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Associations between heteronormative information, parental support and stress among same-sex mothers in Sweden—A web survey

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Abstract

Aim: The aim was to investigate same-sex mothers' self-assessed experiences of forming a family, and the association between heteronormative information, parental support and parenting stress.

Design: A quantitative, cross-sectional study.

Methods: In a web survey conducted in Sweden in 2019, same-sex mothers ($N = 146$) with a child aged 1–3 years answered questions about their experiences of forming a family through assisted reproduction and questions about parenting stress. Descriptive statistics describes the process of forming a family. Pearson's correlation analyses and independent sample t tests were used to test hypotheses about heteronormative information, parental support and parenting stress.

Results: Same-sex mothers experienced going through assisted reproduction treatment as stressful, and parental groups as not being supportive. Heteronormative information correlated with both lower perceived parental support and higher perceived parenting stress. Non-birth mothers experienced less acknowledgement and support than birthmothers.

KEYWORDS

antenatal care, child health care, midwifery, nursing, parental support, parenting stress, same-sex mothers

1 | INTRODUCTION

New legislation and access to assisted reproduction technologies have led to an increased number of same-sex mothers (McManus et al., 2006). In 2005, female couples gained access to assisted reproduction at Swedish clinics (Socialstyrelsen, 2005). Since 2009, when same-sex marriage was allowed in Sweden, 3600 female couples have married (Statistics Sweden, 2018). These legislations

probably contribute to a variety of diverse family constellations and parental roles. Professional antenatal care is included in the reproductive health and rights declaration and consequently is a human right (World Health Organization, 2015). Despite legal access to assisted reproduction, previous surveys from western countries show that same-sex mothers encounter heteronormativity in antenatal and child health care (Appelgren Engström et al., 2018, 2019; Gregg, 2018; Hammond, 2014; Shields et al., 2012; Wells

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& Lang, 2016). Midwives and nurses should be able to provide respectful cultural care regardless of family structure (International Council of Midwives [ICM], 2014; International Council of Nurses [ICN], 2012). This paper intends to contribute with specific knowledge about same-sex mothers' self-assessed experiences of forming a family, heteronormative information and parental support from professionals in antenatal and child health care, and parenting stress. This knowledge might contribute with important insights to professionals providing support to expectant and new parents.

The concepts birthmother and non-birth mother are used in this paper. Birthmother refers to the mother that gave birth to a child in a female couple and non-birth mother refers to the mother who did not give birth to the child.

2 | BACKGROUND

2.1 | Assisted reproduction and same-sex mothers

A growing number of countries, such as Australia, Spain, the UK and the USA, provide assisted reproduction to same-sex couples (Chapman et al., 2012; Imaz, 2017; McManus et al., 2006). In Sweden, female couples planning for children have been offered assisted reproduction in the Swedish National Health Care coverage since 2005 (Socialstyrelsen, 2005). When female couples plan for a family with children, one of the mothers becomes the biological parent. The non-birth mother may find it difficult to settle into her parental role and may need support in this transition. The transition to motherhood is a vulnerable time, and healthcare professionals can facilitate or hinder a healthy transition (Meleis et al., 2000). In previous research, the process leading to parenthood for same-sex mothers is described as a unique entry to parenthood lined by many decisions, for example, place of conception and whom of the women is to be pregnant and give birth to the child (Appelgren Engström et al., 2018; Hayman et al., 2015; Titlestad & Robinson, 2019).

2.2 | Parental support in antenatal and child health care

According to Swedish legislation (SFS, 2017:30), everyone has the right to good health care on equal terms. Parental support should be offered to all new and future parents in both antenatal and child health care. One way of supporting parents is through parental groups. The goal of early parental support and parental groups is to strengthen expectant parents in their parenting role and to promote children's health and development. Professionals in antenatal and child health care have the important task and responsibility to support parents when forming a family (ICM, 2014; ICN, 2012). In previous Swedish studies, it was found that same-sex mothers asked for parental groups with other same-sex families both in antenatal care (Klittmark et al., 2019) and in child health care (Appelgren Engström, 2019; Wells & Lang, 2016).

