




## RESEARCH ARTICLE

## Parental-couple separation during the transition to parenthood

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## Abstract

**Aim:** To evaluate factors associated with parental separation during the parenthood transition.

**Design:** Prospective, longitudinal and explorative.

**Methods:** This is a quantitative longitudinal study of N784 subjects throughout the pregnancy journey with multivariate regression analysis of survey data derived from three validated measurement scales; the Sense of Coherence scale, the Multidimensional Scale of Perceived Social Support and the Perceived Quality of the Dyadic Relationship scale conducted 2014–2016.

**Results:** N17 participants separated at 2 years. Parental separation was significantly greater for those women and partners with low or changing sense of coherence, perceived social support and perceived quality of the parental-couple relationship indexes. Partners with a change in sense of coherence ( $p$ : .003) and perceived quality of the parental-couple relationship ( $p$ : .020) between 1 week and 2 years were at greater risk for separation. Attending professional preparatory support with a partner for women ( $p$ : .013) and attending the “Inspirational Lecture” for partners ( $p$ : .046) were, to a lesser extent, associated with a risk of parental separation.

## KEYWORDS

divorce, midwife, parenthood, pregnancy, transition

## 1 | INTRODUCTION

Becoming a parent actualizes existential reflections on the meaning of life (Prinds et al., 2014). The transition is an overwhelming life event (Barimani et al., 2017) and poses a challenge to the parental-couple relationship (Deave et al., 2008). The person who undergoes a transition to parenthood tends to be more exposed, and pregnancy can make the parental-couple vulnerable (Meleis et al. 2000). First-time parents report stronger ties to the partner and more conversations and thoughts on how life together has changed after the first child's birth (Prinds et al., 2018). Questions related to existentially changing experiences are not prioritized in maternity services since biomedical issues are predominant

(Prinds et al., 2014). Besides, little is known about changes in existential dimensions of health when becoming a parent (Brandel et al., 2018), even though childbearing touches the most fundamental dimensions of human existence (Hall, 2006). Sigurdson (2016) defines “existential health” as an all-encompassing aspect of health since it pertains all of human existence, along with the physical as well as the mental and social.

## 2 | BACKGROUND

Parents are described as unaware and surprised by changes in their parental-couple relationships and wish more information on these

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changes before becoming parents (Deave et al., 2008). Facilitating factors in the transition to parenthood are experiencing social support, receiving professional support and viewing parenting as a normal part of life. Simultaneously, hindering factors are losing control, stress, unrealistic expectations of parenthood and unpreparedness for reality (Barimani et al., 2017).

The separation rate is higher in parents to younger children (except for 0-years-old-children) and lower in parents to older children (Statistics, 2018), with the rate peaking when the first child is 1.5 years old (Ahlborg et al., 2005). In 2-year-old Swedish children, 4.1% have parents who separated during the year 2019 (Statistics Sweden, 2020). Factors associated with separation are lack of intimacy, stressful conditions, parenthood strains, poor communication and no commitment (Hansson & Ahlberg, 2016).

Antenatal parental classes could be facilitating factors to parental transition (Barimani et al., 2017). These are offered in many countries worldwide to prepare expectant parents for childbirth and parenthood (Pålsson et al. 2019) and most frequently are provided by nurses, midwives and physicians (Bryanton et al., 2013). The arrangement of parental classes is commonly based on professionals' conceptions rather than expectant parents' needs (Gagnon & Sandall, 2007) and expectations (Pålsson et al., 2019), such as information on parenting skills and changes in their relationship (Afua Entsieh & Kristensson Hallström, 2016). Moreover, research has shown that it is challenging to measure parental classes' usefulness due to different aims and content. Also, antenatal parental classes' effects are relatively unknown (Gagnon & Sandall, 2007).

Midwives report that women's impact on a trusting relationship with the midwife influences how much information women disclose, which allows a needs-led and enhanced, holistic care (Rayment-Jones et al., 2020). In the early postnatal period, women's ability to connect with the midwives is helping in getting through barriers and successfully transitioning to motherhood (Walker et al., 2019).

In a movement toward health sense of coherence (SOC) makes it easier and is also decisive (Antonovsky, 1996). The salutogenic model is considered useful for all healthcare fields, particularly for health promotion (Antonovsky, 1996), covering a broad perspective of health (Olsson et al., 2006). Research shows that SOC is associated with emotional health and socio-demographical background (Hildingsson, 2017) and the family (Antonovsky & Sourani, 1988). An example that seems to be a description of different ends of comprehensibility, relations and behaviour of close relations can be structured and cohesive and disordered, unexpected, and inexplicable. Rising demands can be conquered by utilizing available resources to relate to the family and close relations behaviour (Olsson et al., 2006). In a parent's everyday life, social support (from family, friends or significant others) may help parents keep a high SOC that could raise health at the individual, group and societal level (Ahlborg et al., 2013). Social support describes a relationship between individuals and is useful as a buffer (Zimet et al. 1988). Social support is identified as a factor influencing how the transition is experienced (Darvill et al., 2010). The QDR36 decreases between pregnancy until 6 months after birth, and a higher amount of social support is

associated with a higher QDR36 in first-time mothers and partners (Bäckström et al., 2018).

The transition to parenthood is a significant life experience that can cause one to reflect on the meaning of life and change parents' views of life. It offers an opportunity for personal development where parents can adapt to new roles. Despite the transition's inherent potential for change, little is known about existential health changes when becoming a parent. Healthcare professionals need to increase their knowledge about parental-couple separation factors and enable parents to reflect on their existential health. Therefore, this study aimed to evaluate factors associated with parental-couple separation during the transition to parenthood.

### 3 | METHOD

#### 3.1 | Design

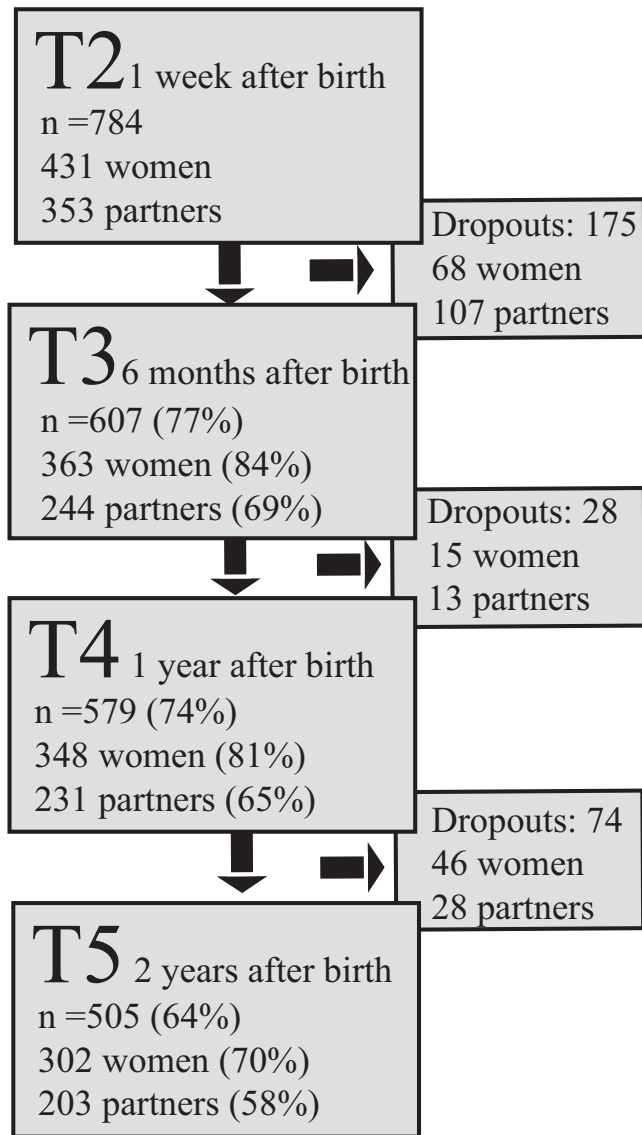
This study forms part of a larger research project, "The Study of Parental Support," a longitudinal cohort study of 918 parents consisting of qualitative and quantitative research focusing on parental support (Bäckström et al., 2018, 2020; Bäckström, Larsson, et al., 2017; Bäckström et al., 2016; Bäckström, Thorstensson, et al., 2017). The larger research project's overall aim is to evaluate first-time mothers' and partners' perceptions of professional parental support during childbearing. Data were collected through web-based questionnaires in the survey tool EvaSys (Evaluation System) (Figure 1). The recruitment was performed during a specific period, and thereby, the participants were selected consecutively (Bäckström, 2018).

