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Family formation in two-mother families

Experiences of parental support in antenatal and child health care in Sweden

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MÄLARDALEN UNIVERSITY
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School of Health, Care and Social Welfare

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Akademisk avhandling

som för avläggande av filosofie doktorsexamen i vårdvetenskap vid Akademin för hälsa, vård och välfärd kommer att offentligen försvaras fredagen den 22 oktober 2021, 09.15 i Gamma samt via Zoom, Mälardalens högskola, Västerås.

Fakultetsopponent: Professor Bente Dahl, Faculty of Health and Social Sciences Department of Nursing and Health Sciences Campus Vestfold i Norge

Akademin för hälsa, vård och välfärd

Abstract

The aim with the thesis was to examine same-sex mothers experiences of forming a family, pregnancy, parenthood and parental support from professionals in antenatal and child health care. An additional purpose was to explore professionals' experiences of meeting and supporting families with two mothers.

The results are based on four articles (three studies). The project started with exploratory semi-structured interviews (n = 20) with mothers in same-sex relationships who had children with the help of assisted reproduction at a Swedish clinic. Thereafter, a web survey was designed based on the results from the first sub-study. The survey, as well as a survey on perceived parenting stress (SPSQ), was answered by 146 mothers in same-sex relationships. Finally, focus groups were held with professionals (n = 13) in antenatal and child health care with experience of meeting and supporting families with two mothers.

The results showed that the mothers in same-sex relationships experienced the process of forming a family as a stressful journey in a heteronormative world, and that they lacked psychological / emotional support (Articles I, III). The results also showed that the mothers strived for equal parenthood and that they lacked professional support (Articles II, III).

Furthermore, the results showed that the non-birth mother experienced a lower degree of acknowledgement from antenatal and child health care than the mother who gave birth, and a lower degree of support from antenatal care but no difference in the experience of support from child health care. The mothers also experienced a low degree of parenting stress (Article III).

Professionals strived for an open approach in meeting new parents. They met well-prepared mothers who planned for equal parenting. Professionals expressed that they either gave equal support to all parents, or that they provided tailored support to same-sex mothers (Article IV).

The thesis contributes with an in-depth understanding and increased knowledge about mothers in same-sex relationships' experience of family formation as well as their experience of treatment and support from professionals in antenatal and child health care. Furthermore, it also shows professionals' experiences of meeting and supporting families with two mothers.

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To my beloved family

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I. Appelgren Engström, H., Häggström-Nordin, E., Borneskog, C., & Almqvist, A.-L. (2018). Mothers in Same-Sex Relationships Describe the Process of Forming a Family as a Stressful Journey in a Heteronormative World: A Swedish Grounded Theory Study. *Maternal and Child Health Journal, 22*(10), 1444–1450. https://doi.org/10.1007/s10995-018-2525-y

II. Appelgren Engström, H., Häggström-Nordin, E., Borneskog, C., & Almqvist, A.-L. (2019). Mothers in same-sex relationships—Striving for equal parenthood: A grounded theory study. *Journal of Clinical Nursing, 28*(19-20), 3700–3709. https://doi.org/10.1111/jocn.14971

III. Appelgren Engström, H., Borneskog, C., Loeb, C., Häggström-Nordin, E., & Almqvist, A.-L. (2021). Associations between heteronormative information, parental support and stress among same-sex mothers in Sweden—A web survey. *Nursing Open, 00*, 1– 10. https://doi.org/10.1002/nop2.986

IV. Appelgren Engström, H., Borneskog, C., Häggström-Nordin, E., & Almqvist, A.-L. Professionals' experiences of supporting two-mother families in antenatal and child health care. *Submitted*.

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Contents

Abbreviations

ART	Assisted Reproduction Technique
GT	Grounded Theory
ICM	International Confederation of Midwifes
ICN	International Confederation of Nurses
IVF	In Vitro Fertilisation
LGBTQI	Lesbian, Gay, Bisexual, Transexual, Queer and Intersex people
SPSQ	Swedish Parenting Stress Questionnaire
VSFG	Very Small Focus Group
WHO	World Health Organization

Definitions and choice of concepts

The concept **two-mother family** in this thesis describes two women who conceived via donation treatment. Other terms also used are **same-sex mothers**, **mothers in same-sex relationships** and **female couples**. **Birth mother** is the mother who gives birth to the child in a two-mother family. A **non-birth mother** is the mother who does not give birth to the child in a two-mother family. Also described as co-mother or social mother in other articles. Another frequently used concept, **early parental support** or **parental group**, means support from antenatal and child health care professionals, aiming to strengthen parents in their parental role. In this thesis, midwives in antenatal care and specialist nurses in child health care are sometimes referred to as **health care professionals**. Another concept that should be mentioned is **heteronormativity**, a norm where heterosexuality is taken for granted and is expected in society (Connell & Pearse, 2015). Abbreviations for LGBTQI have changed over time, so the abbreviation **LGBTQ +** was chosen, where the plus is meant to be inclusive (Lundberg et al., 2017).

Preface

I have been a registered nurse since 1992 and have worked as a nurse in elderly care, cancer care and palliative care. In parallel with working as a nurse, I took courses in caring science. I started as a teaching assistant in the nursing programme at Mälardalen University in 2002. Then I continued as a clinical lecturer and lecturer in caring science. My interest in further education has always been there. I received a bachelor's and a master's degree in caring science, and the idea of undergoing a doctoral degree has emerged over the years. A colleague told me about this project, which I thought sounded fascinating even though it was a completely new area for me. The project still did not feel completely foreign because I have always been interested in treatment issues and caring encounters, and my interest in norms and values has grown stronger during my time as a lecturer in the nursing programme. For me personally, the family is of enormous importance, so this project of family formation is really close to my heart, and I sincerely hope that my contribution to the research can lead to something good.

Introduction

This thesis, *Family formation in two-mother families. Experiences of parental support in antenatal and child health care in Sweden*, is written from a caring science perspective within the research field of health and welfare. The focus of the thesis is on health promotion care, such as encounters and parental support for two-mother families, to understand health and welfare from a caring science perspective with a special focus on the right of receiving health and care on equal terms. Same-sex mothers gained access to assisted reproduction techniques (ART) at Swedish clinics in 2005 (SOSFS, 2005:17), and health care professionals in antenatal and child health care are likely to encounter two-mother families. This thesis explores how legislative change becomes visible in practice. How mothers experience the process of forming a family in Swedish healthcare. Moreover, the thesis explores parental support from a parental perspective as well as from a professional perspective. The parental perspective is based on interviews and a survey with mothers in two-mother families and their experiences of parenthood, and encounter and support from antenatal and child health care. The professional perspective is based on focus groups with midwives and specialist nurses in antenatal and child health care and their experiences of supporting two-mother families. The goal is to contribute to a deeper understanding and increased knowledge of same-sex mothers' experiences of forming a family, parenthood and parental support. Furthermore, professionals' experiences of supporting same-sex mothers in antenatal and child health care are explored.

Background

Health and Welfare

Health can and has been described in many ways. A well-known definition of health is described by the World Health Organization (WHO): "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 1984). With this holistic approach to health, the concept of health expands from including only vital functions to also including resources adequate for other vital goals (Nordenfeldt, 2006). Caring science is a human science with a focus on health. One definition of health from a caring science perspective reads:

> A contextual multifaceted lived reality involving a physical, mental, emotional, spiritual, social and societal dimension, the personal perception of which can be increased or decreased by actions of the individual or others. The lived experience of health can be summarised as a feeling of empowerment where the individual has the ability to achieve his or her vital goals that are connected with his or her long-term happiness (Halldórsdóttir, 2008, p. 645).

The concept of health is central to both nurses and midwives, and caring interventions must be health-promoting. A basic assumption in nursing is that nursing takes place on an individual level. From a public health science perspective, it is instead about creating conditions in society for good health on equal terms for the entire population. Despite increased welfare, there are large differences in public health in Sweden (The Swedish Society of Nursing, 2017). A report describes that a majority of LGBTQ+ people in Sweden have good health but rated their health lower than the rest of the population. Lesbian women have poorer health than the rest of the population, and they rated anxiety, worry and anguish higher than the rest of the population. Stress, pain and a lack of emotional support were also more common among lesbian women than the rest of the population. Homosexuals and bisexuals state to a greater extent than the rest of the population that they have been subjected to abusive treatment (The Swedish Public Health Agency, 2014).

To promote a person's health experience, participation from the person is required. Health-promoting nursing is about enabling the person to achieve health through increased knowledge. According to the WHO (1984), basic

elements in health promotion work include *empowerment*, *equality* and *participation in society.* Health-promoting caring intends to create conditions for individuals to participate in society. Improved health for all and reduced health inequality are emphasised. The best possible health is the fundamental right of every human being, regardless of ethnicity, gender, age, social status, or ability to pay. To improve health and reduce inequalities, early intervention in life is important (WHO, 2013), such as good antenatal and child health care. The Swedish Nurses' Association wants to ensure that all nurses work to promote good health and equal care in every area. Equal care is also linked to the United Nations Declaration of Human Rights (The Swedish Society of Nursing, 2017).

Welfare can be defined as a political system, a governmental support for the citizens of the society. The welfare system aims to provide citizens with health care and education. Welfare is described as a broad concept, with approaches and actions that strengthen participation, promote the wellbeing of individuals, and reduce health inequalities (Raphael, 2014). Social policy research has developed several typologies based on national differences in the rights and obligations of citizens towards the state, and on national differences in policy goals, where one now classic division has been made by Esping-Andersen (1990). Due to the long reign in government, Sweden is categorised as being in the social democratic welfare regime cluster. Sweden is described as a social democratic country where there is a public responsibility for welfare and access to services and benefits is universal. Welfare provision is characterised by comparatively generous benefits such as income protection and promoting equality through a redistributive social security system (Bergqvist et al., 2013). The social democratic welfare regime is characterised by a high degree of de-commodification; individuals are not dependent on the market for their survival. The principle is to maximise individual independence and minimise dependence on the family (Esping-Andersen, 1990).

In the welfare state of Sweden, everyone has the right to good care on equal terms (SFS 2017:30; SFS 2014:958). However, Swedish health care is not equitable, and inequality arises mainly in the meetings between patients and health care professionals. The inequalities in care may be due to professionals acting on the basis of preconceived notions about, for example, gender or unconscious behaviour based on norms and values (The Swedish Society of Nursing, 2017).

The Swedish healthcare system

The responsibility for health care is shared between the government, regions and municipalities. The goal of health care is good health and care on equal terms for the entire Swedish population. Care must be given with respect for the equal value of all people. The government has the overall responsibility, and the National Board of Health and Welfare provides guidelines and recommendations. The regions are responsible for ensuring that all citizens have access to good health care (SOU 2017: 47). Primary care is the basis of Swedish health care. The Health and Medical Services Act (SFS 2017:30) states how Swedish health and medical care is to be conducted. Important prerequisites for equal health are good antenatal and child health care (SOU 2017:47). Antenatal and child health care is part of primary care, which is an important cornerstone of health care, and as such part of the welfare system.

Antenatal and child health care

In Sweden, voluntary, free and general antenatal and child health care was introduced in the 1930s. Fifty years later, mothers and fathers/second parents are invited to participate in parental education to strengthen their parenting skills and knowledge (The National Board of Health and Welfare, 2014). Today, it is a matter of ensuring that everyone is given equal conditions for a safe and secure pregnancy and childbirth and to develop the work of providing new parents with information and psychosocial support (The Swedish Public Health Agency, 2020).

