overlap with previous research into the PMH experiences of birth mothers and fathers. However, within the themes there were notable differences in non-birth mothers' experiences in comparison to fathers, as well as themes that seem distinct to non-birth mothers.

5.2.1 Failure and Inadequacy in Role

Participants' distress seemed to peak with feelings of failure and inadequacy in relation to being a parent, a partner and individually (including personal and professional roles), indicated by internal and external perceptions of failure. Similar findings have been identified within both the maternal and paternal PMH literature, with feelings of failure and incompetency arising from: the discrepancies between expectations and reality of parenthood; comparisons to others; perceived criticism; a perceived inability to meet cultural and personal expectations of a 'good' parent and partner; and inability to perform either at home or work (Edhborg et al., 2016; Knudson-Martin & Silverstein, 2009; Leslie, 2013; McLeish & Redshaw, 2017; Pedersen, Maindal & Ryom 2021). Whilst the non-birth mothers' feelings of failure were similar to both heterosexual father and mothers, there were notable differences in their experiences of failure. Uncertainty about their parental role and a higher-level investment in pursuing parenthood in relation to time, finances and emotions, in contrast with heterosexual couples (excluding those who use assisted conception), potentially meant that expectations were much higher. This seemed to lead to greater disappointment with reality and potentially more intense feelings of failure and inadequacy than for other parents. This coheres with findings from van Dijk, van der Pligt and Zeelenberg (1999) in which disappointment following failure is more

intense if there has been a higher level of instrumental effort invested. Interestingly, participants spoke about feelings of failure arising from unwillingly inhabiting a 'father' role, which seemed to be accompanied by negative stereotypes of fathers' ability to provide care, shaped by societal narratives which are well-documented (Roberts, Coakley, Washington & Kelley, 2014). Whilst fathers may also experience feelings of failure in relation to these negative stereotypes, it seemed that non-birth mothers wanted to be perceived as better than fathers but they feel relegated to the 'inadequate' father role, exacerbating feelings of failure.

Feelings of failure and inadequacy also seemed to underlie some of the symptoms of depression and anxiety experienced by the women that are also reported in the fathers' literature, including low mood, worry, irritability, worthlessness, hopelessness and suicidality (Garfield et al., 2014). However, some research suggests fathers are likely to report more physically tangible symptoms, for example irritability and sleep disturbances, than emotional symptoms, such as low mood or worthlessness (Cochran & Rabinowitz, 1999), whereas the women in this study seemed to report both physical and emotional symptoms. As with fathers, experiencing mental health symptoms, such as intrusive thoughts and suicidality, and their impact on their roles as a parent, partner and individual contributed to feelings of shame, failure and inadequacy (Pedersen et al., 2021; Hambidge et al., 2021).

Resonating with the previous PMH literature, the internal stigma experienced by non-birth mothers in relation to mental health difficulties and the feared implications of disclosing their struggles (i.e., being perceived as a bad parent and worries that their baby may be removed), intensified feelings of failure and inadequacy and acted as barrier at an individual level to help-seeking (Baldwin et al., 2019; Lever Taylor, Billings, Morant, & Johnson, 2018; Smith, Lawrence, Sadler & Easter, 2019). Even for participants who did seek help, fear of stigma and a sense of failure remained, indicating the pervasive power of stigma for individuals and the need for professionals to consider this when supporting parents with PMH difficulties. In addition there were aspects of stigma which appear specific to the LGBT+ community. Stigma about being a same-sex parent and societal expectations of failure, increased the pressure on participants to be seen as 'successful' in parenthood. This fits with research indicating that non-birth mothers feel the need to defend the quality of their parenthood significantly more frequently than fathers (Bos et al., 2004). However, perceived

inability to be 'successful' and confirmation of stigmatised beliefs possibly intensified feelings of failure for non-birth parents.

Decisions around conception and birth, in particular the choice of which partner should carry the pregnancy, appeared to increase feelings of failure and inadequacy, especially if their partner was struggling during and following the pregnancy. The challenges associated with the decision to carry is unique to lesbian relationships, with these decisions typically being based on age, health, gender identity within relationships, and willingness to carry (Hayman, Wilkes, Halcomb & Jackson, 2015). This contrasts with heterosexual cis couples, as the possibility of both partners being able to pursue gestational parenthood adds an additional layer of complexity to feelings of failure and inadequacy experienced by non-birth mothers that is not experienced by fathers.

Most of the women developed coping strategies, typically centred around self-compassion, increasing their sense of internal validation and self-esteem which buffered against these negative feelings. This is in-line with research demonstrating that increasing self-compassion leads to a reduction in depression and anxiety symptoms (MacBeth & Gumley, 2012).

5.2.2. Powerlessness and Intolerable Uncertainty

Contributing to this perception of failure and inadequacy in role were feelings of powerlessness and intolerable uncertainty, which were generally underpinned by both a perceived and experienced lack of control over their journey to becoming first-time parents. This resonates with previous research that demonstrates that sense of control is a significant predictor for mental health outcomes for both mothers and fathers during the first year following birth, with lower sense of control predicting higher levels of self-reported depression and anxiety symptoms (Keeton, Perry-Jenkins & Sayer, 2008).

As seen in the fathers' literature, a lack of control arose from lack of familiarity with parenthood due to being first-time parents, discrepancies between expectations and reality, difficulties balancing competing demands, changes to the relationship with partners, and conflicting messages from both their partner and society contributing to powerlessness and intolerable uncertainty (Steen, Downe, Bamford & Edozien, 2012; Edhborg et al., 2016). This links closely with the lack of parental

template which is discussed in more detail in 'Parenting Without' (Section 5.2.4). However, there was also a lack of control relating to minority stress for non-birth mothers. The additional lack of control and associated powerlessness and intolerable uncertainty associated with their sexual minority identity echoes findings by Malmquist, Jonsson, Wikström and Nieminen (2019) in which minority stress, involving hetero- and cisnormative treatment, hypervigilance to discrimination and internalised homo/transphobia, added an additional layer of fear of childbirth in LBT people. Therefore, whilst there are clear similarities in the lack of control experienced by non-birth mothers and heterosexual parents, there are additional factors which appear to be unique to minority individuals.

To cope with this lack of control and subsequent feelings of powerlessness and intolerable uncertainty, some participants entered a survival mode which included avoidance-oriented coping to avoid becoming overwhelmed, stigma and judgement, and hiding their feelings. Similarly, it has been argued that fathers' gendered responses include being more likely to withdraw and engage in avoidant strategies, such as overworking, substance use and reckless behaviour, which are deemed to be socially acceptable and contribute to delayed or avoidant-help-seeking (Veskrna, 2010). This type of coping may also link to the theme of legitimacy of distress as a non-birth parent. For example, the non-birth parent may perceive that their role is less important than their partners in relation to carrying, birthing and breastfeeding, and therefore may feel less able to voice their distress resulting in engaging in avoidant strategies and hiding feelings. This also might explain why participants prioritised instrumental support over emotional support as it represents tangible validation of their parental role (Goldberg & Smith, 2008). However, whilst there are similarities amongst non-birth parents in engaging in avoidant coping, it could be suggested that the need to enter this survival mode and hide their struggles is greater for non-birth mothers than fathers due to lack of social recognition (see 'Parenting Without' section 5.2.4).

Participants made sense of these feelings of powerlessness and intolerable uncertainty by drawing on previous mental health difficulties, viewing their experiences as part of their identity and as increasing their risk of subsequent PMH difficulties, fitting with the literature in heterosexual mothers and fathers (Ramchandani et al., 2008; Robertson et al., 2004). Sexual minority women in the

general population have higher rates of mental health problems and therefore may be at an increased risk of PMH difficulties (Ross, 2005). It is notable, therefore, that all the women interviewed in this study reported experiencing previous mental health difficulties. Participants also spoke about past mental health as protective, through increased emotional intelligence and coping strategies informed by previous professional support and self-management, which helped them navigate and potentially manage their feelings of powerlessness, uncertainty and failure. This finding may emphasise the value of learning from previous mental health difficulties, including seeing the positive elements this can bring in regard to self-care and the value of planning for well-being when people are well, may help manage symptoms once they have developed.

5.2.3 Legitimacy of (Di)stress as a Non-Birth Parent

The current participants often described their PMH issues as unimportant in comparison to their partner's. There seemed to be a view amongst some non-birth mothers that they should be strong as their primary role in the perinatal period was to support their partner and they should prioritise the birth mother's and baby's needs over their own, consistent with research on paternal mental health and on miscarriage in lesbian couples (Ruffell, Smith & Wittkowsk, 2019; Wojnar, 2007). As with fathers, this fed into their belief that their use of services in the perinatal period was not legitimate, acting as a barrier to seeking and accepting help (Darwin, et al., 2017; Isacco, Hofscher & Molloy, 2016; Lever Taylor, Billings, Morant, Bick & Johnson, 2019). Such similarities concerning legitimacy amongst non-birthing parents may imply that there are culturally embedded expectations that non-birthing parents need to be 'strong' and are on the periphery of these experiences that go beyond gender and are associated with parental role. For further discussion regarding parental roles, see 'Parenting Without' (Section 5.2.4).

Not feeling entitled to support and focus on the birth mother was mirrored and reinforced by messages received from services and society. This perceived exclusion has been evidenced with fathers (Darwin et al., 2017; Baldwin, et al., 2019). Services' focus on birth mothers as primary nurturers/parents is shaped by dominant norms that marginalise non-birthing parents (Lever Taylor et al., 2019). By continuing to adhere to these norms, services are at risk of further marginalising already marginalised groups of parents, such as non-birth mothers (Darwin et al., 2021). There may also be

differences in non-birth mothers' experiences of the legitimacy of their distress in contrast to fathers due to experiencing a double disenfranchisement, as highlighted in the same-sex bereavement literature (Doka, 1989; Cacciatore & Raffo, 2011). That is, same-sex couples may be likely to face greater challenges due to chronic invalidation of their relationship to the baby that further ostracises them and prolongs their difficulties.