An earlier review concluded that healthcare professionals need to be more culturally competent when caring for same-sex mothers (McManus et al., 2006). A more recent review from the Nordic countries (Wells & Lang, 2016) showed that same-sex mothers had quite positive experiences of parental support at child health services, even though they experienced heteronormativity. Heteronormativity is when heterosexuality is taken for granted (Connell & Pearse, 2015). In another review, (Gregg, 2018) all included articles ($N = 10$) from five countries reported that same-sex mothers faced some amount of heteronormativity or homophobia when encountering health care. Lesbian women described both caring and uncaring encounters in maternity care (Lee et al., 2011; Spidsberg, 2007) and tried to deny that negative experiences were related to sexual orientation (Lee et al., 2011).

Same-sex mothers who are becoming parents may not be fully supported in antenatal and child health care, as suggested by studies where the non-birth mother sometimes reported feeling like a second-class parent (Appelgren Engström, 2019; Wells & Lang, 2016; Wojnar & Katzenmeyer, 2014) or having to legitimize her position as a mother (Hayman & Wilkes, 2017). Despite this, in a previous Swedish study, it was reported that same-sex mothers had good psychological health with few symptoms of anxiety and depression (Borneskog et al., 2013).

2.3 | Heteronormativity and parenting stress

Same-sex mothers from different countries have described the process leading to parenthood as stressful (Appelgren Engström et al., 2018; Cao et al., 2016; Cherguit et al., 2013; Goldberg, 2006). Minority stress, such as fear and experience of prejudicial treatment, might add an additional layer of stress to their parenthood (Malmquist et al., 2019). Previous research also found that same-sex mothers faced heteronormative language (Andersen et al., 2017; Appelgren Engström, 2018; Brennan & Sell, 2014; Crouch et al., 2017; Malmquist & Zetterqvist Nelson, 2014; Röndahl et al., 2009; Soinio et al., 2020; Titlestad & Robinson, 2019; Wells & Lang, 2016). Same-sex mothers were described as actively seeking lesbian-friendly health care to avoid homophobia and heteronormativity (O'Neill et al., 2013). To summarize, same-sex mothers face unique challenges when planning for parenthood. Previous research indicates insufficient support during pregnancy and after childbirth. However, studies on same-sex mothers' experiences of forming of family in Sweden are few and mainly qualitative, limiting the opportunity to generalize the results to a population (Andersen et al., 2017; Appelgren Engström et al., 2018; Klittmark et al., 2019; Malmquist et al., 2019; Wells & Lang, 2016). Based on this, the aim was to investigate same-sex mothers' self-assessed experiences of forming a family, and the association between heteronormative information, parental support and parenting stress.

Hypothesis 1 H1 *The higher the degree of perceived heteronormative information, the lower the degree of perceived parental support.*

Hypothesis 2 H2 *The higher the degree of perceived heteronormative information, the higher the degree of experienced parenting stress.*

Hypothesis 3 H3 *Non-birth mothers experience less acknowledgement and support from antenatal and child health care than birthmothers.*

Research question:

Are there differences between birthmothers' and non-birth mothers' experiences of parenting stress?

3 | THE STUDY

3.1 | Design

A quantitative, cross-sectional, web-based study.

3.2 | Method

3.2.1 | Participants

The inclusion criteria for participation were as follows: being a birthmother and/or a non-birth mother in a same-sex relationship; having conceived via donation treatment at a Swedish clinic; having a child aged 1–3 years of age and the mothers having joint custody of the child.

3.2.2 | Measures

A web survey was constructed consisting of three self-reported parts: (1) socio-demographic data, (2) a self-constructed questionnaire based on previous findings about the process of forming a family through assisted reproduction (Appelgren Engström et al., 2018, 2019; Wells & Lang, 2016) divided into the three subareas (a) the process of becoming pregnant, (b) support from antenatal and child health care and (c) heteronormativity (for a–c see Appendix A) and (3) a validated instrument, the Swedish Parenting Stress Questionnaire (SPSQ, Östberg et al., 1997).