Participants to this current study were drawn from the quantitative part of "The Study of Parental Support," and the present study forms stand-alone research with quantitative data. All participants in the entire sample chose to answer the web-based questionnaires in Eva-Sys except for two participants who received and returned the postal questionnaire and responses.

#### 3.2 | Sample and recruitment

Recruitment was performed from 2014–2016 in a southwestern county in Sweden. The setting is representative of the ordinary Swedish population because residents there are both rural and suburban. The number of inhabitants in the county is 280,000. Every year, there are about 2,700 births in the county's only hospital that includes a labour ward.

Inclusion criteria were Swedish-speaking, first-time mothers (referred to as women) and partners expecting or who had given birth to a single infant. In Sweden, ante- and postnatal care consists of midwifery-lead units and child-health services led by child-health nurses. Parental preparatory professional support is provided to expecting parents by midwives through traditional parental classes. Expectant parents are invited to participate in parental groups arranged four to six times during pregnancy. Besides this, parents are provided parental preparatory professional support by midwives



**FIGURE 1** Flow chart of Longitudinal Study, with response rate presented in n and (%): T2 = First week after childbirth; T3 = 6 months after childbirth; T4 = 1 year after childbirth; T5 = 2 years after childbirth

through a large group parental class, "Inspirational Lecture" (IL). The IL aims to support future parents preparing mentally for their child's birth by using humour. The informative support in IL is brought about by different pedagogical aspects such as drama and role-playing (Bäckström et al., 2020).

Participants were recruited by midwives in antenatal care (T1) and postnatal care the first week after birth (T2). After accepting participation, participants received a hyperlink to the web-based questionnaires in the survey tool EvaSys.

### 3.3 | Data collection

The study data were collected at four stages: T2 = 1 week; T3 = 6 months; T4 = 1 year; and T5 = 2 years after birth. A

presentation of the number of participants and each questionnaire's response rate, including the stages of time (T), are presented (Figure 1).

Participants that did not fill out the questionnaire received up to three reminders for each time point (T2–T5). The current study included questions related to sociodemographic factors, professional preparatory support, and three different validated measurements: (a) Sense of Coherence (SOC-13) (Antonovsky, 1996), (b) The Multidimensional Scale of Perceived Social Support (MSPSS) (Ekbäck et al., 2013) and (c) Perceived Quality of Parental-Couple Relationship (QDR36) (Ahlborg et al., 2005) (Figure 2). All three questionnaires are validated and consist of several dimensions. SOC-13 is a scale composed of 13 items. Each item scores on a Likert scale from 1–7. Summing each item enables scores between 13–91. A higher number on the SOC scale is associated with strong SOC (Antonovsky, 1993). SOC entails a general position on the world, conceiving it as manageable, meaningful and comprehensible, which correspond to the three dimensions of SOC-13. The instrument does not depend on culture. Thereby what is essential is life experience, which leads to strong SOC (Antonovsky, 1996). The SOC-13 instrument is validated on pregnant women (Ferguson et al., 2016).

Multidimensional Scale of Perceived Social Support aims to assess perceived Social Support (Zimet et al., 1988) and contains the three dimensions family, friends and significant others. These are covered by 12 items like *My family really tries to help me*, and: *I have friends with whom I can share happiness and sorrow*. Each item is ranged on a Likert scale from 1–7, whereas 1 = very strongly disagree; 7 = very strongly agree. One dimension includes scores between 4–28. All dimensions' scores are summed up and range between 12–84, where a higher score indicates a higher perceived social support. The MSPSS is translated, adapted and evaluated for use in Swedish contexts (Ekbäck et al., 2013).

QDR36 is a modified version (Ahlborg, Persson, et al., 2005) of the Dyadic Adjustment Scale (DAS) instrument (Spanier, 1976) and evaluates first-time parents' perceived quality of the parental-couple relationship the QDR36 was validated on first-time parents 6 months after birth (Ahlborg, Persson, et al., 2005), on parents and non-parents (Gudjonsdottir et al., 2020) and contains 36 questions. The five different dimensions in QDR36 are *Consensus*, *Cohesion*, *Satisfaction*, *Sensuality* and *Sexuality*. The *Consensus* dimension includes questions on the partner's agreement in recreation, economy, friends, career decisions, etcetera, and the *Cohesion* dimension covers questions like *How often do you laugh together?* While *Satisfaction* includes questions like *How often do you quarrel?* The *Sensuality* dimension, *How often do you feel like hugging and cuddling with your partner?* and the *Sexuality* dimension, *How often do you feel sexual desire?* (Ahlborg, Persson, et al., 2005). The responses range on a 6-point Likert scale, from 1–6, where 1 = always disagree, and 6 = always agree.

### 3.4 | Data analysis

The statistical analysis was performed with Statistical Package for the Social Sciences (SPSS) version 25. Descriptive statistics

	QUESTIONS		Possible Score range
SOCIODEMOGRAPHIC FACTORS	Age (yrs) Education (yrs) Length of Couple Relationship (yrs) Planned Pregnancy (yes) Separated from the Partner (yes) Perceived Economy (1=Strained; 2=Adequate; 3=Good; 4=Very good)		Possible Score range 1-4
PROFESSIONAL PREPARATORY SUPPORT	Professional Preparatory Support (Inspirational lecture; Traditional Parental Class; Other preparation; No parental class) Experiences of Professional Preparatory Support (Very satisfactory, satisfactory, less satisfactory, inadequate) Attended Professional Preparatory Support with Partner (Yes, totally; Yes, to a large extent; Yes, to a less extent; No; Don't know)		Possible Score range 1-4  Possible Score range 1-5
	ITEMS		
SENSE OF COHERENCE-SOC-13	Comprehensibility (range 5-35) Manageability (range 4-28) Meaningfulness (range 4-28)	7-point Likert Scale from 1-7	The higher score, the higher perceived sense of coherence  Possible Score range 13-91
MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT-MSPSS	Family (range 4-28) Friends (range 4-28) Significant Others (4-28)	7-point Likert Scale from 1-7	The higher score, the higher perceived social support  Possible Score range 12-84
QUALITY OF DYADIC RELATIONSHIP-QDR36	Consensus (range 1-6) Cohesion (range 1-6) Satisfaction (range 1-6) Sensuality (range 1-6) Sexuality (range 1-6)	6-point Likert Scale from 1-6	The higher score, the higher perceived quality of dyadic relationship  Possible Score range 5-30

**FIGURE 2** Sociodemographic Factors, Professional Preparatory Support and validated Instruments used in this study, *Sense of Coherence* (SOC-13)(Antonovsky, 1996) and *Multidimensional Scale of Perceived Social Support* (MSPSS) (Ekbäck et al., 2013; Zimet et al., 1988) and *Quality of Dyadic Relationship* (QDR36) (Ahlborg, Persson, et al., 2005), number of questions or items, named dimensions, type of scale, ranging and index score range. A higher score represents a high; positive perception assessed SOC, MSPSS or QDR, respectively

were conducted to present the participant's socio-demographics (Table 1). As data were considered normally distributed, parametric tests were used. The index and dimensions were calculated for the different measures included. Univariate analyses (Table 2) and multivariate Cox proportional hazard regression analyses (Table 3) were performed to evaluate factors associated with parental-couple separation during the first 2 years after birth, for all participants (total) as well as for women and partners separately. The participants were considered as individuals, and no couple analysis were performed in this study.