Antenatal care

The overall goal of antenatal care is good sexual and reproductive health for the entire population (The National Board of Health and Welfare, 2014). Sexual health is "a state of physical, emotional, mental and social wellbeing in relation to sexuality" (The Swedish Association of Midwives, 2018, p. 6). One of WHO's Sustainable Development Goals in relation to Sexual and Reproductive Health and Rights (SRHR) is to ensure healthy lives and wellbeing, striving to ensure universal access to sexual and reproductive health care and family planning. Another goal is to achieve gender equality and to empower women by ensuring universal access to sexual and reproductive health and reproductive rights (UNFPA, 2015). The midwife has a central role in maternal health care and works within the following areas: health care in connection with pregnancy, support in parenting and parental groups, family planning, gynaecological screening tests, preventing unwanted pregnancies, and public health work implying living habits. At the maternal health clinic, a team including midwife, a coordinating midwife, physician and psychologists work

(The National Board of Health and Welfare, 2014). The midwife works to promote health and shall, among other things, promote participation and strengthen health-promoting measures as well as offer support before childbirth and parenthood. The midwife should also promote breastfeeding and inform about the importance of breastfeeding (The Swedish Association of Midwives, 2018).

The National Board of Health and Welfare published "Knowledge support for maternal health care" to strengthen the use of evidence-based practice and contribute to equal antenatal care across the country (The National Board of Health and Welfare, 2014). However, there are geographical differences in the design of parental support. In several parts of Sweden, family centres are being developed where different professionals work together. Another development is the merging of smaller units into larger units, and this may make it difficult to promote a social network for families (SFOG, 2016).

The goal for parental support within antenatal care is to promote children's health and development through strengthening the development of parenthood and parents' ability to meet the expected and newborn baby. The parents are supported both through individual meetings and through parental groups. The midwife should have an ethical, holistic and health-promoting approach and offer care based on science and proven experience under applicable statutes and other guidelines (The National Board of Health and Welfare, 2014; The Swedish Association of Midwives, 2018). It is important for parents-to-be to feel empowered. Empowerment in the midwifery context depends on a professional midwife in a nurturing, caring and supporting environment (Hermansson & Mårtensson, 2011). Within antenatal care, an open-minded view on sexuality and various forms of family formation are necessary. One area in need of development is parental support that is adapted to the parents' needs (SFOG, 2016). This thesis aims to contribute to same-sex mothers' experiences and needs of support from antenatal and child health care.

Child health care

The National Board of Health and Welfare's guidelines (2014) provide overall descriptions and frameworks for child health care activities. The goal of child health care is to contribute to the best possible physical, mental and social health for children. This is made possible by promoting children's health and development, preventing ill health in children, and identifying and initiating measures at an early stage for problems with children's health, development and upbringing environment. To achieve these goals, child health care professionals need to offer interventions to all children and parents and further strengthen interventions to children and parents when needed. An important goal with programme design is that it should contribute to equal and fair child

health care for all children in Sweden. The UN Convention on the Rights of the Child is intended to guide the work of child health care (The National Handbook for Child Health Services, 2015). Child health care offers health guidance, parental support, and health monitoring of all connected children. The organisation of child health care can differ, and there are differences between what different regions can offer (The National Board of Health and Welfare, 2014). At a child health care centre, specialist nurses, paediatricians and psychologists work together and offer advice and support to parents with children between 0 and 6 years.

Midwives and nurses in antenatal and child health care have an important task to support parents when forming a family. Nurses and midwives are expected to provide respectful sensitive care to the persons they encounter (International Council of Midwives, 2014; International Council of Nurses, 2012).

Parental support within antenatal and child health care

To promote Swedish parents' involvement in children's health and attachment, a national strategy for developing parental support was undertaken. Parental support is defined as:

> A wide range of initiatives that parents are offered to take part in and which aims to promote children's health and psychosocial development. Parental support shall contribute to: In-depth knowledge of children's needs and rights, Contact and community and to strengthen parents in their parental role (SOU 2008:131, p. 45).

Parental support shall be voluntary and governed by the parents' own need for support. One goal is to offer parents the opportunity to meet and exchange knowledge and experiences with other parents. Parental support should have a child perspective, based on science and proven experience, and on common and equal parenthood and be offered to all parents (SOU 2008:131). The focus should be on general parental support with the goal of offering support to all parents throughout the child's upbringing (SFOG, 2016). Both antenatal and child health care reach most expectant and new parents. Parental support is described as a political effort to increase welfare (Magnusson et al., 2009).

The overall aim of early parental support is to strengthen parents in their parenting. Early parental support should be based on participation, influence and voluntariness. Parental support through maternal health care can be provided in various ways. One way to support parents is through all the individual meetings or through different parental groups. There is little scientific evidence on how to best design parental support (SFOG, 2016).

Despite the fact that almost all parents are invited to parental groups, only 40 per cent accept the invitation (Lefèvre et al., 2016). Parents expressed different reasons for not attending parental education. Parents attending parental education requested more norm-critical parental education (Forslund Frykedal et al., 2019). Another study reported parents' transition to parenthood to be facilitated if the parents received information and professional support and participated in a well-functioning gender-conscious parental group. Further, transition to parenthood was inhibited if the group was not well functioning, lacked information, and was unsupportive (Barimani et al., 2017).

Antenatal and child health care aims to strengthen and support parents to optimise health for both parents and their child (The National Handbook for Child Health Services, 2015). Parental support is important because it both promotes the positive development of the child and is requested by parents. Purposeful parental support will provide parents with knowledge of children's needs and rights, strengthen parents in their parenting, and help form parental networks within the community in which they live (SOU 2008:131). Awareness that family formations vary is essential for midwifes and child health care nurses, and using respectful, neutral and non-heteronormative communication is key to forming a trustful relationship (The National Handbook for Child Health Services, 2015). The enquiry (SOU 2008:131) recommends that parental support be directed to parents who are in similar life situations. Same-sex mothers often reduce the impact of heteronormative encounters from health care professionals, and therefore, it requires extra sensitivity to respond to these mothers in a professional manner (The National Handbook for Child Health Services, 2015).

In a Swedish study, midwives and child health care nurses (n = 437) described their experiences of leading parental groups. Challenges expressed by participants were difficulties in getting the parents to come and then in getting them to attend the whole course. Diversity in the group was another difficulty to handle, as were reaching women with fear of birth, fathers and foreign-born parents. Differences in participants' ages and education levels made it difficult to meet parents' expectations and needs. Some midwifes and child health care nurses also felt that they lacked competence to lead groups and felt uncomfortable in their leader role (Forslund Frykedal et al., 2015). Findings from a survey with child health care nurses (n = 156) showed that several nurses experienced leading parental groups as challenging, especially when they met parents with different needs and demands than before. Parental groups were defined as parental support, with the primary aim of providing networks for parents. The study found that nurses at family centres were more likely to provide specialised parental groups such as, parents of twins, young parents or parents with foreign backgrounds, than child health care nurses (Lefèvre et

al., 2015). Another study found child health care nurses describing both possibilities and challenges for widening their responsibilities to include the non-birth parent (Ståhl et al., 2019).

Since 2020, the Swedish National Association for LGBTQ's Rights (RFSL) organises parental groups for expectant parents that identify as LGBTQ+ to provide a safe environment to share experiences and discuss issues, thoughts and feelings when expecting children. These groups are held online and are led by a midwife. The group is a complement to other parental preparation offered by antenatal care and an opportunity for parents identifying themselves as LGBTQ+ regardless of their place of residence to participate in a group for rainbow families (RFSL, 2019).

Development in family and sexual politics

Sexual and family politics in Sweden has been a pioneer in the world and led to greater equality between women and men, and thus have parenthood become more equal. One example is the introduction in 1974 of a paid parental leave which fathers had the right to share with the mothers (Almqvist & Duvander, 2014). In 1983, joint custody of children in the case of divorce was introduced.

In 1933, the Swedish Association for Sexuality Education (RFSU) was founded by Elise Ottesen-Jensen. This, among other things, facilitated decriminalising homosexuality, something considered illegal until 1944. RFSL is a Swedish federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights, with the goal that people that identify themselves as LGBTQ+ should have the same rights, possibilities and obligations as heterosexuals. RFSL was founded in 1950. In 1979, after a long struggle, homosexuality was removed from being classified as a psychiatric disease in Sweden (RFSL, 2018).

The Discrimination Act (SFS 2014:958) is based on the law of equality and democratic rights, which states that all people have equal value and rights, something that is supposed to have influenced people's attitudes and the development of society. The law states that it is forbidden to discriminate against diversity based on ethnicity, religion or belief, disability, gender, gender identity or gender expression, sexual orientation and age. In an attempt to provide similar rights to homosexual couples as heterosexuals, registered partnership was introduced in Sweden in 1995. The Act meant that same-sex couples could enter partnerships. The law gave rights and obligations similar to married spouses, except legal parenthood or the right to joint custody of the child. In 2003, same-sex couples were given the right to apply for adoption. Even though it provided little opportunity in practice, the law still made it possible

to apply for related party adoption. Since 2009, gender-neutral marriage has existed in Sweden, meaning that two people, regardless of gender, can enter a legal marriage (SFS 2009:253).

In 2005, assisted reproduction with donated sperm became available to female same-sex couples at Swedish clinics. This treatment demands basic medical and psychosocial investigation (SOSFS, 2005:17). According to Swedish legislation regarding gamete donation, both women in a same-sex couple will become legal parents with joint custody of the offspring when signing the donation form before commencement of treatment. When mature enough, the child has the right to have identifiable information about the donor (SFS 2006:351). In 2016, single women also gained access to assisted reproduction with donated semen at Swedish clinics (Sveriges Riksdag, SoU, 2017). The above-described development in family and sexual politics might all have contributed to a more open attitude to diverse partnerships, family constellations, and parental roles.

Assisted reproduction technique

In Sweden, donation treatment, such as assisted reproduction with donated sperm, requires a special assessment regarding the couple's medical, psychological and social conditions. The treatment may only be carried out if it can be assumed that the future child will grow up in good conditions (SFS 2006: 351; The National Board of Health and Welfare, 2016). The assessment considers the couple's age, state of health, living conditions, and willingness to tell the child about their biological origin. The purpose of the special assessment is to find out about the conditions for the child to have a safe upbringing (The National Board of Health and Welfare, 2016).

The woman who is to undergo assisted reproduction must be between 25 and 39 years old with a recommended body mass index (BMI) between 18 and 30. The woman undergoes a medical examination where the uterus is examined with gynaecological and contrast ultrasounds to see if there is passage through the fallopian tubes. Blood samples are taken to measure various hormones. Assisted reproduction with donated sperm can be done through insemination or in vitro fertilisation (IVF). The couple can receive six inseminations or three IVF treatments or two of each via the region, if at least one of the women is childless. The region does not offer "sibling treatments" but might offer self-financed sibling treatment depending on the access to donated sperm in the sperm bank. Until 2019, it was only possible to access ART with donated semen for female couples at a university hospital but is since available at all reproductive clinics (Sweden's municipalities and regions, 2020). According

to RFSU (2017), both the age limit, recommended BMI, number of treatments and costs may vary between different regions in Sweden.