The inclusion of non-birthing parents by services is likely influenced by sociocultural factors. There have been positive efforts in more gender equal societies (i.e., Sweden) to include the non-birth parent, which can signal the importance of their role and help them feel included and noticed (Ståhl, Hallström, Skoog & Vilhelmsson, 2020). There were some examples of participants being included within the context of their partner receiving support, which links in with the NHS Long-Term Plan's (NHS, 2019) proposals of evidence-based assessment and signposting for partners of birth mothers accessing specialist support. These positive experiences further reinforce the importance of including all partners within PMH services (Darwin et al., 2021).

Father-specific services are increasing in the UK and participants contrasted this with the continued lack of services for same-sex partners; for example having seen fathers' mental health services and father-specific antenatal information publicised by local NHS services. Conversely, the participants in this study identified a current lack of perinatal-specific services for same-sex partners. In line with previous findings with non-birth mothers, there appeared to be a lack of recognition of non-birth mothers in clinical settings and the support and information that was available for parents did not acknowledge the unique experiences of becoming a parent for non-birth mothers, meaning accessing appropriate support is more difficult for non-birth mothers (Abelsohn et al., 2013; Ross, et al., 2006; Goldberg, 2006). Interestingly, participants seemed to reflect on an implicit hierarchy of parental roles which influenced the support available to different types of parents, with birth mothers being at the top, followed by fathers, and then other types of parents. This hierarchy fits with the fathers' literature in which men report feeling like a 'second-class' parent in the eyes of society (Darwin et al., 2017; Jungmarker, Lindgren, & Hildingsson, 2010). Non-birth mothers, and other parents who do not fall within a typical role, such as adoptive parents or non-resident fathers, may be seen as third-class parents,

contributing to feelings of unimportance and as though their struggles are not legitimate. This seems likely to be exacerbating mental health difficulties and acting as a barrier to support.

Non-birth mothers in this study expressed a desire for PMH difficulties in partners to be normalised by professionals. Previous research has suggested that normalising distressing symptoms as common experiences amongst parents, such as intrusive thoughts (Abramowitz, Schwartz, Moore & Luenzmann, 2003), may remove barriers to help-seeking for parents (Pedersen et al., 2021). As with fathers, some non-birth mothers also voiced wanting professionals to acknowledge the challenges of their role and ask about their emotional well-being (Lever Taylor et al., 2019). These suggestions are explored in more detail in ‘Dissemination and Clinical Implications’ (Section 5.5).

Current participants described using informal support networks, mainly consisting of friends and same-sex families, which often legitimised their distress. This is consistent with previous findings regarding support networks for same-sex mothers and suggestions that having a social network with a shared identity is a protective factor during identity transitions (Kurdeck, 1998; Praherso, Tear, & Cruwys, 2017). However, some also reported feeling dismissed by friends and betrayed that they were not warned about the challenges of parenthood, potentially indicating that whilst they felt able to draw on their support networks, this was not always supportive and could decrease feelings of legitimacy of their difficulties. Additionally, for some there was a lack of support from their families, including discriminatory attitudes, which fits with previous same-sex research identifying lower levels of support from families as a contributor to PMH issues (Maccio & Pangburn, 2012). Similar to previous research in fathers and non-birth mothers, some participants felt unable to access support from their partner due to believing their role was to support their partner and anxieties about causing issues within their relationship or burdening them, and therefore had to cope alone (Baldwin et al., 2019; Darwin et al., 2017; Wojnar & Katzenmeyer, 2014). Therefore, whilst some non-birth mothers were able to draw on support, this could be inconsistent. Furthermore, despite the similarities with fathers, some non-birth mothers could be less likely to have support from their family of origin due experiences of discrimination, leading them

to further question the legitimacy of their PMH experiences and access to support which in turn exacerbated their difficulties.

5.2.4 Parenting Without

Difficulties common to all first-time parents associated with adjusting to a new parental identity were exacerbated by an apparent lack of a well-defined, socially agreed role and flexible language that captured the complexity of their position and had meaning in a heteronormative society, as evidenced in previous literature (Wojnar & Katzenmeyer, 2014; Brown & Perlesz, 2008), as well as role models to inform their parental identity as non-birth mother. This lack of template meant that, as first-time parents, participants lacked expectations about their role contributing to feelings of uncertainty and failure. Consequently, this created a sense of isolation that other parents, including lesbian birth mothers may not experience (Paldron, 2014). Participants contrasted this lack of a template with their view of a father's role, although there are potentially similarities in that fathers receive conflicting messages about what is expected of them as a parent (Domoney et al., 2017). This lack of a template may vary between non-birth mothers, for example McInerney, Creaner and Nixon's (2021) study showed that some non-birth parents were able to draw on role models which closely resemble the non-birth mothers, for example step-parents, when developing their maternal role, and this supported their transition to parenthood. It is also important to note that these difficulties are likely exacerbated by the current legal context within the UK, as within common law the non-birthing partner in the same-sex couple is neither a mother or a father but is categorised as a parent (*R v. General Registrar*, 2020), potentially contributing to further confusion and uncertainty around their parental identity. Therefore, whilst uncertainty in role and lack of role models due to rapidly changing societal expectations of fathering has been identified with fathers in relation to challenges with transition to parenthood and vulnerability to PMH difficulties, this appears true too - and likely heightened - for same-sex non-birth mothers.

As a result of this lack of a template for the non-birth mothers and a lack of language available within heteronormative discourses to describe their role, some participants tried to align themselves to either mother or father roles within the binary, when their role might lie somewhere between involving elements of both. As identified in the identity literature, being unable to fit within the traditional binary and

subsequent experiences of role incongruence/confusion, contributed to feelings of invisibility and difficulties embracing their parental identity resulting in distress (Paldron, 2014; Padavic & Butterfield, 2011; Walker, 2017; Wojnar & Katzenmeyer, 2014). This role incongruence and struggles to verify their parental identity fits with suggestions that this contributes to decreased well-being in parents as suggested by Identity Theory (Cast, 2004). Changes in established relationship/role dynamics and physiological changes associated with birth also seemed to contribute to this identity confusion.

Over time, parental roles within the relationship became more equal, as found by Goldberg, Downing and Sauck (2008), and participants adjusted to or carved out their own parental identity. Similar to findings by Padavic & Butterfield (2011), participants either reconciled their sense of themselves as parents with the categories available by engaging in behaviours associated with these roles or created a new, hybrid identity moving beyond the heteronormative binary. These findings lend support to queer theories of family, which challenge the notion that family types can be represented by simple binaries, and that gendered parental roles are instead constantly reworked in same-sex parented families (Epstein, 2005; Park, 2013; Gabb, 2005).

The intolerable uncertainty arising from the lack of template and feelings of powerlessness as a parent were fed into by exclusion by services, lack of social recognition and a lack of safety associated with heteronormative/heterosexist care and discrimination and prejudice. Similar to fathers, non-birth mothers reported being excluded by maternity services and feeling on the outside of parenting (Huusko, Sjöberg, Ekström, Hertfelt Wahn, & Thorstensson, 2018). Whilst this may be a common experience as the non-birthing parent, there appeared to be times when participants may have been excluded due to their sexual identity and people not believing they were the partner because they are a woman. This is mirrored in studies with non-birth mothers of older children, where they reported feelings of powerlessness when excluded from acting as a parent and being reliant on others in positions of power, such as doctors or teachers, to recognise their parental status (McInerney et al., 2021).

In contrast to birth mothers, non-birth mothers reported incidences in which they had not been recognised, and therefore validated, as parents and partners by the wider

system. Whilst fathers may also struggle with lack of recognition of their parental role, they are typically recognised as a partner whereas non-birth mothers may face non-recognition in both roles. The experiences of heteronormative/heterosexist systems, care and language contributing to this lack of recognition of non-birth mothers appeared to occur due to cultural incompetence and ignorance within systems, which could be a result of the lack of a schema for lesbian mothers and lack of well-established terminology to communicate non-birth mothers' maternal role within society (McInerney et al., 2021; Padavic & Butterfield, 2011; Paldron, 2014). This lack of recognition and invalidation of their parental status led to non-birth mothers questioning the legitimacy of their parental identity and contributed to difficulties with understanding and adjusting to their parental identity, which in turn negatively impacted their mental well-being (Hayman et al., 2013; Miller, 2012). The evident instrumental role of wider systems in constructing participant's parental identity links to Gender Theory and indicates that a lack of recognition in healthcare systems and informal support networks was an additional barrier to developing a stable and valid parental identity for non-birth mothers, contributing to their distress (Goldberg & Perry-Jenkins, 2007). Interestingly, this lack of recognition was also mainly experienced in triadic interactions (birth mother, non-birth mother and child), in which they were either placed in a position of secondary caregiver or completely dismissed, eliciting feelings of powerlessness and failure. This is likely to link to the concept of monomaterialism (Park, 2013), which is the belief that an individual can only have one mother. Through adhering to a monomaterialistic view, systems distance non-birth mothers into a devalued form of parenting, similar to fathers, rather than motherhood. Furthermore, primacy is given to biological parenthood in western society, as evidenced by the definition of 'mother' and 'father' in UK law (*R v. General Registrar*, 2020), acts as a barrier to the recognition of non-birth mothers by others (Padavic & Butterfield, 2011; McInerney et al 2021). Therefore, due to their unquestioned recognition of their parental identity, birth mothers, regardless of their sexuality, may face less challenges in their transition to parenthood that impact perinatal health issues than non-birth mothers.