For the univariate Cox proportional-hazards model, each variable was analysed separately (Table 2). Variables significantly associated with separation from the univariate analyses' index, mean, and change were included in the multivariate analyses. Factors related to separation in either index, mean or change are presented (Table 2). Results from Cox's proportional-hazards models are presented as standardized values using Z-transformation before analysis to obtain variables at the same level, facilitating the interpretation of the results.  $p$ -values < .05 were considered significant.

### 3.5 | Ethics

The participants were informed both verbally and in written format on study rationale, benefits, and possible risks, also that their answers and participation were treated confidentially. Furthermore, that participation was voluntary and about the right to withdraw participation at any time without explanation. The parents' responses concerning participation were returned to the midwives in sealed envelopes. The parents were ensured that the care they receive would not be affected whether they participated or not (Bäckström, 2018). The Regional Ethical Review Board approved the study in Gothenburg, Sweden (Dnr: 197-14; Dnr T: 623-14).

## 4 | RESULTS

In total, 784 participants (Women  $n = 431$ ; Partners  $n = 353$ ) completed T2 and were eligible for analysis.

One year after birth (T4), six participants had separated, which corresponds to a frequency of 1.0% parental-couple separation

**TABLE 1** Baseline characteristics, QDR36, SOC-13 and MSPSS at different time points (T2–T5), T2 = 1 week, T3 = 6 months; T4 = 1 year; T5 = 2 years

	Total	Women	Partners
	Mean (SD) N = 784	Mean (SD) N = 431	Mean (SD) N = 353
Age	28.9 (5.4)	27.7 (4.2)	30.4 (6.3)
Education (years)	13.6 (2.9)	14.0 (2.9)	13.2 (2.9)
Length of couple relationship at T2	5.2 (3.3)	5.2 (3.2)	5.3 (3.5)
Planned pregnancy (yes), N (%)	600 (1.0)	339 (1.0)	261(1.0)
Separation from the partner (yes)			
Separated at T4, N (%)	6 (1.0%)	4	2
Separated at T5, N (%)	17 (3.4%)	10	7
Perceived economy, range 1–4			
Perceived economy T2	2.9 (0.7)	2.8 (0.7)	3.0 (0.7)
Perceived economy T3	2.6 (0.8)	2.4 (0.7)	2.8 (0.7)
Perceived economy T4	2.4 (0.8)	2.4 (0.8)	2.5 (0.8)
Perceived economy T5	2.8 (0.8)	2.7 (0.8)	2.8 (0.8)
Mean economy T2–T3	2.7 (0.7)	2.6 (0.6)	2.9 (0.6)
Mean economy T2–T4	2.6 (0.6)	2.6 (0.6)	2.8 (0.6)
Mean economy T2–T5	2.8 (0.6)	2.7 (0.6)	2.8 (0.6)
Professional preparatory support			
Large group parental class (IL), N (%)	653 (83.3)	363 (84.2)	290 (82.2)
Traditional parental class, N (%)	507 (64.7)	285 (66.1)	222 (62.9)
No parental class, N (%)	33 (4.2)	18 (4.2)	15 (4.2)
Experiences of professional preparatory support, range 1–4	3.3 (0.7)	3.3 (0.7)	3.2 (0.7)
Professional preparatory support with partner, range 1–4	3.7 (0.6)	3.6 (0.7)	3.8 (0.5)
Sense of coherence (SOC-13)			
SOC-13 index T2, range 13–91	71.6 (10.6)	71.3 (10.8)	72.0 (10.4)
Comprehensibility T2, range 7–35	26.5 (5.0)	26.2 (5.0)	26.9 (4.9)
Manageability T2, range 4–28	21.7 (3.8)	21.5 (3.9)	22.0 (3.6)
Meaningfulness T2, range 4–28	23.3 (3.4)	23.5 (3.4)	23.1 (3.4)
SOC-13 index T3, range 13–91	70.9 (11.7)	70.7 (11.9)	71.1 (11.4)
Comprehensibility T3, range 7–35	26.3 (5.3)	26.1 (5.5)	26.5 (5.1)
Manageability T3, range 4–28	21.6 (4.2)	21.4 (4.4)	22.0 (3.9)
Meaningfulness T3, range 4–28	22.9 (3.7)	23.2 (3.6)	22.6 (3.8)
SOC-13 index T4, range 13–91	70.6 (12.2)	70.3 (12.7)	71.1 (11.6)
Comprehensibility T4, range 7–35	26.3 (5.5)	26.2 (5.7)	26.5 (5.3)
Manageability T4, range 4–28	21.4 (4.4)	21.1 (4.5)	21.8 (4.1)
Meaningfulness T4, range 4–28	22.9 (3.7)	23.0 (3.8)	22.8 (3.5)
SOC-13 index T5, range 13–91	70.3 (12.1)	70.1 (12.4)	70.5 (11.7)
Comprehensibility T5, range 7–35	26.2 (5.4)	25.9 (5.6)	26.7 (5.0)
Manageability T5, range 4–28	21.2 (4.2)	21.0 (4.3)	21.5 (4.1)
Meaningfulness T5, range 4–28	22.8 (3.8)	23.1 (3.8)	22.4 (3.8)
Mean SOC-13 index T2–T3, range 13–91	71.4 (10.2)	71.0 (10.4)	71.8 (10.0)
Mean SOC-13 index T2–T4, range 13–91	71.3 (10.4)	71.1 (10.6)	71.5 (10.0)
Mean SOC-13 index T2–T5, range 13–91	71.1 (10.5)	71.2 (10.6)	70.9 (10.3)
Change in SOC-13 index between T2–T3	0.96 (8.7)	0.32 (8.9)	1.85 (8.3)

(Continues)

TABLE 1 (Continued)