There are other options for women who do not have the right to assisted reproduction at a Swedish clinic. Other ways to achieve parenthood for female couples are, for example, home inseminations or ART at a fertility clinic abroad. These ways to conceive can be costly, as the mother who has not given birth to the child needs to establish her parental rights and status legally (Mägi & Zimmerman, 2015). If conceiving through home inseminations, there might be difficulties when utilising a sperm donor (Nordqvist, 2011; 2012). One major question with home inseminations is how to negotiate the sperm donor's position. In a UK study with 25 lesbian couples, most women wanted an anonymous donor, as they did not want to share parenthood with a third party. A known donor could be seen as both a legal and social threat to the non-birth mother (Nordqvist, 2012). With an anonymous donor, there is no risk that the donor will become involved in the family or claim the right to the child. Moreover, the child cannot seek out the donor, and this avoids any future disappointment if the donor does not want to see the child (Somers et al., 2016). On the contrary, other couples thought it would be important for the child to know the donor, but not as a parent (Nordqvist, 2012). Other difficulties arising with home insemination or ART are economic and legal aspects. The transition to parenthood can be expensive with many insemination attempts and then juridical costs for the non-birth mother to become a legal parent to their child (Goldberg, 2006; Rausch et al., 2021; Wall, 2011).

The number of same-sex mothers conceiving through ART increases (Adlén et al., 2015; Bos & Gartrell, 2020). Except for Sweden, other countries, such as Australia, Spain, the UK and the USA, also provide assisted reproduction to same-sex couples (Chapman et al., 2012; Imaz, 2017; McManus et al., 2006). Due to this legal access to assisted reproduction, previous surveys from Western countries describe that same-sex mothers still encounter heteronormativity in antenatal and child health care settings (Gregg, 2018; Hammond; 2014; Shields et al., 2012; Wells & Lang, 2016).

Supporting two-mother families

In a Norwegian study with midwives (n = 11), they described a lack of knowledge about non-birth mothers. The midwives also expressed that they needed to change their language and documentation forms to assure comfortable encounters with same-sex couples. Furthermore, the midwives described sometimes feeling uncertain and that they needed more time to create a trusting relationship with female couples (Spidsberg & Sorlie, 2012). An Australian study examined nurses' (n = 51) attitudes towards LGBT+ parents seeking

health care for their child. The nurses did not take any notice about parents' sexuality but focused on supporting them in their parenting role. The nurses in the study had different views about the importance of the disclosure of parent's sexuality. Some nurses argued that it might have an impact on treatment, while other nurses preferred to work with the family like any other heterosexual couple. The nurses meant that they had a need for education to develop increased awareness and sensitivity to be able to understand LGBTQ+ parents' unique challenges (Bennett et al., 2017). Focus groups with health care providers (n = 32) in Australia expressed a desire to support same-sex parented families despite lacking confidence. Health care providers also reported that they lacked knowledge, skills, and appropriate language to include same-sex parents and their children (von Doussa et al., 2016).

Same-sex mothers' experience of health care and parenthood

International research

International research reported that heteronormativity was perceived by same-sex couples as both language and forms and information were directed to mothers and fathers (Brennan & Sell, 2014; Crouch et al., 2017; Johnson & Nemeth, 2014; O´Niell et al., 2013; Soinio et al., 2020; Titlestad & Robinson, 2019; Wojnar & Katzenmayer, 2014). Some lesbian women even tried to make sense of negative experiences and denied that they were related to their sexual orientation (Lee et al., 2011). A study from New Zealand showed that same-sex couples actively sought lesbian-friendly health care professionals as a way to protect themselves from homophobia (O´Neill et al., 2013). A study from Australia reported the journey to conception and motherhood to be lined by many decisions, for example, choosing which partner to be pregnant and donor decisions (Heyman et al., 2015). Studies from the US indicated that two-mother families needed support from antenatal and child health care, as many women lacked support from family and friends (Wall, 2011; Wojnar & Katzenmeyer, 2014). Non-birth mothers had difficulties finding their role as a parent because of the absence of role models (Wojnar & Katzenmeyer, 2014) or feelings of having to legitimise their position as a mother (Heyman & Wilkes, 2017). In a study from Canada, non-birth mothers described physical and emotional changes during their transition to parenthood and therefore asked for support throughout pregnancy and when the child was born (Abelsohn et al., 2013). Non-birth mothers in Ireland reported consequences of lacking legal parental rights. In addition to the lack of role models, they feared losing their child in case of separation or partners death (McInerney et al., 2021).

Nordic countries

Previous research from the Nordic countries shows that two-mother families are quite satisfied with both antenatal and child health care. Positive meetings with health care professionals are described in several studies, even though health care is perceived as being heteronormative (Dahl & Malterud, 2015; Erlandsson et al., 2010; Larsson & Dykes, 2009; Röndahl et al., 2009; Spidsberg, 2007). Same-sex mothers wanted to be treated as equal parents by health care professionals, and asked for parental education that focuses on parenting and care designed for same-sex couples (Röndahl et al., 2009; Erlandsson et al., 2010). Two-mother families also described the importance of including the non-birth mother from the very beginning to strengthen the feeling that they should form a family together (Röndahl et al., 2009). Small things were important for the experience of being seen as a family, i.e. how the midwife acted and how she addressed to the couple, affected the experience of feeling included or not (Dahl & Malterud, 2015).

One recent Swedish study explored LGBTQ+ parents' experiences of reproductive health care and concluded that heteronormativity is widespread and leads to a feeling of lack of support (Klittmark et al., 2019). Experiences of nurses' attitudes in child health care among lesbian, gay and bisexual parents reveal both a sense of marginalisation and being respected (Andersen et al., 2017). Another Swedish study focused on fear of childbirth among lesbian, bisexual and transgender people, and it was concluded that minority stress contributes to additional stress (Malmquist et al., 2019).

Previous research from Sweden has examined same-sex couples' parenting stress and couple relationships during and after ART and compared lesbian couples' experiences with heterosexual couples. The results showed that same-sex couples were satisfied with their relationship at the time of assisted reproduction (Borneskog et al., 2012) and reported higher relationship satisfaction than heterosexual couples 2-5 years after assisted reproduction (Borneskog et al., 2014b). Moreover, same-sex women undergoing ART reported good psychological health with low levels of symptoms of anxiety and depression (Borneskog et al., 2013), and reported low levels of parenting stress and significantly lower parenting stress compared with heterosexual couples at the time when the offspring reached 1 year of age (Borneskog et al., 2014a).

In another Swedish study, lesbian mothers (n=96) were interviewed about their experiences of encounters and parental roles. The results showed that the mothers' encounters with health care professionals could be described as both good and heteronormative (Malmquist & Zetterqvist Nelson, 2014). The mothers' experiences of encountering social workers to get a second-parent

adoption was described as stressful and time-consuming by some, but easy by a few mothers (Malmquist, 2015a). Parental roles by lesbian parents were described as being spontaneously equal or struggling for equality and as unequal due to biological differences between the birth mother and the non-birth mother (Malmquist, 2015b). Lesbian mothers who had undergone assisted reproduction at a Swedish fertility clinic met heteronormative assumptions and meant that the treatment was not adapted to their specific needs (Rozental & Malmquist, 2014).

To summarise, different review studies have shown that same-sex mothers experiences of antenatal and child health care indicate insufficient acknowledgement and support (Dahl et al., 2013; Hammond, 2014; Wells & Lang, 2016). There is a limitation of research regarding what kind of support same-sex mothers request from professionals in antenatal and child health care, and this thesis aims to contribute to filling this gap.

Theoretical perspectives

The following theoretical perspectives were selected to discuss the findings of this theses: Transition Theory (Meleis, 2010), Caring and Uncaring Encounters in Nursing and Health Care (Halldórsdóttir, 1996), and A Concept Analysis of Cultural Sensitivity (Foronda, 2008).

In the transition theory (Meleis, 2010), the major life transition to motherhood is described. During women's transition to motherhood, nurse–client encounters occur. Halldórsdóttir (1996) described caring and uncaring encounters and emphasised childbearing women being vulnerable with an extended need for professional caring. Halldórsdóttir (1996) developed the concept of nurse-patient relationship as the core of nursing, at the same time Meleis (2000) argued how stigma and stereotyping interfere with the transition to motherhood (Meleis et al., 2000). Cultural sensitivity is another layer that will impact the experiences of transition to motherhood and caring encounters in same-sex mothers. Cultural sensitivity is discussed by Foronda (2008).

Transition theory

Afaf Meleis' transition theory (2010) described why transition is a concern of nursing, as nurses and midwives support individuals and families when coping with changes in their lives, affecting their health. Meleis (2010) identified four major transitions: developmental, situational, health-illness and organisational transitions. Among developmental transitions, the process of becoming a parent and the transition to motherhood are highlighted. In a situational transition, from nonparent to parent, the roles change when giving birth to a child, and as the family grows, there might be feelings of role insufficiency. Role insufficiency may be a result of poor role definition or lack of knowledge from role behaviours. Public health nurses work to prevent role supplementation among expectant mothers. Strategies for role supplementation are role modelling, but there might not be enough role modelling in a nontraditional culture with new realities. The transition is a movement, a process. Transition is a personal phenomenon, and the person needs to be aware of the changes. The concept of transition is consistent with holistic health, which is central to nursing.

According to Meleis (2010), the concept of transition is central to nursing as nurse–client encounters occur during the client's transition.

The process of transition is a vulnerable time, and nurses can facilitate or hinder a healthy transition. Stress might occur during transitions. The transition to motherhood includes preparations and expectations and is facilitated by information provided by health care professionals or by a role model. Stigma and stereotyping can interfere with the process of healthy transition (Meleis et al., 2000).

The transition theory is useful when discussing how health care professionals' support mothers being in a major life transition, namely the transition to parenthood. Transition can be described as a space between what has been and what is being developed (Meleis, 2010), in this case, the transition to parenthood. The transition theory offers an understanding of development and changes in human lives. Nursing is concerned with growth, development and health promotion. The transition theory introduces a broad view of rationality that includes relationships, change over time, and a person in particular situations and different contexts as giving birth and becoming parents (Meleis, 2010).

Caring and uncaring encounters

Sigridur Halldórsdóttir (1996) developed a theory of caring and uncaring encounters in nursing and health care from a patient perspective. This theory describes caring and uncaring encounters from two major metaphors: the bridge and the wall. The bridge symbolises a professional connection, in caring and communication, between the nurse and the person who needs professional caring. When the nurse is perceived as caring, competent and concerned by the recipient, she feels empowered, and a sense of wellbeing and health increases. If the nurse is perceived as uncaring and incompetent by the recipient who needs professional care, the recipient meets the wall, a symbol of lack of professional caring. The lack of professional caring decreases the recipients' sense of wellbeing and health (Halldórsdóttir, 1996).

To develop a caring encounter with a trusting patient relationship, the nurse needs to genuinely care for the patient, be competent, and have professional wisdom. Halldórsdóttir (2008, p. 644) highlights that the nurse-patient relationship is the core of nursing. The nurse needs to be perceived as caring, competent and wise to be able to develop a trusted nurse-patient relationship. This means that the nurse needs to genuinely care for the patient as a person, be competent through having skills in both nursing and connecting with the patients. Through a combination of knowledge and experience, the nurse

develops professional wisdom. In a trusted nurse-patient relationship, the nurse needs to both develop connection, but at the same time, maintain a comfortable distance symbolised with the metaphor of a bridge. In a life-giving nursing relationship, the nurse can make a great difference and empower the patient (Halldórsdóttir, 2008). Empowerment is described as an "increased sense of wellbeing and health—a subjective sense of being strengthened" (Halldórsdóttir, 2008, p. 645). Halldórsdóttir (1996) is of the opinion that it is important to see the patient from the patient's inner and external context. The patient's inner context consists of expectations and previous experiences, and the external context consists of the patient's social and cultural context.