Socio-demographic data

The first part of the survey consisted of socio-demographic data (10 questions), including year of birth, county and place of residence, birthmother/non-birth mother/or both, number of children, marital status, cohabiting with the other parent or not, educational level, current employment and nationality.

The process of becoming pregnant

The process of becoming pregnant was measured with 13 self-constructed items. One sample item was "I think it was a stressful time to undergo assisted fertilization." Another item was "I found

it difficult to find information about assisted reproduction." Using a Likert scale ranging from 1 (not true at all) to 5 (corresponds very well), participants were asked to indicate the degree to which they agreed or disagreed with each statement. Five questions measured different aspects of choosing who to be birthmother, and the remaining six questions measured different aspects for choosing a Swedish clinic.

Support from antenatal and child health care

Support from antenatal and child health care, was measured with 11 self-constructed items. One item measured being part of a parental group; "Have you participated in a parental group?" (yes/no). The response continuum for the other 10 items was a 5-point Likert scale ranging from 1 (not true at all) to 5 (corresponds very well), where participants were asked to indicate the degree to which they agreed or disagreed with each statement. Six of the questions measured different aspects of emotional support and knowledge to support families with two mothers. The remaining four items formed a scale measuring acknowledgement and support in antenatal and child health care (parental support), one sample item was "Professionals in antenatal care gave me support in my parenting." Internal consistency (α) = 0.80. A value higher than 0.70 is considered acceptable for new measures (Pallant, 2016).

Heteronormativity

Five self-constructed items measured heteronormativity on a Likert scale ranging from 1 (not true at all) to 5 (corresponds very well), where participants were asked to indicate the degree to which they agreed or disagreed with each statement. Two items concerned if participants had met questions about "the father" and the donor. The remaining three items were included in a scale measuring "heteronormative information." One sample item was "Forms, brochures and information in antenatal care have included families with two mothers," internal consistency (α) = 0.88.

Perceived parenting stress

The third part, SPSQ, is a validated instrument designed to measure the perceived stress that parents currently experience in their parenting. SPSQ is partly influenced by Richard Abidin's Parenting Stress Index (PSI; Abidin, 1990) though modified to fit a Swedish context by Östberg et al. (1997). The SPSQ has been found to be reliable and valid for measuring parenting stress in different contexts (Borneskog et al., 2014; Östberg, 1998; Östberg et al., 1997). The questionnaire consists of 34 items divided into five subscales. The first subscale, incompetence, was measured with 11 items. One sample item was "Being a parent is harder than I thought." The second subscale, role restriction, was measured with seven items. One sample item was "Since we had children, we no longer have as much time for each other." The third subscale, social isolation, was measured with seven items. One sample item was "I feel lonely and without friends." The fourth subscale, spouse relationship problems, was measured with five items. One sample item was "Having children has caused a lot of problems in the relationship between me and my partner." The

fifth subscale, health problems, was measured with four items. One sample item was "Since I had children, I have suffered from many different infections." Together these subscales measure the total score of general parenting stress. Using a Likert scale ranging from 1 (not true at all) to 5 (corresponds very well), participants were asked to indicate the degree to which they agreed or disagreed with each statement. Higher scores indicate higher parenting stress and average stressed if >3 . Both the total score and subscale scores were used in the analysis. Internal consistency (α) in the present study was 0.64 for the total scale, range 0.65–0.85 for the subscales. Cronbach alfa divided on birthmothers = 0.89 and non-birth mothers = 0.86 for total SPSQ-scale.

3.2.3 | Pilot study

The survey was tested in a small pilot-study among same-sex mothers ($N = 9$). This resulted in only small modifications on the questions for the three subareas: the process of becoming pregnant, support from antenatal and child health care, and heteronormativity.

3.3 | Participant recruitment

Information about the study, including a link to the survey, was sent to all regional child healthcare units in Sweden ($N = 21$) and was also made available on the websites of various interest organizations for same-sex families. The sample was self-recruiting and the survey completed individually. Data was collected from July to December 2019 using the web-survey software Survey & Report (Artologik).