	Total	Women	Partners
	Mean (SD)	Mean (SD)	Mean (SD)
	N = 784	N = 431	N = 353
Change in SOC-13 index between T2-T4	1.12 (9.1)	0.97 (9.2)	1.33 (8.9)
Change in SOC-13 index between T2-T5	1.31 (9.1)	0.90 (9.3)	1.91 (8.8)
Multidimensional scale of perceived social support (MSPSS)			
MSPSS index T2, range 12-84	78.4 (7.9)	79.5 (6.7)	77.1 (8.9)
Family T2, range 4-28	26.1 (3.4)	26.3 (3.3)	25.8 (3.5)
Friends T2, range 4-28	25.0 (4.0)	25.5 (3.7)	24.4 (4.3)
Significant Others T2, range 4-28	27.3 (2.0)	27.6 (1.5)	26.9 (2.5)
MSPSS index T3, range 12-84	73.3 (10.7)	74.7 (10.5)	71.5 (10.8)
Family T3, range 4-28	24.4 (4.4)	24.6 (4.5)	24.0 (4.3)
Friends T3, range 4-28	23.2 (4.7)	23.6 (4.9)	22.6 (4.5)
Significant others T3, range 4-28	25.9 (3.3)	26.5 (2.9)	25.0 (3.7)
MSPSS index T4, range 12-84	72.6 (11.8)	73.6 (11.5)	71.1 (12.1)
Family T4, range 4-28	24.1 (4.7)	24.2 (4.9)	23.8 (4.5)
Friends T4, range 4-28	23.0 (5.0)	23.4 (5.0)	22.4 (5.0)
Significant Others T4, range 4-28	25.5 (3.8)	25.9 (3.5)	24.9 (4.1)
MSPSS index T5, range 12-84	71.4 (12.3)	72.7 (12.0)	69.6 (12.5)
Family T5, range 4-28	23.7 (4.9)	23.9 (5.0)	23.3 (4.7)
Friends T5, range 4-28	22.7 (5.0)	23.1 (4.9)	22.1 (5.1)
Significant others T5, range 4-28	25.1 (4.0)	25.7 (3.6)	24.2 (4.5)
Mean MSPSS index T2-T3, range 12-84	76.0 (8.3)	77.2(7.7)	74.4 (8.7)
Mean MSPSS index T2-T4, range 12-84	75.0 (8.9)	76.1 (8.5)	73.4 (9.3)
Mean MSPSS index T2-T5, range 12-84	74.2 (9.3)	75.2 (9.2)	72.7 (9.4)
Change in MSPSS index between T2-T3	5.1 (8.0)	4.5 (7.7)	5.9 (8.4)
Change in MSPSS index between T2-T4	6.0 (9.1)	5.7 (8.7)	6.5 (9.5)
Change in MSPSS index between T2-T5	7.0 (9.5)	6.5 (9.2)	7.8 (10.0)
Quality of dyadic relationship (QDR36)			
QDR36 index T2, range 5-30	25.3 (2.1)	25.4 (2.1)	25.2 (2.1)
Dyadic consensus T2, range 1-6	5.3 (0.5)	5.3 (0.5)	5.3 (0.5)
Dyadic cohesion T2, range 1-6	5.2 (0.7)	5.3 (0.7)	5.2 (0.7)
Dyadic satisfaction T2, range 1-6	5.3 (0.4)	5.3 (0.4)	5.3 (0.4)
Dyadic sensuality T2, range 1-6	5.5 (0.6)	5.5 (0.6)	5.4 (0.6)
Dyadic sexuality T2, range 1-6	4.0 (0.7)	4.0 (0.7)	4.0 (0.7)
QDR36 index T3, range 5-30	23.9 (2.6)	25.4 (2.0)	25.2 (2.1)
Dyadic consensus T3, range 1-6	5.1 (0.5)	5.3 (0.5)	5.3 (0.5)
Dyadic cohesion T3, range 1-6	4.8 (0.8)	5.2 (0.7)	5.2 (0.7)
Dyadic satisfaction T3, range 1-6	5.0 (0.6)	5.3 (0.4)	5.3 (0.4)
Dyadic sensuality T3, range 1-6	5.1 (0.8)	5.5 (0.6)	5.4 (0.6)
Dyadic sexuality T3, range 1-6	3.9 (0.8)	4.0 (0.7)	4.0 (0.7)
QDR36 index T4, range 5-30	23.7 (2.8)	23.9 (2.6)	23.9 (2.7)
Dyadic consensus T4, range 1-6	5.1 (0.5)	5.1 (0.5)	5.1 (0.5)
Dyadic cohesion T4, range 1-6	4.7 (0.8)	4.8 (0.8)	4.8 (0.8)
Dyadic satisfaction T4, range 1-6	5.0 (0.6)	5.0 (0.6)	5.1 (0.6)

(Continues)

TABLE 1 (Continued)

	Total	Women	Partners
	Mean (SD)	Mean (SD)	Mean (SD)
	N = 784	N = 431	N = 353
Dyadic sensuality T4, range 1–6	5.0 (0.8)	5.1 (0.8)	5.1 (0.8)
Dyadic sexuality T4, range 1–6	3.9 (0.7)	3.9 (0.8)	3.8 (0.8)
QDR36 index T5, range 5–30	23.3 (2.9)	23.7 (2.8)	23.8 (2.7)
Dyadic consensus T5, range 1–6	5.1 (0.6)	5.1 (0.6)	5.1 (0.5)
Dyadic cohesion T5, range 1–6	4.6 (0.9)	4.7 (0.8)	4.8 (0.8)
Dyadic satisfaction T5, range 1–6	4.9 (0.6)	4.9 (0.6)	5.0 (0.5)
Dyadic sensuality T5, range 1–6	4.8 (0.9)	5.0 (0.8)	5.0 (0.8)
Dyadic sexuality T5, range 1–6	3.8 (0.7)	3.9 (0.7)	3.8 (0.7)
Mean QDR36 index T2–T3, range 5–30	24.6 (2.2)	24.7 (2.1)	24.5 (2.3)
Mean QDR36 index T2–T4, range 5–30	24.4 (2.2)	24.4 (2.2)	24.3 (2.3)
Mean QDR36 index T2–T5, range 5–30	24.2 (2.3)	24.3 (2.2)	24.1 (2.4)
Change in QDR36 index between T2–T3	1.4 (2.0)	1.4 (2.0)	1.4 (1.9)
Change in QDR36 index between T2–T4	1.6 (2.1)	4.3 (2.6)	1.6 (1.7)
Change in QDR36 index between T2–T5	2.1 (2.1)	2.1 (2.3)	2.1 (1.9)

among women and partners. Two years after birth (T5), 17 participants had separated from their partners, which corresponds to a frequency of 3.4%.

Parental-couple separation was significantly greater for those women and partners with a lower SOC-13 index at T2, T3, T4 and T5, a lower MSPSS index at T2, T3 and T4, and a lower QDR36 index at T3, T4 and T5. Further, attending professional preparatory support with a partner and attending the IL was, to a lesser extent, associated with a risk of parental-couple separation (Table 2).

When analysing the *mean* index at different time points (T2 and T3; T2 and T4; T2 and T5), a lower mean score was significantly associated with parental-couple separation for SOC-13 MSPSS and QDR36 (Table 2). A larger *change* in index between different time points (T2 and T3, and T2 and T5) was significantly associated with parental-couple separation for SOC-13 and QDR36 (Table 2).

In the multivariate analysis, attending professional preparatory support with a partner was, to a greater extent, associated with a lower risk of separation at T2, T3 and T4 (Table 3) for women and in total. Attending IL at T3 and T4 lowered the risk of separation for partners. There was no statistical significance in SOC-13 for partners at T2, T3, T4 nor at T5. A higher value in SOC-13 for women at T2 indicated a lower risk of separation. No significant associations were found for social support (MSPSS). A higher value in QDR36 for women at T3 and T5 indicates a lower risk of separation. QDR36 was significant at T5 for women and in total (Table 3).

## 5 | DISCUSSION

Our results reveal that various factors are associated with parental-couple separation during the transition to parenthood.

