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INTERPARENTAL RELATIONSHIPS AND PARENTAL SELF-EFFICACY DURING TRANSITION TO PARENTHOOD

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Abstract

Introduction. The transition to parenthood constitutes a critical period demanding substantial individual and family adjustments. Parental self-efficacy—the beliefs parents hold about their capacity to perform the parental role—is a fundamental resource for successful adaptation to parenthood. Interparental relationships, particularly couple satisfaction and coparenting, emerge as key relational contexts for its development. However, evidence on how these processes unfold longitudinally in mothers and fathers during the perinatal period remains limited.

Objective. The study assessed the contribution of interparental relationships during the transition to parenthood on parental self-efficacy at 6 months postpartum, evaluated as a general domain and as developmental stage-specific tasks, in both parents.

Method. Participants were 234 Chilean couples assessed at three time points: third trimester of pregnancy, three months postpartum, and six months postpartum. Measures included couple satisfaction (DAS), coparenting (CRS), general-domain (EEP) and task-specific (KPCS) parental self-efficacy, and depressive symptoms (BDI). Sequential mediation models with multigroup analysis for dyadic data and an Actor-Partner Interdependence Model (APIM) were implemented.

Results. Coparenting at three months predicted parental self-efficacy at six months in both parents, with a stronger effect for fathers on task-specific self-efficacy. Coparenting mediated the relationship between prenatal couple satisfaction and postpartum parental self-efficacy, with gender differences in the magnitude. The APIM revealed significant actor effects from coparenting on parental self-efficacy at six month postpartum for both parents, but no partner effects were found.

Discussion. Findings highlight the role of coparenting as a central mechanism in the association between couple satisfaction and parental self-efficacy. The stronger influence on fathers suggests that, in contexts where mothers are the primary caregivers, coparenting constitutes a particularly relevant pathway for developing paternal self-efficacy. Results underscore the importance of interventions that strengthen family processes as a resource for both parents during the perinatal period and include fathers in perinatal care.

Keywords: parental self-efficacy, coparenting, couple satisfaction, transition to parenthood.

1. Introduction

For most people, becoming a parent plays a central role in life and provides a fundamental sense of satisfaction (Ryan & Padilla, 2019). However, this transitional period is inherently disruptive, even when desired and planned (Slade, 2009). The transition to parenthood is a time of adjustment and adaptation for the family. The expectant couple must adapt to new roles, responsibilities and identities. New parents begin to renegotiate their relationship as a couple, both emotionally and practically. Also, this process requires finding and developing nurturing competencies to care for the infant (Raphael-Leff, 2019).

Developmental theories conceive the transition to parenthood as a stage of adulthood that involves a series of developmental tasks for both mothers and fathers (Slade, 2009). This process includes a reorganization of major life roles and a significant shift in identity (Cowan & Cowan, 2012), which entails a substantial investment in the parental self as a core component of identity (Cowan & Cowan, 1992). In this context, parents can greatly benefit from having confidence in their ability to acquire parenting skills and positively influence their infant's development, ultimately adapting to their parental roles successfully.

Parental self-efficacy refers to the set of personal beliefs held by the caregivers about their skills and abilities associated with the parental role. This

cognitive construct reflects how individuals' perceptions of their parental skills influence success in parenting tasks (Coleman et al., 2000). Self-efficacy influences goals, aspirations, outcome expectations, effort, and motivation in performing a certain task (Bandura, 2006; Schuengel & Oosterman, 2019). During the transition to parenthood, parental self-efficacy becomes a particularly salient developmental outcome (Song et al., 2022), as it reflects parents' successful psychological adaptation to the parenting role.

Research on parental self-efficacy in fathers and mothers during the first year of life suggests that the precursors of parental self-efficacy in men and women may be different (Leerkes & Burney, 2007), likely due to the distinct parenting experiences of mothers and fathers during this period. However, the interparental relationship represents a common relational context for both parents and has the potential to enhance parental self-efficacy in mothers and fathers. In the present study, the term interparental relationships will be used to refer to the constructs of couple adjustment and coparenting. Couple adjustment is defined as the subjective satisfaction of the caregivers with their couple relationship (Broderick et al., 2019). Likewise, coparenting constitutes the relationship that parents maintain with each other for the purpose of negotiating their roles, responsibilities, and contributions to raising their offspring, and it's motivated by a mutual desire to promote child well-being (Margolin et al., 2001). Despite the acknowledged potential of interparental relationships to influence the development of parental self-efficacy during the

transition to parenthood, there is a lack of research examining how these relationships are articulated and shape parental self-efficacy within the family system.

The present study addresses the influence of interparental relationships on parental self-efficacy during the transition to parenthood. Given that coparenting is a relationship that aligns more closely with parental roles than the couple bond, it is expected to act as a mechanism through which the couple's relationship impacts parental self-efficacy in both parents. Dyadic analyses (i.e., the actor–partner interdependence model (APIM)) is used to examine how a parent's coparenting experience influences the parental self-efficacy perceived by their partner. This methodological approach accounts for the interdependence of individual characteristics within the parental couple (Hughes & Gullone, 2008).

The findings of the present study contribute to a better understanding of the role of family processes in parental self-efficacy, which is a key component of a positive transition to parenthood for mothers and fathers. Specifically, the findings support the statements of family systems theory (Minuchin, 1985) about how the characteristics of different subsystems influence the characteristics of other subsystems within the family system. Beyond their theoretical relevance, the results can inform interventions aimed at promoting individual, couple, and family well-being during the transition to parenthood.

2. Theoretical Framework

2.1 Transition to parenthood

The transition to parenthood is a stage that starts with conception and lasts until an infant reaches its first birthday. This period of development is especially important in parenting research because the birth of a child and the previous preparation require substantial individual and couple adjustments in order to successfully adapt to the new parental roles (Saxbe et al., 2018; Young et al., 2019) .

Most studies on the transition to parenthood are grounded in theories that emphasize family functioning, as this period involves the expansion of the family and the adaptation of each member to the inclusion of a new child (Kuersten-Hogan & McHale, 2021). To understand the adaptation required during this major transition—including shifts in the inner world, roles, and responsibilities—it is necessary to adopt an ecological perspective that considers other important aspects of family life, which may both influence and shape the transition process itself (Cowan & Cowan, 2012). The impact of the transition to parenthood on the psychological adjustment of individual family members and their relationships makes systemic viewpoints particularly relevant for studying and understanding this period.

According to Minuchin (1974) and his theory of family systems, the family constitutes an open sociocultural system under ongoing transformation. This development happens over the course of various stages that require restructuring to properly adapt to the new circumstances while promoting family continuity and the personal growth of its members. As part of a family system, each member also pertains to different subsystems wherein they have varying levels of power and will also learn specific skills. Each subsystem in the family has certain functions and places particular demands on the individuals. Understanding the family as a system implies looking at it as a complex and integrated whole with interdependent members and relationships. Mutual influences are generated between subsystems, between members, and between members and subsystems (Cox & Paley, 1997; Minuchin, 1974).

The arrival of a child requires a major reorganization of the family system. The homeostatic balance of families is affected during the transition to parenthood, starting even during pregnancy. From this perspective, the goal in this context is to reach a new equilibrium in which the family can adapt to the changing demands of a developing child, who also participates as an individual in the family dynamics (Kuersten-Hogan & McHale, 2021).

New subsystems emerge during the transition to parenthood, with infants and parents performing distinct roles. The couple also takes on many tasks, such as renegotiating relationships with the family of origin and life outside of the family. Parenting often becomes an opportunity to strengthen the family

system and increase the personal growth of its members. However, it can also exacerbate unresolved conflicts between the couple that subsequently impact the new subsystems that form within the family (Minuchin, 1974).

In addition to family system´s theory, specific models have been proposed in the study of becoming and being a parent. For example, Belsky´s (1984) model of parenting determinants, which also highlights the interrelationship between subsystems and family members on parenting; considers the active role of children in their interactions with caregivers and the couple relationship as the most influential contextual factor in the development of the parental role. Consistently, coparenting is seen as a mechanism through which the couple's relationship influence parenting (Gable et al., 1992). The model further considers how parents' life history, developmental stage, mental health, attitudes toward parenting, and personality traits collectively contribute to the enactment of the parenting role. The model also addresses the influence of factors like work and support networks, as they may be sources of support or stress that impact parenting (Belsky, 1984).

The present research is informed by Belsky´s (1984) model for understanding the factors that influence the transition to parenthood for both mothers and fathers. Likewise, some general aspects of broader family systems theory will be considered, such as the interdependence between subsystems and family members (Cox & Paley, 1997).

Given the multiple changes involved in the transition to parenthood, the individual processes that occur during this period will be discussed in greater detail in the next section.

2.1.1 Individual and couple's experience of the transition to parenthood

The birth of a child involves negotiating caregiving roles. Usually, women function as primary caregivers, while fathers´ engagement in caregiving-related activities varies greatly across contexts. In Chile, the Third Longitudinal Survey of Early Childhood notes that 95.8% of mothers function as the primary caregivers, while 75.9% of fathers are considered to be in a secondary caregiving role (Ministerio de Desarrollo Social, 2017). Such data reveal gender differences in parenting roles that are still prevalent in society. Nevertheless, this also shows that in most cases, both mothers and fathers are responsible for childcare. Therefore, it is important to consider how becoming parents and adapting to the new role is experienced by both mothers and fathers.

The transition to parenthood is an inherently disruptive period that involves biological, psychological, social, economic, and behavioral changes for mothers and fathers (Saxbe et al., 2018). From theoretical models of development, the transition to parenthood has been considered as a third critical window of development, preceded by early childhood and adolescence

(Saxbe et al., 2018). Starting in pregnancy, both partners experience biological and physiological changes that help them prepare for their role as parents.

For mothers, changes during the prenatal stage are normative, given their physical condition as pregnant women. For fathers, this depends on their participation and involvement in parenting (Edelstein et al., 2015). During pregnancy, mothers undergo a series of changes in the respiratory, cardiovascular, circulatory, and endocrine systems that enable them to meet the metabolic demands of gestation, thereby creating an environment conducive to both fetal development and the survival of the child and mother (Tan & Tan, 2013). Some of the endocrine changes include increased levels of estradiol, progesterone (Edelstein et al., 2015), and oxytocin, the latter are associated with the formation of emotional bonds (Mayes et al., 2012). Men can experience decreased testosterone when having a child (Grebe et al., 2019), and these changes appear to be more pronounced when the father's involvement is greater (Storey et al., 2020). Likewise, studies on the parental brain have detected a series of modifications in the neural networks that comprise and connect the systems of reward, mentalization, emotional regulation, and the main structures of the limbic system. These changes potentially contribute to caregivers' parenting skills (Feldman, 2015).

On a psychological level, the transition to parenthood involves the development of a parental identity, including representations of oneself as a parent and of the child, as well as the formation of an emotional connection with

the child. It also entails the reorganization of individual identities and the activation and re-evaluation of representations associated with caregivers from childhood (Slade, 2009). These processes allow the anticipation of parental roles and the perception of the baby as distinct from the mother.

Psychological adaptations to parenthood tend to develop more quickly in women than men due to the biological and physiological changes women undergo and the greater social importance of their role, which is often strongly linked to women's self-concept (Kaźmierczak & Karasiewicz, 2019). When the mother is pleased about the pregnancy and views it positively, she generally develops representations of her parental role and the baby in a way that gives rise to pleasurable emotions (Ammaniti & Trentini, 2009).

For expectant fathers, the process of developing parental representations and the bond with the infant is more challenging because the baby's presence is more abstract for them during pregnancy. However, men also develop parental representations during the prenatal period, and these tend to find balance during the transition to parenthood, just as in mothers (Vreeswijk et al., 2015). The prenatal formation of parental representations and emotional bonds in men will be significantly influenced by their desire to be a father, the centrality of fatherhood in their identity, the representations they hold about their own father (Slade, 2009), and the quality of the relationship they have with the baby's mother (Ahlqvist-Björkroth et al., 2016). In this regard, in their qualitative study of men during pregnancy conducted in Chile, Herrera &

Pavicevic (2016) found that the prenatal experience of fathers towards their child was influenced by the mother's experience. Silva et al. (2022) show that, in Chilean fathers, the paternal prenatal bond reported by mothers is greater when the couple has been in a relationship for more than two years, lives together, and there is a desire of both individuals to have a baby (reflected in a planned pregnancy or participation of the father in early prenatal check-ups). Although the construction of a paternal identity is more pronounced during the postpartum period (St. John et al., 2005), the representations, attitudes and behaviors that fathers deploy during pregnancy predict their involvement and closeness with the child after birth (Zvara et al., 2013) and in later developmental stages (Fagan et al., 2023).

The emergence of prenatal psychological processes is influenced by both expectant parents' personal lives and their life as a romantic couple (Ammaniti et al., 1992). In a complementary way, the emerging relationship with the baby reshapes the couple's experiences and opens up new opportunities to strengthen the couple's relationship based on their new bond as mother and father (Ammaniti & Trentini, 2009). Accordingly, in a qualitative research with first-time mothers, Darvill et al. (2010) found that women experience a change in their relationship with the father of their child during pregnancy, where they transition from conceiving themselves as a romantic couple to identifying as a family. The couple's ability to discuss their parental representations and to

construct coparenting representations together influences postpartum dyadic and family dynamics (Ammaniti & Gallese, 2014).

The challenges of the transition to parenthood include not only the novelty and lack of experience in parenting, but also the reorganization and adaptation of the family system in response to the arrival of a new infant (Krieg, 2007). For this reason, the birth of a subsequent child also constitutes a period of significant family changes and evolving parental representations. It requires the establishment of new routines, adjustments in roles, and adaptation to a more complex family system, given the demands of raising two or more children simultaneously (Krieg, 2007; O'Reilly, 2004). Under these circumstances, certain concerns become less relevant than during the first transition to parenthood. In this regard, in a study with 771 pregnant mothers, Brunton et al. (2020) found that having a previous child predicted more positive attitudes toward childbirth and greater acceptance of pregnancy, while also contributing to fewer concerns about the baby and oneself, as well as fewer pregnancy-related anxiety. Nevertheless, the transition associated with the arrival of a second child still involves important adjustments, such as the strengthening of the bond with the first child, planning the new family dynamics, and fostering the first child's acceptance of the new sibling. It also requires a process of self-evaluation related to the recognition of one’s own competencies in raising more than one child (Walz & Rich, 1983).

The disruption of the daily life of the family that the birth of a child causes can also impact parental mental health. Constant attention to an infant affects daily behaviors and routines, such as parents' sleep schedules, nutrition, and physical activity (Saxbe et al., 2018). The costs involved in parenting can also impose significant financial challenges for parents (Nelson et al., 2014). All of this can affect the couple's bond and emotional well-being.

Mental health difficulties during the perinatal period are highly prevalent in women and are increasingly reported in men. In general, couples appear to be particularly vulnerable to the co-occurrence of depressive symptoms, a vulnerability that may increase in early parenthood (Thiel et al., 2020). Pineros-Leano et al. (2021) report, in a sample of 4898 American parents, that the prevalence of postnatal depression in low-income couples was 11% for fathers and 16% for mothers. Smythe et al. (2022) found that the co-occurrence of perinatal depression in both parents occurs in 2 to 3% of cases. A meta-analysis in developing countries reported a prevalence of 29% for prenatal anxiety and 24% for postpartum anxiety in mothers (Nielsen-Scott et al., 2022). Although there is great variability among fathers in terms of reported anxiety during the transition to parenthood, such symptoms tend to be higher in early fatherhood than in the general population of men (Leiferman et al., 2021).

Despite the prevalence of mental health problems during the transition to parenthood, becoming a parent is also associated with a number of factors that promote the well-being of mothers and fathers. The infant provides a sense of

transcendence, and the parental role can support and expand a caregiver's sense of purpose in life (Márquez et al., 2019). Moreover, these new identities hold value in many societies. All of this means that the healthy and positive relationships associated with the infant can help temper the costs associated with parenting. Furthermore, positive interactions with children generate pleasurable emotions for parents (Nelson et al., 2014), encourage the development of parenting skills and a sense of self-efficacy in parenting activities (Nystrom & Ohrling, 2004).

The way in which men and women experience parenthood and construct their parental role is different in terms of social expectations and the opportunities to develop the bond and engage in caregiving, especially in the first year of the baby's life. This demarcates different possibilities and demands for parental involvement and performance. In general, the arrival of an infant brings about a traditionalization of gender roles. A study conducted in the USA found that, during pregnancy, couples tend to expect that mothers will be primarily responsible for caring for the baby (Lawrence et al., 2007). Also, quantitative, longitudinal studies during the transition to parenthood have found that family acquires more salience for both parents; however, family roles take on more importance with greater speed and to a greater extent for mothers; whereas job roles are markedly more important for men during this period (Katz-Wise et al., 2010; Kaźmierczak & Karasiewicz, 2019).

For fathers, the arrival of the infant can be experienced as a process that drives greater commitment to their partner, the newborn, and the family unit, but this can raise doubts about what his place is in the new family dynamics. Qualitative studies in Chile report that fathers prioritize their role as economic providers, as they perceive this role to be the most feasible and appropriate way of contributing to family wellbeing during this period. However, there is ambivalence regarding this decision because, in general, they report they would like to have more time to be at home with their family, participate more actively in parenting, and build a close bond with their child (Herrera & Pavicevic, 2016; Pavicevic & Herrera, 2019). However, most Chilean fathers do not think it is acceptable to receive a portion of their partner's postnatal leave, an option available in Chilean parenting policy (Herrera & Pavicevic, 2016; Pavicevic & Herrera, 2019). For fathers, the relationship with the infant becomes stronger as the child learns new ways to communicate, and their development over the first year of life allows for a greater range of interactions (Márquez et al., 2019).

2.2 Parental self-efficacy

Mothers' and fathers' valuation of their parenting skills will greatly influence how they deal with the challenges of parenting. Parental self-efficacy refers to the set of personal expectations and beliefs that parents have about their own skills and abilities associated with the parental role. This cognitive

construct is relevant because parents' perceptions of their abilities affect how successfully they will perform their roles as mothers and fathers (Coleman et al., 2000). This section will focus on parental self-efficacy, its development, and its significance for caregivers' adjustment and parenting practices.

2.2.1 Self-efficacy

The concept of self-efficacy derives from Bandura's social learning theory. It is defined as the judgment, estimation, and personal expectation of achievement as a result of a given course of action required to address particular circumstances (Bandura, 1982). Self-efficacy is a generative capacity that enables us to organize and integrate cognitive, behavioral, and emotional skills to achieve a certain purpose. It involves intention and the mobilization of psychological resources to ensure successful task performance (Bandura, 1999; Gist & Mitchell, 1992). Self-efficacy is dynamic and depends on contextual factors as well as the perceived difficulty of a task. Since it implies a judgement about one's own performance, people naturally differ about how self-efficacious they feel in different spheres of life (Bandura, 2006). The degree to which self-efficacy is developed in a particular domain depends on the importance the person assigns to that domain, the roles he or she performs, and the levels of skill these roles demand (Bandura, 1999).

Self-efficacy plays a key role in human functioning because it affects the process of acquiring new behaviors, the likelihood of displaying a desired

behavior, and the inhibition of those behaviors already established that are not desired or consistent with a given purpose (Strecher et al., 1986). When people believe they can successfully perform a certain task, their willingness to perform increases, especially if it leads to desirable outcomes (Schuengel & Oosterman, 2019). Beyond the behaviors themselves, self- efficacy enhances cognitive and affective processes which are decisive for committing to a given course of action, such as objectives, aspirations, and expectations of certain results (Bandura, 2006). Thus, it affects the degree of effort, time, optimism, and motivation when performing a certain activity. The degree to which people experience self-efficacy will create a standard of behavior that they will use to evaluate their performance and reward themselves (Schuengel & Oosterman, 2019).

2.2.2 Parental self-efficacy in mothers and fathers

Parenting involves significant challenges. Mothers and fathers benefit from trusting their ability to acquire parenting skills and to positively influence their child's development. Albanese et al. (2019) systematic review found that high parental self-efficacy is associated with both, more effective parenting styles and behaviors, and parents' and children´s well-being. This can lead to a virtuous circle, wherein parents attribute the child's developmental achievements to their parenting skills (Jones & Prinz, 2005). This then contributes to the mental and physical health of the child and contributes to the satisfaction and adaptation to parenthood. In contrast, low parental self-efficacy

can hinder the performance of the parental role by limiting parents' ability to apply the knowledge and skills required for caregiving, particularly in stressful contexts (Korja et al., 2015).

Research has consistently acknowledged the role of parental self-efficacy in family functioning. Salo et al. (2022) found that in families where both parents have high levels of parental self-efficacy, open communication in the family is promoted, and women report lower levels of social and emotional loneliness. The contributions of parental self-efficacy to the coordination of triadic interactions (both parents with their infant), as well as a positive parents' couple relationship (Matalon & Turliuc, 2023) have also been reported.