3.4 | Analysis

All analyses of the data were performed with IBM SPSS Statistics 24. Demographic characteristics and the process of forming a family were described with descriptive statistics and were stated as numbers, percentages, means and standard deviations. Pearson's correlation analyses were used to test hypotheses H1 and H2. Independent sample t tests were used to test hypothesis H3 and to compare the differences between birthmothers and non-birth mothers for the following variables: parental support and SPSQ with subscales, incompetence, role restriction, social isolation, spouse relationship problems and health problems. The group of mothers that had experiences of being both a birthmother and a non-birth mother were described with descriptive statistics, but due to the small sample size ($N = 10$), no comparisons with the other groups were made. The term mothers are used when describing both birthmothers and non-birth mothers. Missing data on single items were few in number, varying between one and two questions.

3.5 | Ethics

This study has been approved by the Swedish Ethical Board in Uppsala, Sweden (Dnr: 2018/396), and was designed in accordance with the Helsinki Declaration (World Medical Association, 2008). Participants were informed how to receive more information about the study when interested, and when responding to the survey the participants gave their personal consent to participate.

4 | RESULTS

4.1 | Demographic characteristics

The survey was completed by 146 same-sex mothers. The participants ranged in age from 20–56 years ($M = 34.44$). Most common among the participants was to have one child ($N = 97$) and living with the child's other mother ($N = 140$). The vast majority of the mothers were born in Sweden and had a university degree (Table 1).

4.2 | The process of forming a family

The mothers had different experiences of finding information about assisted reproduction at Swedish clinics. Some mothers (39%; $N = 57$) found it easy to find information, while others (32.2%; $N = 47$) reported having difficulty finding information.

Many mothers (78.4%; $N = 115$) reported that deciding which partner in the couple should be the birthmother was easy. For more than half of the mothers (56.8%; $N = 83$) it was the desire to carry the baby that was crucial for this decision. External factors, such as paid work, were not the main reasons (84.2%; $N = 123$) when deciding who should become the birthmother, nor were health factors (58.2%; $N = 85$) or age (54.1%; $N = 79$).

A number of factors were considered important for the decision to use assisted reproduction at a Swedish clinic. That the opportunity to assisted reproduction for female couples exists in Swedish health care (93.1%; $N = 135$) was considered a strong factor among the mothers, as were legal aspects (that both women become legal parents of the child) (90.3%; $N = 131$). Feeling safe with Swedish health care (84.8%; $N = 123$) was also an important aspect for the mothers, along with practical aspects (proximity to a fertility clinic) (72.2%; $N = 109$), followed by the child's right to identifiable information about the donor (62.1%; $N = 90$), and economic aspects (51.2%; $N = 80$).

However, 60.9% of the mothers ($N = 89$) experienced the process of assisted reproduction as a stressful time, and 37.2% of the mothers ($N = 54$) reported lacking professional emotional support during the process of conceiving. Most mothers (78.1%; $N = 114$) had participated in a parental group, but less than half (43.9%; $N = 50$) reported that the parental group was a support in their parenthood.

Ninety-six mothers (65.8%) considered the professionals at birthing, labour and maternity wards to have sufficient knowledge to

TABLE 1 Demographic characteristics of the participants divided on birthmothers, non-birth mothers, experience of being both (and total)