Those factors are related to the parents' SOC-13, MSPSS and QDR36. The results also show the importance of receiving professional support and that not attending professional support with a partner is significantly associated with parental-couple separation. The reflexive relation to "experienced health," as Sigurdson (2016) labeled existential health, is during the transition to parenthood a complex and appropriate aspect of health, enabling new horizons in professionals' meeting with parents, identifying both inner and outer resources. Our results are interpreted as complex and are related to the identified inner (SOC-13 and experience of meaningfulness) and outer resources (QDR36, social- and professional support) of the parentalcouple.

Connecting to the inner resource in SOC-13, our results show significant associations regarding manageability for women (T3, T4), indicating a woman's ability to utilize her resources sufficiently when encountering challenges (Lindström & Eriksson, 2005). Our results further reveal that the inner resources, that is a larger change in SOC-13, were significantly associated with parental-couple separation for partners (T3, T5). The item of meaningfulness in SOC-13 is considered comparable with existential meaning (Abrahamsson & Ejlertsson, 2002) and suggested as interfering with existential health. Our results reveal that lower SOC-13 scores at all time points were associated with separation for the participants in total (women and partners). Our results align with those of Hildingsson (2017), which show that women's attitudes toward pregnancy and birth, all related to SOC-13 scores, where lower SOC-13 scores are revealed in women lacking partner support.

However, the current study has not specifically explored different types of partner support. Further research is needed to increase knowledge of which partner support lacks when separation occurs

**TABLE 2** Univariate Cox Proportional Hazards Regression of Separation at different time points (T2, T3, T4, T5)

	Total	Women	Partners
	HR (95 % CI)	HR (95 % CI)	HR (95 % CI)
Age (yrs.)	1.03 (0.63–1.69)	0.95 (0.42–2.17)	1.07 (0.57–2.01)
Education (yrs.)	0.88 (0.52–1.50)	0.93 (0.47–1.84)	0.82 (0.36–1.87)
Length of couple relationship at T2 (yrs.)	1.06 (0.51–2.19)	1.23 (0.48–3.14)	0.89 (0.27–2.91)
Planned pregnancy (1=yes)	0.78 (0.37–1.65)	0.97 (0.45–2.08)	0.29 (0.01–14.39) <sup>a</sup>
Perceived economy			
Perceived economy T2	0.71 (0.45–1.14)	0.66 (0.36–1.20)	0.82 (0.39–1.74)
Perceived economy T3	0.96 (0.60–1.56)	0.72 (0.38–1.34)	1.60 (0.68–3.79)
Perceived economy T4	0.64 (0.38–1.09)	0.67 (0.34–1.33)	0.61 (0.27–1.39)
Perceived economy T5	0.75 (0.44–1.28)	0.87 (0.44–1.73)	0.58 (0.24–1.38)
Mean economy T2–T3	0.80 (0.50–1.29)	0.65 (0.36–1.20)	1.16 (0.50–2.66)
Mean economy T2–T4	0.70 (0.42–1.15)	0.65 (0.34–1.24)	0.78 (0.35–1.76)
Mean economy T2–T5	0.77 (0.44–1.34)	0.78 (0.39–1.54)	0.77 (0.30–2.01)
Professional preparatory support (1=yes)			
Large group parental class (IL)	0.70 (0.48–1.04)	0.85 (0.47–1.51)	<b>0.57 (0.32–0.99)<sup>*</sup></b>
Traditional parental class	1.01 (0.63–1.63)	1.09 (0.57–2.07)	0.93 (0.46–1.92)
No parental class	1.10 (0.73–1.64)	0.54 (0.02–12.44)	1.29 (0.84–1.98)
Experiences of professional preparatory support	0.79 (0.52–1.22)	0.85 (0.47–1.55)	0.72 (0.39–1.32)
Professional preparatory support with partner	<b>0.70 (0.50–0.96)<sup>*</sup></b>	<b>0.63 (0.44–0.91)<sup>**</sup></b>	1.11 (0.38–3.22)
T2 1 week after birth			
SOC-13 index T2	<b>0.62 (0.41–0.93)<sup>*</sup></b>	<b>0.43 (0.26–0.71)<sup>***</sup></b>	1.20 (0.54–2.67)
Comprehensibility T2	0.69 (0.45–1.06)	<b>0.40 (0.22–0.73)<sup>**</sup></b>	1.65 (0.68–4.01)
Manageability T2	<b>0.64 (0.44–0.95)<sup>*</sup></b>	<b>0.52 (0.33–0.83)<sup>**</sup></b>	0.99 (0.46–2.14)
Meaningfulness T2	0.69 (0.44–1.07)	0.60 (0.35–1.04)	0.88 (0.42–1.86)
T3 6 months after birth			
SOC-13 index T3	<b>0.54 (0.36–0.80)<sup>**</sup></b>	<b>0.47 (0.28–0.77)<sup>**</sup></b>	0.67 (0.35–1.29)
Comprehensibility T3	<b>0.63 (0.42–0.95)<sup>*</sup></b>	<b>0.52 (0.31–0.87)<sup>**</sup></b>	0.89 (0.41–1.94)
Manageability T3	<b>0.45 (0.31–0.67)<sup>***</sup></b>	<b>0.41 (0.25–0.66)<sup>***</sup></b>	0.53 (0.27–1.02)
Meaningfulness T3	<b>0.61 (0.40–0.92)<sup>*</sup></b>	0.60 (0.34–1.04)	0.62 (0.33–1.15)
T4 1 year after birth			
SOC-13 index T4,	<b>0.55 (0.36–0.84)<sup>**</sup></b>	<b>0.47 (0.28–0.80)<sup>**</sup></b>	0.73 (0.35–1.56)
Comprehensibility T4	<b>0.61 (0.40–0.94)<sup>*</sup></b>	<b>0.51 (0.30–0.87)<sup>*</sup></b>	0.85 (0.40–1.83)
Manageability T4	<b>0.44 (0.29–0.67)<sup>***</sup></b>	<b>0.35 (0.20–0.63)<sup>***</sup></b>	0.58 (0.30–1.14)
Meaningfulness T4	0.74 (0.47–1.17)	0.67 (0.39–1.15)	0.91 (0.40–2.09)
T5 2 years after birth			
SOC-13 index T5	<b>0.50 (0.31–0.81)<sup>**</sup></b>	<b>0.52 (0.30–0.92)<sup>*</sup></b>	0.47 (0.19–1.20)
Comprehensibility T5	<b>0.55 (0.35–0.88)<sup>**</sup></b>	0.60 (0.34–1.04)	0.47 (0.20–1.14)
Manageability T5	<b>0.50 (0.31–0.82)<sup>**</sup></b>	<b>0.41 (0.22–0.75)<sup>**</sup></b>	0.82 (0.33–2.05)
Meaningfulness T5	0.69 (0.42–1.15)	0.65 (0.35–1.21)	0.76 (0.31–1.82)
Mean			
Mean SOC-13 index T2–T3	<b>0.52 (0.35–0.78)<sup>***</sup></b>	<b>0.37 (0.21–0.63)<sup>***</sup></b>	0.87 (0.41–1.84)
Mean SOC-13 index T2–T4	<b>0.53 (0.35–0.80)<sup>**</sup></b>	<b>0.37 (0.21–0.67)<sup>***</sup></b>	0.83 (0.40–1.74)
Mean SOC-13 index T2–T5	<b>0.47 (0.28–0.77)<sup>**</sup></b>	<b>0.37 (0.20–0.72)<sup>**</sup></b>	0.69 (0.27–1.77)
Change			
Change in SOC-13 index between T2–T3	<b>1.68 (1.05–2.67)<sup>*</sup></b>	1.32 (0.68–2.54)	<b>2.33 (1.15–4.74)<sup>*</sup></b>