Paternal self-efficacy has been scarcely studied and is therefore less understood than maternal self-efficacy (Fang et al., 2021; Jones & Prinz, 2005). However, existing evidence shows that paternal self-efficacy has been associated with fewer depressive symptoms (Bamishigbin et al., 2020), greater paternal involvement (Giallo et al., 2013) and is a protective factor for the parenting role in the presence of depressive symptoms (Trahan & Shafer, 2019). Lawrence et al. (2007) found that parental self-efficacy in fathers both prenatally and at six months postpartum, was associated with more positive evaluations of parenting and more favorable perceptions of the child's temperament.

It has been suggested that since mothers and fathers have different experiences and levels of parenting involvement, the predictors of parental self-efficacy would be distinct for each of them (Biehle & Mickelson, 2011). In this regard, Leerkes & Burney (2007) reported that individual factors and the baby's characteristics may be more influential for maternal self-efficacy during the transition to parenthood. While for the development of self-efficacy in fathers, contextual factors and their participation in parenting play a more relevant role.

A key debate in research on parental self-efficacy pertains to how it is conceptualized, operationalized, and measured (Schuengel & Oosterman, 2019; Seetharaman et al., 2022). Since parental self-efficacy constitutes parents' own perceptions or beliefs, it can only be measured through self-report (Seetharaman et al., 2022). However, there is variability in the level of specificity captured by the instruments used. Instruments that address parental self-efficacy differ regarding their specificity. Instruments that measure general domains allow for the assessment of caregiver functioning regarding parenting overall (Wittkowski et al., 2017), whereas other instruments focus on particular parenting tasks in specific developmental stages (Coleman et al., 2000).

2.2.3 Sources of self-efficacy development

According to Bandura, self-efficacy judgments are built from the integration of four main sources of information: *mastery experiences, vicarious experiences, verbal persuasion, and physiological and affective states.*

Mastery experiences constitute the most significant source of information for building self-efficacy, which benefits from successes gained, from the experience of overcoming obstacles, and from learning from the challenges posed by the most complex contextual circumstances in the performance of a task. In contrast, failures tend to decrease self-efficacy, especially when first starting to perform a task (Bandura, 1982, 1999). In the transition to parenthood, parents' prior experience with infants and the frequency with which they engage in caregiving predict self-efficacy and its increase over time (De Montigny Bn & Lacharité, 2005). Ultimately, parenting experience resulting from time spent with the child boosts self-efficacy for mothers and fathers alike. Consistently, Dol et al. (2021), found that multiparous mothers have greater parental self-efficacy than primiparous women. Also, mothers tend to have higher levels of parental self-efficacy (Biehle & Mickelson, 2011; Brage Hudson et al., 2001) compared to fathers, since they are usually the primary caregivers. Yet, Leerkes & Burney (2007) reported that greater paternal involvement during the transition to parenthood predicted parental self-efficacy in fathers.

Vicarious experience can benefit self-efficacy through multiple pathways. Firstly, it offers a point of comparison to assess parents´ individual capabilities in a particular task as they incorporate performance standards from another person for that activity (De Montigny Bn & Lacharité, 2005). Secondly, self-efficacy increases when a person observes another having success in tasks that involve a skill that he/she has already employed elsewhere to achieve other

goals (Bandura, 1982). The circumstances in which a task is performed are always changing, which means success in the face of challenges will likely be variable. For this reason, vicarious experience enables learning via modelling competence, different perspectives, ways of coping with obstacles, and effective strategies for performing tasks. It can also provide a sense of predictability and preparedness for challenges by enabling people to identify circumstances and events to be dealt with at later stages (Bandura, 1999).

During the transition to motherhood, Leahy-Warren et al. (2012) found that the reassurance mothers get from their childhood maternal figure predicts parental self-efficacy. The authors suggest that this may be due in part to vicarious experiences that come with having them as childcare role models.

Verbal persuasion increases the likelihood that someone will mobilize and sustain efforts to perform tasks with substantial concomitant challenges (Bandura, 1999). The influence that verbal persuasion can have on self-efficacy will depend on the trust placed in the person doing the persuading and whether or not claims about developed skills are made within reasonable and credible bounds (Bandura, 1982). Verbal persuasion can be combined with the results of a task to make self-efficacy judgments and can therefore have a marked influence on driving or discouraging behaviors. When feedback from others regarding the outcomes of a task is devaluing, it can lead to the avoidance of challenges, giving up easily in the face of obstacles, and withdrawal behavior (Bandura, 1999).

Some studies on the transition to parenthood have found that the support of family and friends (Leerkes & Burney, 2007) and support from the partner, in particular, influences parental self-efficacy (Biehle & Mickelson, 2011). Fang et al. (2021) reported in a recent systematic review that feeling supported in parenting is one of the main predictor of parental self-efficacy. Similarly, Shorey et al. (2014) reported that informational support is one of the forms of social support that influences parental self-efficacy in women during the postpartum period.

Affective and physiological states influence judgments of self-efficacy through different pathways. People tend to view physiological and somatic signs of stress as indicators of vulnerability, impacting their assessments of one's capabilities to achieve successful results. Additionally, affective states can bias the evaluations and interpretations made about any outcomes and their causes (Bandura, 1999). Depressive symptoms, characterized by negative attribution patterns, can affect self-efficacy (Leerkes & Burney, 2007) by making beliefs of incompetence more salient (Bandura, 1999).

Several studies have observed the influence of mental health on parental self-efficacy during the transition to parenthood. Biehle & Mickelson (2011) report that mental health impairment predicts low own and partner parental self-efficacy. Research in Chile that addresses parental self-efficacy has prioritized the study of the influence of mental health and the presence of certain vulnerabilities. Accordingly, Gallardo (2021) studied migrant mothers and

highlight that increased parental stress as a result of migration, lack of social support, and parental burnout are related to low parental self-efficacy in this population. Farkas & Valdés (2010), in a Chilean study with mothers of infants in the first year of life, found that stress and difficulties in pregnancy were associated with low parental self-efficacy. In addition, they report the influence of factors that increase stress, such as greater economic difficulties, and the role of young age and low educational level in low maternal self-efficacy.

The self-efficacy development model proposed by Bandura has been widely used in studies of parental self-efficacy (Brage Hudson et al., 2001; Porter & Hsu, 2003; Trahan & Shafer, 2019). However, other research also draws information from the Belsky model of parenting determinants (Sevigny & Loutzenhiser, 2010). To understand parental self-efficacy during the transition to parenthood, these models can be integrated. Thus, Bandura's model considers the type of interactions, knowledge, and experiences that constitute sources of information for making judgments about self-efficacy. Whereas Belsky´s model identifies the factors and contexts in which these sources of information on self-efficacy in parenting can emerge. According to the Belsky model, interparental relationships are the most dominant contextual influence on parenting, a topic that will be addressed in the next section.

2.3 Interparental Relationships

Interparental relationship is an umbrella term that has been used to refer to different aspects of the relationship between mothers and fathers (Spjeldnes & Choi, 2008). It has been used broadly to refer to the couple relationship subsystem (Zemp et al., 2016), the coparenting subsystem (Gable et al., 1994, 1995), or both in an integrated manner (Feinberg, 2003). The term also has been used to encompass couple satisfaction and interparental conflict (Van Eldik et al., 2020), as well as the adjustment of the couple relationship and the coparenting relationship (Altenburger & Schoppe-Sullivan, 2020).

From Broderick et al. (2019) perspective, the interparental relationship includes the adjustment to the couple's relationship, interparental conflict, and coparenting. For these authors, couple relationship adjustment is conceptualized as the subjective level of satisfaction that caregivers experience within their relationship with their partner. Interparental conflict is defined as the degree to which parents use physical and verbal abuse to resolve disagreements. Both constitute elements of the romantic bond between the parents (Broderick et al., 2019). Coparenting would be the construct within the interparental relationship closest to parenting (Feinberg, 2003). In line with these authors, the term interparental relationships will be used in this study to refer to both the couple’s adjustment and the co-parental relationship maintained by the parents. The terms adjustment and satisfaction will be used

interchangeably regarding the couple relationship and are addressed in the following section.

2.3.1 Couple satisfaction

Couple satisfaction is one of the most significant indicators of life satisfaction, stability in the romantic bond, and family functioning (Tavakol et al., 2017). More than the maintenance of a marriage or a relationship, the experience of satisfaction in this bond exerts a meaningful influence on individual physical and mental health and family functioning (Tavakol et al., 2017). A satisfying couple relationship contributes to personal development and addresses fundamental needs for belonging and intimacy (Li & Fung, 2011). Adjustment in the couple´s relationship is a process that emerges in the life of the couple, and that requires negotiation, creation of agreements regarding norms, knowledge of personal characteristics, and formation of relational patterns (Tavakol et al., 2017). For most couples, their relationship becomes their main source of support and the context where common objectives and goals are pursued, such as raising children together (Li & Fung, 2011; Tavakol et al., 2017).

A satisfying couple relationship influences family processes and the psychological adjustment of its members. In a recent systematic review, Jiménez-Picón et al. (2021) reported how greater couple satisfaction is associated with the family's positive emotional climate and expressiveness, low

family conflict and aggression, increased family flexibility, as well as satisfaction in performance of family roles among different members of the family system. These authors also point out that, during the transition to parenthood, a better adjustment in the couple's relationship is associated with more positive experiences of becoming parents, a better sense of parental competence, and better adaptation to the arrival of the infant.

Couple satisfaction has an impact on the psychological adjustment of family members. In mothers and fathers, it has been associated with fewer symptoms of anxiety and depression (Figueiredo et al., 2008; Trudel & Goldfarb, 2010) and reduced parental stress (Robinson & Neece, 2015). In Chile, León et al. (2018) discuss the role that partner satisfaction can play in lessening depressive symptoms for men and women, as well as the mediating role of the reflective function in this effect. Concerning children, in their meta-analysis Van Eldik et al. (2020) address the influence of the parents' couple relationship on children's mental health. The authors report that low adjustment in intimate relationships can be a serious risk factor, leading to childhood behavioral problems, internalizing and externalizing symptoms, and negative evaluations of the romantic bond of their parents. The authors suggest that these consequences are similar to those of being exposed to interparental conflict in normative samples.

Classic studies from the 1990s on partner satisfaction during the transition to parenthood consistently report a decline in relationship adjustment

during the first year of the baby's life. However, this decline does not occur uniformly across all couples. It is influenced by factors such as whether the pregnancy was planned and/or the desire for a child (Cox et al., 1999), as well as sociodemographic variables such as the length of the relationship, parental age, income, education, the prenatal quality of the romantic bond, individual personality traits, and child temperament (Belsky & Rovine, 1990). Consistently, Belsky et al. (1983) report that the decrease in relationship satisfaction associated with the couple's adaptation process is accompanied by a shift in the conception of the couple's bond. During the transition to parenthood, mothers and fathers often shift from perceiving their relationship primarily as romantic to viewing it more as a partnership**.** Research on the transition to parenthood associated with the birth of a second child has also linked this period to a decline in couple satisfaction (Krieg, 2007), as the arrival of another child requires a substantial reorganization of the family system.

More recent research in this area corroborates the changes in the couple relationship at this stage and has studied the influence of other predictors. The recent meta-analysis by Bogdan et al. (2022) further demonstrates the decline in relationship satisfaction between parents when the infant arrives. However, they caution that reports on the magnitude of this decline vary between studies. Likewise, the authors find interdependent effects between mothers and fathers, as the decrease in the satisfaction of one member of the couple influences the decrease in the satisfaction of the other. Complementarily, Delicate et al. (2018)

qualitative study highlights that couples may feel unprepared for the changes that parenting will bring to their relationship, as they tend to spend more time anticipating their parental roles. These authors also point out that, during the postpartum period, communication becomes strained and restricted, and is mainly focused on the infant.

Although partner satisfaction during the transition to parenthood decreases significantly, the adjustment in this bond during the prenatal stage can influence the adaptation to parenthood and family functioning. Satisfaction with the couple relationship during pregnancy has shown to influence the parents' prenatal bond with the baby (Bouchard, 2011) and to lower maternal (Zhang et al., 2021) and paternal depressive symptoms during pregnancy (Mangialavori et al., 2021). Moreover, its positive effects on mental health may persist in mothers and fathers in the postpartum stage (Clout & Brown, 2016; Wang et al., 2021; Xie et al., 2010). A couple's satisfaction during pregnancy can also have positive effects in the postpartum period on maternal self-efficacy, parental satisfaction (Lawrence et al., 2007), paternal parenting (Morris et al., 2022; Bradford et al., 2006), and the development of balanced postpartum representations of the parental role in both parents (Vismara et al., 2022).

The transition to parenthood implies an expansion of the couple relationship subsystem, with the emergence of the parental and coparental subsystems within the family (Altenburger & Schoppe-Sullivan, 2020).

Therefore, the prenatal quality of the relationship will have a significant influence on the dynamics that will occur in the other new family subsystems. Delicate et al. (2018) highlight that, although the arrival of the baby affects the time a couple has available for connecting romantically, new forms of closeness associated with their relationship with the child emerge in the new parental couple, which strengthen their relationship and the family identity overall. Thus, the prenatal adjustment of the couple supports the formation of the new coparenting relationship, which will have greater salience for mothers and fathers during the transition to parenthood as a way of staying positively connected. In view of its relevance, the coparental relationship is addressed in the next section.

2.3.2 Coparenting

Coparenting is one of the most significant relationships that adults have with one another (Margolin et al., 2001). It refers to the way in which parents work together in the context of performing their parental roles and is motivated by a mutual desire to promote their child's well-being (Feinberg, 2002; Margolin et al., 2001; McHale & Fivaz-Depeursinge, 2010). Coparenting emerges within parenting contexts characterized by overlapping childcare-related roles, in which negotiation and mutual support are particularly important (Feinberg, 2002). Family systems theory indicates that the coparenting subsystem ensures stability, predictability, and security in the family (Boričević & Kušmić, 2013; Van Egeren & Hawkins, 2004). In his ecological model of coparenting, Feinberg

(2003) describes it as a central dimension of the family that functions as a conduit through which individual, familial, and external variables affect parenting; which in turn influence child health and adjustment.

In mother-father pairs, the coparenting relationship is an extension of the romantic bond from which it emerges (Gable et al., 1992). However, the coparenting relationship has its own unique characteristics and qualities given its focus is on the child. Van Egeren (2004) posits that co-parenting has an internal, representational dimension that includes the individual experience and perception of each parent, and an external, behavioral dimension, which encompasses the coparental interaction patterns in triadic situations.

According to the Ecological Model of Coparenting proposed by Feinberg (2003), coparenting has four main components: *childrearing agreements, division of labor, coparental support or undermining, and joint management of family dynamics. Childrearing agreements* refer to the degree to which mothers and fathers are able to negotiate and reach agreements on issues such as moral values to be instilled, standards of discipline, safety, health, and satisfaction of children's emotional needs.

The division of labor concerns the joint construction of routines regarding parenting and family life. In this domain, beyond mere equity in task allocation, satisfaction with the process of negotiating responsibilities and with the resulting division of tasks is even more important.

Support includes affirming and valuing the other caregiver's competencies, as well as recognizing, respecting, and validating his/her parenting contributions. The negative side of this dimension is undermining the other caregiver's contributions to parenting.

Lastly, the *management of family dynamics* includes coparenting tasks that relate to responsibilities as an executive subsystem of the broader family system. This domain includes how parental couple conflicts, coalitions, and balanced interactions are managed. The extent to which coparents are able to constructively resolve child-related conflicts and limit the infant's exposure to more hostile forms of communication is an indicator of their capacity to provide the child with emotional security. Coalitions refer to the emergence of triangular family relationships. When these kinds of relationships manifest, intergenerational boundaries get blurred and the child becomes an ally in the conflict between his or her parent. Balance refers to the relative proportion of time each caregiver spends interacting with the infant during triadic interactions.

2.3.2.1 Transition to coparenting.

Coparenting begins to emerge during pregnancy as couples develop parental representations and an emotional bond with their baby (Van Egeren & Hawkins, 2004). During this period, as the couple engages in discussions about parenting and jointly prepares for parenthood, coparenting representations start to develop (Feinberg, 2002; Van Egeren & Hawkins, 2004). The emergence of

the coparenting relationship during the prenatal period is expressed through the partners' anticipation of the dynamics of support, partnership, and appreciation in their future coparenting relationship, as well as their engagement in debates about attitudes and expectations regarding parenting responsibilities (Ammaniti & Menozzi, 2021; Kuersten-Hogan, 2017). Simultaneously, other dynamics related to the care of the mother and baby, as well as preparations for birth, come into play within the couple, setting precedents for how matters concerning the infant will be shared and managed (Feinberg, 2002). Ranta et al. (2023) qualitative study on coparental representations during the prenatal period suggests that the anticipation of coparenting support emerges in couples from early stages of pregnancy, where the couple develops expectations about learning and growing together in their parental roles. Although the birth of the infant requires readjustments and changes in the representations and coparenting dynamics formed during pregnancy (Kuersten-Hogan, 2017), prenatal expectations and representations of the coparenting relationship can shape the postnatal experience, beyond the structural changes in the family system that accompany the birth of a child (Ammaniti & Menozzi, 2021; Kuersten-Hogan, 2017).

Consistently several studies have found continuity between the pre- and post-natal coparenting dynamics. Altenburger et al. (2014) studied the relationship between coparenting behaviors during triadic interactions in the last trimester of pregnancy and at nine months postpartum. The authors found

continuity between the pre- and postpartum coparenting dynamics manifested by parents, controlling for the quality of the prenatal couple relationship. McHale & Rotman (2007) investigated the predictive role of prenatal coparental representations in coparenting behaviors during the first and second years of the baby's life. In this study, they report that prenatal coparental pessimism in mothers and fathers predicts greater difficulties in postpartum coparenting dynamics. Similarly, Kuersten-Hogan (2017) analyzed the relationship between coparenting representations and prenatal behaviors, and at three and twelve months postpartum. They found that the quality of prenatal coparenting behaviors predicts postpartum coparenting behavior. Likewise, continuity was observed in the representations of coparental harmony and antagonism, from pregnancy to the first postpartum months.

Even when the members of the couple are already parents, the arrival of another child entails a renewed transition to coparenting. It requires a greater reorganization of the coparenting system, as parents must now coordinate in jointly raising multiple children (Szabó et al., 2012). This period involves the further development of coparental roles (Volling et al., 2021), and may be associated with increased perceptions of coparental cooperation. Such cooperation can be associated with greater paternal involvement in family processes and childcare, which contributes to the successful adaptation of the entire family system to the heightened demands of caring for more than one child (Szabó et al., 2012).

2.3.2.2 Relevance of the quality of the coparenting relationship.

Positive coparenting can promote psychological adjustment for parents and children. This subsystem can be a space of support for mothers and fathers engaged in child-rearing. The coparental relationship provides a context in which both parents can modulate the emotional experiences associated with childcare, reinforce achievements, resignify challenging experiences, and prepare to take on complex tasks (Paley & Hajal, 2022).

Positive coparenting can be a protective factor for parental stress and anxious and depressive symptomatology in parents (Camisasca et al., 2022; McDaniel & Teti, 2012; McRae et al., 2021; M. L. Schulz et al., 2023; Yalcintas & Pike, 2021). In this regard, positive coparenting representations are associated with lower depressive symptoms in mothers during the first three postpartum months (Takeishi et al., 2021). In Chile, Panesso et al. (2022) studied parental burnout in mothers and fathers of children under four years of age during the COVID-19 pandemic, and found that parents who reported higher coparental cooperation had lower parental burnout. Similarly, Aldoney et al. (2023) observed that parents with higher reports of coparental conflict had higher levels of parental stress during the pandemic confinement in Chile.

A recent, growing body of evidence has emerged on the dyadic effects of coparenting representations on parental adjustment. Given the interdependence of roles and subsystems in the family context, the effects of the coparental

experience of one caregiver on the adjustment and parenting exercise of the other have been studied. Yang et al. (2023) report that the quality of the mother's coparental representations predicts lower paternal anxiety and depressive symptomatology. Similarly, Estlein & Shai (2023) found that the parental partner's ability to offer prenatal coparental support contributed to fewer depressive symptoms in the other caregiver at three months postpartum. Additionally, Turgeon et al. (2023) highlight that a parent's coparenting experience may function as a buffer, attenuating the impact of their own parental stress on their partner’s stress.

Positive coparenting has also been associated with increased paternal involvement (Hohmann-Marriott, 2011; Lee et al., 2019) and performance (Altenburger & Schoppe-Sullivan, 2020). Given that the father-infant relationship has greater variability in terms of parenting commitment than the mother-infant relationship, the coparental relationship may influence the quality of the father-infant relationship (Brown et al., 2010; Diniz et al., 2025; Mumin et al., 2025). When fathers consider themselves part of a parenting team, they are likely to place a higher priority on their parental roles (Van Egeren, 2004). In this way, positive coparenting has a beneficial influence on fathers and how they define the tasks, activities, and interactions that characterize their parenting during the first year of the child's life.

Regarding the infant´s well-being, the meta-analysis by Teubert & Pinquart (2010) found that coparenting plays a predictive role in child

adjustment in areas such as attachment and social adaptation. These authors also observed the influence of the quality of mothers' and fathers' coparenting relationship on childhood internalizing and externalizing symptoms, controlling for the dynamics of the couple relationship and individual parenting. In view of the impact of coparenting on family functioning and wellbeing, some studies have explored the predictors of positive coparenting; which will be addressed in the following section.