Variable	Birthmothers N (%)	Non-birth mothers N (%)	Being both N (%)	Total N (%)
Same-sex mothers	77 (52.7)	59 (40.4)	10 (6.8)	146
Age in years				
<29	8 (10.5)	9 (15.2)	1 (10.0)	18 (12.4)
30–39	57 (75.0)	43 (72.9)	8 (80.0)	108 (74.5)
>40	11 (14.5)	7 (11.9)	1 (10.0)	19 (13.1)
Number of children				
1 child	56 (72.7)	40 (67.8)	1 (10.0)	97 (66.4)
2 or more children	21 (27.3)	19 (32.2)	9 (90.0)	49 (33.6)
Marital status				
Married	47 (61.0)	47 (79.7)	7 (70.0)	101 (69.2)
Cohabiting	29 (37.7)	11 (18.6)	2 (20.0)	42 (28.8)
Single ^a	1 (1.3)	1 (10.0)	–	2 (0.014)
Other	–	1 (1.7)	–	1 (0.007)
Live with the one I have children with				
Yes	75 (97.4)	57 (96.6)	8 (80.0)	140 (96.9)
No	2 (2.6)	2 (3.4)	2 (20.0)	6 (4.1)
Living in				
Big city	37 (48.1)	32 (54.2)	3 (30.0)	72 (49.7)
Medium/small town	24 (31.2)	18 (30.5)	5 (50.0)	47 (32.4)
<10,000 inhabitants	15 (19.5)	9 (15.3)	2 (20.0)	26 (17.9)
Region				
Northern Sweden	4 (2.8)	4 (2.8)	4 (2.8)	12 (8.3)
Middle of Swede	37 (25.7)	35 (24.3)	3 (2.1)	84 (58.3)
South of Sweden	35 (24.3)	58 (40.3)	3 (2.1)	48 (33.3)
Educational level				
Elementary school	3 (3.9)	–	–	3 (0.02)
High school diploma	19 (24.7)	9 (15.3)	2 (20.0)	30 (20.5)
University degree	55 (71.4)	50 (84.7)	8 (80.0)	113 (77.4)
Current employment				
Working	57 (74.0)	37 (62.7)	6 (60.0)	100 (68.5)
Student	6 (7.8)	4 (6.8)	–	10 (6.8)
Parental leave	10 (13.0)	13 (22.0)	4 (40.0)	7 (18.5)
Other	4 (5.2)	5 (8.5)	–	9 (6.2)
Born in Sweden				
Yes	71 (92.2)	53 (89.8)	9 (90.0)	133 (91.1)
No	6 (7.8)	6 (10.2)	1 (10.0)	13 (8.9)

Note: N = 146 for all variables except Age in years, Living in = 145 and Region = 144.

^aSingle means living by herself.

meet and support families with two mothers. For child health care, 47.3% of the mothers (N = 69) agreed with the same statement, and for antenatal care the corresponding figure was 40.7% (N = 59). Less than half (43.1%; N = 63) reported being satisfied with the professional emotional support. Many mothers (60.2%; N = 88) had been asked about “the father” and 44.5% (N = 65) had received questions about the donor.

4.3 | Association between heteronormative information, parental support and parenting stress

Results from Pearson Correlation analyses revealed a strong negative correlation between perceived heteronormative information and perceived parental support (N = 146, $p < .01$), with high levels of perceived heteronormative information being associated with lower levels of

perceived parental support (Table 2), which supports H1. The relationship between perceived heteronormative information and perceived parenting stress showed a weak correlation ($N = 146$, $p = .02$) with high levels of perceived heteronormative information being associated with higher levels of parenting stress, partly supporting H2.

Furthermore, all subscales of SPSQ correlated with each other, with the exception of spouse relationship problems and health problems. Worth noting is that the birthmothers and non-birth mothers both estimated role restriction to be higher than the other dimensions in the SPSQ instrument.

4.4 | Different experiences of support and stress between birthmothers and non-birth mothers

A series of independent-samples *t*-tests revealed the following results when comparing birthmothers' and non-birth mothers' experiences of total parental support, acknowledgement and professional support (Table 3). Non-birth mothers experienced significantly lower total parental support ($t(134) = 2.49$). Also, non-birth mothers experienced lower acknowledgement both in antenatal care ($t(90) = 4.24$) and child health care ($t(102) = 4.08$). Moreover, non-birth mothers experienced lower parental support in antenatal care ($t(134) = 2.63$). These results support H3. However, about support from child health care, no statistically significant difference was found between birthmothers and non-birth mothers.

Independent-samples *t* tests were conducted to answer the research question whether there were differences in experienced parenting stress between birthmothers and non-birth mothers. The results revealed no statistically significant differences for general parenting stress or the subscales incompetence, role restriction, social isolation, spouse relationship problems and health problems.