Halldorsdottir and Karlsdottir (2011) evaluated the theory to describe the professionalism of the good midwife through five aspects. These aspects are the midwives' inter-personal and professional caring, wisdom, development, and competence. All these aspects are important for enabling the midwife to empower the patient. The childbearing woman is described as a vulnerable individual who has a special need for professional caring.

Halldórsdóttir's (1996) theory is appropriate when discussing encounters between health care professionals and the mothers, as the theory explores the nature of caring and uncaring encounters in nursing and health care. Halldórsdóttir (1996) also emphasised the concepts of openness, respect, good communication and a trusting relationship between the patient and the nurse to strengthen and empower the patient, in this case, mothers. Her theory also highlights encounters with both nurses and midwives, which makes the theory appropriate to discuss the mothers' encounters with professionals in both antenatal and child health care.

Cultural sensitivity

Cultural sensitivity is described in a concept analysis as "employing one's knowledge, consideration, understanding, respect, and tailoring after realising awareness of self and others and encountering a diverse group or individual" (Foronda, 2008, p. 210).

Knowledge is the first attribute and is defined as knowledge of cultural differences, norms, values and beliefs. This knowledge can be obtained through education or experience of different cultures. The second attribute is consideration, meaning caring for others by taking the individual identity into consideration and avoiding cultural stereotyping. The third attribute, a desire to understand, is described as a key component in cultural sensitivity. Respect is the fourth attribute in cultural sensitivity, which is fundamental. Nurses need to respect and accept the patient's needs. Tailoring is the fifth attribute,

meaning that nurses need to tailor or adapt their care for individuals or different groups. All these attributes—knowledge, consideration, understanding, respect and tailoring—are important for cultural sensitivity. Other relevant aspects of the concept, cultural sensitivity, are the antecedents of diversity, awareness and encounter. Differences in, for example, norms and values is diversity. Awareness is both to be aware of one's own norms and values, and then aware of other perspectives. The experience of cultural sensitivity is shown in encounters between different cultures. The consequences of cultural sensitivity are effective communication and interventions, and satisfied patients and nurses (Foronda, 2008).

Cultural sensitivity is about knowing differences between cultures but avoiding stereotyping (Burkey et al., 2021). Cultural sensitivity is valuable when discussing research involving sexual minorities (Bauer & Wayne, 2005), as in this thesis, same-sex mothers. Sexual minorities might have difficulties in establishing a trusting relationship with health care professionals, but through cultural sensitivity, health care professionals can overcome distrust (Bauer & Wayne, 2005).

Rationale

As the Swedish law changed and female couples gained access to assisted reproduction (SOSFS 2005:17), midwives and nurses in antenatal and child health care will encounter two-mother families. This thesis explores how the changed legislation becomes visible in practice. Early parental support is provided by professionals aiming to strengthen and support health for both parents and their child. The transition to motherhood is a vulnerable time, something nurses and midwives can facilitate by providing professional support. Previous research reported that same-sex mothers encounter heteronormativity, insufficient support, and stress in their transition to motherhood. More knowledge is needed about how same-sex mothers experience the process of forming a family and their experience of professional support from antenatal and child health care. There is a limitation of research regarding what kind of support same-sex mothers request from professionals in antenatal and child health care, and this thesis aims to contribute to filling this gap. Few studies have explored professionals' experiences of supporting same-sex mothers; therefore, this thesis also aims to contribute a professional's perspective. This thesis aims to contribute with same-sex mothers' experiences of forming a family, parenting and support from antenatal and child health care, and midwives and child health care nurses' experiences of supporting same-sex mothers through the transition to motherhood.

Aim

The overall aim is two-fold. First, to examine same-sex mothers' experiences of forming a family, parenthood, early parental support, and parenting stress. Second, to explore how professionals in antenatal and child health care support same-sex mothers.

The specific aims of papers I–IV were:

Paper I: To gain insight into how women in same-sex relationships experience the process of forming a family through the use of assisted reproduction technique, from planning the pregnancy to parenthood, and their experience of parental support from healthcare professionals.

Paper II: To gain a deeper understanding of how mothers in same-sex relationships think and reason about their parenthood in terms of gender equality, and how they experience early parental support from child healthcare professionals.

Paper III: To investigate same-sex mothers' self-assessed experiences of forming a family, and the association between heteronormative information, parental support and parenting stress.

Paper IV: To explore professionals' experiences of supporting two-mother families in antenatal and child health care.

Methods

This thesis includes three empirical studies. The project started with exploratory interviews with same-sex mothers, followed by an online survey to investigate whether the results from the first study could also be applied to a larger number of respondents. The third study consisted of focus group discussions with professionals in antenatal and child health care to explore how they support same-sex mothers. The purpose of each study guides the choice of research approach and method. Therefore, qualitative and quantitative approaches were used to supplement each other. An overview of the studies included in the thesis is presented in Table I.

Table I Design, methods and participants of the studies included in the thesis

Study	**Design and Methods**	**Study Sample**	**Instruments**	**Analysis**
I (Papers I & II)	Exploratory, qualitative design, Grounded Theory methodology	20 same-sex mothers (12 birth mothers and 8 non-birth mothers)	Semi-structured interviews	Grounded Theory
II (Paper III)	Cross-sectional, quantitative design	146 same-sex mothers (77 birth mothers, 59 non-birth mothers, 10 mothers with experience of both)	Web survey about forming a family and parental support, SPSQ	Descriptive Statistics, Pearson Correlation, independent sample t-test,
III (Paper IV)	Qualitative design	6 focus groups with 8 midwives and 5 child health care nurses	Semi-structured focus groups	Inductive content analysis

Grounded theory methodology was useful when aiming to generate explanations and a preliminary model that is grounded in empirical data. Grounded theory (GT) is an inductive theory, meaning that the analysis and findings is grounded in data (Corbin & Strauss, 2008). Therefore, GT was the choice for study I (Papers I and II), as the first study aimed to explore same-sex mothers' experiences of forming a family, pregnancy, parenthood and early parental support.

Paper I and II

Study setting

The empirical data collection for Papers I and II were performed in Mid Sweden with participants from both urban and rural areas. The interviews took place during 2015 and 2016.

Participants and data collection

A letter with information about the study was distributed to prospective participants by nurses at child health care and shared via a web page for same-sex families. Inclusion criteria were birth mothers and non-birth mothers in a same-sex relationship that had a child through assisted reproduction at a Swedish clinic, the child being around 1–3 years old, and parents having joint custody and living in Mid-Sweden. The motivation for the selection of a Swedish clinic was that both mothers then become legal parents to the child, something that can affect the experience of support. The choice of age for the child was related to the mothers then having experience of both antenatal and child health care.

In line with GT methodology, the sampling method was both purposeful and theoretical. Purposeful sampling is intended to produce the maximum diversity (Corbin & Strauss 2008); therefore, participants were selected with a geographical spread from both rural and urban areas. Theoretical sampling is concept-driven, meaning that data collection continued until saturation was reached (n=20). There were eight couples and an additional four birth mothers that participated. These 12 birth mothers and eight non-birth mothers had an age ranging from 25 to 42 years. Twelve mothers had one child, and eight mothers had two or more children. Thirteen mothers were married, seven were cohabiting. The length of their relationship varied from 4, 5 years to 13 years. Fourteen mothers had a university degree, and six mothers had a high school degree.

An interview guide with open-ended questions originating from the research questions with the themes *planning for parenthood*; *pregnancy, childbirth, and parental support*; and *parenthood and gender equality* was constructed. The interview guide was tested in a pilot interview with one birth mother and one non-birth mother, and as no changes in the interview guide were made, these interviews were included in the analysis. The interviews were conducted by the author in a quiet place chosen by each participant. All the participants were interviewed separately. The interview started with an open-ended question from the interview guide: Please tell me how you thought and reasoned about your decision to form a family. The analysis was an ongoing process, where data generated new questions, which were addressed in the next interview. The interviews lasted between 35 and 70 minutes and were recorded and transcribed verbatim by the author.

Data analysis

Constant comparative analysis consisted of three steps. The analysis began with open coding, where the material was read line by line to find codes. These codes were data-close words from the participants that were compared and sorted out to form categories. The process of collecting and analysing data was an ongoing procedure and took place simultaneously, as described by Corbin and Strauss (2008). The second step, axial coding, involved coding around each category to find its properties and the relationships between categories and subcategories. The last step, selective coding, was conducted until saturation of the categories and subcategories was reached and linked around the core category (Corbin & Strauss 2008; Hallberg, 2009). During the data analysis, the material was divided into two parts: (Paper I) exploring the experience of forming a family and support from professionals at antenatal care, and (Paper II) exploring the experience of parenthood and support from professionals at child health care.

Theoretical memos were collected and written down during the whole process and were used to link and verify analytical interpretations with the empirical data. Codes were integrated and refined to develop categories and subcategories. The categories were developed through constant comparison and had to be moved between data collection and analysis to reach saturation of categories. Finally, a core category was identified, and a preliminary model was constructed illustrating how the categories were linked to the core category. The first paper describes the process of forming a family through assistant reproduction with the core category: A stressful journey through a heteronormative world. The second paper describes experiences of equal parenthood and support from child health care professionals with the core category: Same-sex mothers request professional support to achieve equal parenthood.

Grounded theory also generates hypotheses (Corbin & Strauss, 2008). The hypotheses generated in the first study:
Hypothesis 1: The higher the degree of perceived heteronormative information, the lower the degree of perceived parental support.
Hypothesis 2: The higher the degree of perceived heteronormative information, the higher the degree of experienced parenting stress.
Hypothesis 3: Non-birth mothers experience less acknowledgement and support from antenatal and child health care than birth mothers.

These hypotheses were then tested in study II to see if the results could be applied in a broader context. The hypotheses were supplemented with the research question: Are there differences between birth mothers' and non-birth mothers' experiences of parenting stress?

Paper III

Study setting

The empirical data collection for Paper III was performed in Sweden between July and December 2019.

Participants and data collection

Inclusion criteria for participants of the study were birth mothers and/or non-birth mothers in a same-sex relationship having conceived via donation treatment at a Swedish clinic, children around 1-3 years, and mothers having joint custody of the child.

Measurement instruments

An online survey was constructed based on the findings from study I and previous research (Wells & Lang, 2016) to investigate whether the results could be applied in a broader context. The online survey consisted of three self-reported parts: (1) demographic data, (2) a self-constructed questionnaire based on previous findings about the process of forming a family through assisted reproduction (study I; Wells & Lang, 2016) and (3) the validated instrument, the Swedish Parenting Stress Questionnaire (SPSQ; Östberg et al., 1997).

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

The second, self-constructed part of the survey consisted of 29 items divided into three subareas. The survey had one yes-or-no question: Have you participated in a parental group? For all other items, using a 5-point 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. The first sub-area, *the process of becoming pregnant*, was measured with 13 items. One sample item was "I found it difficult to find information about assisted reproduction". Another item was "I think it was a stressful time to undergo assisted fertilisation". The remaining questions measured different aspects of choosing who to be birth mother and different aspects for choosing a Swedish clinic. The second sub-area, *support from antenatal and child health care*, was measured with 11 items. Four questions were included in the scale "parental support." One sample item was "I was acknowledged as a mother at antenatal care". Another item was "Professionals at child health care give me support in my parenting". The remaining questions measured different aspects of support and knowledge to support families with two mothers. One sample item was "I lacked professional emotional support during the process of conceiving". The third sub-area, *heteronormativity*, was measured with five items. Three questions were included in the "heteronormative information" scale. One sample item was "Forms, brochures and information in antenatal care have included families with two mothers". Another item was "Forms, brochures and information at child health care have included families with two mothers". The remaining two items concerned if participants had met questions about "the father" and the donor. Both single items and scale scores were used in the analysis.