(Continues)



TABLE 2 (Continued)

	Total	Women	Partners
	HR (95 % CI)	HR (95 % CI)	HR (95 % CI)
Change in SOC-13 index between T2-T4	1.45 (0.90–2.34)	1.23 (0.63–2.40)	1.81 (0.87–3.74)
Change in SOC-13 index between T2-T5	1.62 (0.98–2.66)	1.01 (0.48–2.09)	<b>2.50 (1.36–4.61)**</b>
<b>T2 1 week after birth</b>			
MSPSS index T2	<b>0.62 (0.43–0.87)**</b>	<b>0.55 (0.36–0.82)**</b>	0.77 (0.41–1.42)
Family T2	<b>0.69 (0.53–0.89)**</b>	0.73 (0.52–1.02)	<b>0.59 (0.37–0.95)*</b>
Friends T2	<b>0.69 (0.47–0.99)*</b>	<b>0.52 (0.32–0.84)**</b>	1.01 (0.51–1.98)
Significant Others T2	0.80 (0.63–1.01)	<b>0.78 (0.62–0.98)*</b>	1.09 (0.41–2.85)
<b>T3 6 months after birth</b>			
MSPSS index T3	<b>0.56 (0.38–0.81)**</b>	<b>0.59 (0.36–0.94)*</b>	<b>0.52 (0.28–0.97)*</b>
Family T3	<b>0.59 (0.43–0.83)**</b>	<b>0.62 (0.39–0.99)*</b>	<b>0.58 (0.36–0.92)*</b>
Friends T3	<b>0.64 (0.43–0.95)*</b>	0.65 (0.41–1.03)	0.61 (0.28–1.35)
Significant Others T3	<b>0.68 (0.50–0.93)*</b>	0.69 (0.44–1.07)	0.66 (0.41–1.06)
<b>T4 1 year after birth</b>			
MSPSS index T4	<b>0.60 (0.40–0.90)*</b>	0.70 (0.41–1.20)	<b>0.47 (0.24–0.90)*</b>
Family T4	0.70 (0.48–1.02)	0.85 (0.50–1.45)	<b>0.55 (0.32–0.94)*</b>
Friends T4	0.67 (0.43–1.05)	0.69 (0.39–1.25)	0.64 (0.32–1.31)
Significant Others T4	<b>0.53 (0.38–0.75)***</b>	<b>0.58 (0.37–0.91)*</b>	<b>0.46 (0.26–0.81)**</b>
<b>T5 2 years after birth</b>			
MSPSS index T5	0.72 (0.44–1.19)	0.71 (0.39–1.27)	0.74 (0.30–1.81)
Family T5	0.77 (0.47–1.24)	0.78 (0.44–1.39)	0.72 (0.30–1.72)
Friends T5	0.76 (0.44–1.29)	0.74 (0.39–1.37)	0.79 (0.28–2.23)
Significant Others T5	0.74 (0.47–1.18)	0.67 (0.37–1.21)	0.80 (0.37–1.74)
<b>Mean</b>			
Mean MSPSS index T2–T3	<b>0.56 (0.40–0.78)***</b>	<b>0.54 (0.36–0.80)**</b>	0.61 (0.34–1.10)
Mean MSPSS index T2–T4	<b>0.55 (0.38–0.80)**</b>	<b>0.59 (0.36–0.97)*</b>	<b>0.49 (0.26–0.93)*</b>
Mean MSPSS index T2–T5	<b>0.56 (0.35–0.89)*</b>	0.57 (0.32–1.00)	0.55 (0.25–1.25)
<b>Change</b>			
Change in MSPSS index between T2-T3	1.35 (0.86–2.15)	0.99 (0.51–1.94)	1.92 (0.998–3.71)
Change in MSPSS index between T2-T4	1.23 (0.78–1.95)	0.86 (0.41–1.80)	1.74 (0.94–3.21)
Change in MSPSS index between T2-T5	0.99 (0.56–1.74)	0.92 (0.45–1.88)	1.13 (0.44–2.95)
<b>T2 1 week after birth</b>			
QDR index T2	0.82 (0.45–1.47)	0.46 (0.21–1.04)	1.58 (0.58–4.34)
Dyadic Consensus T2	0.80 (0.55–1.15)	0.75 (0.52–1.08)	1.05 (0.43–2.60)
Dyadic Cohesion T2	<b>0.50 (0.32–0.78)**</b>	<b>0.36 (0.19–0.69)**</b>	0.70 (0.36–1.36)
Dyadic Satisfaction T2	<b>0.57 (0.37–0.88)*</b>	<b>0.50 (0.29–0.86)*</b>	0.69 (0.33–1.42)
Dyadic Sensuality T2	0.90 (0.55–1.47)	0.63 (0.34–1.16)	1.45 (0.59–3.56)
Dyadic Sexuality T2	1.24 (0.71–2.16)	0.90 (0.41–1.93)	1.81 (0.77–4.27)
<b>T3 6 months after birth</b>			
QDR36 index T3	<b>0.45 (0.28–0.72)***</b>	<b>0.34 (0.18–0.62)***</b>	0.65 (0.30–1.42)
Dyadic Consensus T3	<b>0.56 (0.41–0.78)***</b>	<b>0.50 (0.35–0.71)***</b>	0.80 (0.37–1.73)
Dyadic Cohesion T3	<b>0.42 (0.27–0.68)***</b>	<b>0.30 (0.16–0.55)***</b>	0.67 (0.33–1.35)
Dyadic Satisfaction T3	<b>0.43 (0.28–0.65)***</b>	<b>0.35 (0.20–0.60)***</b>	0.55 (0.28–1.06)
Dyadic Sensuality T3	0.76 (0.47–1.23)	0.55 (0.29–1.02)	1.16 (0.53–2.52)
Dyadic Sexuality T3	0.63 (0.36–1.10)	0.62 (0.28–1.38)	0.64 (0.29–1.42)

(Continues)

TABLE 2 (Continued)