5 | DISCUSSION

Our results support the two hypotheses that high perceived heteronormative information correlates with a lower degree of perceived

parental support and a higher degree of perceived parenting stress. The third hypothesis was also supported, showing that non-birth mothers received less perceived parental support from antenatal and child healthcare professionals than birthmothers. Furthermore, the process of forming a family through assisted reproduction was experienced as stressful, and parental groups were not considered very supportive. However, the mothers experienced a low level of parenting stress.

The first hypothesis was supported, as high perceived heteronormative information was associated with low perceived parental support (H1). Heteronormative assumptions from healthcare professionals and heteronormative language and written forms are described in previous research (Appelgren Engström et al., 2018, 2019; Klittmark et al., 2019; Wells & Lang, 2016). Moreover, same-sex mothers reported avoiding parental groups, despite their expressed need for support (Appelgren Engström et al., 2019). This indicates that same-sex parents do not receive the support they strive for. In former studies it was shown that healthcare professionals lacked knowledge about the consequences of forming a two-mother family, and same-sex mothers lacked emotional support (Appelgren Engström et al., 2018; Klittmark et al., 2019). However, those who attended parental groups for same-sex parents felt supported (Klittmark et al., 2019). This indicates that general parental groups need to be updated to better include and support same-sex mothers. Professionals need an increased awareness of how their own and societal norms affect the encounter with parents who do not identify with the heteronorm.

The second hypothesis, that high perceived heteronormative information correlated with a higher degree of parenting stress (H2), was partly supported, even though same-sex mothers experienced a low degree of parenting stress. This high perceived heteronormative information shows that heteronormativity exists in antenatal and child health care and needs to be challenged. Forms and informational materials need to be updated to reflect a variety of family constellations. This is also in line with the ethical code of midwives and nurses, which calls for members of these professions to provide culturally respectful care regardless of family structure (ICM, 2014; ICN, 2012).

TABLE 2 Descriptive statistics and Pearson correlations between measures of perceived parental support, heteronormative information, and parenting stress (SPSQ)

Scale	M	SD	1	2	3a	3b	3c	3d
1. Parental support	3.32	0.90	—					
2. Heteronormative information	3.58	1.05	-.50**	—				
3. SPSQ	2.68	0.46	-.25**	.19*	—			
Subscales of SPSQ								
3a. Incompetence	2.31	0.66	-.19*	.07	—			
3b. Role restriction	3.56	0.65	-.16	.10	.50**	—		
3c. Social isolation	2.20	0.62	-.21*	.11	.47**	.25**	—	
3d. Spouse relation problems	2.36	0.54	-.20*	.22**	.31**	.26**	.33**	—
3e. Health problems	2.96	0.84	-.14	.15	.30**	.56**	.30**	.08

* $p < .05$, ** $p < .01$.

TABLE 3 Summary of means and standard deviations for study variables on perceived parental support, acknowledgement and professional support divided into birthmothers and non-birth mothers

Variable	Birthmothers (N = 76)		Non-birth mothers (N = 59)		p	Eta squared
	M	SD	M	SD		
Parental support ^a	3.45	0.82	3.08	0.94	.014	0.04
Acknowledgement in antenatal care	4.57	0.88	3.59	1.32	<.001	0.12
Parental support antenatal care	3.58	1.21	3.02	1.29	.01	0.05
Acknowledgement child health care	4.65	0.79	3.97	1.08	<.001	0.11
Support from child health care	3.66	1.08	3.42	1.22	.19	

^aTotal measure.

The third hypothesis, that non-birth mothers experienced less acknowledgement and support from healthcare professionals than birthmothers (H3), was supported. This is in line with previous research where the non-birth mother sometimes felt excluded during meetings with healthcare professionals (Appelgren Engström et al., 2018) and felt like a secondary parent in the parental groups they attended (Wells & Lang, 2016). Further, earlier research shows that same-sex mothers need to defend and justify themselves as parents (Malmquist & Zetterqvist Nelson, 2014). Both parents need to be supported and acknowledged as mothers when preparing for parenthood (Erlandsson et al., 2010; Larsson & Dykes, 2009). Insufficient acknowledgement and support to same-sex mothers is also reported in different review articles (Dahl et al., 2013; Hammond, 2014; Wells & Lang, 2016). When the support is not adequate, the mothers seek support in other groups. Non-birth mothers may choose to participate in sexual minority parenting groups to get a sense of support and belongingness (Cao et al., 2016). Both midwives and nurses in antenatal and child health care need to better acknowledge and support same-sex mothers' transition to parenthood.