The third part, SPSQ, is a validated instrument designed to measure the perceived stress that parents experience in their parenting. SPSQ is partly influenced by Richard Abidin's Parenting Stress Index (Abidin, 1990), though modified to fit a Swedish context by 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". Another item was "I need help to cope with my parenting". 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". Another item was "Almost all my time is now spent with the child". The third subscale, *social isolation*, was measured with seven items. One sample item was "I feel lonely and without friends". Another item was "Since we had children, we have started spending time with many other parents of young children". 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". Another item was "Since we had children, I have received less support and help

from my partner than I had expected". 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". Another item was "Due to a changed sleep pattern, I often feel tired and out of shape". Together, these five subscales measure the total score of general parenting stress. Using a five-point 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. Both the total score and subscale scores were used in the analysis.

The survey was tested in a small pilot study among same-sex mothers (n = 9). This only resulted in small modifications of the self-constructed part of the survey. The pilot study is not included in the analysis.

Information about the study, including a link to the survey, was sent to all regional child health care units in Sweden (n = 21), and was also made available on the websites of various interest organisations. The sample was self-recruiting. Data was collected using the web survey software Survey & Report (Artologik). The survey was completed by 146 participants, of which 77 (52,7%) were birth mothers, 59 (40,4%) non-birth mothers and 10 (6,8%) mothers with experiences of being both. The participants ranged in age from 20 to 56 years (mean 34.44). Most common among the participants was having one child (n = 97) and living with the child's other mother (n = 140). The vast majority were born in Sweden (n = 133) and had a university degree (n = 113).

Data analysis

All data analyses were performed with IBM SPSS Statistics 24. Categorical variables were calculated as percentages, and continuous variables were computed as means (standard deviations). Pearson correlation analysis was used to explore the interrelationship among some of the variables and independent-sample *t*-tests were used to compare differences (Pallant, 2016).

Pearson correlation analysis was used to explore the interrelationship among perceived parental support, heteronormative information and parenting stress (SPSQ) to test hypotheses 1 and 2. An independent sample *t*-test was used to compare the differences between birth mothers and non-birth mothers for the following variables: parental support and total parenting stress with subscales to test hypothesis 3 and to answer the research question. The group of mothers that had experiences of being both birth mothers and non-birth mothers (n = 10) are described in descriptive statistics, but no comparisons with the other groups were made due to the small sample. Missing data on single items were few.

Paper IV

Study setting

The empirical data collection for Paper IV was performed in central Sweden from October 2020 to May 2021.

Participants and data collection

Participants were recruited through coordinating midwives and child health care nurses in the different regions. Inclusion criteria were midwives and nurses at antenatal and child health care with experiences of supporting same-sex mothers and with an interest in participating in the study. Six very small focus groups (VSFG) with 13 participants were held (eight midwives and five child health care nurses). The groups were held online due to the Covid-19 pandemic.

An interview guide with different themes, based on previous research, was conducted to explore professionals' experiences of supporting families with two mothers. The interview guide was tested in a small focus group with participants with experiences of working in antenatal and child health care. No changes were made in the interview guide. The focus group guide included themes such as own experiences of encountering two-mother families, how do you view your knowledge of encountering families with two mothers? Do you have any education / training in LGBTQ+ issues? Tell me/us how you work to support families with two mothers.

There are three steps in a focus group discussion, according to Krueger and Casey (2015). A moderator leads the discussion, and an assistant moderator takes notes during the session. As the moderator, the author welcomed participants, gave a brief introduction to the research project and informed them about the aim of this discussion and ethical aspects. The participants introduced themselves, and the moderator started the discussion with an open-ended question. The role as a moderator was to stimulate the discussion and to "keep on track". Each session lasted between 46 and 84 minutes. When the subject was fully discussed, the moderator assistant summarised the discussion, and the moderator asked if there were something participants would add. After that, we thanked all participants for taking their time to share their experiences. The focus group discussions were tape-recorded and then transcribed verbatim by the author. Field notes from the assistant moderator were then used in the analysis process. The pilot focus group was not included in the analysis.

Data analysis

A qualitative inductive content analysis by Elo and Kyngäs (2008) was suitable as there are few studies about this phenomenon, supporting two-mother families, from the caregiver's perspective. Content analysis, as described by Elo and Kyngäs (2008), includes three phases: preparation, organisation and reporting.

The first step in the preparation phase is to select the unit of analysis and make sense of the data and as a whole (Elo & Kyngäs, 2008). Each focus group discussion was selected as a unit of analysis. The next step in the analytic process was to make sense of the data and to learn 'what is going on' and obtain a sense of whole. In this process, to become familiar with the data, it was helpful to ask questions to the data when reading the text (focus group discussions). The written material was read several times as the aim was to become immersed in and familiar with the data.

After making sense of the data, the next step was to organise the data. This process included open coding, creating categories and abstraction. Open coding means that notes and headings were written in the text while reading it. The written material was read through again, and headings were written in the margins to describe all aspects of the content. The headings were then grouped into subcategories. Abstraction means formulating a general description of the research topic through generating categories. Subcategories with similar events and incidents are grouped together as categories. The abstraction process continues until the categories provide a description of the phenomenon and the main category are identified (Elo & Kyngäs, 2008). The analysis resulted in the main category: Striving to be open-minded in supporting same-sex mothers. Finally, the results are reported through the main category, categories and subcategories with clarifying quotes.

Ethical considerations

An ethical application was submitted before each sub-study, as the sub-studies followed one another, and the results guided the next study. Study I (Papers I & II) was approved by the Swedish Ethical Board (Dnr.2014/514) as well as study II (Dnr 2018/396). Concerning study III, the Swedish Ethical Board had no ethical objections about the study (Dnr 2020–01334). All studies were designed and performed per the WMA Declaration of Helsinki (2013).

Participants were informed about the study in different ways. Participants in studies I and III (or Papers I, II and IV) were informed both orally and in writing about the study and were guaranteed confidentiality. Written, informed consent was obtained from each participant included in study I. In study II (or Paper III), written information about the study was posted on different interest organisations' websites, with the possibility of contacting the researcher to gain more information. When participants answered the questionnaire, they gave consent to participate in the study. In study III, participants gave their informed consent to participate in the study when entering the web-based focus group. To create confidentiality, the material is stored in a locked safety at Mälardalen University for ten years after completion of the studies, and no unauthorised person will have access to the material. When the results are reported, no participant could be identified. For quotations, fictitious names have been used. The participants were also informed that participation was voluntary and that they could cancel their participation at any time, without giving any reason. Both the interviews and the questionnaire could have led to a reflection about the mothers' own choices, and then both the birth mother and non-birth mother may have had conversations about motives, decisions and expectations of parenthood. Therefore, there was a person (independent of the project) that participants in the web study could turn to with any thoughts. It could also have resulted in a greater understanding of both parenthood and both positive and negative impacts of the implemented decision. The focus groups with health care professionals could also have led to reflections about their work and professional caring. An ethical dilemma with focus groups is that they include several participants, and therefore they were asked not to talk to anyone about what the group discussed. It is unlikely that knowledge about parental support in two-mother families would result in an

ethical problem, as knowledge would decrease rather than increase any prejudices against a minority group.

Maintaining ethical principles throughout the research process is also about how the results are communicated. Researchers have an obligation to describe the participants' experiences in a respectful way, and how and where the results are published is an ethical stance. By publishing the articles in international, peer-reviewed, open access journals, high quality research is verified and made available to all.

Results

The findings are divided in two parts. First, same-sex mothers' experiences of forming a family, parenthood, early parental support, and parenting stress are presented. Second, health care professionals' experiences of supporting same-sex mothers are presented.

Same-sex mothers experiences

The results from paper I-III are presented under the following headings: the process of forming a family through assisted reproduction, encounter and support from health care professionals, and experience of parenthood and parenting stress.

The process of forming a family through assisted reproduction

The process to parenthood can be described as a stressful journey through a heteronormative world (see Fig. I) (I). Assisted reproduction was experienced as stressful by 60.9% (n = 89) of the mothers (III). Same-sex mothers expressed a need for more information regarding access to assisted reproduction and described difficulties in locating counselling (I) 32.2% (n = 47) of the mothers reported having difficulty finding information, while 39% (n = 57) found it easy to find information (III). They also lacked information and someone who could guide them through the process (I).

Assisted fertilisation at a Swedish clinic was an obvious option for most mothers (I). The following factors were considered important for the decision to use assisted reproduction at a Swedish clinic: that the possibility exists within Swedish healthcare (93.1%; n = 135), legal aspects (that both women become legal parents of the child) (90.3%; n = 131), feeling safe with Swedish healthcare (84.8%; n = 123), practical aspects (proximity to a fertility clinic) (72.2%; n = 109), the child's right to identifiable information about the donor (62.1%; n = 90), and economic aspects (51.2%; n = 80).

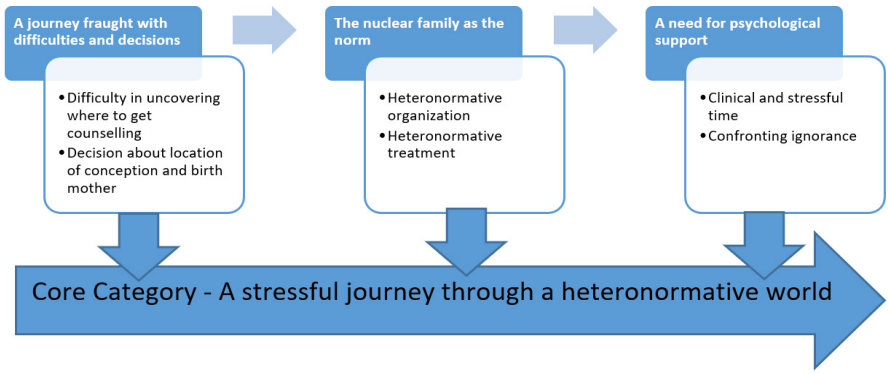

Figure I. Process of forming a family through assisted reproduction for women in same-sex relationships

The decision of whom to be the birth mother was described as an easy choice (I), and 78.4% (n = 115) reported that deciding which partner in the couple should be the birth mother was easy (III). It was the desire to carry the baby that was crucial for this decision (56.8%; n = 83). External factors, such as work, were not the main reasons (84.2%; n = 123) in deciding on the birth mother, nor were health factors (58.2%; n = 85) or age (54.1%; n = 79) (III).

Some mothers felt confused when they had to undergo the same medical procedure as in-fertile heterosexual couples. Almost all mothers perceived the process of conceiving as stressful and out of control, as nobody asked the mothers how they felt during this process (I), and 37.2% of the mothers (n = 54) reported lacking professional emotional support during the process of conceiving (III).

Encounter and support from health care professionals

Same-sex mothers described health care professionals as mostly friendly (I). Most mothers (76.7%; n = 112) reported having felt acknowledged as a mother in antenatal care, and 50% (n = 73) reported that professionals in antenatal care supported them in their parenthood. In child health care, the majority (84.3%; n = 123) felt acknowledged as mothers, and 54.8% (n = 80) felt supported by professionals (III).