2.3.2.3 Predictors of coparental relationship quality.

In his ecological model of coparenting Feinberg (2003) discusses the influence of individual characteristics of the parents and the child, the couple relationship , and environmental factors on the development and functioning of the coparenting relationship. Among the individual characteristics of parents, mental health plays a critical role. Depression in parents can manifest through withdrawal and reduced involvement in interparental and parental relationships. It can also result in heightened conflict and increased difficulty in preventing the child from being exposed to these situations (Feinberg, 2003); therefore, it negatively impacts coparenting (McDaniel & Teti, 2012; Tissot et al., 2017).

The couple relationship is among the most influential family subsystems in the coparenting process (Le et al., 2016). In the next section, the

associations between the couple's relationship and coparenting will be discussed in greater depth.

2.3.3 Couple relationship and Coparenting

The couple relationship and coparenting are bidirectionally linked, and constitute dynamics that are particularly relevant during the transition to parenthood (Camisasca et al., 2022; Liu & Wu, 2018; McHale et al., 2004; Pedro et al., 2015).

The coparenting relationship is shaped by the initial romantic relationship, inheriting previously established styles of communication and conflict resolution, as well as patterns of mutual support and respect (Feinberg, 2002; Van Egeren, 2004). Altenburger et al. (2014) report how adjustment in romantic bonding in couples during the last trimester of pregnancy predicts coparenting support behaviors at nine months postpartum. Likewise, reports of negative partner interactions are predictors of coparental undermining in the same period. Similarly, Schoppe-Sullivan et al. (2016) study on the influence of the couple relationship on parents' adaptation in the first year of life shows that partner adjustment in the third trimester of pregnancy predicts the quality of coparenting representations at three months postpartum. In couples expecting their second child, Kuo (2017) found that couple satisfaction during the second pregnancy predicts both individuals' own and their partners' representation of coparenting at four months postpartum.

Interestingly, to date no studies have considered the predictive role of couple relationship adjustment on the quality of prenatal coparenting representations in primiparous parents. However, validation studies of instruments that assess the quality of prenatal coparenting representations (Coparenting Relationship Scale, CRS; Feinberg et al., 2012) have reported associations of this variable with the quality of the couple's relationship in the prenatal stage. For example, Pinto et al. (2019) studied 91 expectant fathers living in Portugal during the first trimester of gestation, and found four dimensions of the coparent relationship in the CRS: lack of coparental support, coparental conflict, coparental disagreement, and coparental undermining. The authors report that coparenting disagreements has a moderate direct association with negative aspects of the couple relationship and an inverse association with its positive aspects.

Similarly, Lindroos et al. (2023) found that the dimensions of co-parental cooperation and conflict (measured by the CRS) were positively and negatively associated, respectively, with the quality of the positive couple relationship in a sample of 157 Finnish first-time parent couples in the third trimester of pregnancy. However, in their work, the discriminant validity analyses indicated that the positive aspects of coparenting in women were not completely differentiated from the quality of the couple relationship during this stage. Further research is therefore needed to clarify how and when coparenting becomes a distinct relational subsystem from the couple relationship during the

prenatal period, considering also that this differentiation process may be shaped by cultural aspects. Given that Finland is one of the countries with lower levels of gender inequalities (United Nations Development Programme, 2026), this may influence the way in which parents expect to share responsibilities in their parental role, which could differ from the patterns observed in more traditional countries.

In some couples, the stability of the relationship may be affected by the arrival of a first child and the stress of parenthood, increasing the chances of separation (Feinberg, 2002). In this context, for both new mothers and fathers, aspects of the coparental relationship, such as talking about emotions, mutual support, and understanding during parenthood, allow them to stay positively connected and confident that their relationship will continue (McHale & Rotman, 2007; Ranta et al., 2023). Research has found that the quality of the coparenting relationship during the first year of an infant's life is a predictor of the couple's adjustment in later stages of the child's development (Le et al., 2016; Schoppe-Sullivan et al., 2004). Thus, the complementarity of the couple relationship and coparenting during the transition to parenthood allows for a certain stability and promotes the continuity and adjustment of the family system in general and its subsystems in particular.

2.4 Couple relationship and parental self-efficacy

The couple relationship may serve as an important precedent for forging beliefs in the parents' capacity to deal with the challenges of parenthood. There is evidence of a positive association between parents' relationship dynamics and parental self-efficacy (Calvo & Bianco, 2015; Kwok et al., 2013; Sevigny & Loutzenhiser, 2010) at four and twelve months postpartum (Elek et al., 2003).

The influence of the couple relationship on parenting has often been studied from the perspective of family systems theories. Within this context, the spillover hypothesis and the compensatory hypothesis are among those most supported by research. The spillover hypothesis suggests the existence of a positive association between the couple relationship and parenting. It addresses the transfer of moods, affection, and behaviors from the couple to the parenting context. Couples who experience their relationship as mutually supportive and satisfying are more likely to be sensitive and responsive when interacting with their child. In contrast, couples with more difficulties with their romantic bond will also be less emotionally available in their parental role (Zimet & Jacob, 2001). From this perspective, it is considered very hard for parents to limit the effects of couple difficulties on the parental relationship they have with their offspring (Erel & Burman, 1995). In support of this hypothesis, several studies have documented positive associations between dimensions of couple relationship quality—such as couple adjustment—and cognitive parenting dimensions,

including parental self-efficacy (Calvo & Bianco, 2015; Kwok et al., 2013; Sevigny & Loutzenhiser, 2010).

The compensatory hypothesis posits that parents can try to compensate for negativity in the couple's relationship by focusing on parenting. The greater closeness in the relationship with the infant under such circumstances functions as a way to satisfy the need for intimacy, given the challenges in the romantic bond (Grych, 2002). Coalitions and triangulations in the family system are frequent in these situations. The compensatory hypothesis suggests that the negativity of the couple relationship predicts a better parental relationship with one caregiver and greater difficulties in the parental relationship with the other (Erel & Burman, 1995). Consistent with this perspective, studies have documented associations between dimensions of the couple relationship and cognitive parenting constructs. For example, Harwood et al. (2007) in a study of 71 mothers, observed that parental self-efficacy at four months postpartum negatively predicted satisfaction in the relationship with a partner during this period, controlling for the couple´s relationship before the birth of the child and prenatal expectations about parenthood.

Few longitudinal studies have addressed the predictive role of the quality of the couple relationship during pregnancy on parental self-efficacy during the first postpartum year. Porter & Hsu (2003) studied parental self-efficacy in 61 mothers during the transition to parenthood. These authors found that satisfaction in the couple relationship during pregnancy predicted parental self-

efficacy prenatally and at one month postpartum, but not at three months postpartum. Another research by Kershaw et al. (2014) focuses on the influence of family factors during pregnancy on parenthood at six months postpartum in 434 adolescent and young adult couples. The authors found that the couple relationship during pregnancy predicted parental self-efficacy in the postpartum period for both parents.

The evidence described regarding the association between the couple relationship and parental self-efficacy during the transition to parenthood is more inclined to support the spillover hypothesis. This is consistent with the meta-analyses on the influence of the couple relationship on parenting (Erel & Burman, 1995; Krishnakumar & Buehler, 2000).

2.5 Coparenting and parental self-efficacy

The coparenting relationship can be particularly conducive to the development of parental self-efficacy. According to Bandura´s source of self-efficacy, coparenting enhances the development of self-efficacy principally by means of verbal persuasion. One of the things that parents have in common is their shared daily experience of the process of shaping and performing their parental roles. Due to the intimate nature of their relationship, the coparent can influence the other parent's understanding of his or her own parenting abilities.

In families where both mother and father are the primary caregivers, the coparent may have a greater understanding of the efforts, challenges, and

contextual factors influencing the upbringing of their child. In this context, the individual can contribute by acknowledging the partner's parenting skills and by understanding the demands of the role within the contexts in which it is performed. The coparent can also help reinforce the parental performance achievements and significantly encourage perceptions of parental self-efficacy (Feinberg, 2003). In a qualitative study on coparenting during the postpartum period, Sheedy & Gambrel (2019) found that receiving emotional support, verbal praise, and validation from their partners for the numerous parenting tasks was especially meaningful for women. Likewise, a qualitative coparenting study in Chile found that mothers greatly appreciate emotional support and encouragement from their partner as a contribution to the construction of their maternal role (Pérez et al., 2021).

The coparental subsystem can be a protective factor for managing the parents´ emotional states, as it provides support in the face of the experience of exhaustion and the daily challenges of parenting (Paley & Hajal, 2022). Sheedy & Gambrel (2019) found that for both parents, coparenting dynamics such as sharing feelings and needs, working as a parenting team, and being able to openly and respectfully discuss disagreements, promoted well-being during the transition to parenthood. Negative coparenting, such as one member of the couple excluding the other parent from major child-related decisions, can lead to feelings of discomfort and resentment in the disrespected person. In addition, the criticism that mostly men receive when they fail to perform a parenting task

in the way their partners expect may affect expectations about the likelihood of successfully performing parental roles (Sheedy & Gambrel, 2019). In line with this, several studies have focused on the influence of coparenting on the mental health of parents during the transition to parenthood (McDaniel & Teti, 2012; Takeishi et al., 2021), with particular focus on the father's psychological adjustment to parenthood in this period (Wells et al., 2023; Wells & Jeon, 2023).

With respect to vicarious learning and mastery experiences, the coparental relationship can be a particularly useful space to foster these sources of self-efficacy in men. Given that the father-infant relationship presents greater variability in terms of participation in childrearing than the mother-infant relationship, the coparenting relationship can substantially influence the potential for fathers to construct their parental role (Brown et al., 2010; McHale & Fivaz-Depeursinge, 2010) and increase their participation in parenting activities. Other research has also found that while mothers tend to feel supported during the perinatal period by their partner, family, friends, and health professionals, men feel that their partner is their main source of support during this time, as they often feel excluded from the advice provided by other sources (Deave et al., 2008; Halle et al., 2008). In this sense, fathers appreciate receiving information and instrumental advice to care for their infant. This helps alleviate any experiences of confusion and makes them feel more prepared to perform caregiving activities (Halle et al., 2008). In this way, coparenting

dynamics can be particularly useful for enhancing vicarious learning and successful parenting.

Parental self-efficacy can also have important influences on the coparenting relationship. If parents feel highly effective in parenting tasks, they are more likely to be involved in parenting, be more willing to collaborate as a team in caregiving, have greater involvement in decision-making around child development, and be a source of support for the other coparent. On the other hand, feeling insecure in the role can lead to withdrawing from the coparenting relationship (Biehle & Mickelson, 2011).

Despite the potential associations between coparenting and parental self-efficacy during early parenting, to date there are few studies on this subject, and their results are mixed.

Calabrese & Schoppe-Sullivan (2023) studied the moderating role of coparenting between emotional regulation and parental self-efficacy in 182 couples with school-age children. The authors found that the mother's coparental representations predict her parental self-efficacy when controlling for maternal and paternal emotional self-regulation, paternal coparental representations, and socio-demographic characteristics. None of the predictors of self-efficacy considered in this study were significant for fathers. However, the authors found an interactive effect between coparenting representations and paternal emotional self-regulation as predictors of paternal self-efficacy.

Solmeyer & Feinberg (2011) conducted a longitudinal study in a sample of 139 cohabiting parents during the first and second year of the baby's life. These authors analyzed the influence of temperament and coparenting on stress, depressive symptoms, and parental self-efficacy and observed that coparental support at 13 months postpartum positively predicts parental self-efficacy in both parents, while undermining had an inverse effect.

Some studies during the first year of life have also found non-significant results regarding the association between coparenting and parental self-efficacy. Biehle & Mickelson (2011) studied 104 couples who were new parents to examine how participation in caregiving and play, anxiety, depression, coparenting support, and family social support influence parental self-efficacy. They found that coparenting support did not predict parental self-efficacy in fathers or mothers when controlling for the aforementioned variables. However, the study of coparenting support is based on a series of questions and not on a specific instrument, so it remains unclear which aspects of the interparental relationships and family processes it captures.

Part of the research on the predictive role of coparenting representations in parental self-efficacy has been conducted only in men, given the importance of coparenting for constructing the parental role and fostering paternal involvement. In this regard, Donithen & Schoppe-Sullivan (2021) studied 182 first-time fathers in the perinatal stage to identify factors that influence parental self-efficacy in men. The authors found that coparenting representations at

three months postpartum contributed to parental self-efficacy in this period, controlling for attachment styles, socioeconomic status, personality characteristics, and beliefs around the division of childcare. Pinto et al. (2016) developed a linear growth curve model to investigate the development of parental self-efficacy from early pregnancy to six months postpartum in 86 first-time fathers. Results show that the fathers reported a significant increase in parental self-efficacy during the period under consideration, and that the quality of coparenting representations predicts parental self-efficacy when controlling for fathers' mental health.

In contrast, Klode et al. (2025) conducted a cross-lagged longitudinal study in Denmark examining the bidirectional influence of coparenting representations and parental self-efficacy in first-time fathers, assessing children at 10 months, 19 months, and four years of age. These authors found that, although coparenting and parental self-efficacy were related at the same time point, only parental self-efficacy at 10 months predicted coparenting at 19 months. The authors suggest that these results may be attributable to gender equality in Denmark and to parenting policies that mean fathers in this context are more involved, expected to contribute more to parenting, and therefore more confident in their parental role.

Additionally, studies have analyzed parental self-efficacy and coparenting behaviors that arise in triadic interactions. Frascarolo et al. (2015) modelled a linear growth curve analysis to examine the association between

parental self-efficacy, coparenting, and parental satisfaction in 68 couples evaluated at 3, 9, and 18 months postpartum. The authors found that the fathers ‘parental self-efficacy at each time point in the study positively correlated with the quality of coparenting interactions. This study suggests there is a bidirectional relationship between parental self-efficacy and coparenting. However, no significant effects were found for self-efficacy on coparenting in mothers. Given the aforementioned importance of coparenting in fathers’ parental self-efficacy, it may be more influential for them than for mothers. Thus, the low sample size included in the study may not allow for capturing an association between parental self-efficacy and coparenting in women. Along these lines, Favez et al. (2016) investigated the influence of parental self-efficacy on coparenting behaviors during triadic interactions. Their research included 69 couples with an infant at ages 3, 9, and 18 months. Results showed that parental self-efficacy predicted coparenting in triadic interactions at three months postpartum. Furthermore, parental self-efficacy of fathers at three months predicted coparenting behaviors at 18 months postpartum. The authors suggest that parental self-efficacy may be one of the factors underlying parents' motivations to engage in triadic interactions.

The presented results show the bidirectional influence between coparenting and parental self-efficacy during the transition to parenthood. However, the reviewed research suggests that this influence may vary depending on whether coparenting is assessed as coparenting experience or as

coparenting behaviors. Since coparenting representations capture one’s individual experience of coparenting as well as perceptions of the other caregiver's parental capabilities (Calabrese & Schoppe-Sullivan, 2023), such representations can more directly inform the process of formulating and integrating the parents' own parental self-efficacy beliefs. On the other hand, positive parents' beliefs about their parenting abilities may benefit coparenting behaviors during triadic interactions. This bidirectional influences may also depend on cultural factors. Where more egalitarian caregiving is expected, men may need less of their partner's support to develop their parental role. However, this may also signify that sharing parental responsibilities and feeling satisfied with this relationship are more normative, with less variability in such egalitarian societies, meaning that their effect over time on parental confidence development is no longer significant. Nevertheless, there is scarce evidence regarding these nuances, and more research is needed on this matter.

To our knowledge, only one previous study has examined the joint influence of the couple relationship and coparenting on parental self-efficacy. Merrifield and Gamble (2013) studied 175 couples with children between two and seven years of age, exploring how couple relationships and coparenting were interrelated and predictive of parental self-efficacy. Their findings show that the interaction between higher levels of coparental support and greater couple commitment and satisfaction predict higher levels of parental self-efficacy. They also reported that the interaction between couple conflict and

coparental undermining predicted lower parental self-efficacy. Overall, the authors identify a cumulative effect of the quality of interparental relationships on parental self-efficacy

As mentioned in previous chapters, the arrival of the first child entails a temporary deterioration of the couple's relationship. The coparenting relationship, which emerges from the couple relationship, is a protective factor during this period for the couple and individual adjustment.

Interdependencies between representations of the coparenting relationship and parents' self-efficacy may also manifest during the first year of life. Thus, a parent's parental self-efficacy may be influenced by the validation provided by their coparent, regarding their achievements and efforts in the exercise of parenting.

If both parents perceive that they share common goals and feel confident in their ability to reach agreement on important parenting issues, this can foster a sense of confidence in the decisions they make and strengthen their beliefs about their parenting abilities. In the reviewed literature, only one study that examined the interdependent association between coparenting perceptions and parental sense of competence was identified (Pan et al., 2024). This study employed an Actor–Partner Interdependence Model (APIM) with a mediation framework to investigate how one’s own and their partner’s coparenting perceptions influenced individual parental self-efficacy, in turn predicting child

behavior problems. The study did not find a partner effect of coparenting on parental sense of competence. However, this was a cross-sectional study conducted with parents of kindergarten-aged children. Considering the developmental differences between parents during the transition to parenthood and those of older children, the complexity of the Pan et al. (2024)' model, and the limited available research, we argue that further studies should explore the interdependence between coparenting representations and parental self-efficacy during earlier stages of parenting.

2.6 The present study

Research on parental self-efficacy in fathers and mothers during the first year of life suggest that the precursors of parental self-efficacy in men and women may differ (Leerkes & Burney, 2007) due to the differentiated experiences for fathers and mothers during the transition to parenthood in everyday parenting. However, given that the couple and coparental relationship are common and meaningful experiential spaces for both parents, they may constitute precursors of parental self-efficacy for mothers and fathers. Moreover, given that co-parenting is closer to the parental performance than the couple relationship, it may constitute a mechanism by which the couple relationship influences the parental self-efficacy of both parents.

Informed by the revised literature, the present study aimed to examine the influence of satisfaction with the couple's relationship on coparenting

representations during the transition to parenthood, as well as the contribution of these representations to parental self-efficacy. A repeated-measures design allowed the assessment of these variables from late pregnancy to six months after childbirth.

The study employed the Family Systems Theory framework to conceptualize the transition to parenthood as a critical stage in family life and to examine the interdependence of family subsystems and individual members. Accordingly, an actor-partner interdependence model was used to examine the reciprocal influence of parents' coparenting representations and parental self-efficacy during this period.

Developmental theoretical models were also considered to account for the timing and processes underlying the development of parental roles (Cowan & Cowan, 1992). Bandura's model of self-efficacy and Belsky's (1984) model of parental development—within the framework of family systems theory—was integrated to identify and understand the family-level factors from which sources of parental self-efficacy may emerge. Feinberg's (2003) Coparenting Ecological Model, also aligned with Family Systems Theory, which highlights the mediating role of coparenting between contextual factors and parental adjustment, further informed the present study.

Although observational measures of dyadic and triadic interactions have been widely and successfully used for measuring interparental relationships—

and, in the case of coparenting, are often considered the gold standard for its assessment—the present research focuses specifically on parents' subjective perceptions and experiences of their interparental relationships. This more subjective and experiential dimension of the interparental relationship is likely to be more directly related to parental self-efficacy, which is primarily a cognitive construct. In the present study, parental self-efficacy was assessed using both domain-general and domain-specific measures. Using both measures enabled a comprehensive assessment of parental self-efficacy and the contribution of interparental relationships to its development.

The extensive parenting experience that mothers typically accumulate during the first year of life makes it more likely that daily experiences— as a sources of self-efficacy information—will shape their parental self-efficacy. Therefore, the predictive power of coparenting on parental self-efficacy was expected to be stronger in fathers than in mothers, in both mediation and interdependence models. Both primiparous and multiparous couples were included in this study, because both experiences involve a transition to parenthood characterized by important developmental tasks at both the individual and family levels.

The study also intended to advance current understanding of interdependence between partners and interpersonal influences in the development of parental self-efficacy. We expected to find interdependence between coparenting and parental self-efficacy at six months postpartum, given

that coparenting was considered the interparental influence most closely related to parental self-efficacy. Although couple satisfaction was considered to provide a stronger prenatal foundation for the development of the new family subsystems, it itself decreased during the transition to parenthood. On the other hand, given that both coparenting and parental self-efficacy were constructs that developed across the transition to parenthood, we expected to find interdependence only at six months postpartum, considering that this was a time when coparenting was considered to have developed sufficiently to function as a relational space that could influence not only one's own parental self-efficacy but also that of one's partner.

Studies of parental self-efficacy in fathers are scarce at the international level (Fang et al., 2021) and Chile joins this trend. In the reviewed literature few Chilean investigations that assess parental self-efficacy include fathers (Ortega, 2013;Jiménez et al., 2012). Also, no Chilean study was found that assessed parental self-efficacy in both parents during the transition to parenthood. Therefore, the present study provided novel evidence on how parental self-efficacy develops in both parents across this critical period and on potential gender differences in its developmental trajectories.