The decision about who should be the birthmother was reported to be easy by most of the mothers, which previous research also supports (Appelgren Engström et al., 2018; Goldberg, 2006). As expected, most mothers reported that their choice of a Swedish clinic was based on the availability of assisted reproduction for same-sex mothers in Swedish health care and on legal aspects. The right to assisted reproduction treatment and the other legal aspects (that both mothers become legal parents) were also described in previous research (Appelgren Engström et al., 2018). In this study, most mothers reported that they felt safe with Swedish health care, unlike one Swedish study where several couples turned to a fertility clinic abroad because of unfriendly treatment at Swedish fertility clinics (Malmquist & Zetterqvist Nelson, 2014). The difference may be due to the fact that in this study, all participants had chosen assisted reproduction at a Swedish clinic.

Another finding was that same-sex mothers experienced the process of forming a family as stressful, echoing previous research (Appelgren Engström et al., 2018; Cherguit et al., 2013; Goldberg, 2006). Less than half of the mothers reported receiving satisfying emotional support from professionals during the transition

to parenthood. Stress occurs during transitions (Meleis et al., 2000) and professionals in antenatal and child health care need to be aware of this fact, in order to better support same-sex mothers. These results, that the process to parenthood is stressful and there is insufficient emotional support, might also apply to heterosexual couples undergoing assisted reproduction treatment. But same-sex couples might risk further stress due to minority stress (Malmquist et al., 2019).

Despite participating in parental groups, less than half of the mothers felt supported. In previous research, it was found that non-birth mothers felt excluded due to language and forms (Andersen et al., 2017; Appelgren Engström et al., 2018, 2019; Brennan & Sell, 2014; Crouch et al., 2017; Soinio et al., 2020; Titlestad & Robinson, 2019; Wells & Lang, 2016). In order to support parents in the process of forming a family, information and brochures need to be developed, in order not only to avoid heteronormative language but also to include same-sex parent families in the diversity of family constellations of today. Professionals in antenatal and child health care need to be sensitive and provide tailored care that supports same-sex mothers in their transition to parenthood. This is based on the correlation between a high degree of experienced heteronormative information and a lower degree of support and a higher degree of perceived parenting stress. Fifteen years after the introduction of same-sex women's access to assisted reproduction and Sweden's acknowledgement of equal rights of forming a family with children, regardless of sexual orientation, it is surprising to conclude that this support still is not sufficient in a society claiming to be gay-friendly. It is evident that equal rights to assisted reproduction treatment is no guarantee that health care is organized to support same-sex families.

Furthermore, the mothers in this study reported low levels of parenting stress when they had a child, in contrast to the stressful journey before. Findings from previous research support our findings of a low degree of parenting stress in same-sex couples with children aged 12–36 months (Borneskog et al., 2014). The lack of differences in experiencing parenting stress between birthmothers and non-birth mothers in this study might be understood as a consequence of same-sex mothers striving for equal parenthood (Appelgren Engström et al., 2019; Malmquist, 2015).

5.1 | Limitations

The sample in this study was self-selected, limiting the opportunity of drawing conclusions that can be generalized to all same-sex mothers. For ethical reasons, random sampling cannot be used to select this group, as no “registry” of same-sex parents is available or allowed by law. Therefore, the results and the conclusions must be interpreted with caution. However, our sample represented a varied national demographic spread and was not geographically biased. Although the participants had varying socio-demographic characteristics, most mothers were born in Sweden and the majority of the women had a university degree. Previous research support same-sex mothers being highly educated (Appelgren Engström et al., 2018, 2019; Dahl, 2018).

A strength is that this study is one of few quantitative studies, with a relatively large sample size of same-sex mothers in Sweden. One limitation, however, was the small group of mothers who had experience of being both birthmothers and non-birth mothers, this group was too small to allow for comparison with the other two groups. However, the few mothers with experience of both indicated that this practice is not uncommon among same-sex mothers, suggesting that this topic is worthy of further exploration. Further limitations with the recruitment process are that we do not know where or how participants found the survey, and if some of the participants were couples, which could have affected the results.