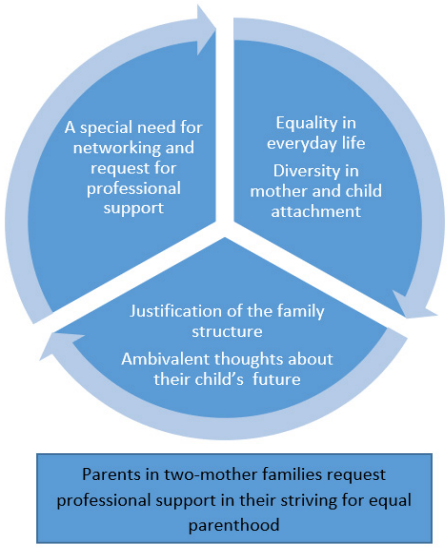

Figure II. Parenthood and parental support from professionals, as experienced by mothers in same-sex relationships

However, participants' perceived organisation and treatment in health care as heteronormative, where the nuclear family was considered the norm (I). As many as 60.2% (n = 88) of the mothers had been asked questions about "the father" and 44.5% (n = 65) had received questions about the donor. Almost half of the mothers (44.6%; n = 65) reported that they had been dealt with from a heteronormative perspective. Only 11% (n = 16) reported not being dealt with from a heteronormative perspective at all (III). Some felt that the midwife did not always seem to be prepared to meet two-mother families (I).

Same-sex mothers request professional support to achieve equal parenthood (see Fig. II). Some mothers expressed that they were not always treated as a couple, and they sometimes had to justify their family structure (II). Even though most mothers (78.1%; n = 114) had participated in a parental group, less than half (43.9%; n = 50) reported that the parental group was a support in their parenthood (III). The use of terms and vocabulary can be either including and parental supportive or excluding and dismissive (II). High perceived heteronormative information correlated with a lower level of perceived parental support ($p < .01$), and a higher level of perceived parenting stress ($p = .02$) supporting hypothesis 1 and 3 (III). Less than half of the mothers (43.1%; n = 63) reported being satisfied with the professional emotional support (III). A series of independent-samples t-tests revealed that non-birth mothers experienced lower parental support ($t(134) = 2.49$, $p = .01$) than birth mothers. The magnitude of the differences in the means was small to moderate (eta squared = 0.044). Single items show that non-birth mothers experienced

lower acknowledgement in antenatal care (t (90) = 4.24, p = < .001). The magnitude of the differences in the means (mean differences = 0.48, 95% CI: 0.26 to 0.70) was large (eta squared = 0.118). Non-birth mothers experienced lower parental support in antenatal care (t (134) = 2.63, p = .01). The magnitude of the differences in the means (mean differences = 0.57, 95% CI: 0.14 to 0.99) was small to moderate (eta squared = 0.049). Non-birth mothers experienced lower acknowledgement in child health care (t (102) = 4.08, p = < .001). The magnitude of the differences in the means (mean differences = 0.68, 95% CI: 0.35 to 1.02) was moderate to large (eta squared = 0.111). Regarding support from child health care, no significant difference was found between birth-mothers and non-birth mothers (III).

Experience of parenthood and parenting stress

Same-sex mothers strived for equal parenthood through equality in everyday life. The mothers described that they strove to share parenthood equally by sharing parental leave and practicing equality in their everyday lives (II). The mothers described the attachment to their child in different ways, through breastfeeding or spending time and being intimate. Only a few mothers talked about the possibility for the non-birth mother to breastfeed their child. The mothers described their thoughts for the future in terms of hopes and fears for their child, based on their assumptions that their child needed to challenge the norm (II). In the mothers seeking safety for their child, they expressed a need for support and networking with other LGBTQ+ families (II).

Both birth mothers and non-birth mothers reported low levels of parenting stress, with no significant difference between the two groups (III). No significant differences in the scores for birth mothers and non-birth mothers were found for general parenting stress, or for the subscales' incompetence, role restriction, social isolation, spouse relationship problems, and health problems. Further, no differences were found regarding the experience of support and stress between mothers with different demographic characteristics, such as age and size of city. 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 hypothesis 2. Furthermore, all subscales of SPSQ correlated with each other, except spouse relationship problems and health problems. It is worth noting that the mothers estimated role restriction to be higher than the other dimensions in the SPSQ instrument (III).

Health care professionals' experiences

The main category, striving to be open-minded in supporting same-sex mothers, includes the four categories: (a) meeting well-prepared mothers; (b) providing support through empowerment; (c) handling challenges; and (d) reflection on one's own professional competence.

Health care professionals reported that they met well-prepared mothers, with equal commitment among mothers and mothers on guard for heteronormative views. Participants found that same-sex mothers had a strong ideal about parenthood with an equal commitment and a great ambition to share parenthood equal (IV).

Health care professionals supported same-sex mothers by creating an inclusive environment. Professionals had looked over the environment in the waiting room and highlighted the importance of attributes such as rainbow flags and pictures, including a variety of family constellations. They also posed open-ended questions and used the concepts of parent and partner to be more inclusive. Some focus groups stated that they provided equal support and parental groups regardless of family constellation. Some even divided the parents into mother and father groups. Other focus groups highlighted the importance of tailored support to same-sex mothers, and parental groups where they discussed norms and parenthood and especially the fragile position of the non-birth mother. Further, some focus groups reported holding breastfeeding meetings for LGBTQ+ families and were informed about support on how to initiate breastfeeding for non-birth mothers (IV).

Health care professionals found it challenging to acknowledge both mothers. Participants described that they included and supported both mothers, but the focus was on the pregnant mother. Moreover, participants described that they struggled with documents and communications. Almost all material was heteronormatively designed, which made it impossible to document the non-birth mother as a parent. Some health care professionals described they were terrified of saying mom and dad instead of partner or parent. Participants also found the insufficient medical information about the donor challenging, creating information barriers on heritage when assessing the child's development (IV).

Health care professionals reflected on their own professional competence regarding supporting same-sex mothers. Some participants had attended LGBTQ+ courses but lacked the subject in both nursing and midwifery education. Through reflection and experience, participants described they got a feeling for issues relevant for same-sex mothers (IV).

Discussion

The overall aim of the thesis was to examine same-sex mothers' experiences of forming a family, parenthood, early parental support, and parenting stress. A second aim was to explore professionals' experiences of supporting two-mother families in antenatal and child health care. The main findings reveal that same-sex mothers experienced the process to parenthood as a stressful journey in a heteronormative world (I), and same-sex mothers requested professional support to achieve equal parenthood (II). Heteronormative information correlated with both lower perceived parental support and higher perceived parenting stress; non-birth mothers experienced less acknowledgement and support than birth mothers (III). Health care professionals strived to be open-minded in supporting same-sex mothers (IV). These findings are discussed in relation to theoretical perspectives, to the research field of health and welfare and, in relation to clinical practice.

The findings related to theoretical perspectives

The findings are discussed related to *the transition theory*, *caring and uncaring encounters*, *cultural sensitivity,* and previous research under the following headings: The transition to parenthood, parental support within antenatal and child health care *and* parenthood and parenting stress among same-sex mothers.

The transition to parenthood

Same-sex mothers experienced the process of parenthood as a stressful journey in a heteronormative world (I). This feeling of entering a heteronormative world, where everyone is expected to be heterosexual (Connell & Pearse, 2015), seems to be common within antenatal and child health care. Other studies also describe that female couples challenge heteronormativity when forming a family (Juntereal & Spatz, 2020; Malmquist & Zetterqvist Nelson, 2014; O'Neill et al., 2013; Somers et al., 2016; Wojnar & Katzenmeyer, 2014). Caring for another should include sensitivity and respectful care to avoid stereotyping (Foronda, 2008). Stigma and stereotyping tend to interfere with a healthy transition to motherhood (Meleis et al., 2000), and childbearing

women are vulnerable and have an extended need for professional support during the transition to parenthood (Halldorsdottir & Karlsdottir, 2011). Even though most mothers felt safe with assisted reproduction through Swedish healthcare, they experienced the process to parenthood as stressful and lacked emotional support (I, III). The transition to parenthood is a vulnerable time, and stress occurs during transitions (Meleis et al., 2000). Previous research supports the mothers' experience of a stressful transition to parenthood. Stress during the fertility process was associated with fear of miscarriage and insufficient support (Cao et al., 2016; Cherguit et al., 2013; Goldberg, 2006; Rausch et al., 2021). This stressful transition to parenthood could also apply to heterosexual couples, but same-sex mothers' risk additional stress due to concurrent minority stress (Malmquist et al., 2019). The mothers felt lonely during this process of conceiving, as they went to the fertility clinic to undergo assisted reproduction and then went home alone with their worries (I). This suggests a lack of a cohesive care chain during the process of forming a family.

As described above, the results reveal that same-sex mothers lack professional and emotional support during the transition to parenthood (I, II, III). A caring encounter and a caring relationship between health care professionals and the mothers should include emotional support, and thereby facilitate the vulnerable transition to parenthood. Health care professionals need to raise their awareness of what same-sex mothers go through to get pregnant. Previous research reports that midwives lack knowledge about the difficult path to parenthood for same-sex parents (Klittmark et al., 2019). One caring aspect described by Halldórsdóttir (1996) is to be sensitive to the mother's needs and previous experiences.

Insufficient information, lack of advice, and inadequate support are described as inhibitors of a healthy transition to motherhood (Meleis et al., 2000). The findings revealed that some same-sex mothers had difficulty getting information about where to get counselling (I). Halldorsdottir and Karlsdottir (2011) emphasised that the midwife is an important person who can guide both the woman and her family through the journey towards parenthood. To really strengthen or empower the woman, the midwife needs to have enough knowledge to facilitate the transition to motherhood and be informative. Meleis et al. (2000) posited that a healthy transition is dependent on competent health care professionals who could answer questions from the mothers and also provide a feeling of being connected to health care professionals.

Study IV showed that health care professionals strived to create an inclusive environment through rainbow flags and appropriate pictures in the waiting room. However, cultural sensitivity is more than choosing appropriate pictures; it is a broad and deep understanding of minority groups to improve

health care (Bauer & Wayne, 2005). Cultural sensitivity is dependent on health care professional's knowledge of norms to avoid stereotyping, a desire to understand and respect the mothers, and tailor or adapt their care for two-mother families. Health care professionals need to provide sensitive care to same-sex mothers to empower them in the transition to parenthood.

Some mothers also described that the mandatory treatment with hormones is based on heterosexual couples who have difficulty getting pregnant, even if there are no signs of difficulty getting pregnant for same-sex women (I). This indicates that health care professionals need to better inform same-sex mothers of the reason for hormone treatment. Health care professionals need to provide culturally sensitive and tailored care (Foronda, 2008) and listening to the women's needs. Delivering sensitive care is also considering that hormone therapy can cause serious side effects (Grainger et al., 2006). Care is partly dependent on structural factors, such as how care is organised and how professionals treat and encounter patients. Professionals' norms and values affect the meeting with the patient (Foronda, 2008). Not surprisingly, increased awareness of one's own norms and values should benefit all care.

The results clearly show that the nuclear family norm and the heteronorm are prevalent in antenatal and child health care (I, II, III), even though health care professionals strive to be open-minded and ask open-ended questions when they encounter new parents (IV). For example, some health care professionals described being terrified of saying mom and dad instead of partner (IV). This indicates that health care professionals would benefit from culturally competency training to feel safe and to ensure the delivery of culturally sensitive care.

Parental support within antenatal and child health care

The results show both good and less good experiences of encounter and support from professionals in antenatal and child health care (I, II). There is a wish to provide tailored parental groups and material adapted to same-sex mothers to meet their unique needs and to provide culturally sensitive care (Foronda, 2008). It is important to understand the unique need for support and information for same-sex mothers, as for example can same-sex mothers normally, both give birth, and equally contribute with breastfeeding. Few mothers knew about initiated breastfeeding for non-birth mothers (II), and not all health care professionals had knowledge of this (IV). A recent study (Juntereal & Spatz, 2020) highlights that health care professionals need education about same-sex mothers' possibility to equally contribute to breastfeeding.