3. Research Question, Objectives and Hypotheses

This study addressed the following research question: How do interparental relationships (including couple satisfaction and coparenting representations) during the transition to parenthood contribute to the development of parental self-efficacy in both parents?

3.1 Objectives

General Objectives. To assess the contribution of interparental relationships during the transition to parenthood on parental self-efficacy at 6 months postpartum, evaluated as a general domain and as developmental stage-specific tasks, in both parents.

Specific objective 1. To examine the influence of coparental representations at 3 months postpartum on parental self-efficacy, assessed as general domain and as developmental stage-specific task- at 6 months postpartum in both parents.

Specific objective 2. To examine the indirect effect of prenatal couple relationship satisfaction on parental self-efficacy, assessed as general domain and as developmental stage-specific task- at 6 months postpartum, through prenatal and at 3 months postpartum coparental representations.

Specific objective 3. To examine the interdependence between coparental representations at 6 months postpartum and parental self-efficacy

assessed as general domain and as developmental stage-specific task at 6 months postpartum in both parents.

3.2 Hypothesis

General Hypothesis. Interparental relationships during the transition to parenthood influence parental self-efficacy at 6 months postpartum in both parents.

Hypothesis of specific Objective 1

- In parents, positive coparental representations at 3 months postpartum will contribute to higher parental self-efficacy at 6 months postpartum.
- The contribution of positive coparental representations at 3 months postpartum to parental self-efficacy at 6 months postpartum will be higher in fathers than in mothers.

Hypothesis of specific objective 2

- In parents, prenatal couple satisfaction will contribute indirectly to higher parental self- efficacy at 6 months postpartum via positive coparental representations assessed during third trimester of pregnancy and at 3 months postpartum.

Hypothesis of specific objective 3.

- Positive coparental representations of one parent at 6 months postpartum will contribute to higher parental self-efficacy of the other parent at 6 months postpartum.
- The partner effect from mothers' positive coparenting representations to fathers' higher parental self-efficacy will be stronger than the partner effect from fathers to mothers.

The following figures show the theoretical models corresponding to the Specific Objectives. Thus, Figure 1 presents the theoretical model proposed for the Specific Objective 2 and Figure 2 presents the theoretical model for the Specific Objective 3.

Figure 1

Two serial mediators' Theoretical Model

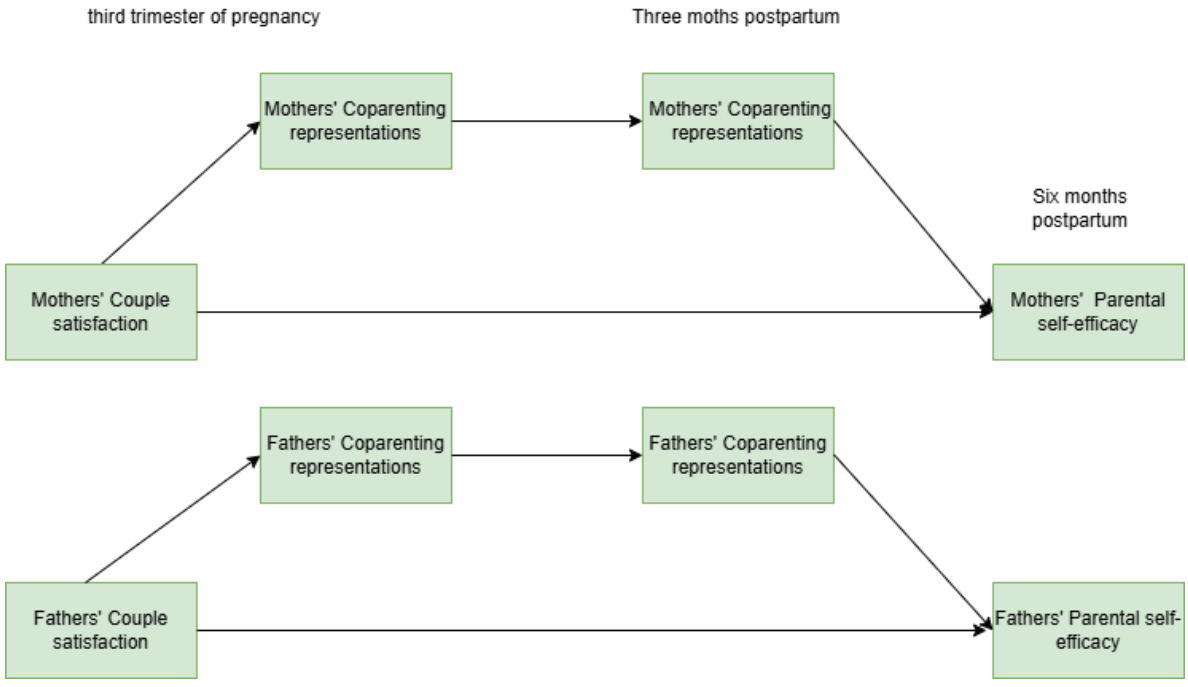
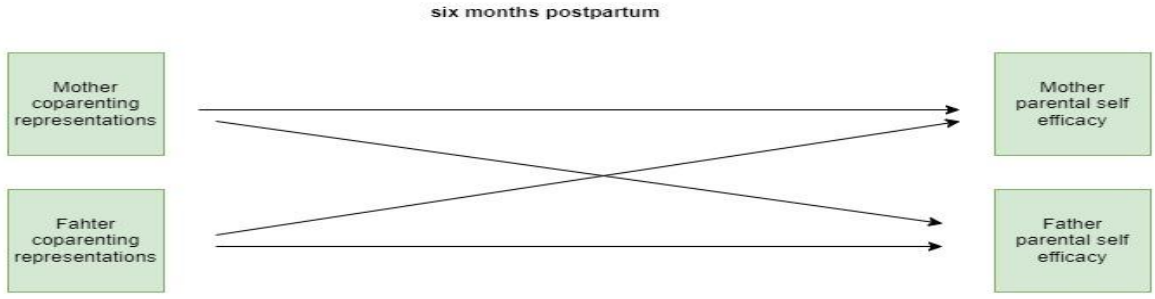


Figure 2

Interdependence Theoretical Model



4. Method

This study is a non-experimental, quantitative, longitudinal research. Participants provided data (self-report questionnaire) at three times across the transition to parenthood.

4.1 Procedures

Both members of the couple were asked to complete an online survey individually at three assessment times, namely:

- Time 1: Third trimester of pregnancy

- Time 2: 3 months postpartum

- Time 3:6 months postpartum.

Recruitment was conducted through targeted advertising on social media (May 2024–March 2025). Typically, one member of the couple (97.1% woman) responded to the advertisement and was contacted via WhatsApp chat by the researcher, who explained the study objectives and procedures. If the individual expressed interest, the researcher requested the contact information of their partner to also inform them about the study and confirm their willingness to participate. Once both members of the couple agreed to participate, they received a link with the informed consent form, followed by a link to complete the survey from the first assessment time. Couples were asked to complete the survey independently and were informed that they would enter a raffle for educational toys once they completed the three waves of the study, as

compensation for their participation. Participants were contacted around the expected date of birth to obtain the exact birth date to schedule follow-up assessments at three and six months postpartum. All measures of target variables were applied in all assessment times to both parents.

4.2 Participants

Inclusion and exclusion criteria for couples were as follows:

Inclusion criteria: (1) heterosexual couple living together, (2) expecting their biological baby, (3) being in the third trimester of pregnancy, (4) being in a romantic relationship, (5) both partners agreeing to participate in the study, (6) the ability to complete the survey in Spanish, and (7) being of legal age.

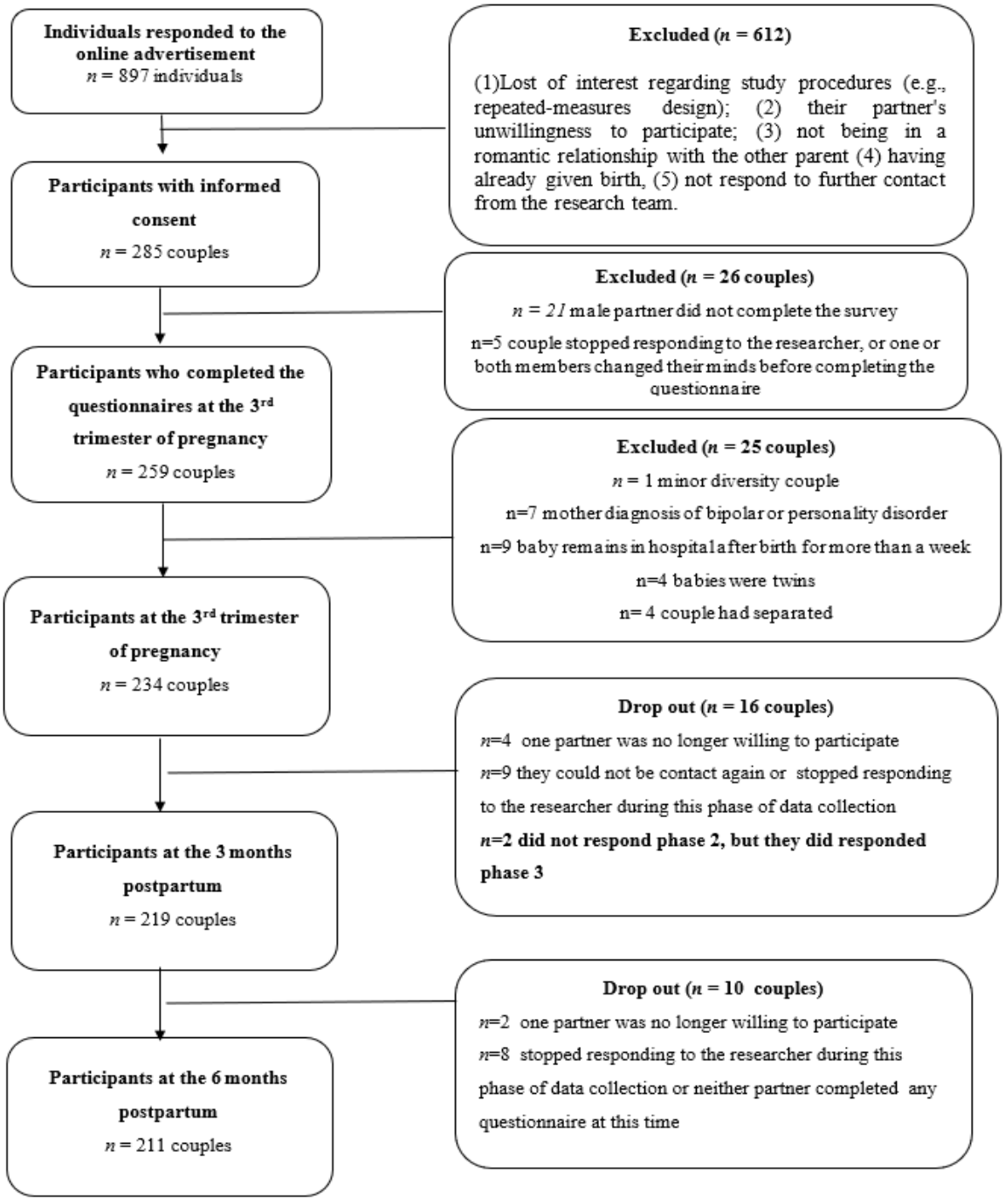
Exclusion criteria: (1) the baby had been diagnosed prenatally with a severe pathology or was hospitalized for a significant period after birth, (2) babies were twins, (3) parents present a major mental health disorder (4) couple separated during study.

The sample was non-probabilistic. Figure 3 presents the flowchart of participant recruitment and attrition across the study waves. A total of 259 couples (N = 518 participants) completed the first wave of data collection. Of these, 25 couples were excluded from the analyses, resulting in a baseline sample of 234 couples. At this time point, four fathers and one mother did not complete one or two questionnaires included in the survey. At Time 2, 219 couples participated in the study, with 15 couples lost to follow-up. Among the

participating couples, 17 individuals (all fathers) did not complete any questionnaires at this wave, and 14 participants did not complete one or two questionnaires. At Time 3, the sample comprised 211 couples, as 10 additional couples did not continue to participate in the final wave of the study. Among participating couples at this time point, nine individuals (all fathers) did not complete any questionnaires, and six participants did not complete one or two questionnaires.

Figure 3

Participants´ Flowchart



Attrition analyses were conducted to examine whether participants who did not complete Time 2 or Time 3- or both- differed from those who remained in the study at the three time points on demographic and study variables assessed at Time 1. Regarding mothers, those lost to follow-up were significantly younger ($t(232) = -2.63$, $p = .009$), reported shorter relationship duration ($t(230) = 2.93$, $p = .004$), and exhibited higher levels of depressive symptoms at Time 1 ($t(231) = -2.12$, $p = .034$) compared to mothers who completed all time points. No significant differences were found with respect to parity, education level, housing arrangement, employment status, perceived income adequacy, infant sex, or type of delivery, nor on Time 1 measures of parental self-efficacy, coparenting, or couple satisfaction.

Regarding fathers, those lost to follow-up reported shorter relationship duration ($t(229) = 2.21$, $p = .03$) and higher initial expectations (Time 1) regarding task-specific parental self-efficacy ($t(231)=-1.99, p=.05$) compared to fathers who completed all assessments. No significant differences were observed for age, depressive symptoms, general domain parental self-efficacy, coparenting, or couple satisfaction, nor for parity, education level, employment status, perceived income adequacy, housing arrangement, or infant sex.

4.3 Measures

Study variables

Sociodemographic information. At their third trimester of pregnancy, expectant mothers and fathers were asked to report their age, level of education, occupation, family household income, family members living in the household, support networks (main people in their support network), mental health history, parity, obstetric variables (i.e., previous miscarriage, assisted reproduction, complications during pregnancy), desire to have a baby and care during pregnancy (beginning of prenatal check-ups, person accompanying the expectant mother to prenatal check-ups, attendance at prenatal classes, accompaniment during delivery intentions).

Postpartum and baby information. At three months postpartum, mothers and fathers were asked to provide information about the child (e.g., sex, gestational age at birth), their current perception of social support, and access to parental leave. Mothers were also asked about their childbirth experience, including labor-related information, whether they were accompanied during childbirth, infant birth weight, and if the infant or mother had required prolonged hospitalization after birth.

Couple relationship satisfaction. The Dyadic Adjustment Scale (DAS; Spanier, 1976) contains 32 items (30 items were used in this study, see Annex 1) that measure the level of agreement between the couple and the frequency

with which certain issues are expressed using a 6-point Likert scale (except for items 29-32). The measure has 4 dimensions: consensus, general satisfaction with the relationship, cohesion, and expression of affection. Consensus evaluates the degree of agreement of the couple on important issues such as family finances, major decisions, religion, philosophy of life, etc., for example: “Agreement making major decisions”. Satisfaction evaluates the degree of tension in the couple's relationship, with items such as: “How often do you discuss or have you considered divorced, separation, or terminating your relationship?” Cohesion assesses the common interests and activities of the couple, for example: “How often... Do you calmly discuss something?” Affective expression assesses the level of satisfaction with the expression of affection and sexual relations, e.g., “Difference of opinion about.... Not showing love”. The instrument provides a global score and a specific score for each dimension. Higher scores indicate a better level of adjustment in the couple's relationship. The scale has been validated in Chile (Tapia et al., 2009). This instrument was completed by mothers and fathers. Detailed descriptions of the confirmatory factor analyses conducted separately for mothers and fathers, as well as the measurement invariance testing across the three time points, are provided in the Annex section. Reliability properties observed in the sample are in Table 1. Given the low reliability of some subscales, only the total scale score was used in the analysis:

Table 1

Reliability of the Dyadic Adjustment Scale for mothers and fathers across timepoints.

Time point	Scale/Subscale	Mothers α	Mothers ω	Fathers α	Fathers ω
T1	Consensus	.88	.88	.90	.90
	Cohesion	.62	.64	.62	.64
	General Satisfaction	.81	.81	.59	.59
	Expression of affection	.66	.72	.61	.67
	Total Scale	.91	.91	.89	.89
T2	Consensus	.90	.91	.86	.86
	Cohesion	.65	.68	.59	.60
	General Satisfaction	.82	.83	.75	.77
	Expression of affection	.63	.69	.55	.61
	Total Scale	.93	.93	.90	.90
T3	Consensus	.85	.85	.90	.90
	Cohesion	.61	.65	.63	.66
	General Satisfaction	.78	.79	.70	.71

Expression of affection	.63	.67	.62	.69
Total Scale	.91	.91	.90	.90

Note. N for mothers: T1 = 233, T2 = 217, T3 = 209. N for fathers: T1 = 233, T2 = 199, T3 = 202.

Coparenting representations. The Coparenting Relationship Scale (CRS; Feinberg et al., 2012) is a self-report questionnaire designed to assess coparenting, based on the dimensions proposed in Feinberg's Ecological Model of Coparenting (2003). In the present study, the items and factor structure of the prenatal version of the CRS were used to assess both prenatal and postpartum coparenting representations. This version of the scale comprises 18 items rated on a 7-point Likert scale ranging from 0 to 6. The CRS has a two-factor structure including Cooperative Coparenting and Coparental Conflict. Cooperative Coparenting assesses the degree of support, validation, and closeness perceived in the coparenting relationship (e.g., "My partner is a good parent"), and Coparental Conflict, which evaluates the extent of conflict perceived in the coparenting relationship (e.g., "I sometimes find myself having a mildly tense or sarcastic interchange with my partner"). The instrument yields both a global coparenting score and dimension-specific scores. For the total scale, higher scores indicate more positive coparenting representations.

This version of the CRS has been validated for prenatal coparenting in Chile (Bennett et al., under review). The questionnaire was completed by both

mothers and fathers. Detailed descriptions of the confirmatory factor analyses conducted separately for mothers and fathers, the measurement invariance testing across the three time points, and the rationale for the version of the instrument used in the analyses are provided in Annex 1. In the present sample, the instrument demonstrated the reliability indices reported in Table 2. However, given the low reliability observed for some subscales, only the total scale score was used in the analyses.

Table 2

Reliability of the Coparenting Relationship Scale for mothers and fathers across timepoints.

Time point	Scale/Subscale	Mothers α	Mothers ω	Fathers α	Fathers ω
T1	Cooperative coparenting	.93	.93	.87	.88
	Coparental conflict	.68	.71	.52	.63
	Total Scale	.92	.93	.87	.87
T2	Cooperative coparenting	.90	.90	.87	.88
	Coparental conflict	.75	.76	.72	.76
	Total Scale	.88	.89	.87	.87
T3	Cooperative coparenting	.88	.88	.87	.88

Coparental conflict	.71	.71	.70	.71
Total Scale	.88	.88	.88	.88

Note. N for mothers: T1 = 233, T2 = 217, T3 = 209. N for fathers: T1 = 233, T2 = 199, T3 = 202.

Parental self-efficacy (task specific measure). Karitane Parental Confidence Scale (KPCS; Črnčec et al., 2008) is a 15-item self-report scale that measures parental self-efficacy in specific tasks in parents of infants aged 0-12 months, using a 4-point Likert scale (0-3). The original scale has 3 dimensions: Support, Parenting, and Child Development. Support evaluates the degree of support in parenting experienced by parents, for example: “I feel sure that my partner will be there for me when I need support”. Parenting evaluates the degree of confidence experienced by parents in parenting tasks, for example: “I can settle my baby”. Child development evaluates the degree of confidence of parents regarding the health and development of their baby, for example: “I am confident that my baby is doing well”. Nevertheless, the authors recommend its use as a unidimensional scale. Higher scores indicate greater parental self-efficacy. The scale has not been validated in Chile or any Spanish- speaking country, however it has been used in studies with Spanish-speaking participants (Camero et al., 2022; Jones et al., 2018). For this sample, the scale presented a one-factor structure, which is consistent with findings from the Brazilian (Pereira et al., 2018) and Nepali (Shrestha et al., 2016) versions of the questionnaire. This instrument was completed by mothers and fathers. Detailed

descriptions of the confirmatory factor analyses conducted separately for mothers and fathers, as well as the measurement invariance testing across the three time points, are provided in Annex 1 For the present sample, the instrument demonstrated the following reliability properties (see Table 3):

Table 3

Reliability of the Karitane Parental Confidence Scale for mothers and fathers across timepoints.

Time point	Mothers α	Mothers ω	Fathers α	Fathers ω
T1	.87	.88	.83	.84
T2	.77	.78	.81	.82
T3	.75	.74	.80	.81

Note. N for mothers: T1 = 233, T2 = 216, T3 = 209. N for fathers: T1 = 225, T2 = 203, T3 = 200.