In contrast with heterosexual parents, there was a lack of individual and familial safety associated with becoming a same-sex parent due to experienced or anticipation homophobia, prejudice and discrimination, leading non-birth mothers to question the legitimacy of their role/family and contributing to powerlessness, intolerable

uncertainty and failure. This links to the research focusing on minority stress, the chronically high levels of stress experiences by stigmatised groups which is contributed to by exposure to external distal stress and internal proximal stressors (Meyer, 2003). Actual experiences of homophobia and discrimination, including rejection, judgement and microaggressions in the form of inappropriate questions from both professionals and others, increased feelings of threat and fed into feelings of internalised homophobia, which led to participants questioning their right to have children and feelings of inadequacy (Touroni & Coyle, 2002). The consistency of this finding over time is particularly interesting considering the rapid changes to legal entitlements for same-sex parents and potentially indicates that social acceptance within societal systems rather than legal recognition may currently play a more significant role in PMH difficulties in non-birth mothers. In addition to contributing to perinatal depression and anxiety, the discomfort and distress caused by these experiences may decrease the likelihood of accessing services or the perceived availability of support from others and therefore act as a barrier to help-seeking which may then further exacerbate their mental health difficulties (Hayman et al., 2013). For many of the non-birth mothers it was the anticipation of discrimination, rather than the actual experience, that contributed to their PMH difficulties, a finding that has been mirrored in studies with non-birth parents of older children (McInerney et al., 2021). Living alongside anxiety about having their parenthood questioned created doubt and insecurity and potentially negatively impacted maternal identity development, suggesting that anticipation of discrimination and prejudiced events may be as stressful as the actual events themselves (Padavic & Butterfield, 2011). Interestingly, the women in this study spoke about the steps they took to manage their minority stress and to reduce the potential of experiencing discrimination and prejudice. Participants spoke about impression management, ‘crusading’ and taking responsibility for educating others about same-sex issues and surrounding themselves with other same-sex couples, strategies which have been previously identified literature on stigmatised groups (Hayman et al., 2013; Kaufman & Johnson, 2004). Whilst lesbian birth mothers will also face these challenges, the social recognition of their role and the primacy of biology in motherhood may act as a buffer which potentially protects against questions of the legitimacy of their role.

Participants also spoke about the lack of parental connectedness to their child, which contrasted with their expectations of parenthood, added to confusion around

their parental identity and resulted in feelings of intolerable uncertainty, powerlessness and failure. Whilst this a significant area of concern for all new parents, for non-birth mothers in this study difficulties developing a parental bond to their child were sometimes linked to a lack of biological connectedness, especially in relation to carrying. This finding echoes Paldron's (2014) study in which non-birth mothers expressed beliefs that the process of carrying a child helps women form their new parental identity. Breastfeeding has been potentially linked to some elements of maternal identity and bonding (Zizzo, 2009), and this may also explain why non-birth mothers who do not breastfeed struggle with their parental identity and connectedness. In this study, a lack of connectedness was also linked to exclusion from the mother-infant bond and perceiving preference for the birth mother as rejection of themselves, especially during the breastfeeding period. This perceived exclusion and rejection which was accompanied by feelings of maternal jealousy and resentment, uncertainty and inadequacy echoes the experiences of fathers (Goodman, 2005) However, these feelings appeared more pronounced for the non-birth mothers in this study, potentially due to the desire and ability to carry themselves. This links with research by Paldron (2014) in which non-birth mothers who had wanted to carry felt like "third wheel" and expressed uncertainty in relation to feeling adequate as a parent when the child relied on the birth mother, leading to lower self-esteem and feeling less bonded. Furthermore, anxiety and sensitivity relating to perceived rejection and disconnection may be increased for non-birth mothers due to the potential lack of a biological or genetic connection and the privilege given to biology in parental roles and bonding, exacerbating existing feelings exclusion and inadequacy (Goldberg et al., 2008; McInerney et al., 2021). In the current study, despite being able to rationalise that the baby was not rejecting them, some non-birth mothers still feared this was the case, further indicating that potential rejection is perceived more intensely in the absence of a biological tie (Pelka, 2009). Whilst negotiating biological connectedness may also be challenging for fathers, it could be argued that the potential to become gestational mothers themselves may make these issues more difficult to negotiate for non-birth mothers.

As with fathers, feelings of parental connectedness seemed to be reciprocally linked to participants' mental health, with some highlighting the impact of their mental health experiences on their ability to effectively engage with their child

(Sethna et al., 2015). However, it should be noted that only a few of the participants reported this and there is a need for more research into this area.

In this study, the women who struggled with their parental bond took steps to help address these feelings, for example by spending more time with the baby doing ‘mothering duties’, helping them feel to as much as a primary parent as the birth mother (Goldberg & Perry-Jenkins, 2007). The use of self-compassion to protect against negative emotions arising from bonding has also been found to be a protective factor more general for maternal postnatal well-being and attachment (Cohen, 2010). Additionally, all the women interviewed in the study reported that their concerns regarding bonding had lessened over time and that they were beginning to feel equally bonded to their child as the birth mother, mirroring findings by Gartrell et al. (2000). This may lend further support to the notion that mothering behaviour, rather than biological connection determines motherhood (Goldberg & Perry-Jenkins, 2007). However, it should be noted that non-birth mothers who do not feel as bonded with their children over time are less likely to come forward and take part due to stigma and shame, and so conclusion should be drawn cautiously.

5.2.5 Changed Relationship Dynamics

The second significant contributing factor to participants’ experiences of perinatal depression and anxiety were the changes that occurred in their relationship over the course of the perinatal period, which is also mirrored in both the maternal and paternal PMH literature (Goodman, 2005; Highet et al., 2014). For some participants, this was related to their partner’s health, both physical and mental, resulting in them taking on more of a carer role, both for their partner and child, and a role reversal in their relationship. This additional stress of taking on this carer role, including the impact on roles as parent and partner, and the need for additional support for partners to help manage feelings of powerlessness, uncertainty and failure arising from this has been echoed within the paternal perinatal research (Reid, Wieck, Matrunola & Wittkowski, 2017; Ruffel et al., 2019). Building on these findings, national guidelines recommend that services should consider, assess and address the needs of partners that might affect women with PMH problems (NICE, 2014). In doing this, the strain of being a carer might be reduced resulting in improvements to non-birth mothers’ mental well-being during the perinatal period. However, informal evidence and findings from participants in this study indicates that this does not currently happen in practice. It is

also important to note that there were positive unintended consequences in taking on more of a carer role. As in the fathers' literature, participants experienced that taking on more of a primary caregiver role facilitated bonding with the baby, potentially protecting against feelings parental disconnectedness (Ruffel et al., 2019).

Within this study, there was an indication of a correlation between participants' and their partner's mental health that has also been found in research with fathers (Goodman, 2004; Iles et al., 2011; Paulson & Bazemore, 2010), with participants reporting increased levels of distress when their partner was also distressed. There was a suggestion that this correlation between distress, especially when relating to the pregnancy and birth, was exacerbated by the participants' gender due to potential for both individuals in the couple to carry. However, more research exploring this gender difference is needed. Regardless, these findings emphasise the importance of assessing supporting non-birthing parents, especially if the birth parent is struggling with their mental health.

Additionally, unexpected changes to the couple relationship as a consequence of becoming parents, including changes of the roles within the relationship, spending less time together and resentment of each other's roles, contributed to powerlessness and intolerable uncertainty, echoing the fathers' literature (Edhborg et al., 2016). Tammentie, Paavilainen, Åstedt-Kurki and Tarkka (2003) highlighted spousal estrangement and role resentment as a common problem following the birth of the child, resulting from a lack of attention paid to each other and being jealous of each other's time, for example fathers feeling like onlookers and excluded from the mother-child dyad, whereas mothers envied the father's opportunities to leave the house for work and to socialise. Similar feelings of resentment have been found in studies exploring transition to parenthood with non-birth mothers, stemming from not feeling equal to birth mothers and feeling more like a 'servant' (Paldron, 2014). Whilst fathers also report not feeling equal to birth mothers, it could be that being treated unequally despite both being mothers exacerbates the resentment felt by non-birth mothers. Interestingly, this feeling of jealousy and resentment appeared more pronounced for some due to their desire to carry. This is perhaps indicative that feelings of jealousy and resentment contributing to PMH difficulties may at times be qualitatively different from those experienced by fathers, especially if the non-birth mother desires and has the ability to carry. As with fathers, the introduction of a baby into the

relationship and the shift in attention towards the baby by birth mothers left some feeling neglected and uncared for by their partner, resulting in feelings of maternal jealousy (Philpot, 2006; Goodman 2005). This is an important finding to be considered by services due to the evidence linking jealousy and increases in domestic violence during pregnancy and postpartum periods in fathers (Mezey,1997). Finally, similar to findings with heterosexual parents, participants' PMH experiences could also impact on the quality of their relationships, resulting in interparental conflict (Ramchandani et al., 2018). Therefore, significant changes to relationships and their influence on PMH difficulties indicates the need for mental health assessments to involve discussing the relationship, whilst also remaining mindful of potential differences for same-sex parents, and perhaps a need for tailored joint interventions that involve both partners to improve communication and co-parenting (Darwin et al., 2021).

5.2.6 Moving Forward

Participants spoke about moving forward from their PMH problems by taking back control of their mental health experiences through help-seeking, labelling their experiences and using coping strategies, such as externalising and practical strategies. Keeton et al.'s (2008) study, demonstrated that increasing sense of control during the transition to parenthood led to decreases in anxiety and depressive symptoms over the course of 14 months. As well as increased confidence, the current participants also used compassion and acceptance to reduce feelings of powerlessness, intolerable uncertainty and failure, strategies which have been identified as effective in maternal PMH research (Waters et al., 2020). Furthermore, self-compassion has been highlighted as protective against distress in minority populations, suggesting that the use of compassion by these non-birth mothers may have reduced their anxiety and depression and act as a buffer to future minority stress (Bowlen, 2020; Chan, Yung & Nie, 2020). Finally, participants spoke about the positive consequences of their PMH experiences, incorporating them into their identity and learning from their experiences, potentially indicating the value of reframing recovery from mental health difficulties as personal growth and agency (Yanos, Roe, & Lysaker, 2010).