The results showed that even though most mothers (78.1%; n = 114) had participated in a parental group, less than half (43.9%; n = 50) reported that the

parental group was a support in their parenthood (III). Health care professionals reported that the main reason with parental groups is to create networks for parents (IV). Perhaps professionals and parents have different views and expectations on parental groups. Or maybe the experience of low support is an expression of same-sex mothers' lack of parental groups with other LGBTQ+ families, with whom they can form networks.

Non-birth mothers experienced lower acknowledgement both in antenatal care and child health care. Moreover, non-birth mothers experienced lower parental support in antenatal care; however, regarding support from child health care, no significant difference was found between birth mothers and non-birth mothers (III). Health care professionals said that they included and supported both mothers in a two-mother family, but a common expression among midwives was that the birth mother gets the most attention (IV). The difference in experience of support in antenatal and child health care may be due to the midwife's primary task is to care for the pregnant woman (The Swedish Association of Midwives, 2018), while the nurse in child health care focuses on the child. Non-birth mothers might need more support in their transition to parenthood, as there is no bio-genetic tie to the child, and they might lack role models. Parental support together with other same-sex families was appreciated, and the results showed that some mothers found support groups online (II).

Most mothers described health care professionals as friendly and supportive, and their one-to-one encounter with professionals as satisfying (II). In these one-to-one encounters, most mothers felt respected and truly cared for, symbolised as a bridge by Halldórsdóttir (1996, 2008) when this professional connection leads to a trusting patient relationship. Halldórsdóttir (1996) means that it is only in this trusting nurse-patient relationship that the mothers can be empowered by professionals. Parental support in groups was described as heteronormative and not tailored to same-sex parents. This made the mothers (especially the non-birth mother) feel excluded (I). This feeling of exclusion might be an example of what Halldórsdóttir (1996) describes as an uncaring encounter, or the wall, which is characterised by a lack of genuine concern for the patient. Professionals in antenatal and child health care need to be aware of their own norms and values, and also be aware of other perspectives. The findings show that a few health care professionals divided parental groups into mother and father groups (I, IV), which should reasonably hinder, instead of facilitating, the transition to parenthood for same-sex parents. Moreover, health care professionals stated that they provided equal support to all parents (IV) however, providing equal support requires individualised care. Parental groups with other LGBTQ+ parents are highlighted in previous research (Malmquist, 2016; Wells & Lang, 2016) and asked for by same-sex mothers (I, II).

Health care professionals showed cultural sensitivity when asking open-ended questions to avoid stereotyping (IV). Previous research describes that parents felt empowered when health care professionals avoided gender-specific terms or asked what to call them (Kerppola et al., 2019; Klittmark et al., 2019). Health care professionals had different experiences of supporting same-sex mothers, but a common expression was to be open-minded and ask open-ended questions when encountering all new parents (IV). But if professionals have a normative view of family formation, then they may not realise their heteronormative starting point. Health care professionals reflected that both knowledge and experiences contributed to their professional competence (IV). Halldórsdóttir (2008) described this combination of experiences and knowledge as professional wisdom.

Parenthood and parenting stress among same-sex mothers

Same-sex mothers strived for sharing parenthood equally by sharing parental leave equally and practicing equality in their everyday life (II). Similar results, that Swedish same-sex mothers share parenthood equally, are found by Malmquist (2015b). Health care professionals reported that they encountered well-prepared and equally committed mothers (IV). Because mothers strive for equal parenting, and since equal parenting, with two committed parents, is valuable from the child's perspective, it is important that professionals truly address and support both mothers.

Mothers reported a low level of parenting stress when they had the child, in contrast to the stressful journey to parenthood. 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., 2014a). The lack of differences in experiencing parenting stress between birth mothers and non-birth mothers in this study (III) might be understood as a consequence of same-sex mothers striving for equal parenthood (Malmquist, 2015b). However, same-sex mothers estimated role restriction higher than the other dimensions of the SPSQ scale. Role restriction was also reported highest among the SPSQ dimensions by heterosexual parents in a previous Swedish study (Widarsson et al., 2013). A high estimation of role restriction might indicate a lack of role models for same-sex mothers. In the transition to motherhood, there might be feelings of role insufficiency for same-sex mothers, as there are few role models in a nontraditional culture (Meleis, 2010). Previous research describes how non-birth mothers struggle to find their parental role (Dahl & Malterud, 2015; Wojnar & Katzenmeyer, 2014).

The findings related to the research field of health and welfare

These findings are discussed related to the research field of health and welfare, with a focus on the right to health and care on equal terms. In Sweden, everyone has the right to good care on equal terms (SFS 2017:30; SFS 2014:958). Prerequisites for equal health are good antenatal and child health care (SOU 2017:47). Antenatal and child health care is part of primary care and, as such, part of the welfare system. In 2005, same-sex mothers gained access to assisted reproduction at Swedish clinics (SOSFS 2005:17). The findings showed that assisted reproduction at a Swedish clinic was an obvious option for most mothers (I), which indicates that the law of assisted reproduction for same-sex mothers (SOSFS 2005:17) has been of great importance. But the organisation does not seem to have changed in line with this legislation, as same-sex mothers experienced heteronormative organisation and treatment in health care, with the nuclear family ideal as the norm (I, II, III). Although different legislation works to combat discrimination (SFS 2014:958), the studies (I, II) show that mothers still encounter various obstacles on the path to parenthood. Heteronormativity and insufficient support in fertility clinics are reported in a recent published review (Kirubarajan et al., 2021). A heteronormatively designed care risk contributes to unequal care, contrary to what the Swedish health care system strives for.

Health promotion work includes empowerment, equality and participation in society (WHO, 1984). The results (I, II, III) indicated that mothers in two-mother families sometimes need to justify their family structure. Some mothers expressed that they were not treated as a couple and that the midwife did not always seem to be prepared to meet same-sex mothers (I). Also previous research reported that same-sex mothers met heteronormative language (Andersen et al., 2017; Crauch et al., 2017; Well & Lang, 2016; Wojnar & Katzenmeyer, 2014).

The design of parental groups in antenatal and child health care, which is part of the welfare sector, can be important for mothers' participation in parental groups. Health care professionals reported an organisational limitation in providing tailored parental groups for same-sex mothers in smaller communities (IV), even though parental support to parents in similar life situations is recommended (SOU 2008:131). Both parents have a joint responsibility for the child's upbringing and development, with the support of the state (UNICEF Sverige, 2018). Therefore, tailored support to same-sex mothers would be desirable.

As parental support is a political effort to increase welfare (Magnusson et al., 2009) to strengthen parents in their parental role (SOU 2008:131), there is a

need to update parental support. This need for updated parental support are also reported in previous research (Wells & Lang, 2016). A more inclusive parental group does not only benefit same-sex mothers. All parents should have the right to feel included and be able to participate in parental groups on equal terms, as Swedish health care should provide good care on equal terms (SFS 2017: 30; SFS 2014: 958). Previous research also highlights that parents attending parental groups asked for more norm-critical parental groups (Forslund Frykedal et al., 2019). The environment affects the mothers' ability to participate. Caring takes place in a context that is influenced by political decisions and values at different levels. The Health Care Act (SFS 2017:30) regulates care, but at the individual level, care depends on a professional's ability to establish a trusting relationship with the mothers.

The findings related to clinical practice

Same-sex mothers experienced the transition to parenthood as stressful and lacked emotional support (I, III). Health care professionals need to offer more informational and emotional support to expectant parents in the process of forming a family. The midwife must support the patient's mental, physical and emotional needs to create security (The Swedish Association of Midwives, 2018). Emotional support to same-sex mothers is especially important as lesbian women rated anxiety, worry and a lack of emotional support higher than the rest of the population (The Swedish Public Health Agency, 2014).

Heteronormatively designed information material and documentation systems were something two-mother families reported (I, II, III) and health care professionals found to be a challenge (IV). A suggestion is to develop forms and documents that include a variety of family constellations so that same-sex mothers feel included and health care professionals are guided by the documents.

It is important that professionals acknowledge and support both mothers, as same-sex mothers strived for sharing parenthood equally (II). Equal parenting with two committed parents, is valuable from the child's perspective, and also in line with the goal of parental support (SOU 2008: 131). Parental groups were not perceived as very supportive (I, II, III). Health care professionals must consider same-sex mothers when planning for parental groups, and parental groups need to be developed to be supportive and non-heteronormative. It would be better to not divide parental groups in mother and father groups, if parental groups for same-sex parents cannot be offered. Malmquist (2016) highlights that non-birth mothers are put in a difficult situation if the parental groups are divided. In parental groups for same-sex parents, topics relevant for same-sex mothers can be discussed (Wells & Lang, 2016).

Health care professionals reflected on their own professional competence and gained knowledge through LGBTQ+ courses and experiences but lacked a discussion about these issues in both nursing and midwifery education (IV). Nurses and midwives should provide respectful cultural care and have a norm-conscious approach (International Council of Midwives, 2014; International Council of Nurses, 2012; The Swedish Midwifery Association, 2018). Therefore, nursing and midwifery education must provide this.

Same-sex mothers gained the right to ART in Sweden in 2005, and both mothers legally became parents of their child. However, from these studies, it is evident that for same-sex mothers, the automatic legal right and status as parent to the child might not just be the one and only key to a successful and healthy transition to parenthood. Instead, this thesis has proven the complexity and extended need for professional support for minority groups as same-sex mothers when forming a family.

Methodological considerations

This project started with an exploratory design that was suitable when entering a new area. A qualitative approach can be selected when you want to explore the experience of something and have little knowledge about the topic (Polit & Beck, 2012). Grounded theory was useful to generate explanations and a theory grounded in reality (Creswell, 2013; Corbin & Strauss, 2008). Grounded theory is an inductive theory, meaning that both analysis and findings are grounded in data (Polit & Beck, 2012). Grounded theory was chosen to explore how same-sex mothers experience the process of forming a family through assisted reproduction. The goal was to generate a theory grounded in empirical data. Grounded theory is suitable when the aim is to gain a deeper understanding of how mothers in same-sex relationships experience the process of forming a family through assisted reproduction, from pregnancy to parenthood and parental support.

Study I

To ensure trustworthiness in the qualitative studies, the criteria of creditability, dependability, confirmability and transformability will be discussed (Lincoln & Guba, 1985). Trustworthiness is about offering the reader the opportunity to follow the analysing process.

Credibility refers to the ability to really capture the multiple realities of participants (Dahlgren et al., 2004). To increase credibility and transferability, participants in study I were recruited in both urban and rural areas. A strength of study I is the geographical spread of participants. The interviews in the first study were conducted, transcribed and coded by the author. To meet the criteria of creditability and dependability, my supervisors read and coded some transcriptions. The author also discussed the categories and core categories with the supervisors who are experienced in grounded theory methodology and have knowledge about same-sex mothers forming a family.

Confirmability is easily met in grounded theory studies, as the theory could be modified when needed (Dahlgren et al., 2004). To test transformability, the results from study I (Papers I & II) were tested in a larger population in study II. This could be seen as a form of triangulation or mixed methods to view

same-sex mothers experiences from different perspectives (inductive and deductive). Triangulation in research methodologies combines qualitative and quantitative methodologies when studying the same research area (Dahlgren et al., 2004).