Parental self-efficacy (general domain measure). The Parental Evaluation Scale (EEP; Farkas-Klein, 2008) is a 10-item self-report instrument developed in Chile to assess parents' perceptions of their general parental abilities during infancy (0–2 years). Items are rated on a 10-point Likert scale. The scale has a two-factor structure, including Negative Attitudes towards Parenting and Positive Attitudes towards Parenting. Negative Attitudes towards Parenting assesses the extent to which negative perceptions and emotions experienced in the parental role (e.g., "I feel that I have not able to be the kind of parent I would like to be"). Positive Attitudes Towards Parenting evaluates

positive perceptions and emotions associated with the parental role (e.g., “Being a parent makes me feel fulfilled and happy”). The instrument yields both dimension-specific and global scores, with higher total scores indicating higher parental self-efficacy. The EEP was validated in mothers but has been used with both Chilean mothers and fathers (Jiménez et al., 2012). This instrument was completed by mothers and fathers. Detailed descriptions of the confirmatory factor analyses conducted separately for mothers and fathers, as well as the measurement invariance testing across the three time points, are provided in Annex 1. Reliability indices found in the study are in Table 4. Due to the low reliability observed in some subscales, only the total scale score was retained for the analyses.

Table 4

Reliability of the Parental Evaluation Scale for mothers and fathers across timepoints.

Time point	Scale/Subscale	Mothers α	Mothers ω	Fathers α	Fathers ω
T1	Negative Attitudes towards Parenting	.79	.80	.70	.70
	Positive Attitudes towards Parenting	.73	.74	.76	.76
	Total Scale	.82	.83	.74	.73
T2	Negative Attitudes towards Parenting	.70	.70	.63	.63
	Positive Attitudes towards Parenting	.69	.69	.77	.80
	Total Scale	.77	.77	.72	.71
T3	Negative Attitudes towards Parenting	.69	.68	.70	.71
	Positive Attitudes towards Parenting	.79	.80	.80	.82
	Total Scale	.76	.75	.75	.75

Note. N for mothers: T1 = 234, T2 = 216, T3 = 209. N for fathers: T1 = 231, T2 = 203, T3 = 200.

Control Variables

Mental health. Parental mental health was considered as a control variable due to its influence on parental self-efficacy, coparental and couple relationship. To assess parents' mental health, the following measure was used:

Beck Depression Inventory (BDI-IA; Beck et al., 1993). This is a 21-item self-report questionnaire that screens for depressive symptoms experienced in the past week, using a 4-point Likert scale ranging from 0 to 3. The instrument has a one-factor structure and contains items such as "Sadness: I feel sad most of the time." The higher the score, the greater the depressive symptomatology. The instrument has been validated in Chile (Valdés et al., 2017) and it has been used to assess depressive symptoms of Chilean parents during the postpartum period (Pérez et al., 2018). This instrument was completed by mothers and fathers. Detailed descriptions of the confirmatory factor analyses conducted separately for mothers and fathers, as well as the measurement invariance testing across the three time points, are provided in Annex 1. Table 5 shows the reliability indices found in the study sample.

Table 5

Reliability of the Beck Depression Scale for mothers and fathers across timepoints.

Time point	Mothers α	Mothers ω	Fathers α	Fathers ω
T1	.86	.86	.89	.89
T2	.90	.90	.89	.89
T3	.90	.90	.90	.90

Note. N for mothers: T1 = 229, T2 = 212, T3 = 203. N for fathers: T1 = 228, T2 = 199, T3 = 197.

Depression Anxiety Stress Scale (DASS-21). The Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995) is a 21-item self-report questionnaire designed to assess perceived mental health difficulties experienced during the previous week, using a 4-point Likert scale ranging from 0 to 3. The instrument comprises three subscales: Depression, Anxiety, and Stress, each consisting of seven items. The Depression subscale assesses symptoms such as dysphoria, meaninglessness, loss of interest, and anhedonia (e.g., “I didn’t feel enthusiastic about anything”). The Anxiety subscale captures subjective and somatic symptoms of fear, autonomic arousal, situational anxiety, and anxious affect (e.g., “I felt afraid for no reason”). The Stress subscale evaluates persistent, non-specific arousal, difficulty relaxing, irritability, and impatience (e.g., “I found it difficult to relax”). Higher scores indicate greater symptom severity. The DASS-21 has been validated in Chile (Antúnez & Vinet,

2012) and has been used in studies with Chilean perinatal women (Coo et al., 2023). In the present study, only the Stress subscale was used. This subscale was completed by both mothers and fathers. Detailed descriptions of the confirmatory factor analyses conducted separately for mothers and fathers, as well as the measurement invariance testing across the three time points, are provided in Annex 1. Reliability indices of the Stress subscale are reported in Table 6.

Table 6

Reliability of the Depression Anxiety Stress Scale for mothers and fathers across timepoints.

Time point	Mothers α	Mothers ω	Fathers α	Fathers ω
T1	.83	.84	.78	.78
T2	.84	.85	.84	.84
T3	.82	.81	.86	.87

Note. N for mothers: T1 = 229, T2 = 216, T3 = 209. N for fathers: T1 = 228, T2 = 200, T3 = 200.

4.4 Statistical Analyses

Firstly, descriptive statistics (means, standard deviations, and correlations) were calculated to characterize the sample. Independent-samples t-tests were conducted to examine differences in parental self-efficacy according to parity, in line with the study's theoretical framework. These analyses were performed using SPSS Statistics version 27.0.1.0. Repeated-

measures analyses of variance (ANOVAs) were conducted separately for mothers and fathers to examine changes in parental self-efficacy across time points (for ANOVA analysis we used all items of the questionnaires rather than the invariance-achieved versions, as the analyses were conducted separately for mothers and fathers and we were interested in individual change over time). Because the assumption of sphericity was violated for the KPCS and EEP in both mothers and fathers, Greenhouse–Geisser corrections were applied. Holm-adjusted post hoc tests were used to identify specific differences between time points. These analyses were performed using JASP version 0.19.3.

The analytical approaches needed to address specific objectives 1, 2, and 3 (described in detail later in this section) involve dyadic data. According to Sakaluk et al. (2021), this requires the establishment of both dyadic configural invariance, whereby the pattern of item loadings and factor structure is equivalent across dyad members, and metric invariance, where item loadings are equivalent across mothers and fathers. Thus, measurement invariance was assessed to establish equivalence between mothers and fathers (Ledermann & Kenny, 2017) for all variables of interest—namely, couple satisfaction, coparenting relationship, parental self-efficacy, and mental health—across all study time points i.e., (third trimester of pregnancy, three months postpartum, and six months postpartum). Requirements for dyadic measurement invariance analyses were followed as outlined by Sakaluk et al. (2021). Full results of the

dyadic measurement invariance analyses for each instrument, together with detailed descriptions of the procedures, are provided in Annex 1.

Specific Objective 1: To examine the influence of coparental representations at 3 months postpartum on parental self-efficacy, assessed as a general domain and as developmental stage-specific tasks at 6 months postpartum in both parents.

For this objective, a multigroup framework was used using dyadic data. Firstly, correlations were established between the same variables measured at the same time point across partners (for example: Correlation of coparenting in mothers and coparenting in fathers at Time 2). These models were estimated for both task-specific parental self-efficacy and parental self-efficacy as a general domain. The Maximum Likelihood Robust (MLR) estimator was employed to account for non-normality in the data.

Subsequently, we tested whether the predictor effect of coparenting on parental self-efficacy was equivalent for mothers and fathers. This was achieved by comparing two nested models: (1) a model in which all paths were freely estimated across parents, and (2) a constrained model in which the path from coparenting to parental self-efficacy was fixed to be equal for mothers and fathers. Model comparison was conducted using the Satorra–Bentler scaled chi-square difference test. A non-significant difference ($p > .05$) indicates that the actor effect is equivalent across parents.

To deal with confounding or covariate variables (i.e., those that correlate with both a predictor and its outcome and occur temporally prior to the predictor (Frank, 2000)), we selected covariates measured preferably at the first time point of the study that were significantly associated with both variables of interest for mothers and fathers. Accordingly, we examined correlations between all sociodemographic, postpartum, and infant-related variables with coparenting at three months postpartum and parental self-efficacy at six months postpartum, for both the general-domain and task-specific parental self-efficacy models. Analyses for this objective were conducted in MPLUS version 6.11.

Specific Objective 2: To examine the indirect effect of prenatal couple relationship satisfaction on parental self-efficacy, assessed as general domain and as developmental stage-specific task- at 6 months postpartum, through prenatal and at 3 months postpartum coparental representations.

Given that the proposed mediation model specified a direct path between couple satisfaction and coparenting at Time 1, discriminant validity analyses were conducted to determine whether prenatal coparenting constituted a construct empirically distinct from couple satisfaction during the third trimester of pregnancy. Accordingly, this section is divided into two parts: (1) the assessment of discriminant validity between couple satisfaction and coparenting at Time 1, and (2) the mediation models testing the indirect effect of couple satisfaction on parental self-efficacy through coparenting.

Discriminant validity analysis. A discriminant validity analysis was conducted to examine the distinction between prenatal coparental representations (CRS-P) and prenatal couple satisfaction (DAS) at the third trimester of pregnancy, analyzed separately for mothers and fathers. Only couples expecting their first child together (regardless of whether one or both partners had children from previous relationships) were included in this analysis (n = 202). This was the group for whom couple satisfaction and coparenting expectations were likely to be most intertwined, given that they lacked prior experience of sharing parental responsibilities together.

There is no clear consensus regarding the criteria for establishing discriminant validity (Rönkkö & Cho, 2022). Reichardt and Coleman (1995) proposed that discriminant validity is supported when: (a) measures A and B assess constructs W and Y, respectively; (b) the measures cannot be used interchangeably to assess the same target construct; and (c) the constructs are not perfectly correlated. This conceptualization was adopted because it allows for the examination of whether prenatal coparental representations constitute a construct that is empirically distinguishable from couple satisfaction during pregnancy for both parents. Guided by this construct validity framework, discriminant validity was assessed in two steps. Firstly, confirmatory factor analyses (CFAs) were conducted to examine the factorial structure of both measures. Variables were treated as categorical and Weighted Least Squares Mean and Variance adjusted (WLSMV) estimator was used, as it is appropriate

for categorical indicators and robust to deviations from normality (Liang & Yang, 2014).

Model fit was evaluated using the chi-square statistic (χ^2), the Comparative Fit Index (CFI), the Root Mean Square Error of Approximation (RMSEA; 90% CI), and the Weighted Root Mean Square Residual (WRMR). Good model fit was defined as follows: non-significant χ^2 ($p \geq .05$; Batista-Foguet et al., 2004), CFI close to .95 and RMSEA close to .06 (Hu & Bentler, 1999). Standardized factor loadings of .40 or higher were considered acceptable (Shrestha, 2021). Factor loadings for both instruments and details of factor analysis for this subsample are reported in Annex 2. CFA analyses were conducted using Mplus version 6.11.

Secondly, discriminant validity was further examined using the Heterotrait–Monotrait ratio (HTMT) proposed by Henseler et al. (2015). HTMT estimates the correlation between constructs by incorporating both monotrait–heteromethod correlations (i.e., correlations among indicators of the same construct) and heterotrait–heteromethod correlations (i.e., correlations among indicators of different constructs). According to this approach, discriminant validity is supported when HTMT values are below .85 (Henseler et al., 2015).

HTMT analyses were conducted across the factors of both scales to ensure that there was no substantial overlap between factors assessing these

theoretically distinct constructs. HTMT analyses were conducted using RStudio 2025.09.2 , employing the lavaan, ggplot2, reshape2, and viridis packages.

Mediational models. For this objective a multigroup framework using dyadic data was implemented. Correlations were established between the same variables measured at the same time point across partners. These models were estimated for both task-specific parental self-efficacy and parental self-efficacy as a general domain.

Following Hayes and Rockwood (2017), the primary focus of mediation analysis is the estimation of the indirect effect, rather than the significance of the individual causal paths linking the predictor to the mediator (path a), the mediator to the outcome (path b), and the predictor to the outcome (path c). The indirect effect is quantified as the product of paths a and b (a × b). Accordingly, mediation can be supported even if one or more of the individual paths (a, b, or c) are not statistically significant, provided that the indirect effect is significant.

For these analyses, we aimed to control for potential confounders affecting both variables involved in predictor-mediator, mediator-outcome, predictor-outcome paths —also in mediator (1)-mediator(2) path — in the mediational models. Following VanderWeele (2016), confounders must not occur after the predictor—or, if they do occur later, they must not be associated with it—so as not to disrupt the mediational process. Accordingly, correlations were examined between all variables of interest and a range of

sociodemographic, infant-related variables and mental health control variables measure at Time1.

Stability paths were included to control for autoregressive effects: (1) the influence of coparenting — measured either at Time 1 or Time 2, depending on the proposed model — on parental self-efficacy at Time 2; (2) the influence of parental self-efficacy at Time 2 on parental self-efficacy at Time 3.

In addition, we tested whether the casual paths of interest were equivalent for mothers and fathers across the models. For this purpose, two models were estimated: one in which the paths were freely estimated and another in which the paths of interest were constrained to be equal across parents. A chi-square difference test was then conducted to determine whether imposing this constraint significantly worsened model fit ($p < .05$). We also examined the equivalence of the indirect effect of interest (i.e., couple satisfaction → coparenting → parental self-efficacy). To do so, we estimated a parameter representing the difference between the indirect effects for mothers and fathers. If this difference was not statistically significant, the indirect effects were considered equivalent across parents.

Model fit was evaluated using standard criteria: $\chi^2/df \leq 3$, CFI ≥ .95, RMSEA ≤ .06, and SRMR ≤ .08 indicated good fit, whereas $\chi^2/df \leq 5$, CFI ≥ .90, RMSEA ≤ .08, and SRMR ≤ .08 indicated acceptable fit (Kline, 2005) . All

analyses were conducted using Mplus version 6.11, with Maximum Likelihood (ML) estimation, 5 000 bootstrap resamples, and 95% confidence intervals.

Specific objective 3. To examine the interdependence between coparental representations at 6 months postpartum and parental self-efficacy assessed as general domain and as developmental stage-specific task at 6 months postpartum in both parents.

For this analysis and Actor–Partner Interdependence Model (APIM) was used. The APIM allows for the estimation of two types of effects: (1) actor effects, which refer to the influence of an individual's own independent variables on their own dependent variables, and (2) partner effects, which refer to the influence of one partner's independent variables on the other partner's dependent variables (Cook & Kenny, 2005; Kenny & Ledermann, 2010). This approach is particularly suitable for samples in which non-independence is present, such as couples, caregiver–infant dyads, and siblings.

Interdependence within dyads was further assessed using the intraclass correlation coefficient (ICC). The ICC for parental self-efficacy measured as a general domain was low, indicating that dyad members shared approximately 7% of the variance. The ICC for task-specific parental self-efficacy was 0. Consequently, APIM analyses were conducted only for parental self-efficacy as a general domain.

To deal with confounding or covariate variables (Frank, 2000), we selected covariates measured preferably at earlier time points of the study that were significantly associated with both variables of interest for mothers and fathers. Accordingly, we examined correlations between all sociodemographic, postpartum, infant-related and mental health variables with coparenting and parental self-efficacy at six months postpartum.

A critical step in APIM analyses is determining whether dyads are distinguishable or indistinguishable. Dyads are considered indistinguishable when their members cannot be meaningfully ordered or categorized (e.g., siblings, same-sex couples). In contrast, distinguishable dyads can be differentiated using a categorical variable (e.g., parent–infant dyads, male–female couples). The present study focused on heterosexual couples during the transition to parenthood, a developmental stage characterized by increased traditionalization of gender roles. Therefore, it was expected that dyads would be distinguishable based on gender. Distinguishability was evaluated statistically by comparing the fit of a linear mixed model that included differentiation by the categorical variable (gender) with a model that did not include such differentiation (Kenny & Ledermann, 2010). A chi-square difference test was conducted using the −2 log-likelihood values and the corresponding degrees of freedom for both models. A statistically significant difference indicated that the distinguishable model provided a better fit than the indistinguishable model. When the predictor (coparenting), the outcome

(parental self-efficacy), and the control variables (depressive symptoms, housing arrangement, and type of health insurance) were included, the distinguishable model fitted the data significantly better than the indistinguishable model ($\chi^2(4) = 12.29$, $p = .015$). Therefore, data was treated as distinguishable.

Model fit was evaluated using standard criteria: $\chi^2/df \leq 3$, CFI ≥ .95, RMSEA ≤ .06, and SRMR ≤ .08 indicated good fit (Kline, 2005). Predictor (coparenting) and control variable (depressive symptoms) were mean centered. Maximum Likelihood (ML) estimation and Mplus version 6.11 was used to conduct the APIM analysis. SPSS version 27.0.1.0 was used to conduct the distinguishability and ICC analyses.

4.5 Ethical Considerations

This project was evaluated by the Ethics Committee of the Faculty of Psychology at Universidad del Desarrollo and was approved in May 2024. The study adhered to the guidelines of the Declaration of Helsinki (World Medical Association, 2009). Participants were fully informed about the terms of their participation and were asked to read and sign an informed consent form before joining the study.

Participation in the study was voluntary, and participants were free to withdraw at any time without any consequences. Confidentiality in the handling of personal data was guaranteed. During data collection, the researcher had

access to participants' contact information and names in order to reach out to them throughout the different waves of the study and to refer them to appropriate health services in case any mental health concerns were identified. Once data collection was completed, all databases were anonymized. There were no known risks or costs associated with participation in this study.

At each time point, mothers' and fathers' depressive symptoms were calculated. If scores indicated clinically significant depressive symptoms, parents were informed of their results and offered options for mental health care during the perinatal period. These included services available through both private (Unidad Perinatal del Servicio de Psicología Integral de la Universidad del Desarrollo) and public (Fundación Más Mentes) health insurance.

5. Results

5.1 Participants' characteristics

Table 7 presents the sociodemographic information of the participants. Participants came from 112 communes across Chile. The mean age of the women was 32.50 years (SD = 4.42, range = 20–44), and the mean age of the men was 33.71 years (SD = 4.96, range = 23–51). On average, couples had been in a relationship for 7.11 years (SD = 4.62, range = 0.58–21 years). At the Time 1 of data collection, women were, on average, at 30.76 weeks of pregnancy (SD = 4.1).

Most couples were cohabiting but not married. A majority of women and men were expecting their first child. Most pregnancies were planned and wanted. Nearly all women (99.6%) reported wanting to be accompanied during childbirth, primarily by their partners (98.8%).

Table 7

Expectant woman and man sociodemographic characteristics and pregnancy related information (N=234 couples)

Characteristics	Woman	Man
Age		
20-29 years	21.4%	18%
30-39 years	71.8%	68.8%
40-49 years	6.8%	11.9%
50-52 years		.8%
Nationality		
Chilean	97.4%	95,7%
Other countries[(a)]	2.6%	3,9%
Education		
Completed university studies	80.8%	66.7%
Started but not completed university education	6%	12%
Completed higher technical education	9.4%	14.5%
Completed secondary education	3.8%	6%
Not completed secondary education		.4%
Employment status		
Employed in paid work	85.5%	91.5%
Not employed in paid work	14.1%	8.1%
Income perception		
Income more than sufficient	8.1%	7.3%
Income sufficient	51.7%	53.8%
Income just sufficient	28.6%	28.2%
Income insufficient	9%	6.4%
Income largely insufficient	2.1%	1.7%
Not response	.4%	2.6%
Relationship length		
Less than 2 years	11.6%	
2-10 years	65.4%	
More than 10 years	34.6%	
Relationship status of the couple		
Married	36.3%	

Cohabiting	59%	
Civil partnership	4.3%	
Romantic relationship without living together	.4%	
Housing status		
Own home	43.2%	
Rent a house	40.2%	
Rent a room	.4%	
Live at home with family members	12%	
Other	4.3%	
Number of people living in the household		
Live only with partner	66.2%	
3-4 people live together	30.3%	
5-6 people live together	3.4%	
Diagnosis of current anxiety or depressive disorder		
Yes	4.3%	4.2%
No	94.4%	94.5%
Other	1.3%	1.3%
Parity		
First child	76.5%	82.1%
Having a child already	23,5%	17.5%
First child with current partner		
Yes	87.2%	
No	12.8%	
Beginning of prenatal medical check-ups		
0-8 weeks	84.5%	
9-12 weeks	11.2%	
13-20 weeks	3%	
More than 20 weeks	1.3%	
Pregnancy intention		
Planned and wanted	48.7%	50.9%
Not planned but wanted	42.3%	43.2%
Not planned, unwanted	9%	5.1%
Search for information on pregnancy and parenting		
Yes	97%	89.7%
No	3%	9.8%
Attendance at prenatal classes		
Yes	46.2%	29.1%
No	53.8%	68.8%
Previous pregnancies		
Yes	44%	
No	56%	
Previous Miscarries		

Yes	32.9%
No	67.1%
Wants to be accompanied during childbirth	
Yes	99.6%
No	.4%
By whom she wants to be accompanied during childbirth	
Partner	98.7%
Mother	.9%
Other	.4%

(a) Other Nationalities are Venezuela, Colombia, Cuba, Ecuador, Francia, China

Regarding post-birth characteristics (see Table 8), the majority of deliveries were vaginal and occurred after 37 weeks of gestation. Most women were accompanied by their partners during childbirth. The majority of mothers and fathers in the study took their postnatal leave (24 weeks for mothers and five days for fathers).