Participants also spoke about the influence of their experiences on the future of their family. Similar to McInerney et al.'s (2021) study on identity transition for non-birth mothers, participants reported feelings of love and pride developing overtime

through engaging in parenting activities. This perhaps enabled the participants to shift away from internalised views about the pre-eminence of biological motherhood and the role of biological relatedness in being a mother, lessening the distress caused by these views and allowing participants to move forward (Park, 2013; Paldron 2014). Participants' experiences also helped them develop their expectations of the parent they wanted to be, mainly in terms of being emotional role model for their children. Children observing parents model emotional intelligence has been shown to have a positive impact on children's wellbeing (Sánchez-Núñez, García-Rubio, Fernández-Berrocal, & Latorre, 2020). The PMH experiences of some participants negatively impacted on their future reproductive choices as the risk of history repeating itself felt overwhelming and unmanageable. Whilst there is no current evidence of this in fathers, this is echoed in research in birth mothers that found a decrease in the likelihood in having children following experiencing of postpartum mental health difficulties (Liu et al., 2020). It could be argued that non-birth mothers' parental desire and ability to carry may influence their decision to have children in the future, allowing them to overcome these fears.

Therefore, despite the distress associated with PMH difficulties, participants were able to move forward from these experiences. Whilst there were some negative implications to their experiences, there was also evidence of learning and growth, cohering with the posttraumatic growth literature which highlights the potential for positive change following struggling with highly stressful events (Tedeschi & Calhoun, 2004).

5.2.7 Impact of Covid-19 on Perinatal Mental Health Experiences

Whilst the influence of Covid-19 pandemic on PMH was not the focus of this study, due to the timing of data collection Covid played a role in the experiences of some of the women which cannot be dismissed. Interestingly, the pandemic and subsequent restrictions appeared to have both a detrimental and protective impact on different aspects of PMH experiences. For example, whilst not being allowed into hospital after the birth, exclusion from antenatal appointments and barriers to accessing mental health support were all highlighted as negative consequences of the pandemic, the opportunity to spend more time at home and the subsequent impact on increasing bonding opportunities and availability/perceived supportiveness as partner was identified as a positive. This mixed impact of Covid-19 on PMH experiences

resonates with findings from the recent Babies in Lockdown (2020) report and a review of the Covid-19's impact on maternal mental health (Papworth, Harris, Durcan, Wilton & Sinclair, 2021). Additionally, whilst not evidenced in the current study, recent research has demonstrated that non-birth mothers may be more susceptible to being excluded from wards during the pandemic due to the emphasis on partners as a result of stricter visiting protocols and heteronormative assumptions that they are not the partner due to their gender (Stacey et al., 2021). Services will need to consider these findings and how they can address the negative impact of Covid on the inclusion of partners. The more positive consequences of lockdown may influence policies on parental leave (i.e., supporting arguments for non-birth parents to have more parental) which may have a trickle-down effect on PMH issues.

5.3 Strengths and Limitations

One of the key strengths of this research is that this study was well designed to meet the aims of the research. The sample size was within the recommended range identified by Smith et al. (2009) and contributed rich data to the analysis. Additionally, the rigorous approach to analysis utilised in IPA allowed for the generation of rich, detailed phenomenological data which has allowed the research to make a significant and valuable contribution to the understanding of non-birth mothers' experiences of perinatal depression and anxiety, an area previously neglected. Finally, keeping a record of my reflections during the study and continuing to engage in reflexivity helped me understand and manage the influence of my own position and views on the data and the analysis.

Another strength of this study is that it meets all four principles set out by Yardley (2000) for establishing the quality of qualitative research. This study demonstrates sensitivity to context through conducting a thorough review of the existing literature, demonstrating awareness of the socio-cultural milieu in which the study in was conducted, and sensitivity to the data collected from participants, evidenced by the wealth of verbatim interview extracts to support the findings. The study also meets the criteria of commitment and rigor through the careful selection of the sample and conducting interviews that were attentive to participants. Additionally, to ensure the rigour of the analysis, myself and the two members of the supervisory team undertook a process of peer debriefing, which involved each member of the team reading all the interview transcripts and discussing them fully in supervision,

discussing the individual and group analysis and considering alternative interpretations of the data. This allowed for our different perspectives to be considered during the analyses, including as clinical psychologists, PMH experts and as birthing and non-birthing parents. In regard to transparency and coherence, the study was conducted in line with IPA principles, the methodology has been described in-depth and the steps taken for analysis have been evidenced in the appendices. Finally, this study also meets Yardley's (2000) final principle of impact and importance, evidenced through how much it was valued by the women who took part in it. During recruitment and subsequent interviews, several of the women expressed their gratitude that research was being conducted into their experiences and the importance of this type of research for families such as theirs. This has been mirrored by the considerable interest in the research within maternity and PMH services and the LGBT+ community, observed through our dissemination activities both with services and via public engagement. The women were also thankful for the opportunity to share their experiences, with the hope that their contribution to the study would be influential in educating others and making changes within services to improve the experiences of other women in the future. Additionally, some women expressed that they found the interview cathartic, helping them process and develop a greater understanding of their experiences.

The findings of this study were not checked with participants, which would have provided an additional quality check to assess the credibility of the results. However, dissemination of the study through webinars and workshops has informally demonstrated that the findings resonate with other same-sex parents not involved in the study, lending credibility to the results.

Within an IPA approach, researchers aim for a homogenous sample to capture an in-depth account of the shared experiences of a group of people (Smith et al., 2009). Whilst significant efforts were made to maintain the homogeneity of the sample, there were some factors that were not controlled for, which may have weakened this. The participants interviewed in this study varied in the length of time since their experiences of PMH issues. Whilst for some participants their PMH experiences were current, for others these experiences were less recent, although still within five years. These participants had had more time to reflect on their PMH difficulties and subsequently may have made sense of their experiences in ways that were different from those whose experiences were more current. For example, one participant spoke

about how at the time, she would not have interpreted her experiences as postnatal depression but as a reaction to a significant life change. Additionally, some participants accessed formal mental health support whereas others did not. Accessing this support may have also influenced how participants made sense of their experiences and this was indicated in how some people spoke about their experiences. All the women interviewed seemed to be ‘Moving Forward’ from their experiences of PMH and their distress appeared to be less acute; indicating that this study may not have captured the experiences of those who were currently experiencing high levels of distress. The lack of these types of experiences could be due to several factors, including their symptoms making it more difficult to discuss their experiences, feelings of shame associated with PMH issues, and not wanting to add to evidence that may show lesbian mothers as being seen to be failing as parents. The Covid-19 Pandemic greatly impacted on maternity services and the care experienced by families during this time. Whilst efforts were initially made to control for this, as outlined in the ‘Inclusion and Exclusion Criteria’ Section (see Section 3.2.2), it was decided not to control for this due to challenges with recruitment. Whilst some women reflected on the impact of Covid on the PMH issues, Covid did not appear to dominate to their experiences. Finally, the study was advertised throughout the UK, but all participants were recruited from England. Geographical factors may have influenced the homogeneity of the sample and dictated participants’ experiences, for example, the participants’ geographical location may have dictated the availability of funding for assisted conception and the PMH support available to them. However, restricting recruitment to one area of the UK could have led to difficulties with recruitment and it may have been more difficult to maintain participants’ anonymity in such a small target population.

The transferability of findings is typically spoken about in relation to IPA studies (Smith et al., 2009). Whilst having a homogenous sample is important for IPA, this may limit the transferability of the findings. For example, there was a lack, although not an absence, of intersectionality within the sample. All participants were white, with the majority identifying as British and were aged between their late 20s and their 40s. All were employed and all had used assisted conception through clinics to pursue parenthood. Consequently, although this meant that sample was relatively homogenous, and therefore captures a detailed account of the shared experiences of this group of non-birth mothers, the findings of this study may not be transferable to

other same-sex non-birth mothers who also identify with other minority populations, such as Black, Asian and Minority Ethnic communities, individuals with disabilities and individuals from other socio-economic backgrounds. It is possible that the experiences of non-birth mothers who are part of multiple minority groups are different to the current study due to factors relating to their other areas of social difference, such as cultural factors or experiences of racism in addition to homophobia. There was some evidence of this within the study as one participant, Sarah, spoke about the intersection of her religious identity (Christianity) with her sexual identity and the subsequent difficulties she experienced in relation to this, including discrimination/others' attitudes as well as internalised homophobia.

5.4 Further Research

As discussed in the limitations section, there was a lack of intersectionality within this study. Whilst there are currently no studies exploring the experiences of PMH in non-birthing partners in other minority populations, studies with birth mothers, such as heterosexual women from ethnic minorities, have highlighted similar findings to this study, including culturally insensitive and incompetent care and stigma, but also identified issues such as cultural expectations playing a considerable role in their experiences (Watson, Harrop, Walton, Young, & Soltani, 2019). Therefore, a future study could focus on sexual minority non-birth mothers who identify with other minority statuses, exploring their experiences of PMH and how the intersection between these minority identities influences this experience, comparing those findings to this study to draw out similarities and differences.

This study focused on current or recent (within the last five years) experiences of PMH issues and the impact of these experiences on longer term outcomes remains uncertain. Therefore, longitudinal research may be warranted to explore impact of these experiences and the themes identified in the analysis in the long term. Additionally, all the participants in this study were discussing their experiences in relation to becoming a first-time parent. Whilst some had gone on to pursue further assisted conception, PMH experiences in subsequent pregnancies were not explored. Research with fathers has demonstrated that past experiences of PMH issues provided learning but also provoked anxiety in subsequent pregnancies and that subsequent fathers faced additional challenges in meeting the needs of multiple children (Darwin et al., 2017). Therefore, research should be conducted to explore the PMH experiences

in non-birth mothers who go on to become parents again and the influence of previous experiences on this.

Relationship dynamics were highlighted as an important area contributing to and being influenced by PMH experiences. The significant relational influence on many of the difficulties faced by participants and differences in relationship dynamics in same-sex couples indicates that this may be an area which could be explored in more depth in research with couples. Studies that include the perspective of both partners on experiences of PMH issues within relationships may highlight different interpretations of these experiences and the wider impact of the mental health issues may have within a couple and could contribute to joint PMH support for same-sex couples within services where appropriate.