	Total	Women	Partners
	HR (95 % CI)	HR (95 % CI)	HR (95 % CI)
T4 1 year after birth			
QDR36 index T4	<b>0.44</b> (0.28–0.70) <sup>***</sup>	<b>0.39</b> (0.22–0.69) <sup>***</sup>	0.54 (0.24–1.21)
Dyadic Consensus T4	<b>0.51</b> (0.35–0.73) <sup>**</sup>	<b>0.51</b> (0.33–0.78) <sup>**</sup>	0.45 (0.18–1.12)
Dyadic Cohesion T4	<b>0.53</b> (0.30–0.91) <sup>†</sup>	<b>0.42</b> (0.21–0.83) <sup>†</sup>	0.79 (0.31–2.04)
Dyadic Satisfaction T4	<b>0.40</b> (0.26–0.62) <sup>***</sup>	<b>0.37</b> (0.21–0.64) <sup>***</sup>	<b>0.44</b> (0.20–0.96) <sup>†</sup>
Dyadic Sensuality T4	0.65 (0.39–1.08)	0.54 (0.28–1.02)	0.85 (0.38–1.92)
Dyadic Sexuality T4	<b>0.50</b> (0.28–0.89) <sup>†</sup>	0.49 (0.23–1.07)	0.52 (0.22–1.23)
T5 2 years after birth			
QDR36 index T5	<b>0.35</b> (0.21–0.58) <sup>***</sup>	<b>0.28</b> (0.16–0.50) <sup>***</sup>	0.84 (0.26–2.73)
Dyadic Consensus T5	<b>0.39</b> (0.26–0.57) <sup>***</sup>	<b>0.34</b> (0.22–0.54) <sup>***</sup>	0.82 (0.24–2.83)
Dyadic Cohesion T5	<b>0.48</b> (0.24–0.95) <sup>†</sup>	<b>0.38</b> (0.17–0.84) <sup>†</sup>	0.86 (0.27–2.78)
Dyadic Satisfaction T5	<b>0.42</b> (0.30–0.59) <sup>***</sup>	<b>0.39</b> (0.26–0.56) <sup>***</sup>	0.88 (0.27–2.81)
Dyadic Sensuality T5	<b>0.32</b> (0.17–0.59) <sup>***</sup>	<b>0.26</b> (0.12–0.57) <sup>***</sup>	0.47 (0.15–1.46)
Dyadic Sexuality T5	0.69 (0.35–1.34)	<b>0.42</b> (0.19–0.95) <sup>†</sup>	1.84 (0.55–6.19)
Mean			
Mean QDR36 index T2–T3	0.76 (0.36–1.59)	0.43 (0.12–1.54)	1.06 (0.42–2.72)
Mean QDR36 index T2–T4	0.47 (0.22–1.02)	<b>0.07</b> (0.01–0.74) <sup>†</sup>	0.86 (0.30–2.49)
Mean QDR36 index T2–T5	<b>0.21</b> (0.06–0.68) <sup>**</sup>	0.05 (0.001–2.28)	0.29 (0.06–1.48)
Change			
Change in QDR36 index between T2–T3	<b>2.25</b> (1.27–4.00) <sup>**</sup>	<b>2.71</b> (1.12–6.54) <sup>†</sup>	1.96 (0.85–4.51)
Change in QDR36 index between T2–T4	1.81 (0.93–3.51)	2.03 (0.88–4.65)	1.58 (0.42–5.93)
Change in QDR36 index between T2–T5	<b>3.28</b> (1.49–7.24) <sup>**</sup>	2.82 (0.88–9.06)	<b>3.51</b> (1.22–10.07) <sup>†</sup>

Note: Standardized Values presented—HR-values with a significant *p*-value, marked in bold.

<sup>a</sup>Did not converge.

\**p*-value ≤ .05.

\*\**p*-value ≤ .01.

\*\*\**p*-value ≤ .001.

during the first 2 years after birth. On the other hand, women discontented with partner support are more likely to separate during the first year after birth (Hildingsson et al., 2008). Likewise, women find it frustrating having to ask for help, describing resentment toward their partner (Ayers et al., 2019).

It is known from earlier studies that more confidence in parenthood is related to a strong SOC (Ahlborg et al., 2013). When a person has a strong SOC, it provides inner resources (motivational, thoughtful, and behavioural) to solve emotional and instrumental problems caused by stressors. These stressors pose problems, meaning that the person with a strong SOC has confidence in managing those problems, seeking appropriate available inner resources. Besides, with motivation, the person views the stressor as a challenge that adds an inner resource (Antonovsky & Sourani, 1988).

Prinds et al. (2018) describe the motherhood transition as a significant partnership-relation transformer that interferes with existential meaning-making in parental relationships. The existential meaning-making is described as a feeling of connectedness, together with the partner, with something greater than oneself.

Moreover, it refers to a sense of being part of a bigger relational unit, including a child or a change in the existential fundamentals of life with their partner. Staneva et al. (2016) argue that psychosocial interventions would be particularly salutary for women during pregnancy to improve SOC by striving for self-care, self-compassion and promoting acceptance. Our results reveal significant associations in the risk of separation for women regarding SOC-13 at T3.

In Swedish society, the mother is often on parental leave (i.e. taking care of the child at home) at 6 months. Parental leave is suggested to enable time for reflection, which enhances the experience of coherence. Motherhood is described as giving rise to the woman's inner dialogue and dialogue with her partner on the life change (Prinds et al., 2018). The women conceive of themselves and their partners through the act of childbearing as being fundamentally transformed from individuals or a couple to founders of a new family (Darvill et al., 2010), and the reflections of the parental couple are suggested to enhance the experience of coherence and enable reflections on experienced health (Sigurdson, 2016).

Index	Total	Women	Partners
	HR (95% CI)	HR (95% CI)	HR (95% CI)
<b>T2 1 week after birth</b>			
Large group parental class (IL)	—	—	0.57 (0.32–1.01)
Professional preparatory support with partner	<b>0.71 (0.51–0.99)<sup>†</sup></b>	<b>0.67 (0.45–0.99)<sup>†</sup></b>	—
SOC-13	0.69 (0.42–1.13)	<b>0.54 (0.31–0.94)<sup>†</sup></b>	1.85 (0.67–5.14)
MSPSS	0.69 (0.44–1.09)	0.70 (0.40–1.22)	0.62 (0.28–1.37)
<b>T3 6 months after birth</b>			
Large group parental class (IL)	—	—	<b>0.46 (0.24–0.88)<sup>†</sup></b>
Professional preparatory support with partner	<b>0.64 (0.43–0.96)<sup>†</sup></b>	<b>0.59 (0.37–0.96)<sup>†</sup></b>	—
SOC-13	0.68 (0.37–1.25)	0.60 (0.28–1.30)	1.31 (0.56–3.02)
MSPSS	0.59 (0.35–1.02)	0.68 (0.35–1.31)	0.45 (0.18–1.12)
QDR 36	0.64 (0.32–1.25)	<b>0.40 (0.16–0.996)<sup>†</sup></b>	0.69 (0.27–1.79)
<b>T4 1 year after birth</b>			
Large group parental class (IL)	—	—	<b>0.37 (0.18–0.74)<sup>**</sup></b>
Professional preparatory support with partner	<b>0.57 (0.38–0.85)<sup>**</sup></b>	<b>0.48 (0.27–0.84)<sup>**</sup></b>	—
SOC-13	0.93 (0.43–2.00)	0.56 (0.22–1.44)	2.85 (0.66–12.28)
MSPSS	0.75 (0.43–1.30)	0.75 (0.39–1.43)	0.54 (0.22–1.33)
QDR 36	0.55 (0.28–1.06)	0.74 (0.32–1.72)	0.42 (0.13–1.33)
<b>T5 2 years after birth</b>			
Large group parental class (IL)	—	—	0.71 (0.26–1.97)
Professional preparatory support with partner	0.83 (0.44–1.58)	0.83 (0.41–1.69)	—
SOC-13	0.83 (0.34–2.03)	1.27 (0.40–4.06)	0.64 (0.20–2.06)
MSPSS	0.75 (0.41–1.38)	0.79 (0.40–1.54)	0.65 (0.19–2.23)
QDR 36	<b>0.34 (0.16–0.71)<sup>**</sup></b>	<b>0.26 (0.10–0.68)<sup>**</sup></b>	1.16 (0.26–5.16)

Note: Standardized values are presented. Large group parental class (IL) (Partners) and attended professional support with partner (Total & Women) are included as constants. HR-values with a significant *p*-value are marked in bold.

<sup>†</sup>*p*-value ≤ .05;

<sup>\*\*</sup>*p*-value ≤ .01;

<sup>\*\*\*</sup>*p*-value ≤ .001.