Table 8

Postpartum and baby information (N=219 couples)

Characteristics	Woman	Man
Baby´s sex		
Girls	48.9%	
Boys	51.1%	
Weeks of pregnancy at the time of delivery	*M*= 38.44; *SD*=1.22	
Infant weight at birth (gr)	*M*=3 353; *SD* = 427	
Type of delivery		
Vaginal	41.3%	
Unplanned Caesarean section	29.8%	
Planned Caesarean section	26.6%	
Assisted delivery	2.3%	
Support during childbirth		
Partner	98.1%	
Other relative	.9%	
Nobody	.9%	
Take prenatal leave		
No	25.2%	
Yes	74.8%	
Take postnatal Leave		
No	24.2%	28.7%
Yes	75.8%	71.3%

Regarding parental mental health, during third trimester of pregnancy, 24% (n=56) of mothers and 17% (n=39) of fathers scored above the cutoff point on the BDI scale, indicating clinically significant depressive symptoms. These symptoms increased to 40.6% (n=89) in mothers and 21.3% (n=43) in fathers at three months postpartum. At six months postpartum, 35.7% (n=75) of mothers and 17.4% (n=35) of fathers continued to present clinically significant symptoms.

With regard to parental self-efficacy, among mothers, non-significant changes in parental self-efficacy across Time points were observed for the general domain ($F(1.9, 389.8) = 37.37$, $p < .001$) but there were significant changes on the task-specific domain ($F(1.6, 342.2) = 50.23$, $p < .001$). Post hoc comparisons indicated a significant increases from Time 1 to Time 2, ($t(204) = -6.87$, $p<.001$), from Time 2 to Time 3, ($t(204) = -6.303$, $p = .02$) and from Time 1 to Time 3 ($t(204) = -8.65$, $p<.001$). Among fathers, non-significant changes over time were observed for parental self-efficacy as a general domain or as a task specific.

No differences in parental self-efficacy (measured as a task specific or as general domain) were found between primiparous and multiparous parents for either mothers or fathers at any time point. Furthermore, no differences were observed between parents expecting their first child together and parents who already had children together.

Table 9 presents the means, standard deviations, and correlations among study variables for mothers and fathers across time points. As expected, parental self-efficacy – measured as both a general domain and a task-specific construct – correlated positively with couple satisfaction and coparenting representations at each time point. Parental self-efficacy was also negatively correlated with depressive symptoms and stress at each time point for mothers and fathers.

Table 9

Correlation matrix, mean and standard deviation of variables of interest across time points

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Mean (SD)m	Mean (SD)f
1. BDI_T1	**.22****	.73***	-.57***	-.56***	-.48***	-.59***	.49***	.46***	-.35***	-.37***	-.21**	-.35***	.44***	.40***	-.36***	-.43***	-.23**	-.35***	9.50(5.68)	7.13(6.50)
2. DASS_T1	.69***	**.23****	-.43***	-.39***	-.43***	-.52***	.42***	.47***	-.26***	-.27***	-0.09	-.23**	.37***	.45***	-.33***	-.31***	-.18**	-.30***	2.41 (2.59)	1.73(2.12)
3. EEP_T1	-.38***	-.36***	**.19****	.68***	.49***	.46***	-.43***	-.37***	.50***	.43***	.23**	.28***	-.33***	-.35***	.45***	.41***	.19**	.25***	69.61(12.91)	75.41(10.59)
4. K_T1	-.34***	-.31***	.56***	**.15***	.53***	.52***	-.43***	-.35***	.41***	.59***	.26***	.29***	-.27***	-.20**	.37***	.59***	.24***	.26***	34.15(4.78)	33.38(4.15)
5. CRS_T1	-.30***	-.29***	.51***	.56***	**.37*****	.79***	-.35***	-.27***	.36***	.29***	.46***	.46***	-.22**	-.20**	.33***	.40***	.42***	.42***	85.41(11.84)	87.29(9.20)
6. DAS_T1	-.36***	-.31***	.51***	.42***	.74***	**.39*****	-.40***	-.32***	.35***	.34***	.44***	.59***	-.29***	-.31***	.28***	.41***	.45***	.63***	123.27(12.98)	124.33(12.39)
7. BDI_T2	.56***	.44***	-.28***	-.28***	-.29***	-.33***	**.20****	.80***	-.60***	-.59***	-.42***	-.51***	.58***	.51***	-.42***	-.44***	-.29***	-.32***	13.81(8.33)	9.23(6.94)
8. DASS_T2	.41***	.47***	-.27***	-.30***	-.24***	-.23**	.73***	**0.09**	-.58***	-.54***	-.32***	-.43***	.51***	.58***	-.39***	-.36***	-.22**	-.27***	4.18(3.47)	2.84 (2.93)
9. EEP_T2	-.33***	-.25***	.53***	.38***	.39***	.42***	-.47***	-.34***	**0.11**	.56***	.37***	.37***	-.41***	-.42***	.62***	.47***	.29***	.24***	72.22(12.34)	74.07(11.34)
10. K_T2	-.27***	-.14*	.31***	.49***	.33***	.36***	-.42***	-.30***	.50***	**.16***	.27***	.35***	-.36***	-.30***	.41***	.66***	.29***	.29***	35.93(3.38)	33.23(4.42)
11. CRS_T2	-.19**	-.15*	.29***	.26***	.56***	.51***	-.45***	-.37***	.39***	.39***	**.43******	.71***	-.14*	-0.09	.18**	.25***	.56***	.48***	68.29(10.16)	69.72(9.03)
12. DAS_T2	-.28***	-.24***	.29***	.23**	.52***	.63***	-.51***	-.34***	.44***	.34***	.71***	**.41******	-.26***	-.23**	.24***	.31***	.49***	.63***	117.70(14.426)	119.68(12.50)
13. BDI_T3	.49***	.42***	-.31***	-.29***	-.24***	-.21**	.65***	.59***	-.39***	-.30***	-.31***	-.33***	**.18****	.76***	-.58***	-.47***	-.42***	-.48***	13.24(7.87)	8.67(6.92)
14. DASS_T3	.38***	.44***	-.24***	-.20**	-0.12	-0.09	.51***	.59***	-.27***	-.16*	-0.14	-.21**	.75***	**0.1**	-.54***	-.42***	-.39***	-.43***	3.99(3.21)	2.47(3.06)
15. EEP_T3	-.28***	-.23**	.36***	.30***	.24***	.23**	-.33***	-.25***	.53***	.32***	.30***	.30***	-.55***	-.41***	**0.1**	.50***	.40***	.41***	77.32(13.52)	82.14(12.67)
16. K_T3	-.19**	-0.13	.39***	.56***	.38***	.34***	-.31***	-.27***	.44***	.65***	.48***	.36***	-.36***	-.20**	.44***	**0.06**	.39***	.35***	36.67(2.86)	33.57(4.25)
17. CRS_T3	-.17*	-.16*	.31***	.35***	.47***	.41***	-.36***	-.30***	.31***	.29***	.65***	.53***	-.43***	-.26***	.46***	.51***	**0.35*****	.75***	73.45(10.36)	73.40(10.38)
18. DAS_T3	-.23**	-.20**	.41***	.35***	.51***	.58***	-.35***	-.26***	.35***	.31***	.56***	.68***	-.38***	-.28***	.46***	.42***	.75***	**.41*****	122.94(12.92)	124.03(12.98)

Note. Correlations for mothers are shown above the diagonal, and those for fathers are shown below the diagonal. The diagonal entries represent the correlations between mothers and fathers for the same instrument at the same assessment time.

EEP = Parental Evaluation Questionnaire; higher scores indicate greater parental self-efficacy (scale range: 0–63). BDI = Beck Depression Inventory; higher scores indicate more depressive symptoms (scale range: 0–63). DASS = Depression, Anxiety and Stress Scale; higher scores indicate more stress symptoms (scale range: 0–21). K = Karitane Parental Confidence Scale; higher scores indicate greater parental self-efficacy (scale range: 0–39). CRS = Coparenting Relationship Scale; higher scores indicate more positive coparental relationship (scale range: 0–96). DAS = Dyadic Adjustment Scale; higher scores indicate higher couple satisfaction (scale range: 0–174). See Annex 1 for details on the specific items removed to achieve metric invariance.

Subscripts T1, T2, and T3 refer to assessment times 1, 2, and 3, respectively.

**p < .05. **p < .01. ***p < .001*

5.2. Results of Specific Objective 1.

The influence of coparenting at Time 2 on parental self-efficacy at Time 3, both as a general domain and as a task-specific domain, was examined while controlling for depressive symptoms and housing arrangement.

Preliminary analysis. Preliminary analysis to identify potential covariates revealed that housing arrangement (coded as 0 = own home, 1 = rented home, 2 = rented room, 3 = living with another relative, 4 = other arrangement) was significantly associated with fathers' coparenting ($r = -.17$, $p = .014$), fathers' general-domain parental self-efficacy ($r = -.17$, $p = .013$), and both mothers' and fathers' task-specific parental self-efficacy (mothers: $r = -.14$, $p = .049$; fathers: $r = -.16$, $p = .024$). Consequently , housing arrangement was included as a covariate in the analyses for both the general-domain and task-specific parental self-efficacy models.

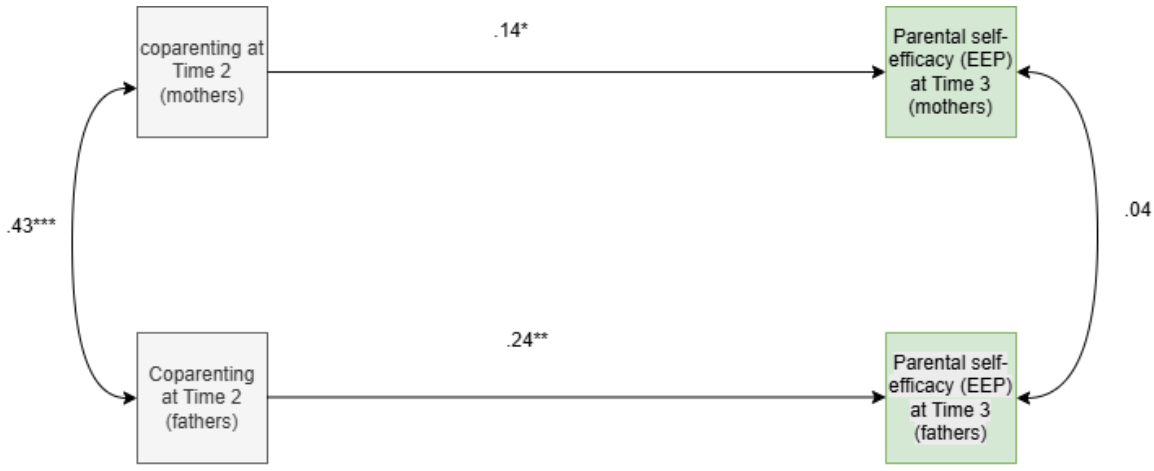
We also controlled for depressive symptoms measured during the third trimester of pregnancy, as these temporally preceded both variables of interest and were significantly correlated with all these variables for mothers and fathers (see Table 9). Stress was not included as a covariate. Stress at Time 1 was highly correlated with depressive symptoms (mothers: $r = .73$, $p < .001$; fathers: $r = .69$, $p < .001$), and it was not significantly associated with all of the variables of interest. Parity, although theoretically relevant and initially considered, was

not significantly correlated with any of the variables of interest for either mothers or fathers and was thus excluded.

Influence of Coparenting on Parental self-efficacy as a general domain. Figure 4 shows the predictive effect of coparenting at Time 2 on parental self-efficacy as a general domain at Time 3. For both mothers and fathers, coparenting at Time 2 had a significant effect on parental self-efficacy at Time 3. Controlled variables were also included in the regression of parental self-efficacy: depressive symptoms (β= -.37.*p* <.001 for mothers; β= -.21.*p* =.003 for fathers) and housing arrangement (β= .10, *p* =.11 for mothers; β= -.09, *p* =.22 for fathers). Based on modification indices, the correlation between fathers' housing arrangement and their paternal depressive symptoms was also established (*r* = .19, *p* = .006).When equality constraints were imposed to fix the predictive path from coparenting to parental self-efficacy to be equal across mothers and fathers, the constrained model did not differ significantly from the model in which the paths were freely estimated (see Table 10). These results suggest that the influence of coparenting at Time 2 on parental self-efficacy as a general domain at Time 3 is equivalent for mothers and fathers. The model explained 17% of parental self-efficacy for mothers and 14% for fathers.

Figure 4

Multigroup analysis for the relationship between coparenting and parental self-efficacy as a general domain.



*Note: EEP Parental Evaluation Scale, *p<.05, p<.01**, p<.001. The model controlled for housing arrangement and depressive symptoms*

Table 10

Comparison of model fit between the constrained and freely estimated models examining the relationship between coparenting and parental self-efficacy as a general domain.

Models	**S-Bχ ²ML**	**S-Bχ ²MLR**	**(*Df*)**	**Factor correction**	**CFI**	**RMSEA**	**RMSEA 90%CI**		**ΔS-BX² (*df*),*p***	**ΔCFI**	**ΔRMSEA**
Free estimated model	3.56, *p*=.46	2.76 *p*=.60	4	1.30	1.00	0	0-	.036			
Model Constrain	4.89 *p*=.46	3.73 *p*=.59	5	1.31	1.00	0	0-	.078	$X^2(1)=.99.p=.32$		

χ² Chi-square statistic, , S-By ML Satorra-Bentler Scaled Chi-square Maximum Likelihood, S-By MLR Satorra-Bentler Scaled Chi-square Maximum Likelihood Robust, DF Degree of Freedom, CFI Comparative Fit Index, RMSEA Root Mean Square Error of Approximation, CI Confident Indices

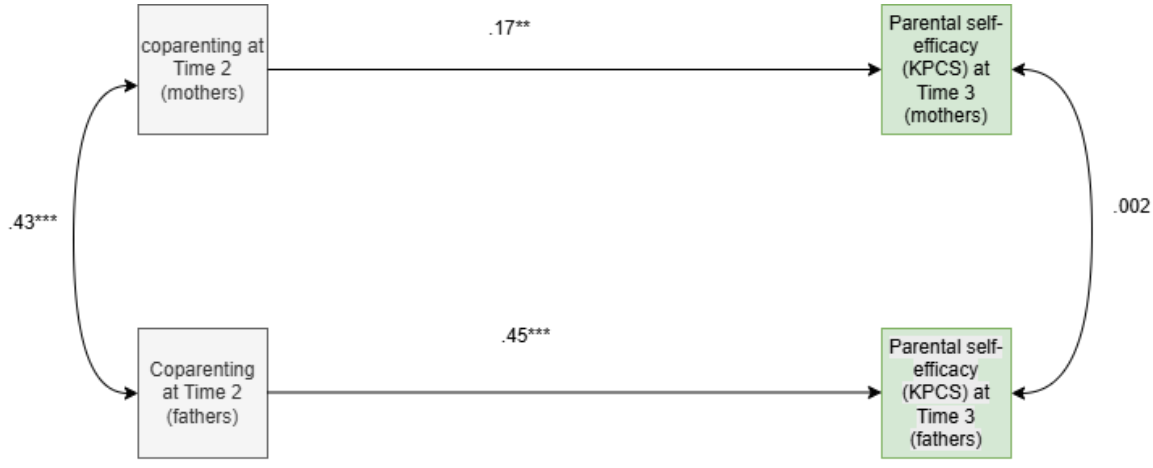
Influence of Coparenting on Parental self-efficacy as a task specific.

Figure 5 shows the predictive effect of coparenting at Time 2 on parental self-efficacy as a task specific domain at Time 3. For both mothers and fathers, coparenting at Time 2 had a significant effect on parental self-efficacy at Time 3. Controlled variables were also included in the regression of parental self-efficacy: depressive symptoms (β= -.41, *p* <.001 for mothers; β= -.08, *p*=.26 for fathers) and housing arrangement (β= -.01, *p*=.88 for mothers; β= -.06, *p*=.35 for fathers). The model, considering also controlled variables, explain 23 % of parental self-efficacy for mothers and 24% for fathers. When equality

constraints were imposed to fix the predictive path from coparenting to parental self-efficacy to be equal across mothers and fathers, the constrained model differed significantly from the model in which the paths were freely estimated. These results indicate that the influence of coparenting at Time 2 on parental self-efficacy as task specific domain at Time 3 is not equivalent across parents and is stronger for fathers than for mothers (See Table 11).

Figure 5

Multigroup analysis for the relationship between coparenting and parental self-efficacy as a task specific.



*Note: KPCS Karitane Parenting Confidence Scale, *p<.05, p<.01**, p<.001. The model controlled for housing arrangement and depressive symptoms.*

Table 11

Comparison of model fit between the constrained and freely estimated models examining the relationship between coparenting and parental self-efficacy as a task specific.

Models	**S-Bχ²ML**	**S-Bχ²MLR**	**(*Df*)**	**Factor correction**	**CFI**	**RMSEA**	**RMSEA 90%CI**	**ΔS-BX² (*df*),*p***	**ΔCFI**	**ΔRMSEA**
Free estimated model	8.51, *p*=.07	7.94 *p*=.09	4	1.07	.96	.065	0-.13			
Model Constrain	28.32 *p*<.001	24.89 *p*<.001	5	1.13	.79	.13	.082-.18	$X^2(1)=14.46.p<.001$	.17	-.065

χ² Chi-square statistic, , S-By ML Satorra-Bentler Scaled Chi-square Maximum Likelihood, S-By MLR Satorra-Bentler Scaled Chi-square Maximum Likelihood Robust, DF Degree of Freedom, CFI Comparative Fit Index, RMSEA Root Mean Square Error of Approximation, CI Confident Indices

5.3 Specific objective 2

Specific Objective 2 aimed to examine the mediating role of coparenting at Time 1 and 2 in the association between couple satisfaction at Time 1 and parental self-efficacy at Time 3. Given that the proposed mediation model specified a direct path between couple satisfaction and coparenting at Time 1, discriminant validity analyses were conducted to determine whether prenatal coparenting constituted a construct empirically distinct from couple satisfaction during the third trimester of pregnancy. Accordingly, this section is divided into two parts:

(1) the assessment of discriminant validity between couple satisfaction and coparenting at Time 1, and (2) the mediation models testing the indirect effect of couple satisfaction on parental self-efficacy through coparenting.

Discriminant validity of couple satisfaction and coparenting at T1

Confirmatory factor analyses (CFAs) were conducted to examine the factorial structure and goodness of fit of the **Prenatal Coparenting** (CRS-P) and **Couple Satisfaction** (DAS) measures during the third trimester of pregnancy. Table 12 presents the model fit indices for the CRS-P and DAS for mothers and fathers. Overall, both instruments showed good model fit – with the exception of significant chi-square – supporting the proposed factorial structure and indicating that the measures function adequately to capture the intended constructs.

Table 12

Model Fit Indices for the Coparenting Relationship Scale and the Dyadic Adjustment Scale for mothers and fathers.

Models	X^2 **WLSMV**	**(*Df*)**	**CFI**	**RMSEA**	**RMSEA 90%CI**
CRS-P (M)	184.7***	102	.98	.064	.049-.068
CRS-P (F)	198.7***	102	.96	.069	.055- .083
DAS (M)	496.6***	371	.95	.041	.031-.050
DAS(F)	479.0**	371	.97	.038	.027-.048

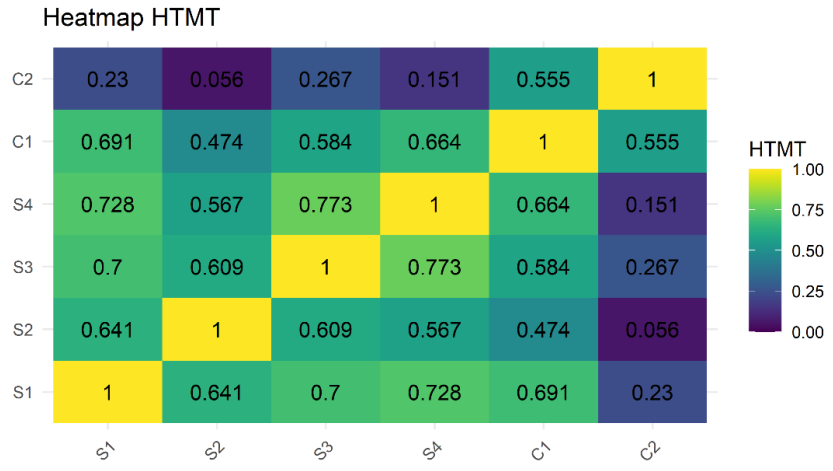
Prenatal CRS, Prenatal Coparenting, DAS Couple Satisfaction, (M) Mothers, (F) Fathers, χ^2 Chi-square statistic, WLSMV Weighted Least Squares Mean and Variance, DF Degree of Freedom, CFI Comparative Fit Index, WRMR Weighted Root Mean Square Residual, RMSEA Root Mean Square Error of Approximation, CI Confident Indices

****p<.001.*

Next, **Heterotrait–Monotrait (HTMT)** analyses were conducted to examine whether the factors demonstrated sufficient discriminant validity to ensure that coparenting dimensions were empirically distinguishable from couple satisfaction dimensions during the third trimester of pregnancy. Figures 6 and 7 present heatmaps displaying the HTMT estimates. For mothers, no evidence of discriminant validity problems was observed between prenatal coparenting and couple satisfaction factors.