Within the study, trauma was raised by a few of the participants. Though the current study focused on experiences of depression and anxiety, studies focusing on birth trauma have indicated that heterosexual partners may experience post-traumatic stress following traumatic incidents during the perinatal period (Andersen, Melvaer, Videbech, Lamont & Joergensen, 2012). Whilst this is not necessarily distinct from experiences of depression and anxiety and there is likely to be some overlap, there may be value in focusing on post-traumatic stress in the perinatal period in non-birth mothers.

Many of the women in this study spoke about their partner's experiences of PMH issues in addition to their own and the impact that this had on their own experiences. Although not all of these birth mothers were receiving mental health support, some were receiving specialist perinatal mental health support. Some participants briefly reflected on the impact of this support on their own mental health experiences, such as the reducing the burden of caring from themselves, however, more in-depth exploration of partners of birth mothers being cared for by specialist PMH services or maternal mental health services is needed.

Finally, this study focused on non-birth mothers in same-sex female relationships. However, there is also a lack of research on other types of parents in the same-gender community, such as gay fathers, and within the transgender community. There would likely be significant difference between the experiences of these populations. For example, though it is likely that gay cis-fathers may struggle with their identity as a parent, there may be less confusion over their role as a father due to the lack of a carrying partner in these relationships. Additionally, transgender parents

may experience or fear experiencing transphobia within services. Consequently, similar future qualitative studies are needed to explore the PMH experiences and experiences of accessing support within these parents.

5.5 Dissemination and Clinical Implications

Several steps have been taken to disseminate the findings from this research so far. Provisional findings from the analysis were presented for a webinar series focusing on perinatal mental health care of LGBTQ+ individuals hosted by Public Health England Yorkshire and Humber Centre. Provisional findings were also presented at a Queer Birth public engagement workshop aimed at LGBTQ+ parents. A live illustration of the presentation from the workshop can be found in Appendix L. Finally, the study and finalised results were presented at the international Society for Reproductive and Infant Psychology (SRIP) conference.

From our findings, it is evident that currently there is a general lack of culturally competent care within fertility and maternity services and from individual professionals which significantly contributes to the PMH experiences of non-birth mothers. Many of the participants spoke being asked intrusive questions by professionals and their shock about the lack of awareness regarding same-sex families, leading some to taking on an educative role with service providers. Although this was not always perceived negatively, clearly there is an urgent need for more training regarding same-sex parents and PMH issues within this population to increase the culturally sensitive and competent care provided by services and individual professionals which recognises diverse family forms, including the potential for both parents to be pursuing gestational parenthood. As one participant put it, service providers need to understand: *“that people in same-sex relationships are coming in with all these layers of, like homophobia and things they have to deal with.”* However, services and professionals also need to go beyond cultural competence and commit to developing cultural humility (Tervalon, & Murray-Garcia, 1998), engaging in continual self-reflection around cultures to increase service providers awareness and to ensure that they do not apply a ‘one-size-fits-all’ approach to care of same-sex parents. This links to the principle of ‘stay curious’ in NHS good practice guidance for PMH services (Darwin et al., 2021). Importantly, service providers must be willing to discuss the issues faced by these women and their families in ways that promote safety, understanding and self-compassion, in addition to be willing to get these

discussions wrong and recognise when they do so. In doing this, services can reduce some of the stressors within the systems that contribute to PMH experiences of these women. There was some evidence of this in the current study where individual professionals apologised for making heteronormative assumptions which helped lessen feelings invisibility.

Another clear issue identified in this study was experiences of heteronormative and heterosexist care from systems, including policies, protocols and the language used by systems, leading to a lack of social recognition and validation and creating feelings of invisibility which contributed to PMH experiences. Fertility and maternity policies and protocols need to be reviewed and adjusted where appropriate to be more inclusive of those who do not identify as heterosexual. When they cannot be adjusted, professionals need to explain why certain protocols are in place so that same-sex families understand and feel less powerless in the fertility process. Additionally, language used by systems should be adjusted to be more inclusive of diverse family forms. For example, changing the wording of 'father/husband/male partner' on fertility forms to include 'co-mother/wife/female partner', plus terms that are outside of the binary. In this study, there was a few occurrences of individual professionals taking it upon themselves to change the language on the forms without being asked, allowing the non-birth mother feel included. Professionals could also clarify the language regarding role preferred by women to ensure they are providing culturally competent care which validates the role of these women and improve emotional well-being, as identified within the trans pregnancy literature (Hahn, Sheran, Weber, Cohan, & Obedin-Maliver, 2019; Obedin-Maliver & Makadon, 2016). Making these changes will help ensure that care being provided is person-centred and reduce feelings of invisibility which may subsequently positively influence PMH experiences.

The exclusion of non-birthing parents is an issue within both heterosexual and same-sex relationships. Whilst services should increase their attempts to include the non-birthing parent in procedures and appointments regardless of sexuality, it may be particularly important to do this for non-birth mothers whose additional concerns about their role and experiences of homophobia and discrimination may make them more sensitive to being excluded. By including non-birth mothers in the care of their partner and child, these women will feel recognised and a sense of legitimacy in their

role, as well as increase feelings of being in control and potentially reducing minority stress.

There is a clear need for more inclusive PMH services and support for partners. Professionals need to acknowledge and include partners when assessing the emotional wellbeing of families during the perinatal period. Encouraging examples were provided in this study of individual professionals recognising and normalising PMH difficulties in the non-birthing partners emphasising the significant positive impact that professional interactions have on parental mental health. Moreover, whilst there is clear evidence that support for fathers is increasing, there is perhaps an indication that specific support for non-birth mothers that addresses the nuances of their experiences is also needed. Although including other types of partners in fathers' support services could reduce feelings of difference, there are some clear qualitative differences to their experiences which may mean that combined support might lead to these differences being ignored. However, more research is needed to ascertain whether separate support or combined support (either with fathers or birth mothers) is most beneficial for non-birth mothers. Therapeutic approaches that promote acceptance and self-compassion, including Compassion Focused Therapy and Acceptance and Commitment Therapy, may be particularly helpful for non-birth mothers with perinatal depression and/or anxiety due to evidence demonstrating their effectiveness for PMH difficulties in birth mothers and for individuals from sexual minority groups, especially those with high levels of self-stigma (Waters et al., 2020; Petrocchi, Matos, Carvalho, & Baiocco, 2016). Additionally, the clear influence of the relationship dynamics on PMH experiences may indicate the need for joint support for both birth and non-birth mothers or signposting to therapies that focus on relationships, as highlighted in current guidance in involving and supporting partners in PMH services (Darwin, et al., 2021). However, further research is needed within the area.

Finally, the use of genograms as part of the pen portraits in this study has demonstrated their utility in mapping out complicated family dynamics. This aligns with current guidance which highlights the importance of mapping out the family as a way of acknowledging and validating perinatal mental distress in partners (Darwin et al., 2021). Professionals and/or services could utilise genograms to not only to ask about partner's mental health experiences but to also recognise and validate family dynamics and roles without being intrusive.

5.6 Conclusion

This study explored the experiences of perinatal depression and anxiety of non-birth mothers in same-sex parented families. Six superordinate themes were identified in the IPA analysis that provided insight into participants' experiences of perinatal depression and anxiety, factors contributing and being influenced by these experiences and moving forward from these experiences. Overall, the non-birth mothers in this study described feelings of failure and inadequacy in their roles (parent, partner and individual), contributed to by feelings of powerlessness and intolerable uncertainty. These feelings fed into and were influenced by their own and the wider system's perceptions of the legitimacy of this distress due to their non-birthing role, which impacted the support they were able to access. Non-birth mothers' experiences of perinatal mental health difficulties were contributed to by the absence of factors that facilitate the transition to parenthood, including a template for parental identity, inclusion, recognition and safety and difficulties with parental connectedness. Additionally, changes to their relationship dynamics as a result of their partner's health during the perinatal period and changes to the relationship that occur when becoming parents also contributed PMH difficulties. Participants' experience of perinatal mental health difficulties also reciprocally influenced these factors. Participants spoke about moving forward from their experiences, taking back control to increase their mental well-being and reflecting on the impact of their experiences on their family life in the future. Many experiences of non-birth mothers were similar to those previously identified by heterosexual fathers, however, there also appear to be additional unique experiences associated with participants' sexual identity which exacerbated the stressors associated with the non-birthing role. Furthermore, whilst some of the experiences are also similar to lesbian birth mothers, there were also key differences in relation to the non-birth mother role. Therefore, the results of this study indicate that experiences of perinatal mental health in non-birth mothers may not necessarily be dictated by gender or sexuality, but is potentially linked to the parental roles they adopt and the social recognition of those roles.

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Appendix A: Glossary of Terms

Artificial insemination (AI): the medical procedure of inserting or injecting sperm into the womb. Also known as 'Intrauterine insemination (IUI)'.

Assisted reproduction/conception: the use of medical procedures to bring about conception of a child by means other than sexual intercourse, including intrauterine insemination (IUI), in vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI) and donor insemination (DI).

Biological mother: the mother who is biologically related to their child

Birth/carrying/gestational mother: the mother who carries and gives birth their child but may or may not be biologically related to them.

Bisexual: Individual who is romantically or sexually attracted to more than one gender.

Cisgender or Cis: an individual whose gender identity is the same as the sex they were assigned at birth.

Egg sharing: when an individual undergoing IVF donates some of their eggs to the fertility clinic where they're having treatment, usually in return for some free or discounted treatment.

Heteronormative: the assumption or cultural bias that heterosexuality is the only preferred or 'normal' sexual orientation.

Heterosexism - discrimination or prejudice against people who identify as LGBT+ on the assumption that heterosexuality is the normal sexual orientation and therefore, superior.

Heterosexual/Straight: an individual who is sexually attracted to a person of the opposite sex.

Homophobia: fear or dislike of someone based on prejudice or negative attitudes, beliefs or views about homosexuality and people who are identified as or perceived as being LGBT+.

In vitro fertilisation (IVF): A medical procedure whereby eggs are collected from a woman and fertilised with sperm outside the body before being implanted into the womb.

Internalised homophobia - the internalisation of negative social views about homosexuality resulting in distress.