Our results indicate that midwives must promote SOC and thereby existential health and parents' inner resources, which is in line with Abrahamsson and Ejlertsson (2002), who claims that pregnancy can be seen as a period with high existential meaning. More than that, Ferguson et al. (2016) suggest that midwives working on interventions that aim to strengthen a woman's SOC can enhance women's health outcomes. Further research is needed to learn about parents' needs for fundamental existential reflections in life during the parenthood transition.

Our results reveal that a larger change in the QDR36 index for partners between T2 and T5 was significantly associated with

**TABLE 3** Multivariate Cox proportional hazards regression of separation at different time points (T2, T3, T4, T5)

parental-couple separation. These results are supported by Hansson and Ahlberg (2016) comparing separated and non-separated couples, revealing that the QDR36 index differs significantly at 6 months after birth. In contrast, separated couples show less agreement in different matters and are less satisfied in their relationships.

After birth, partners reported a constant increase in problem intensity (Doss et al., 2009). Tiredness is also a problem, but by mothers to a higher degree than partners (Hansson & Ahlberg, 2016). However, sharing parental leave is associated with higher QDR36 at 18 months after birth in partners but not in mothers, compared with not sharing equally (Lidbeck & Bernhardsson, 2021). Our results

show that a higher value in QDR36 for women (T3, T5) indicates a lower risk of separation. A higher QDR36 is in line with earlier research showing parents being generally satisfied with their intimate relationships 6 months after birth (Ahlborg, Persson, et al., 2005). Our results suggest that midwives highlight the couples' awareness of their inner and outer resources related to dyadic relationships' perceived quality, thereby considering its importance.

Social support from significant others was shown as necessary for both women and partners to avoid separation at T4. This may be due to an expected shift between the parents regarding parental leave. Nowadays, forming a family can occur in large geographical distances from the origin family for both partners due to study and career possibilities. A lack of social support in everyday life can result from living far from relatives (Hansson & Ahlborg, 2016). Social support is significant for young children's parents to experience health (Ahlborg et al., 2013) and adjust successfully to the parenthood transition (Polomeno, 2000).

Our results also reveal that more significant change and lower scores in the MSPSS index (T2–T3) were associated with parental-couple separation. Along with previous research, women in contemporary western society report stressors during the early postpartum period as a lack of support from the child's father, other family members and healthcare professionals (Ayers et al., 2019). Mothers face difficult periods after birth, and contact with other new mothers appears to be an essential form of support for women (Darvill et al., 2010). Additionally, a significant other as a close person to the family is considered an outer resource that can help the parental-couple find balance, feel at ease in their new parental roles and transition to parenthood.

Our results reveal that attending the IL lowered the risk of separation for partners at T3 and T4, supported by Thorstensson et al. (2020). They revealed that participating in IL has a positive effect on QDR36 6 months after birth and that the IL can enhance perceived consensus at T3 and manageability, particularly for partners. Our results suggest that not attending the IL is associated with a greater risk of parental-couple separation. It is known from previous studies (Bäckström et al., 2016; Bäckström, Thorstensson, et al., 2017) that this specific IL successfully involves and captures the partners' roles with a humorous approach. Theisen et al. (2019) argue that especially partners can be helped by humour in communicating emotions or attitudes about parenthood.

In our results, the parents perceived that couple *cohesion* and *satisfaction* are essential factors lowering the risk of separation at all time points for women and, in total, in two different dimensions within QDR36. *Cohesion* regards how often the parental-couple laughs together (Ahlborg, Dahlöf, et al., 2005). Since the IL has a humorous content, participating in the IL could support the dyadic *cohesion* of the couple, which is in line with previous studies by Bäckström et al. (2016), Bäckström, Thorstensson, et al. (2017), revealing that expectant parents benefit from laughing together during the IL, which, in turn, prevents separation which is why midwives'

professional support and, further on, child-healthcare nurses and family counselling units, need to be enabled.

Parental-couple need access to professional support since our study also reveals that not attending professional preparatory support with a partner was, for women, significantly associated with a higher risk of separation. Women want their partners to be as prepared as themselves (Persson et al., 2011), and the importance of including the partner in preparatory support is indicated (Deave et al., 2008). Feelings of belonging and recognition in first-time parents are facilitated when sharing experiences with other expectant parents during pregnancy (Bäckström, Larsson, et al., 2017; Bäckström et al., 2016). Reasons for not participating in parental classes can be either the unavailability of classes or a lack of awareness about the classes (Forslund Frykedal et al., 2019). Many separations occur at 4 years after birth, which indicates the value of further exploration of separations, or cohesion, between parental-couples during the transition to parenthood, in a more longitudinal perspective.

## 5.1 | Limitations and strengths

This current study's strength was its prospective, longitudinal design, which allowed us to follow the parents over a more extended period. Regarding 1 week after childbirth (T2), the first comments of the experience after childbirth may, though, have been coloured by euphoric reactions and relief regarding the birth of the child (Waldenström, 2003).

The parents were followed the first 2 years after birth, and the longitudinal design allowed us to embrace the parental transition. There were a high response rate and a low dropout rate in a setting where economic incentives for midwifery and child healthcare are low.

Our study's limitations were that non-Swedish-speaking parents were excluded; hence, the sample is not fully representative of the pregnant Swedish population.

Furthermore, few parents had separated at 2 years, which is a limitation that can affect the generalizability of the study. The QDR36 instrument is a modified (Ahlborg, Persson, et al., 2005) Dyadic Adjustment Scale (DAS) (Spanier, 1976), the latter used for assessing quality in the dyadic relationship in several hundred studies in various contexts worldwide (Ahlborg, Persson, et al., 2005). Additionally, the QDR36 instrument has its specificity in assessing new first-time parents (Ahlborg, Persson, et al., 2005), which could be a strength. Still, this study's strength comes from the population, with a relatively large number of participants included. The responders to the postal questionnaires may have been more auspicious than non-responders (Waldenström, 2003). The questionnaires might have been subject to reporting bias even when their responses were anonymous if the responder was concerned about social judgment (Van de Mortel, 2008). The use of validated instruments was also a strength in this study.

## 6 | CONCLUSIONS AND CLINICAL IMPLICATIONS

These results suggest the importance of midwives organizing professional preparatory support, including and enabling partners' participation. The findings have implications for the parental-couple and the midwives, who can examine the parental-couples' available social support and emphasize its significance to lower separation risk. Further questions enabling reflection on the transition's existential health experience are *How do you understand your role in child-birth? What does it mean to you to become a parent?* The results of this study serve midwives and child-healthcare nurses to help women and partners to form themselves and prepare to become a family. Furthermore, this report shows the importance of social support, preserving the relationships' quality, and allowing couples to focus on the growing child. Because becoming a parent is an uttermost complex change in life, involving the existential dimension is an all-embracing aspect of health.

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### CONFLICT OF INTEREST

The authors have no conflict of interest.

### AUTHOR CONTRIBUTIONS

ÅGL, CB, and JH: Statistical Analysis. CB: Data Collection. All authors were responsible for the study's manuscript. All authors approved the final version to be published. All authors have discussed and revised the interpretations of the data.

### ETHICAL APPROVAL

The Regional Ethical Review Board approved the study in Gothenburg, Sweden (Dnr: 197-14; Dnr T: 623-14).

### DATA AVAILABILITY STATEMENT

The data set analyzed during the current study is available from the corresponding author on reasonable request.

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