Figure 6

Heatmap HTMT for prenatal coparenting and couple satisfaction dimensions at third trimester of pregnancy for mothers

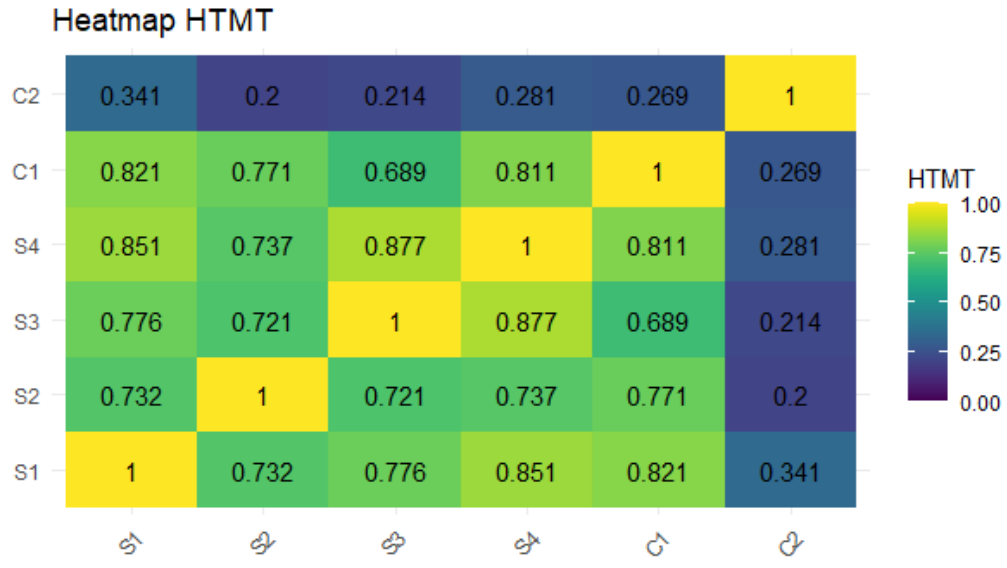


Note: S Dimensions of Couple Satisfaction dimensions: S1 Consensus; S2 Cohesion, S3 Satisfaction, S4 Expression of affection, C dimensions are Prenatal Coparenting Dimensions: C1 Cooperative Coparenting, C2 Coparental Conflict.

Similarly, for fathers, no discriminant validity concerns were identified. For fathers, the cooperative coparenting dimension showed relatively higher overlap with certain couple satisfaction dimensions—particularly Consensus and Expression of Affection—, although HTMT values did not exceed the recommended cut-off point. This indicates that, in this sample of expectant fathers, cooperative coparenting and couple satisfaction remain sufficiently distinguishable constructs during the third trimester of pregnancy.

Figure 7

Heatmap HTMT for prenatal coparenting and couple satisfaction dimensions at third trimester of pregnancy for fathers.



Note: S Dimensions of Couple Satisfaction dimensions: S1 Consensus; S2 Cohesion, S3 Satisfaction, S4 Expression of affection, C dimensions are Prenatal Coparenting Dimensions: C1 Cooperative Coparenting, C2 Coparental Conflict.

Mediation models from couple satisfaction to parental self-efficacy through coparenting

Preliminary analysis. Preliminary analysis to identify potential covariates revealed that for fathers, housing arrangement emerged as a potential covariate, as it was associated with couple satisfaction at Time 1 (r = –.17, p = .010), coparenting at Time 2 (r = –.17, p = .014) and Time 3 (r = –.18, p

= .010), and parental self-efficacy at Time 3, both as a general domain (r = –.18, p = .013) and as a task-specific construct (r = –.16, p = .024). Additionally, having paid employment (0 = no paid work; 1 = paid work) was associated with coparenting at Time 2 (r = –.17, p = .020) and Time 3 (r = –.14, p = .044). Type of health insurance (coded as: 0 = no health insurance; 1 = FONASA—national public health insurance; 2 = ISAPRE—private health insurance; 3 = other; 4 = do not know) was also related to fathers' parental self-efficacy as a general domain at Time 3 (r = –.15, p = .036), as well as to coparenting at Time 2 (r = –.18, p = .012) and Time 3 (r = –.17, p = .016).

For mothers, educational level (coded from 0 = completed basic education; 1= Incomplete Secondary Education ;2= Completed Secondary Education ;3= Higher technical education; 4= Incomplete University level Education ; 5 = completed university education) was associated with coparenting at Time 3 (r=.14, p=.043) and parental self-efficacy as a task specific at Time 3 (r=.14, p=.042) . Perceived income (coded as 0 = no response; 1= Monthly Income very insufficient; 2= Monthly income insufficient ; 3= Monthly income just sufficient ; 4= Monthly income more than sufficient ;5 = Wealthy) was associated with couple satisfaction at Time 1 (r = .24, p < .001), coparenting at Time 1 (r = .22, p < .001), and parental self-efficacy at Time 3, both as a general domain (r = .18, p = .009) and as a task-specific construct (r = .16, p = .023). The number of people living in the household (continuous variable) was associated with coparenting at Time 1 (r = –.14, p = .040) and

couple satisfaction at Time 1 (r = –.17, p = .009). Parity (coded as 0 = primiparous; 1 = multiparous) was associated with couple satisfaction at Time 1 (r = –.27, p < .001) and coparenting at Time 1 (r = –.15, p = .018).

These variables were considered for inclusion as covariates in the mediation models, specifically as predictors of the paths they were found to significantly affect. However, including all potential covariates simultaneously substantially impaired model fit — although it did not alter the significance of the paths of interest — and these variables collectively reflect socioeconomic status. Therefore, covariates were introduced stepwise, beginning with those associated with the greatest number of paths. Only covariates that preserved acceptable model fit were retained in the final specification. Each model is presented later in this chapter alongside the covariates included in its final specification.

Only depressive symptoms at Time 1 were considered and included as a mental health covariate, as they were significantly associated with all variables of interest in the models and represented the only time point at which mental health could plausibly be included without disrupting the mediational process under examination. Depressive symptoms were therefore specified as a predictor of all relevant paths in the mediation analyses. Stress at Time 1 was not included as a covariate in order to preserve model parsimony: (1) stress was highly correlated with depressive symptoms (mothers: r = .73, p < .001; fathers: r = .69, p < .001), which was the mental health variable retained in the

models; (2) stress was not significantly associated with all variables of interest in these analyses (see Table 9).

Original models. First, we tested a sequential double mediation model, examining the mediating roles of coparenting at Times 1 and 2 in the association between couple satisfaction at Time 1 and parental self-efficacy at Time 3. However, some of the paths required to support mediation were not statistically significant for mothers or fathers when all relevant variables were included in the models. This pattern was consistent across models measuring parental self-efficacy as both a general domain and a task-specific construct. These models are presented in detail in Annex 3.

In light of these findings, an alternative model was tested in place of the originally proposed one. The alternative models examined the sequential mediation process through the two postpartum coparenting measures: couple satisfaction at Time 1 → coparenting at Time 2 → coparenting at Time 3 → parental self-efficacy at Time 3. This alternative model was conducted separately for parental self-efficacy measured as a general domain and as a task-specific construct.

Model for Parental Self-efficacy as a Task Specific Domain: Couple satisfaction at Time 1 → Coparenting at Time 2 → Coparenting at Time 3 → Parental self-efficacy at Time 3.

Figure 8 presents the model examining the indirect effect of couple satisfaction at Time 1 on parental self-efficacy (specific task) at Time 3 through coparenting at Times 2 and 3. It was considered a stability path by including in model parental self-efficacy at time 2. Therefore, it was modelled the effect of coparenting at Time 2 on parental self-efficacy at Time 2 (β = .47, *p* = .001 for mothers; β = .55, *p* = .001 for fathers). Based on modification indices, instead of the autoregressive path (from parental self-efficacy at Time 2 on parental self-efficacy at Time 3) a correlation between parental self-efficacy at Time 2 on parental self-efficacy at Time 3 were included (r= . 59, *p*<.001 for mothers and r=. 57, *p*<.001 for fathers). A correlation between coparenting and parental self-efficacy at Time 2 was model (r=-.29, *p*=.046 for mothers; r=-.24, *p*=.14 for fathers).

We controlled for the effects of depressive symptoms at Time 1 on coparenting at Time 2 (β = .02, *p* = .86 for mothers; β = −.03, *p* = .64 for fathers), coparenting at Time 3 (β = −.03, *p* = .79 for mothers; β = .02, *p* = .67 for fathers), and parental self-efficacy at Time 3 (β = −.31, *p* =.002 for mothers; β = −.08, *p* = .26 for fathers) and parental self-efficacy at Time 2 (β = −.27, *p* =.01 for mothers; β = −.16, *p* = .07 for fathers).

Additional covariates were included as indicated by preliminary analyses. Housing arrangement was controlled for in the regression predicting fathers' coparenting at Time 2 (β = −.06, *p* = .43), coparenting at Time 3 (β = −.06, *p* = .41), and parental self-efficacy at Time 3 (β = .01, *p* = .90). Educational level was controlled for in the regression predicting mothers' parental self-efficacy at Time 3 (β = .04, *p* = .46).

The model showed acceptable fit to the data, $\chi^2(48) = 91.24$, $p < .001$, CFI = .94, RMSEA = .062, 90% CI [.042, .081]. For mothers, significant total effect (β = .31, 95% bootstrap CI [.02, .12]) was found from couple satisfaction at Time 1 on parental self-efficacy at Time 3. Indirect effects of couple satisfaction at Time 1 on parental self-efficacy at Time 3 were observed through coparenting at Time 3 (β = .05, 95% bootstrap CI [.001, .033]) and through coparenting at Times 2 and 3 (β = .04, 95% bootstrap CI [.001, .023]). For fathers, also a significant total (β = .28, 95% bootstrap CI [.04, .16]), and total indirect (β = .23, 95% bootstrap CI [.04, .14]) were found from couple satisfaction at Time 1 on parental self-efficacy at Time 3. Indirect effects of couple satisfaction at Time 1 on parental self-efficacy at Time 3 were observed through coparenting at Time 2 (β = .10, 95% bootstrap CI [.002, .09]) and through coparenting at Times 2 and 3 (β = .09, 95% bootstrap CI [.01, .06]).

We also examined whether the paths of interest were equivalent for mothers and fathers. For this analysis, only the focal structural paths were constrained to equality; covariates and stability paths were included in the

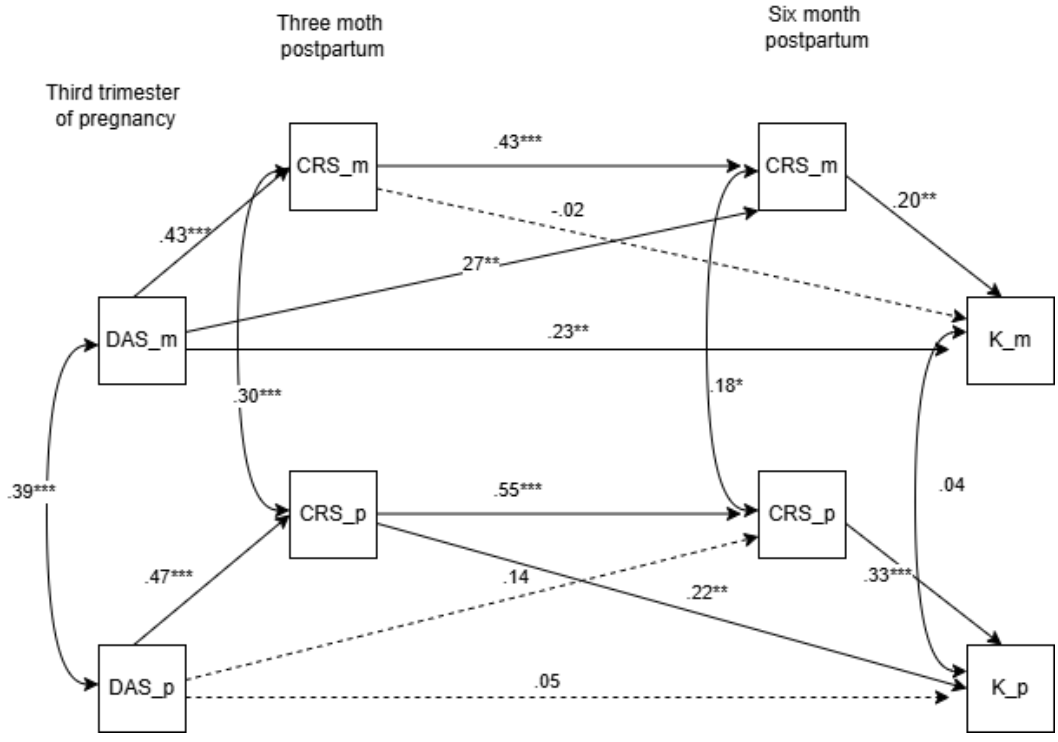
model but were not constrained. Specifically, the following paths were fixed to be equal across parents: (1) the effect of couple satisfaction at Time 1 on coparenting at Time 2, (2) the effect of coparenting at Time 2 on coparenting at Time 3, (3) the effect of coparenting at Time 3 on parental self-efficacy at Time 3, and (4) the direct effect of couple satisfaction at Time 1 on parental self-efficacy at Time 3.Imposing equality constraints on all four paths significantly worsened model fit. However, when path (3) the effect of coparenting at Time 3 on parental self-efficacy at Time 3 were freely estimated, the constrained model did not differ significantly from the unconstrained model ($\chi^2(3) = 5.58$, $p = .13$). This suggests that the remained paths were equivalent for mothers and fathers.

In addition, we tested the equivalence of the indirect effect of couple satisfaction on parental self-efficacy through coparenting at Times 2 and 3 across parents. The difference between the indirect effects for mothers and fathers was statistically significant (95% bootstrap CI [−.14, −.02]). These results indicate that the indirect effect was not equivalent for mothers and fathers.

The model explained 33% of the variance in parental self-efficacy at Time 3 for mothers and 29% for fathers. In addition, it accounted for 18% and 24% of the variance in coparenting at Time 2, and 24% and 40% of the variance in coparenting at Time 3, for mothers and fathers, respectively. The model also explained 11% of the variance in parental self-efficacy at Time 2 for mothers and 14% for fathers.

Figure 8

Doble mediation of coparenting at Time 2 and 3 in the relationship on couple satisfaction and parental self-efficacy as task-specific



Note: p<.05, **p<.01, p***<.001. DAS_m Couple satisfaction in mothers, DAS_p Couple satisfaction in fathers, CRS_m Coparenting in mothers, CRS_p Coparenting in fathers, K_m parental self-efficacy in mothers, K_p parental self-efficacy in fathers. The model controlled for housing arrangement for fathers, level of education for mothers and depressive symptoms for both parents.*

Model for Parental self-efficacy as a general domain: Couple satisfaction at Time 1 → Coparenting at Time 2 → Coparenting at Time 3 → Parental self-efficacy at Time 3.

Figure 9 presents the model examining the indirect effect of couple satisfaction at Time 1 on parental self-efficacy (general domain) at Time 3 through coparenting at Times 2 and 3. It was considered a stability path by including in model parental self-efficacy at time 2. Therefore, the effect of coparenting at Time 2 on parental self-efficacy at Time 2 was modelled (β = .37, p = .01 for mothers; β = .69, p < .001 for fathers). Based on modification indices, instead of the autoregressive path (from parental self-efficacy at Time 2 on parental self-efficacy at Time 3) a correlation between parental self-efficacy at Time 2 on parental self-efficacy at Time 3 were included (r = .58, p <.001 for mothers; r = .39, p <.001 for fathers). We controlled for the effects of depressive symptoms at Time 1 on coparenting at Time 2 (β = .02, p = .84 for mothers; β = −.02, p = .75 for fathers), coparenting at Time 3 (β = −.02, p = .81 for mothers; β = .01, p = .92 for fathers), parental self-efficacy at Time 3 (β = -.31, p <.001 for mothers; β = -.21, p = .01 for fathers) and parental self-efficacy at Time 2 (β = −.27, p < .001 for mothers; β = −.20, p = .04 for fathers) and a correlation between coparenting and parental self-efficacy at Time 2 was model (r=-.06 p=.71 for mothers; r = -.42, p=.023 for fathers)

Additional covariates were included as indicated by preliminary analyses. Housing arrangement was controlled for in the regression predicting fathers'

coparenting at Time 2 (β = −.07, *p* = .34), coparenting at Time 3 (β = −.06, *p* = .39), and parental self-efficacy at Time 3 (β = −.04, *p* = .52). Perceived income was controlled for in the regression predicting mothers' parental self-efficacy at Time 3 (β = .11, *p* = .058).

The model showed acceptable fit to the data, $\chi^2(48) = 101.36$, $p < .001$, CFI = .92, RMSEA = .069, 90% CI [.050, .088]. For mothers, a total indirect effect of couple satisfaction at Time 1 on parental self-efficacy at Time 3 were observed (β = .14, 95% bootstrap CI [.03, .30]). In addition, an indirect effect through coparenting at Time 3 (β = .01, 95% bootstrap CI [.03, .21]) and through coparenting at Times 2 and 3 (β = .07, 95% bootstrap CI [.03, .15]) were observed. For fathers, a significant total indirect effect was also found (β = .16, 95% bootstrap CI [.04, .32]). In addition, a specific indirect effect through coparenting at Times 2 and 3 was observed (β = .11, 95% bootstrap CI [.03, .24]).

We also examined whether the paths of interest were equivalent for mothers and fathers. For this analysis, only the focal structural paths were constrained to equality; covariates and stability paths were included in the model but not constrained. Specifically, the following paths were fixed to be equal across parents: (1) the effect of couple satisfaction at Time 1 on coparenting at Time 2, (2) the effect of coparenting at Time 2 on coparenting at Time 3, (3) the effect of coparenting at Time 3 on parental self-efficacy at Time 3, and (4) the direct effect of couple satisfaction at Time 1 on parental self-

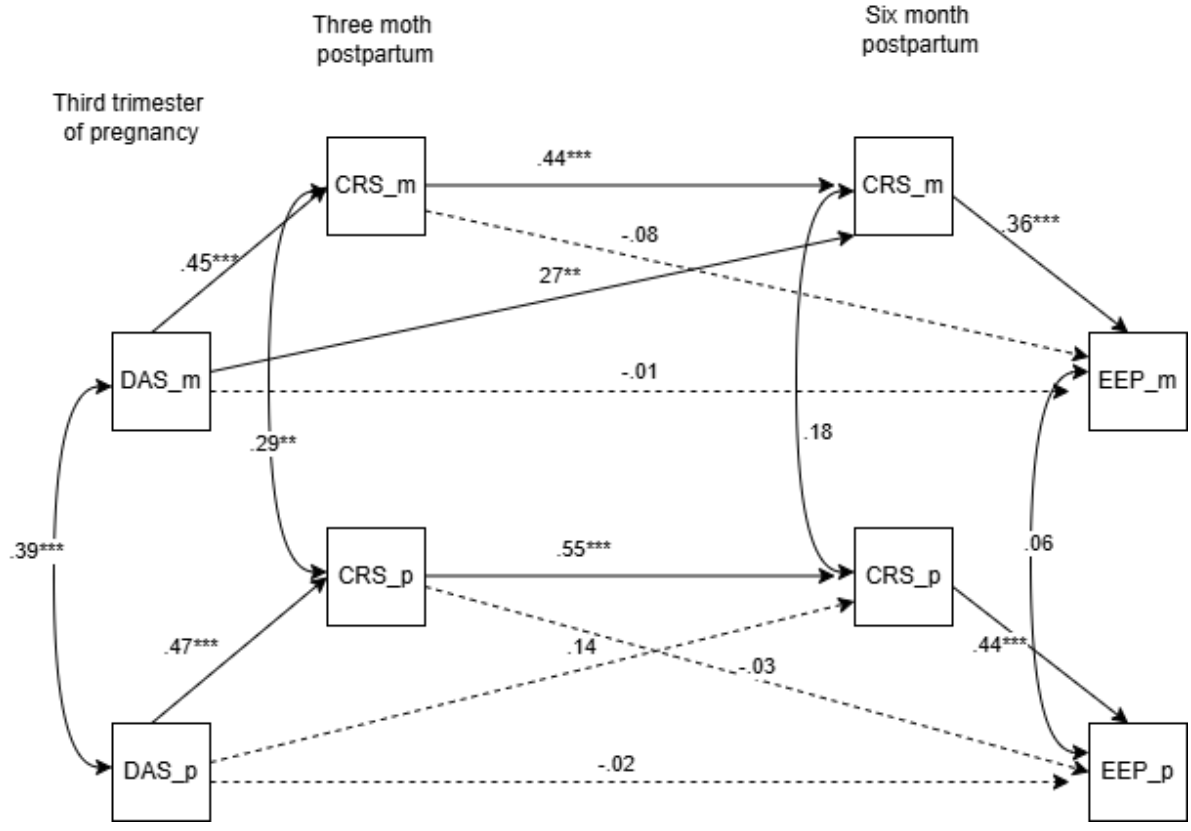
efficacy at Time 3. Imposing these equality constraints did not significantly worsen model fit ($\chi^2(4) = 4.56$, $p = .34$), suggesting that these paths were equivalent for mothers and fathers.