Intrauterine insemination (IUI): see 'Artificial Insemination'

Lesbian: A woman who is romantically or sexually attracted to another woman.

LGBT+: acronym for lesbian, gay, bisexual, transgender and related communities, including people with gender expressions and sexual orientations outside traditional norms, such as non-binary, intersex, queer, asexual, etc.

Microaggression - a statement, action, or incident of indirect, subtle, or unintentional discrimination against members of a marginalized group.

Minority stress: chronically high levels of stress faced by members of stigmatised minority groups caused by direct and indirect experiences prejudice and discrimination.

Non-birth/non-carrying/non-biological/co-mother: the mother that does not carry the child during pregnancy but may be biologically related to the child.

Perinatal period: the period of time covering from conception, pregnancy, birth and the first year postpartum.

Postpartum: following childbirth.

Sexual orientation: A person's sexual attraction to other people, or lack thereof.

Appendix B: Recruitment Flyer

Leeds Institute of Health Sciences/ Faculty of Medicine and Health



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Exploring co-mothers' experiences of perinatal anxiety and depression: understanding the perspectives of the non-carrying parent in same-sex parented families



Do you identify as a non-birth mother? Non-carrying mother? Co-mother? Other Mother?

We are inviting people to take part in an interview study about non-birth mothers' personal experiences of perinatal anxiety and depression in same-sex relationships.

Lots of parents experience depression and anxiety during pregnancy and the first year after a baby's birth and services are being expanded nationally to improve the support available. LGBT+ parents have been overlooked in studies of those experiences and research on partners has focused mainly on fathers and male partners.

Can you help?

You are eligible to take part if ALL of the following apply:

- You are the non-birth mother who has been in or is currently in a same-sex female relationship in which your partner is either pregnant or has given birth within the last five years.
- You felt depressed or anxious during your partner's pregnancy or first year since your child was born. For example, you may have felt persistently sad or tearful, nervous, anxious or on edge, empty, guilty and irritable, or experienced changes in appetite, trouble sleeping, loss of enjoyment in activities, problems concentrating, heart racing, not being able to stop or control worrying etc. These feelings or symptoms may have lasted for a few weeks or months.

What does taking part involve?

An individual interview lasting approximately 1 hour either by phone or online video conferencing software. Face-to-face interviews in your home or a private location of your preference will be offered as an alternative if Covid-19 restrictions are lifted. The interview would discuss your personal experiences of perinatal depression and anxiety.

As compensation for participating in the study, you will receive a **£10** voucher.

If you would like to find out more, please contact:
Alexandra Howat (Clinical Psychologist in Training)
umaho@leeds.ac.uk

This study is supervised by: Dr Zoe Darwin and Dr Ciara Masterson.

This study has been reviewed by the School of Medicine Research Ethics Committee (MREC 19-055. Date approved: 05/06/2020).

Appendix C: Participant Information Sheet

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Participant Information Sheet (V. 3, 27/07/20)

Exploring co-mothers' experiences of perinatal anxiety and depression: understanding the perspectives of the non-carrying parent in same-sex parented families.

Thank you for expressing interest in taking part in this study. I'm a Clinical Psychologist in Training currently completing my Doctorate in Clinical Psychology at the University of Leeds. I am interested in the mental health experiences of partners in the LGBT+ community during pregnancy and the first year of an infant's life. You are being invited to take part in a research project which aims to use individual interviews to explore the personal experiences of depression and anxiety in the perinatal period of non-birth mothers, also described as non-carrying mothers, in same-sex relationships. This study will form part of my qualification in Clinical Psychology.

Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the project?

Many parents struggle with depression and anxiety during pregnancy, birth and the first year of an infant's life, also known as the perinatal period. The majority of research has focused on perinatal mental health in mothers meaning that the experiences of partners have been largely neglected. Recently, there has been research on the experiences of fathers and male partners, however, parents from the LGBT+ community continue to be fairly under-represented in the research. This is despite the growing number of births to same-sex female couples and indeed the growing number of births across LGBT+ communities. Therefore, the aim of this study is to explore and understand the views and personal experiences of anxiety and depression in the perinatal period of non-birth mothers in same-sex parented families. It is hoped that this research could potentially help inform clinical and support services for this population.

Why have I been chosen?

You have been approached to take part in this project because you are a non-birth mother currently or previously in same-sex relationship where your partner is either pregnant or has given birth within the last five years. In addition, you have also had lived experience of depression and/or anxiety symptoms within the perinatal period. This may not have involved a diagnosis or accessing formal mental health support. Between 7 and 9 participants will be recruited to this project.

We use the term non-birth mother here to refer to the non-carrying parent, regardless of which parent is biologically linked to the child. We recognise that other terms may be preferred including co-mother, non-carrying mother, non-gestational mother and other mother. The focus of this research is on co-mothers, but we also recognise some parents will be non-binary, gender fluid or transgender.

Do I have to take part?

Participation in this study is entirely voluntary and it is up to you to decide whether or not to take part. If you do agree to take part, you will be given this information sheet to keep and be asked to sign a consent form agreeing to participate in the research. You can withdraw from the study at any point, without giving a reason and without any negative consequences,

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by emailing the researcher, Alex (see contact details below). You may also decline any question that you do not wish to answer. If you decide to stop the interview, we will discuss if you wish to withdraw all of the data you have already provided or whether I can retain that. You can withdraw your data within three weeks of the interview, which would result in all your data being destroyed. After three weeks it will not be possible to withdraw your data because the data will have been analysed.

What will happen to me if I agree to take part?

The researcher will contact you to arrange a date and time to be interviewed. Interviews will typically take place by telephone call or secure online video conferencing platforms (e.g. Microsoft Teams, Zoom or Skype), depending on your preference and access to systems. If the current restrictions regarding the Covid-19 pandemic are lifted, you will also be offered the option to have a face-to-face interview which will take place in your own home or a location of your preference. We ask that this is an individual interview, with minimal distractions and without your partner or children present. However, if you are caring for a young infant and are unable to organise childcare, please let the researcher know. Copies of the consent form and a basic information questionnaire, which will be used to collect information regarding characteristics such as your age, ethnicity, sexuality and employment, will be sent to you by email. You will be asked to complete these as soon as possible and email them back to the researcher before your interview. Please note, we will accept electronic signatures on the consent form. In the event of a face-to-face interview, you will be given paper copies of the consent form and basic information questionnaire to complete immediately before the interview.

On the day of the interview, the researcher will contact you (either by telephone or by an online platform) and you will be given the opportunity to discuss the project further and to ask any questions. The researcher will then verbally re-establish your consent to participate in the project. In the event of a face-to-face interview, the researcher will give you the opportunity to discuss the project further and to ask any questions before completing the consent form and basic information questionnaire. The interview will probably last for minimum of one hour and will be audio-recorded so that the discussion can be typed up word for word by the researcher or the University of Leeds's professional confidentially bound transcription service, and then analysed. The interview will involve an open discussion focusing on your own personal experiences of having perinatal depression and/or anxiety, how these experiences have affected you personally, your relationship and the family, and your experiences of support regarding your mental health during this time. Pen portraits, an informal description of you using non-identifiable information, will be written to provide context for the data gathered from the interview.

At the end of the interview, you will have the opportunity to discuss your participation in the project with the researcher.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

Information about your lifestyle and general characteristics will be collected from you to provide an overview of our participants. Information regarding your experiences of perinatal depression and anxiety will be gathered from the interviews so that significant themes capturing these experiences can be drawn out through analysis and provide insight into the experiences of this community.

Will it be confidential?

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Although the interviews are for research and not therapy, the researcher still has a duty of care if she feels there is a risk of harm to you or someone else. In this situation, she would share her concerns with you and might need to share these concerns with other professionals on a need to know basis. Please feel free to discuss this with the researcher before signing the consent form if you have any questions.

Will I be recorded, and how will the recorded media be used?

All interviews will be recorded on a password protected audio-recording device or using OneNote. Audio-recordings will be transferred from the device/software and stored on the secure University of Leeds's OneDrive as soon as possible. The recordings will then be typed up word for word and made anonymous, changing any names or places, after which they will be permanently deleted. Direct quotes which have been anonymised will be used from the interviews to illustrate findings. No one outside the project will be allowed access to the original recording.

What are the possible disadvantages and risks of taking part?

The study explores personal experiences of depression and anxiety. You may find it distressing to discuss and it could potentially trigger difficult feelings. If we think that this is happening, we will discuss together how best to manage the situation – it may be useful to take a short break. The researcher will discontinue the interview if they feel that proceeding will become too distressing for you. Supportive resources can be found at the end of this information sheet in case you feel you would like to access additional support.

What are the possible benefits of taking part?

There are no intended benefits to this study, although you will receive a £10 voucher for taking part. You may find that speaking about your experiences of perinatal mental health and having an opportunity to have your story heard can be personally meaningful. Furthermore, it is hoped that this work will potentially inform future clinical practice and support services available to others.

What will happen to my personal information?

We will not record any personal data, such as date of birth. Your name will only be used for your consent form. All contact information will be stored separately from the research data and deleted after you have finished the study. Any identifiable information will be removed or changed from the interview transcripts and pen portraits. You will be assigned a false name pseudonym to protect your anonymity.

What will happen to the results of the research project?

As this study forms part of a doctoral thesis, it will be published on the White Rose E-thesis portal where you will be able to access a copy of the published results. The project may also be published in a journal for health professionals and shared at conferences/with organisations providing support regarding perinatal mental health and LGBT parenting. You will not be identified in any report.

Using and storing research data

Data collected in this study will be used to write a doctoral thesis which will then be published on White Rose E-Thesis portal. We will also seek to publish the data in a peer reviewed journal.

Audio-recordings will be deleted after they have been transcribed. All other data collected will be stored for 3 years after the completion of the study on a secure, password-protected

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computer server managed by the Doctorate in Clinical Psychology Training programme after which it will be deleted in full accordance with the GDPR.

For more information regarding the use of personal data in research, please see the University of Leeds's [Privacy Notice for Research](#).