Another important limitation has to do with the psychometrics of the total scale of SPSQ, and the results must therefore be interpreted with caution. Worth noting is that SPSQ is not designed for same-sex parents and may miss specific challenges same-sex mothers face in their parenting, something that may have affected the result. In any case, the present study offers important knowledge about same-sex mothers' self-assessed parenting stress.

5.2 | Conclusion

The findings show that same-sex mothers experienced the process of forming a family through assisted reproduction to be stressful and that they lacked emotional support from healthcare professionals. Parental groups were not perceived as very supportive. Professionals need to offer more informational and emotional support to expectant parents in the process of forming a family, and parental groups need to be developed to be supportive and non-heteronormative. Future research could explore interventions of emotional support and parental groups aimed for same-sex parents. Heteronormative information is associated with both lower perceived parental support and higher perceived parenting stress. Forms, brochures and information need to be updated in order to avoid heteronormativity in antenatal and child health care. Non-birth mothers experienced significantly lower parental support from antenatal and child health care than birthmothers. When working with same-sex families, professionals in antenatal and child health care need to recognize and support both mothers. The non-birth mother in particular needs to

be acknowledged and supported to a greater extent. Professionals need to reflect on how their view of parenthood and how heteronormative assumptions negatively affects the encounter with expectant or new parents. The nursing and midwifery education should also prepare students to meet all parents in a respectful, open-minded and professional manner.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

AUTHORS CONTRIBUTIONS

Study Design: HAE, CB, CL, EHN, ALA. Data Collection and Analysis: HAE, CL. Manuscript Writing: HAE, CB, CL, EHN, ALA.

DATA AVAILABILITY STATEMENT

The data are not publicly available due to ethical restrictions.

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APPENDIX A

ITEMS INCLUDED IN THE SELF-CONSTRUCTED PART OF THE SURVEY

The process of becoming pregnant

1. I found it difficult to find information about assisted reproduction
2. For me, the choice of which partner in the couple should be the birthmother was easy
3. I think it was a stressful time to undergo assisted fertilization
4. For me, this was crucial in choosing who should be the birthmother;
 - a. Age
 - b. The desire to carry the baby
 - c. External factors (for example paid work)
 - d. Health factors
5. For me, the following alternatives were important for choosing a Swedish clinic
 - a. Legal aspects
 - b. Economic aspects
 - c. Practical aspects
 - d. That the opportunity exists in Swedish health care

- e. Feeling safe with Swedish health care
 - f. The child's right to information about the donor's identity
- Support from antenatal and child health care

1. I lacked professional emotional support during the process of conceiving
2. My experience is that the professionals in antenatal care that I have met have sufficient knowledge to support families with two mothers
3. My experience is that the professionals at childbirth and maternity wards that I met have sufficient knowledge to support families with two mothers
4. My experience is that the professionals at child health care that I have met have sufficient knowledge to support families with two mothers
5. I feel that the professional emotional support was satisfactory
6. (a) Have you participated in a parental group? (b) If yes, parental group was a support in my parenting
7. Professionals in antenatal care gave me support in my parenting[†]
8. Professionals at child health care give me support in my parenting[†]
9. I was acknowledged as a mother at antenatal care[†]
10. I get confirmed as a mother in child health care[†]

[†]Items included in the scale parental support
Heteronormativity

1. Forms, brochures and information in antenatal care have included families with two mothers[‡]
2. Forms, brochures and information at birthing, labour and maternity wards have included families with two mothers[‡]
3. Forms, brochures and information at child health care have included families with two mothers[‡]
4. I have met questions about the father
5. I have met questions about the donor

[‡]Items included in the scale heteronormative information

The survey includes one yes-or-no question, and for all other items, there are a 5-point Likert scale ranging from 1–5 (1—not true at all, 2—corresponds quite badly, 3—sometimes true and sometimes not, 4—corresponds quite well, 5—corresponds very well).