Study II

To ensure rigour in quantitative studies, the criteria of validity and reliability will be discussed (Polit & Beck, 2012). The survey consisted of three self-reported parts: demographic data, a self-constructed questionnaire to test the results from study I, and the SPSQ. The SPSQ was included in the survey to investigate parenting stress among same-sex mothers, as the findings in the first study showed stress during the transition to parenthood.

There were several challenges in designing a web survey. A "statistician" helped with the design of the questions as well as analysis and reporting of the data. An advantage of a validated instrument, as SPSQ, is that the results can be compared with previous studies that have used the instrument.

The internal reliability of the scales was tested using Cronbach's alpha. Cronbach's alpha for the scale parental support was found to be 0.76 and for the scale heteronormative information 0.88. A Cronbach's alpha higher than 0.70 is considered acceptable for new measures (Pallant, 2016). The SPSQ has been found to be reliable and valid for measuring parenting stress in different contexts (Borneskog et al., 2014a; Östberg, 1998; Östberg et al., 1997). One important limitation is that Cronbach's alpha in study II was 0.64 for the total SPSQ scale, ranging from 0.65 to 0.85 for the subscales; therefore, the results must be interpreted with caution.

The sample in this study was self-selected, limiting the possibility of drawing conclusions that can be generalised to all same-sex mothers. Although there was a variation in socio-demographic characteristics, most mothers were born in Sweden and well-educated. Also therefore, the results need to be interpreted with caution.

Study III

In the last study, some focus group discussions with professionals at antenatal and child health care were used to gather different experiences of supporting same-sex mothers. The purpose drives the study as described by Krueger and Casey (2015), and midwives and child health care nurses with experiences of supporting same-sex mothers were invited to participate. The focus groups were web-based, due to the Corona situation. In a small study, both researchers and participants found that Zoom was a useful method for conducting qualitative interviews. Some even preferred Zoom before face-to-face interviews,

while others found Zoom to be the next best alternative (Archibald et al., 2019).

The size of the focus groups depends on the number of questions, participants' level of expertise and passion about the topic. In a smaller group, there is room for participants to share their experiences, which leads to a deeper understanding of the topic (Krueger & Casey, 2015, Morgan, 2012). Furthermore, Malterud et al. (2016) described that fewer participants are needed when the study aim is narrow, participants are highly specified for the study aim, and the interview dialogue is strong. Toner (2009) found and argued that VSFG with two participants in each focus group gave intimate interaction and generated rich data. This was also the case with the focus groups in this study; even if there were few participants in each focus group, they generated rich data. The goal was to have homogeneous groups; therefore, participants were divided into different groups. There were three groups with midwives, two groups with child health care nurses, and one mixed-focus group.

The purpose of focus groups was that participants could feel free to talk about their experiences and could learn from each other. As the focus group discussion took place through Zoom, there were small-sized groups, as recommended by Krueger and Casey (2015). With a homogenous group and if using a semi-structured interview guide, two or three focus groups are enough to capture 80% of the themes of a topic, and three to six focus groups will capture 90% of the themes (Guest et al., 2017). Despite social distancing web-based focus groups provided valuable opportunity for data collection (Lobe et al., 2020).

A clear description is provided of the study context, selection and characteristics of participants, data collection and process of analysis to strengthen transferability. To meet the criteria for trustworthiness, the analysis process is described in detail, with clarifying citations, enabling the reader to follow the process (Elo et al., 2014). Co-authors independently read and coded part of the data, and all authors discussed the formation of categories.

Strengths and limitations

It was valuable, albeit time-consuming, that the results from the first study guided the design of the second study and then the third study. One of the strengths of the thesis is that the first study was inductive, with empirical grounded data. Another strength is the combinations of different methods, from inductively to deductively, from interviews to the design of the web-based survey. A third strength is that parental support in two-mother families is viewed from both the mothers' and the professionals' perspectives. One more strength is the focus on just same-sex mothers conceiving at a Swedish clinic, instead of the whole LGBTQ+ group, as in many other studies. The

theoretical perspective might be a strength. In a review of 30 papers with homosexual parented families (20 papers focused on lesbian mothers), most studies discussed the findings from a heteronormative perspective or from a policy perspective (Farr et al., 2017), but no paper had a caring science perspective. As theories are useful to describe phenomena and to broaden and deepen our understanding of new findings, it felt important and natural to discuss the findings of encounters and support in two-mother families within antenatal and child health care from a caring science perspective.

A limitation is the recruitment and sampling of participants in the studies included in the thesis. In the first study, there were 20 same-sex mothers from urban and rural areas recruited through child health care nurses and a web page for LGBTQ+ families. In the second study, the sample was self-selected, limiting the opportunity to generalise the results to all same-sex mothers. The majority of research with same-sex mothers consists of highly educated, middle- to upper-middle-class white mothers from urban areas (Bos & Gartrell, 2020; Dahl 2018). This was also the case in study I and study II, even if there were a variation among participants. Most mothers were born in Sweden and had a university degree. In the third study, 13 health care professionals participated. Even though there were VSFG conducted via Zoom, which might be a limitation, it was important to also get professionals' experiences. It cannot be stated that participating same-sex mothers and health care professionals represent all same-sex mothers and health care professionals; rather, they are voices with various experiences and backgrounds describing their experiences of parental support in antenatal and child health care. Other limitations have to do with the context, limiting the transferability of the results to other countries with another organisation in antenatal and child health care.

In qualitative studies, there is a need to reflect on my role as a researcher. Reflexivity becomes a core concept in qualitative research and is about the researcher's awareness of the role as a "research instrument" (Thornquist, 2021). Knowledge generated in qualitative research is dependent on the interaction between participants and researcher (Corbin & Strauss, 2008; Dahlgren et al., 2004). It is therefore important to be aware that the researcher's role to the participants is of great importance, as is the researcher's role in the research field (Thornquist, 2021). Since the researcher influences the results, it is important that I have clarified and tried to describe my preunderstanding. I do not belong to the group of same-sex mothers, midwives or child health care nurses, but I am a mother and a nurse.

I have also become aware of the risk of expressing myself normatively. If all researchers have the same profession, norms and traditions, it is easy to become "blind" (Thornquist, 2021). Therefore, it was an advantage that there was a variety of disciplines and traditions in my supervisor group. Discussions

with my supervisors, who are experienced in qualitative research within the field, have led to an awareness of the importance of being open-minded when analysing qualitative data.

Other aspects to consider are transparency and positioning (Thornquist, 2021). Transparency is about making it easy to follow the research process; therefore, the research process is described in detail with clarifying quotes. Positioning is about clarifying one's own interests and theoretical points of departure. My intention has been to be clear that the thesis is written from a caring science perspective in the field of health and welfare. It is important to admit that the researcher is a part of constructing knowledge. Therefore, the results from the interviews and the focus groups could have been different if another researcher had collected and analysed data, as the results depend on the researcher's perspective and background.

Conclusion and implications

The findings in this thesis contribute with an in-depth understanding and increased knowledge of parenthood and parental support in two-mother families. The findings show that same-sex mothers experienced the process of forming a family through assisted reproduction to be stressful. Health care professionals need to provide information how to access assisted reproduction and offer more emotional support to expectant parents in the process of forming a family.

Same-sex mothers experienced both the organisation and treatment in antenatal and child health care as heteronormative. Heteronormative information is associated with both lower perceived parental support and higher perceived parenting stress. Forms, brochures and information need to be updated to avoid heteronormativity and guide health care professionals.

Non-birth mothers experienced significantly lower parental support from antenatal and child health care than birth mothers. When working with same-sex families, professionals in antenatal and child health care need to recognise and support both mothers as equal valued parents. The non-birth mother in particular needs to be acknowledged and supported to a greater extent, and also informed about the ability to breastfeed.

Parental groups were not perceived as very supportive. Parental groups need to be developed to be supportive, inclusive and non-heteronormative. If possible, parental groups for same-sex parents is to recommend.

Some of the challenges that same-sex mothers bump into when longing for children exist both in countries where ART for same-sex families is legal or not. Equal rights for same-sex mothers compared to heterosexual couples, as concerning assisted reproduction, do not guarantee that health care is organised to accommodate same-sex families.

Professionals need to reflect on how their view of parenthood and how heteronormative assumptions negatively affect the encounter with expectant or new parents. Nursing and midwifery education should also prepare students to meet all patients as unique individuals without heteronormative assumptions.

Through an inclusive language that welcomes both mothers, professionals can contribute to a caring encounter and equal care.

The thesis also contributes to health care professionals' experiences and challenges of supporting same-sex mothers. Some health care professionals would benefit from education and discussions about how to support the non-birth mother in her parental role. Otherwise, health care professionals might risk losing same-sex mothers' confidence as well as their professional mission of providing equal support to both parents. Finally, health care professionals need to have time to reflect on their own norms and the challenges they met in their important work with supporting expectant and new mothers.

Future research

Further research is needed to develop a theory of professional parental support in two-mother families, especially large-scale quantitative studies that reach all same-sex mothers, not only highly educated mothers born in Sweden. Same-sex mothers experiences need to be explored from an intersectional perspective. Future research could explore interventions of emotional support during the transition to parenthood, and parental groups aimed at same-sex parents.

Further research on health care professionals' experiences of supporting same-sex mothers is also needed, as there is so little research in this area. It would be valuable to explore how to support professionals to caring encounters with same-sex mothers as well as a variety of family formations.

Summary in Swedish

Syftet med avhandlingen var att undersöka vilka erfarenheter kvinnor i samkönade relationer har av att bilda familj, graviditet, föräldraskap och av professionellas bemötande och stöd inom mödra- och barnhälsovård. Ett ytterligare syfte var att utforska professionellas erfarenheter av att möta och stödja familjer med två mammor.

Resultaten baseras på fyra artiklar (tre studier). Projektet startade med explorativa semistrukturerade intervjuer (n = 20) med mammor i samkönade relationer som fått barn med hjälp av assisterad befruktning vid svensk klinik. Därefter utformades en webbenkät ifrån resultaten från första delstudien. Enkäten, samt en enkät om upplevd föräldrastress (SPSQ) besvarades av 146 mammor i samkönade relationer. Avslutningsvis hölls fokusgrupper med professionella (n = 13) inom mödra- och barnhälsovård med erfarenhet av att möta och stödja familjer med två mammor.

Resultaten visade att mammorna i samkönade relationer upplevde processen att bilda familj som en stressfylld resa i en heteronormativ värld och de saknade psykologiskt/emotionellt stöd (Artikel I, III). Resultaten visade även att mammorna strävade efter ett jämlikt/jämställt föräldraskap och saknade professionellt stöd (Artikel II, III). Vidare visade resultaten att medmamman (mamman som ej fött barnet) upplevde lägre grad av bekräftelse från mödra- och barnhälsovården än mamman som fött barnet, samt lägre grad av stöd från mödravården men ingen skillnad i upplevelsen av stöd från barnhälsovården. Mammorna upplevde en låg grad av föräldrastress (Artikel III). Professionella strävade efter ett öppet förhållningssätt i mötet med nya föräldrar. De mötte väl förberedda mammor som planerade för ett jämställt föräldraskap. Professionella uttryckte att de antingen gav lika stöd till alla föräldrar, eller att de gav ett anpassat stöd till samkönade mammor (Artikel IV).

Avhandlingen bidrar med en fördjupad förståelse och ökad kunskap om mammor i samkönade relationers erfarenhet av familjebildning samt erfarenhet av bemötande och stöd från professionella inom mödra- och barnhälsovård. Vidare, professionellas erfarenheter av att möta och stödja familjer med två mammor.

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