Who is organising the research?

This research is organised by the Doctorate in Clinical Psychology course at the University of Leeds. Ethical approval for this study has been granted by the School of Medicine Ethics and Research Committee (MREC 19-055) on 05/06/2020.

Contact for further information

If you wish to receive more information about this project or have any questions/concerns, then please contact either:

Researcher: Alexandra Howat (Postgraduate Student, Doctorate in Clinical Psychology)
Address: Leeds Institute of Health Sciences, Level 10, Worsley Building, University of Leeds, Leeds, LS2 9NL
Email: umaho@leeds.ac.uk
Telephone: TBC (For REC info: this will be a project specific number, not a personal phone number).

Supervised by: Dr Ciara Masterson

Address: Clinical Psychology Training Programme, School of Medicine, Leeds Institute of Health Sciences, Level 10, Worsley Building, University of Leeds, Leeds, LS2 9NL

Email: c.masterson@leeds.ac.uk
Telephone: 0113 343 2712

Finally ...

Please keep a copy of this information sheet for future reference. The researcher will contact you in one week to answer any questions and if wanting to, arrange a convenient time for interview. You will be emailed a consent form and basic information questionnaire which you will be asked to complete and return by email to the researcher as soon as possible.

Thank you for taking the time to read through this information sheet and we look forward to hearing from you.

Appendix D: Topic Guide

Topic Guide and Possible Prompts (V2, 07/05/20)

Opening

My name is Alex and I'm clinical psychologist in training currently completing my Doctorate in Clinical Psychology at the University of Leeds. As part of my work I am speaking to non-birth mothers in same sex relationships, like yourself, in order to learn more about their personal experiences of perinatal depression and anxiety. I hope that this information will provide insight into the experiences of these parents and will be useful for informing future clinical practice and services for this population. The interview will last approximately one hour but if you need to take a break please let me know. However, before we begin, I would like to clarify some information with you:

- 1) The perinatal period – this refers to the period of time that spans pregnancy, birth and first year of life. This may be some time ago for you now, so I may be asking you to cast your mind back to that time.
- 2) Preferred terminology - whilst we have used the term non-birth mother in the research, we understand that the preferred terms used to refer to this role may vary between individuals, for example co-mother, non-carrying mother, non-gestational mother and other mother. What are your preferences?
- 3) Verbally re-establish consent – have had the opportunity to look through participant information sheet, had all questions answer, understands right to withdraw and use of data, etc.

If you are happy with what has been discussed, then let us begin the interview

Interview Topics

- 1) Topic: Previous mental health history (before perinatal period)

Question 1: Thinking back to before you embarked on parenthood, can you describe your past mental health experiences?

Possible prompts: Can you describe your mental health experiences when you were younger? Formal diagnoses? How did you cope? What support did you receive?

- 2) Topic: Experiences during perinatal period

Question 2: Can you tell me about when you and your partner decided to have a baby?

Possible Prompts: What led you to this decision? How was the decision made? How did you feel about that (at the time and later)? What happened after your partner became pregnant? Can you describe what you were feeling and thinking during this time? Can you tell me when you began feeling like that? What did you notice that was different/what changed? Symptoms? What did you think was happening? How did you cope? Formal diagnosis? What happened next?

Question 3: Can you tell me about how you found/felt during the pregnancy? And the first year after your child was born?

Possible prompts: How did you find the first 12 months? Can you describe what you were feeling and thinking during this time? Can you tell me when you began feeling like that? What did you notice that was different/what changed? Symptoms? What did you think was happening? How did you cope? Formal diagnosis?

- 3) Topic: Influences on experiences of mental health during perinatal period

Question 4: What sense do you make of what happened?

Possible prompts: Can you tell me about any particularly difficult times for you? What was happening for you at this time? What aspects of your life/the situation influenced how you were feeling? How did your role as (non-birth mother) influence your experiences? How did your identity as a (insert preferred term here) woman influence your experiences?

- 4) Topic: Relationship and partner's mental health during perinatal period

Question 5: Can you tell me about the relationship between you and your partner during this period?

Possible prompts: Can you tell me about your relationship during this time? Tell me about your partner's mental health during the perinatal period? What did you notice? What support did they receive?

- 5) Topic: Effect of perinatal mental health on individual (health, work, social life), relationship and family.

Question 6: In what ways do you think these experiences affected you at the time?

Possible prompts: How did it affect you personally e.g. health, work life, social life? How did it affect your relationship with your partner? How did it affect your relationship with your child(ren)? How about other types of relationships (wider family and friends)? Who was aware? How did they become aware? Why do you think these experiences affected you in these ways?

- 6) Topic: Mental health support during perinatal period.

Question 7: Can you tell me about any support you received during this time?

Possible prompts: How did it could about? What was the reaction of those around you to your experiences (e.g. partner, family, friends, professionals)? Did any professionals ask how you felt? Did you feel recognised as a new parent? What services were available to you and how able did you feel to access them? How able did you feel to speak to others about your experiences? What would have liked to be different/How could things have been different e.g. support, information, reactions of others? Tell me more/in what way?

- 7) Topic: Long-term effects of perinatal mental health experiences.

Question 8: How are things now?

Possible prompts: What changes have you noticed e.g. individually, relationship and family? What effect did these experiences have on decisions to have children in the future? What does life look like for you now? What have been the negative and positive consequences of your experiences?

Closing

Thank you for sharing your experiences of perinatal mental health with me today. I appreciate the time you have taken to be interviewed today and the information you have contributed will be invaluable in this research. Is there anything else you would like to say before we end the interview?

Again, thank you for your participation today, we will now take some time to discuss the next steps and I will answer any questions you may have for me.

Appendix E: Example of Preliminary Comments on Interview Transcripts from Transcript 7

Interview ID: PID007

Unlike other interviews because both didn't feel strongly about it.

Why didn't they feel strongly about it? Is this in comparison to others.

30 it about ... 3 years ago, I think [uh huh]. And it's just something we discussed but both of us didn't feel
 31 like really strongly about it? [Yeah.] Like we know people who really desperately wanted children. It
 32 was like their mission you know? They would pay anything to, to have it happen! And we were just,
 33 [Laughs] the whole way though actually! Even up to the point where we actually got pregnant, it was
 34 sort of like "well, let's try it! And if works then it works, and if it doesn't, then it doesn't!" [Yeah.] You
 35 know it wasn't like em ... you know ... I don't know how to explain it really! Just wasn't, wasn't
 36 something that either of us really felt terribly strongly about when we started the journey.

If they didn't feel strongly then why? Less invested.

37 Interviewer: Yeah... And what led you to making the decision?

38 Participant: Em well time! [Laughs] [uh huh] Em time, I guess. Em she's about 3 years younger than
 39 me! So I'm almost 40 but it was that sort of, we just didn't know what was the right decision, you
 40 know? Should we or shouldn't we? If we don't, will we regret it? Will we regret it more if we do or we
 41 don't? It was a lot of indecision the whole way, the whole way through while we were em deciding
 42 really! [Mm] Even so I think it's hard to know whether you are making the right decision at the time

fear of regret = pressure

43 or not? [Yeah.] You just feel like ... you know ... Em I've got lots of kids in my family so I do love kids
 44 and everything. But it's always a hard decision to, should I be doing this? Or am I just doing it because
 45 I think I should be doing it?

46 Interviewer: Yeah, yeah. And once, once you made the decision, how did you feel about it?

47 Participant: Em yeah! Sort of excited. Em ... again neither of us were 100% sure that either decision
 48 was the correct one! So em ... you know, it's always a bit of anxiety there [uh huh]. But em ... but once
 49 we were on the journey then it was, it was exciting. We were, we were excited at the beginning. Em
 50 but then, yeah, once we actually got pregnant then my partner was em, became really depressed. The
 51 first half of the pregnancy was pretty awful actually so it all, there was a lot of up and downs in the
 52 whole journey really. [Yeah.] Of taking it in turns for both of us really.

political statement

both struggled

53 Interviewer: Yeah, it sounds really difficult.

54 Participant: Yeah, it wasn't easy!

55 Interviewer: Well em, can I ask by, which method you decided to get pregnant or that you ended up
56 getting pregnant?

Interview ID: PID007

57 Participant: Yeah. So it was em IVF. We did try IUI. [Yeah.] Erm so we tried that I think twice? 2 or 3
58 times? And, and that didn't work. And then in the end we em ... we were told IVF would be a better
59 bet for us. [Yeah.] And that worked. Em first time, I think? Yeah, first time.

60 Interviewer: And obviously you said that once your partner got pregnant, your partner experienced,
61 you know, started to feel quite depressed? *Investment in terms of time + resources*

62 Participant: Yeah, almost immediately from the first day! [Yeah] And so it was a really difficult journey
63 from there.

64 Interviewer: Yeah. What were you thinking and feeling during this time? *Why? Immediacy. No time to be happy.*

65 Participant: Em I was, em, excited. I was excited about the baby but I was also very anxious because I
66 could see that my partner was in a really low place. Em [coughs], so obviously from that point I was *feelings being modulated by partner's MH.*

67 thinking have we made the right decision? [Uh huh] Because I was, you know, we were worried that
68 she wouldn't be able to bond with the baby, when the baby arrived, Em but it actually got so bad *link between partner's her MH. worried for partner.*

69 during the pregnancy that we actually didn't know whether she would be able to keep the pregnancy? *Questioning decision: catastrophising? forecasting? foreboding*
70 [Yeah.] Em she had to get a lot of help at the hospital. And em ... had, had her own sort of mental *partner MH*
71 health care team looking after her. So em, yeah, there was a lot going on in that first half. And she had *traumatic pregnancy*
72 that, em, I forget the name of it, but the thing where you're constantly sick. Not, not normal morning *lots of stress*
73 sickness but where you can't hold anything down? [Yeah, yeah.] She had that. Em so that was, yeah,

74 really bad as well. She had to take all this medication to just be able to hold water down and
75 everything! So [coughs] ... Yeah it's been a, quite a weird, a weird journey! [Yeah. Sounds--] --I was
76 excited at the beginning. And then it was a mixture of like excited and, and anxious!

77 Interviewer: Yeah. It sounds like it was quite a difficult pregnancy? *mix of emotions uncertainty of how to feel.*

78 Participant: Oh it certainly was! Yeah, it was.

79 Interviewer: And you, cos I'm going to talk about your partner's mental health a little bit later on but
80 em, for you, did you notice, you said you started to feel any, like a little bit anxious. Did you notice any
81 symptoms of anxiety during that time?

82 Participant: Em I think I was so worried about [sighs] sort of her and trying to make sure that I could *need to be there to support partner.*
83 make the pregnancy go as smoothly as possible, em ... that I ... I didn't really know, it just felt like it all *focus on partner*
84 went really quickly? [Yeah.] So I didn't feel like I was depressed or anything. I was just trying to sort of *disconnected from own feelings/world - focus on partner*
85 stay upbeat and positive and try and make her a little bit excited about it. [Coughs] sorry. Excuse me. *not on self*

putting a brave face.

is this really selfless? doing it for as gain? Self sacrifice selflessness

Appendix F: Example of Initial Noting on Interview Transcript from Transcript 2

Emergent Themes	Transcript	Exploratory Comments Normal Text - descriptive <i>Italics - Linguistic</i> <u>Underlined - Conceptual</u>
<p>Honorary title</p> <p>Carrying & connectedness</p> <p>Lack of social recognition</p> <p>Professionals normalising experiences</p> <p>Increasing awareness of perinatal mental health in partners</p> <p>Birth trauma & PMH</p>	<p>P: Yeah yeah yeah, so I'm Ava's mum but I'm not her <i>mum</i> [You're not biologically related.] Yeah yeah yeah yeah. Or or-- yeah that, but also that I didn't give birth to her which I think is-- [yeah yeah] so it's not even necessarily about the biology, I think it's about having that [yeah yeah] experience with her and like her being being inside Jennifer and stuff. Erm it was almost like they already knew each other, do you know what I mean? [yeah yeah]. Erm, whereas I was just a bit like oh hello you know [laughter]. Erm erm erm, yeah and I don't know if I don't know if dads feel like a similar way, but I think if you're a dad like, I'm sure dads have a difficult time as well and because they are men that's not well catered for, but they're like a recognised group of people in their own right [yeah yeah]. Erm erm, but certainly certainly things like the GP the GP was like "no you can definitely like have postnatal depression' and like, you know, they were <i>really</i> great and, I've been to that GP all my life. Erm and so they've got like some new cool young doctors now who are like, [laughter] you know? Erm who are like-- I mean the older doctors are great too but, you know, like I guess they would have had like newer training and stuff and [yeah]. Erm and also I wonder actually, I don't-- we</p>	<p>Mum but not mum. <u>Honorary title. Less of a mum because not birth mum?</u></p> <p>Carrying & bond. <u>What makes a mum? Beyond biological connectedness? Carrying provides different experience of motherhood and bonding. How is this linked to her role confusion? Exclusion & like a stranger.</u></p> <p>Recognition of dads. <u>Experiences different from dads due to lack of social recognition. Does the lack of recognition make it harder for her to understand and accept? Different stressors from dads.</u></p>

<p>Diagnosis & access to support</p> <p>Cared for as family</p>	<p>never we never looked at it, but I wonder if actually we'd both been it was a bit of a trauma that [hm], the birth and that whole thing, you know [yeah], erm.</p> <p>I: You said you spoke to the GP and they said you could have postnatal depression as well [yeah]. So did you receive a formal diagnosis then?</p> <p>P: Yeah I mean I think PND is on my record [yeah yeah]. Yep.</p> <p>I: And it sounds like, you know,--</p> <p>P: And sorry they were also seeing Jennifer at the same time.</p> <p>I: Yep. So you both ended up with diagnoses?</p> <p>P: Yeah [Yep] yeah yeah. And Jennifer's doctor in particular, was like really good, you know, really good and, if ever her if ever-- certainly Jennifer's at first but if Ava's name ever comes up on like, you know, the walk in clinic [hm], like Ava just gets seen straight away [yeah]. You know like cos [yeah] I think that they really do care about <i>us</i> and like how we're doing and stuff [good]. Erm certainly when she was tiny that was just like</p>	<p>Validation by professionals. <u>Informed and included in care. Values continuity and being know. Is this a training improving or is there change in society attitudes towards PMH in partners/more research?</u></p> <p>Trauma. <u>Why did they never look at it? How does this inform her view of her mental health experiences?</u></p> <p>Diagnosis & benefits of this. <u>Wish I had asked when the diagnosis was given - was she aware of this diagnosis at the time or since? If she was, how did it inform her sense making? Being cared for as a family due to diagnosis. Does this happen within the context of birth-mum being supported? Could</u></p>
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<p>Adjusting to change</p> <p>Timing of changes</p>	<p>it was like go to the doctor with her because you'd get seen straight away you know like [laughter].</p> <p>I: So it sounds like there were-- so you describe some depressive symptoms [yeah] and you also describe a lot of anxiety as well [yep]. And were you able to label them as such at the time? [Er] Or what did you think was happening?</p> <p>P: What I mean the-- [sigh]. I guess I wouldn't have thought of it in terms of like postnatal depression but I would of thought, I probably would have thought something like "this is a normal reaction to a big life change" or something [yeah yeah] like that [yeah]. Erm, yeah.</p> <p>I: And how did you cope with all these sort of difficult thoughts and feelings that were coming up for you?</p>	<p><u>this be seen as stigmatising by other participants?</u></p> <p><i>Emphasis 'us' - them as a family not individual</i></p> <p>Response to life change. <u>Rationalising feelings. Looking back though explains experiences different (PMH), why? Are the two explanations actually different? Timing of changes and the explanation attached to them.</u></p>
<p>Powerlessness & uncertainty</p> <p>Living alongside symptoms</p>	<p>P: Erm, so I guess those initial really intense like intrusive thoughts and stuff were, reasonably short lived like they didn't feel short lived at the time like I think that, that like period that I was off with Ava, so it ended up being two weeks because she was two weeks late. But that felt like about a year [yeah yeah]. You know so like the perception of time was really odd and, erm so I think those initial really intense symptoms probably went <i>reasonably</i> quickly.</p>	<p>Length of symptoms. <u>Is there a sense of being trapped by symptoms. Perhaps Feelings powerlessness and uncertainty at the time. Does she still continue to experiencing intrusive thoughts but less intensely? Indication of on-going difficulties. Emphasis - indication of lingering symptoms?</u></p>

Appendix G: Photographs of Developing Connections Across Emergent Themes

G.1 Participant 1 - Post-it Notes



G.2 Participant 2 - Paper



Appendix H: Photographs of Group Analysis



Appendix I: Consent Form

Leeds Institute of Health Sciences/ Faculty of Medicine and Health



UNIVERSITY OF LEEDS

Consent to take part in Exploring co-mothers' experiences of perinatal anxiety and depression: understanding the perspectives of the non-carrying parent in same-sex parented families (V.3, 27/07/20)

Add your initials
next to the
statement if you
agree

I confirm that I have read and understand the information sheet (V.3) dated 27 th July 2020 explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason and without there being any negative consequences. My contributions may be kept unless I specifically withdraw consent for this. I understand that I am free to withdraw my data within three weeks of the interview, which would result in all my data being destroyed. After three weeks it would not be possible to withdraw my data because it will have been analysed. In addition, I am free to decline any question that I do not wish to answer. To discuss withdrawal please contact Alexandra Howat (Lead Researcher) at umaho@leeds.ac.uk .	
I give permission for the discussion to be audio-recorded for the purposes of data collection and analysis. I understand that all identifiable data is removed or changed from interview transcripts and the recording is permanently deleted after analysis.	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	
I understand that my responses will be kept strictly confidential unless the researcher feels there is a risk of harm to me or someone else. In this situation, the researcher will share her concerns with me and might need to share these concerns with other professionals on a need to know basis.	
I agree for the data collected from me to be stored and used in relevant future research by in an anonymised form by the research team.	
I understand that relevant sections of the data collected during the study, may be looked at if the research is audited by staff at the University of Leeds where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	
Signature	
Date	

<i>Project title</i>	<i>Document type</i>	<i>Version #</i>	<i>Date</i>
Exploring co-mothers' experiences of perinatal anxiety and depression: understanding the perspectives of the non-carrying parent in same-sex parented families	Consent form	3	07/20

Appendix J: School of Medicine Research and Ethics Committee Confirmation of Ethical Approval (Email)

Dear Alex

MREC 19-055 - Exploring co-mothers' experiences of perinatal anxiety and depression: understanding the perspectives of the non-carrying parent in same-sex parented families

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

With sincere apologies for the delay, I am pleased to inform you that the above research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and on behalf of the Chairs, I can confirm a favourable ethical opinion based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see <https://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Amendments.aspx> or contact the Research Ethics Administrator for further information (FMHUniEthics@leeds.ac.uk) if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study goes well.

Best wishes
Rachel

On behalf of Dr Naomi Quinton and Dr Anthony Howard, co-Chairs, SoMREC

Appendix K: School of Medicine Research and Ethics Committee Confirmation of Ethical Approval of Study Amendment (Email)

Dear Alexandra

MREC 19-055 Amd July 2020 - Exploring co-mothers' experiences of perinatal anxiety and depression: understanding the perspectives of the non-carrying parent in same-sex parented families

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

I am pleased to inform you that the above research ethics application amendment has been reviewed by the School of Medicine Research Ethics (SOMREC) Committee and I can confirm a favourable ethical opinion based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any further amendments to the research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see <https://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Amendments.aspx> or contact the Research Ethics & Governance Administrator for further information fmhuniethics@leeds.ac.uk if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study continues to go well.

Best wishes
Kaye Beaumont

On behalf of Dr Naomi Quinton and Dr Anthony Howard, Co Chairs SOMREC

Appendix L: Live Illustration from Queer Birth Workshop