In addition, we tested the equivalence of the indirect effect of couple satisfaction on parental self-efficacy through coparenting at Times 2 and 3 across parents. The difference between the indirect effects for mothers and fathers was not statistically significant (95% bootstrap CI [−.42, .06]), which suggests that the indirect effect was equivalent for mothers and fathers.

The model explained 26% of the variance in parental self-efficacy at Time 3 for mothers and 24% for fathers. In addition, it accounted for 19% and 23% of the variance in coparenting at Time 2, and 37% and 40% of the variance in coparenting at Time 3, for mothers and fathers, respectively. The model also explained 9% of the variance in parental self-efficacy at Time 2 for mothers and 23% for fathers.

Figure 9

Double mediation of coparenting at Time 2 and 3 in the relationship on couple satisfaction and parental self-efficacy as a general domain



Note: p<.05, **p<.01, p***<.001. DAS_m Couple satisfaction in mothers, DAS_p Couple satisfaction in fathers, CRS_m Coparenting in mothers, CRS_p Coparenting in fathers, EEP_m parental self-efficacy in mothers, EEP_p parental self-efficacy in fathers. The model controlled for fathers' housing arrangement, mothers' perception of income and both parents' depressive symptoms at Time 1, and parental self-efficacy at Time 2.*

5.4 Specific Objective 3

An Actor–Partner Interdependence Model (APIM) was estimated to examine the interdependence between coparenting at Time 3 and parental self-efficacy at Time 3, measured as a general-domain construct (see

Figure 10). Consistent with the preliminary covariate analyses (see Specific Objective 2 for coparenting and parental self-efficacy at six months postpartum), housing arrangement (β = −.09, *p* = .15) and type of health care insurance (β = −.09, *p* = .16) were included as control variable in the prediction of fathers' parental self-efficacy. We also modelled the association between fathers' coparenting and housing arrangement (*r* = −.18, *p* = .01), as well as with type of health care insurance (*r* = −.19, *p* = .01).

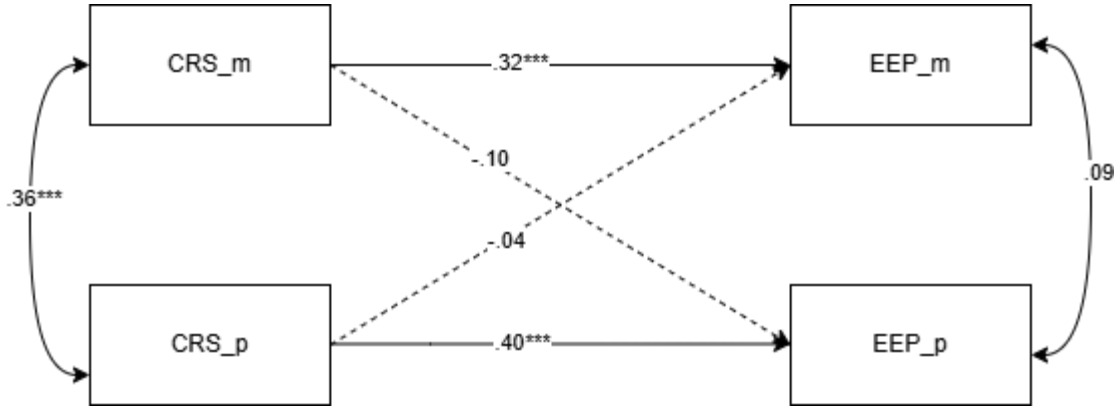
Depressive symptoms at Time 2 were also included as a control variable. We controlled for the effects of depressive symptoms at Time 2 on parental self-efficacy at Time 3 (β = −.34, *p* < .001 for mothers; β = −.18, *p* = .01 for fathers). Stress symptoms were not included due to potential collinearity with depressive symptoms, given the high correlations observed between these variables (r = .80, p < .001 for mothers; r = .73, p < .001 for fathers). We also modelled the correlation between mothers' and fathers' depressive symptoms within this model (*r* = .22, *p* = .002), as well as the correlation between coparenting at Time 3 and depressive symptoms at Time 2 (*r* = −.32, *p* < .001 for mothers; *r* = −.35, *p* < .001 for fathers).

As shown in Figure 10, for both mothers and fathers, more positive perceptions of coparenting predicted higher parental self-efficacy. No partner effects were found for mothers' or fathers' parental self-efficacy. The model demonstrated a good fit to the data: $\chi^2(4) = 7.98$, *p* = .09; CFI = .97; RMSEA =

.07, 90% CI [.000, .13]; and explained 28% of the variance in mothers' parental self-efficacy and 27% in fathers' parental self-efficacy.

Figure 10

Actor Partner Interdependence Model (APIM) for coparenting and depressive symptoms predicting parental self-efficacy as a general domain



Note: p<.05, **p<.01, p***<.001. CRS_m Coparenting in mothers, CRS_p Coparenting in fathers, EEP_m parental self-efficacy in mothers, EEP_p parental self-efficacy in fathers. The model controlled for depressive symptoms for both mothers and fathers and housing arrangement and type of health care insurance for fathers. Coparenting and depressive symptoms were mean-centered.*

6. Discussion

Parents' perceptions, expectations, and beliefs regarding their competence to manage childrearing—encompassing challenges, joys and achievements—constitute an important developmental outcome during the transition to parenthood (Song et al., 2022). Parental self-efficacy, influences individuals' behaviors, goals, standards, level of optimism, and capacity to seek effective strategies for problem solving, as well as the way in which challenges and opportunities are perceived (Bandura, 2006). Consequently, the development of parental self-efficacy during the transition to parenthood plays a crucial role in parents' ability to respond effectively to their infants' needs and to successfully construct their parental identity.

Considering the relevant influence of parental self-efficacy in both parental roles and infant development, the present study sought to advance our understanding of how interparental relationships are intertwined in shaping parental self-efficacy for both mothers and fathers during the transition to parenthood. Specifically, this study examined the influence of couple satisfaction and coparenting on parental self-efficacy from late pregnancy to the postnatal period. To address this aim, a quantitative, non-experimental repeated measure design was employed, following mothers and fathers from the third trimester of pregnancy to six months postpartum. Parental self-efficacy was assessed with a self-report survey at two complementary levels: (1) as a

general domain, capturing parents' overall perceptions and experiences of competence in the parental role, and (2) as a task-specific construct, reflecting confidence in caregiving activities that are particularly salient during early infancy. Examining both dimensions is theoretically warranted, as mothers and fathers may differ not only in their involvement in childcare tasks but also in their subjective confidence and role identification.

Overall, the findings support the general objective highlighting the relevance of interparental relationship processes in the development of parental self-efficacy during the transition to parenthood. To facilitate the discussion of the findings, this section is organized around four thematic areas: (1) sociodemographic characteristics, mental health and their association with parental self-efficacy; (2) findings related to Objective 1, addressing the influence of coparenting at three months postpartum on parental self-efficacy at six months postpartum; (3) findings related to Objective 2, examining the mediating role of coparenting in the influence of couple satisfaction during the third trimester of pregnancy on parental self-efficacy at six months postpartum; and (4) findings related to Objective 3, exploring dyadic interdependence between mothers and fathers regarding parental self-efficacy development.

6.1 Sociodemographic characteristics of the sample and their association with parental self-efficacy

The participants in the present study constitute a relatively low-risk and socioeconomically advantaged sample when compared with the general Chilean population. In this study, 80.6% of mothers and 66.7% of fathers had completed university education, in comparison to the 46.6% reported for the general adult population (Instituto Nacional de Estadística - INE, 2024). In addition, at Time 1 of the study, 85.5% of women and 91.5% of men were employed. By comparison, national data indicate employment rates of 47.6% for women and 65.8% for men in the general population; among parents with children under five years of age, employment rates rise to 53% for women and 80.6% for men (Observatorio de Contexto Económico UDP et al., 2025).

Indicators of paternal early involvement in the present sample were also higher than national estimates. Specifically, 98.1% of women were accompanied by their partner during childbirth, and 71.3% of fathers reported having access to paternity leave. In contrast, data from the IMAGES Chile study (Aguayo et al.,2011) indicated that only 49.8% of fathers accompanied their partner during childbirth. Although national rates of paternal participation during labor may have increased in recent years—and the IMAGES Chile study reported higher involvement among younger fathers and those with higher educational attainment—the available evidence suggests that the levels

observed in the present sample remain higher than those observed in the broader population. Direct national data on the actual uptake of paternity leave in Chile are limited. However, the Work–Life Balance Report of Chile Crece Más (Ministerio de Desarrollo Social, 2018) found that 69.5% of working parents perceived that their workplace would be willing to allow the use of paternity leave. This figure may be a very rough estimate of access to paternity leave but is also slightly lower than the proportion of fathers in the present sample who reported having used this benefit. In addition, the present study included only couples who live together while expecting and having a child, which further differentiates the sample from the broader population of parents having a child. In Chile, according to the Longitudinal Study of Early Childhood (Ministerio de Desarrollo Social, 2017), approximately 72% of children aged 0 to 2 years live in a biparental family.

With regard to parental self-efficacy, increases were observed across all time points for mothers in parental self-efficacy related to specific childcare tasks relevant to this developmental period. Bandura's self-efficacy theory (1982) identifies mastery experiences as the most influential source of self-efficacy development. Accordingly, the time mothers spend caring for their child during the first six months postpartum— a period that largely coincides with the 24-week maternity leave in Chile—appears to play a central role in strengthening parental self-efficacy. This extended period of direct caregiving

likely facilitates stronger beliefs in one's ability to successfully perform specific caregiving tasks appropriate to the infant's developmental needs.

Among participating fathers, no significant changes were found over time in fathers' parental self-efficacy either related to specific childcare tasks or as a general domain. These findings are aligned with studies observing a shift towards more traditional gender roles during transition to parenthood (Kaźmierczak & Karasiewicz, 2019; Ražauskienė, 2024). At this stage, fathers' understanding of their parental role may be more strongly oriented towards a traditional provider model rather than towards direct involvement in day-to-day caregiving. In this regard, a recent systematic review of fathers' participation during the postpartum period (Li et al., 2025) highlights fathers' strong willingness to be involved and their central role in supporting the mother–infant dyad. The review indicates that, during the perinatal period, fathers tend to prioritize the health and wellbeing of both mother and infant and engage in a wide range of supportive activities, including economic provision, household management, support for relevant learning processes such as breastfeeding, and the provision of emotional support. Evidence in Chile has highlighted that fathers, although they would like to be more present in family and infant care life, tend to prioritize their role as economic providers during this period (Herrera & Pavicevic, 2016; Pavicevic & Herrera, 2019). Taken together, these findings suggest that, during the postpartum period, maternal and paternal roles may be particularly differentiated as a result, mothers tend to gain greater confidence in

childcare tasks than fathers. Also, the overall sense of confidence in their parental role during this postpartum period appears to remain stable for both mothers and fathers. This may be because increases in parental competence may take place over a period beyond the first six months after childbirth, and may be influenced by other important family and individual factors that emerge later.

Regarding differences in parental self-efficacy according to parity, no significant differences were found at any time point for either mothers or fathers. This finding is counterintuitive, as it was expected that multiparous parents would report higher levels of parental self-efficacy than primiparous parents. Previous studies focusing on mothers have indeed shown that primiparous mothers tend to report lower parental self-efficacy than multiparous mothers (Dol et al., 2021). However, qualitative research highlights that multiparous women also experience a substantial period of adaptation and family reorganization, characterized by specific challenges related to caring for a new infant while simultaneously attending to the needs of older children (Krieg, 2007). Although most research in this area has been conducted with samples of mothers, the results of the present study suggest that participating fathers show a similar pattern. In the present study, it appears that expecting and having a child constitutes a major challenge for parents, regardless of prior experience in the parental role. This pattern may be more expected for parental self-efficacy evaluated as a general domain, as caring for multiple children during the

postpartum period may challenge parents' overall confidence in their parental role, now defined by the demands of parenting more than one child. Nevertheless, the findings also suggest that previous experience with task-specific caregiving during this developmental period may not substantially differentiate multiparous and primiparous parents. Specific childcare tasks in early infancy may represent a comparable level of challenge for parents irrespective of parity, which may help explain the absence of differences in task-specific parental self-efficacy.

An association between parental self-efficacy at six months postpartum and several sociodemographic variables was identified. Specifically, more comfortable housing arrangement was associated with paternal parental self-efficacy. For mothers, higher educational level and income satisfaction was associated with higher parental self-efficacy. These results are consistent with previous Chilean studies of parental self-efficacy in mothers (Farkas & Valdés, 2010; Gallardo, 2021). Findings are also aligned with the meta-analysis by Ayoub and Bachir (2025), which examined the association between socioeconomic status and parenting and reported a small but significant effect of socioeconomic status —considered either as a global construct or through specific indicators such as income, employment status, and education—on parenting.

For fathers, circumstances such as home ownership and access to private health care insurance—often associated with shorter waiting times and more comfortable conditions of care— may be particularly relevant to perceptions of parental self-efficacy insofar as they are linked to the ability to fulfil a provider role, which aligns with previous qualitative findings in Chile regarding their paternal role construction (Herrera & Pavicevic, 2016; Pavicevic & Herrera, 2019). For mothers, educational level may influence perceptions of competence related to supporting their child's development (Ayoub and Bachir, 2025), as well as the ability to access and use information about infant care and development. Perceived income satisfaction may also shape mothers' parenting contexts by constraining access to material conditions, resources, and services that are relevant for infants' health and developmental needs (Ayoub & Bachir, 2025), thereby affecting mothers' perceptions of parental competence.

Parental mental health was also included as a control variable in the prediction of mothers' and fathers' parental self-efficacy at six months postpartum. Although both stress and depressive symptoms were assessed in the present study, only depressive symptoms were retained as a control variable in the final models, as they were the only mental health indicator that influenced the relevant variables in all time points. These results may be explained from a theoretical standpoint. Stress symptoms at the third trimester of pregnancy may be more contextually driven, reflecting situational demands

related to the anticipation of the baby's arrival and early caregiving adjustments. In contrast, depressive symptoms at this time point are more likely to exert a pervasive influence on parenting processes. In this regard, Dix and Meunier's (2009) model proposes that depressive symptoms affect parenting through disruptions in key regulatory processes, including negative appraisals of the self and the child, impaired emotional regulation, and reduced behavioral flexibility, which together increase the likelihood of ineffective responses to children's needs. In addition, Banduras' theory proposes that depressive symptoms — characterized by negative attributional patterns—may also render beliefs of personal incompetence more salient and persistent (1999). Moreover, depressive symptoms—particularly in mothers—have been shown to display substantial stability over time (Horwitz et al., 2009) and other studies also indicate that paternal depressive symptoms are associated with father performance (Cheung et al., 2019).

6.2 Predictive role of Coparenting at three months postpartum on parental self-efficacy at six months postpartum

Objective 1 aimed to assess the predictive role of coparenting at three months postpartum on parental self-efficacy at six months postpartum for both mothers and fathers, considering parental self-efficacy both as a general domain and as a task-specific construct. The hypotheses formulated for this objective were partially supported.

Consistent with our expectations, reports of more positive coparenting at three months postpartum significantly predicted higher parental self-efficacy at six months postpartum in both mothers and fathers. This finding is in line with previous research conducted during the perinatal period and infancy (Donithen & Schoppe-Sullivan, 2021; Pinto et al., 2016; Solmeyer & Feinberg, 2011). From a theoretical perspective, the coparent represents a particularly salient source of social reinforcement for parenting competence. As proposed by Feinberg's ecological model of coparenting (Feinberg, 2003), supportive and coordinated coparenting constitutes a relevant relational context through which parents' confidence in their caregiving abilities is fostered, ultimately strengthening parental self-efficacy.

The hypothesis that perceptions of coparenting would be a stronger predictor of their own parental self-efficacy for fathers than for mothers was supported for task-specific self-efficacy only. This finding is theoretically and contextually meaningful. In the Chilean context, as well as in most cultural settings, mothers remain the primary caregivers of children (Ministerio de Desarrollo Social, 2017; Schmidt et al., 2023). Consequently, mothers' perceptions of competence in everyday childcare tasks are likely to be shaped by multiple sources of mastery experience, which may attenuate the relative contribution of relational processes such as coparenting for mothers' task-specific self-efficacy.

In contrast, fathers' opportunities to engage in infant care during the perinatal period are more heterogeneous and constrained, partly due to the short duration of paternity leave in Chile, but also due to the significant variability in paternal involvement in childrearing (Brown et al., 2010). In this context, supportive coparenting may play a particularly important role in facilitating fathers' engagement in caregiving and in legitimizing their participation in activities that are still frequently perceived as a predominantly maternal domain. When fathers feel recognized, encouraged and included by their partner in childrearing decision-making and everyday caregiving practices, they may be more likely to develop confidence in their ability to carry out specific childcare tasks. Consistent with this interpretation, previous research indicates that, although mothers typically receive support during the perinatal period from multiple sources—including partners, family members, friends and health professionals—fathers tend to identify their partner as their primary, and sometimes only, source of support (Deave et al., 2008; Halle et al., 2008) to receive practical information and instrumental advice about infant care (Halle et al., 2008).

Interestingly, no significant gender differences were observed in the relationship between coparenting and parental self-efficacy when it was measure as a general domain. Mutual support, recognition of effort and validation of each partner's contribution may therefore be particularly relevant to the development of both mothers 'and fathers´ sense of competence in the

parental role —shaped by each parent's own understanding of their role and functions during this period.

6.3 The mediating role of coparenting on the relationship between couple satisfaction and parental self-efficacy.

Objective 2 aimed to examine the mediating role of coparenting at the third trimester of pregnancy and at three moths postpartum in the association between couple satisfaction in the third trimester of pregnancy and parental self-efficacy at six months postpartum for both mothers and fathers, using a dyadic multigroup analytical framework.

Discriminant validity analysis. In order to test the proposed model, it was first necessary to examine whether coparenting in the third trimester of pregnancy was sufficiently distinct from couple satisfaction at the same time point for both mothers and fathers. The CFA results indicated good model fit for both instruments, supporting the adequacy of the proposed factor structures. The HTMT analyses further showed that the coparenting and couple satisfaction subscales were sufficiently distinct for both mothers and fathers, according to established cut-off criteria. Nevertheless, although none of the coparenting subscales exceeded the recommended thresholds for lack of discriminant validity, fathers' cooperative coparenting was more strongly associated with specific dimensions of couple satisfaction, particularly Consensus and Expression of Affection.

This pattern differs from the findings of Lindroos et al. (2023), who reported that, among expectant mothers in Finland, cooperative coparenting was not empirically distinguishable from couple relationship satisfaction. These discrepancies may reflect cultural differences. Finland is among the countries with the lowest levels of gender inequality worldwide, whereas Chile is closer to the global average in terms of gender inequality (United Nations Development Programme, 2026). Our findings are consistent with the more gender-traditional context found in Chile. Previous research suggest that the development of paternal representations is strongly shaped by the quality of the relationship with the partner during pregnancy (Ahlqvist-Björkroth et al., 2016; Herrera & Pavicevic, 2016). At this stage, mothers are directly experiencing the physical and emotional processes associated with fetal development, whereas fathers' access to the emerging parental role is largely intertwined with their relationship with the mother. Consequently, a more positive and satisfying couple relationship may provide the relational context in which representations of the baby and of parenthood are shared and constructed, and may therefore exert a particularly strong influence on fathers' prenatal coparenting representations.

Mediation analysis. Firstly, the initially hypothesized mediational model was tested with the dyadic multigroup framework. However, this initial hypothesis was not met given the scarce influence of the coparenting at three months postpartum in the mediational model. Coparenting, as well as parental self-efficacy are constructs that evolve and develop during the transition to

parenthood. Therefore, early levels of coparenting may not be sufficiently consolidated to predict later levels of parental self-efficacy when other significant factors are also considered.

In this regard, paternal involvement in childcare typically increases around six months postpartum, (Belsky et al., 1983; Lawrence et al., 2010), as infants become more interactive, alternative feeding practices become more common, and opportunities for shared play and communication expand. Thus, more frequent interactions with the child may promote paternal self-efficacy beyond early coparenting representations. In addition, maternal postpartum leave in Chile extends until 24 weeks after childbirth and, as suggested by Costantini et al. (2022), when mothers resume work-related activities fathers are typically required to assume greater involvement in both household and childcare tasks than before. In the present study, 85.5% of the women were employed during the third trimester of pregnancy, although we did not assess how many of them returned to work after their maternity leave, it is likely that a large proportion of them resumed paid employment. This transition is likely to introduce important changes in family functioning, and particularly in the coparenting relationship (Costantini et al. (2022). Taking together, these changes may present an important developmental context for coparenting during the first year of a babies' life .

At this point it was necessary to propose an alternative model that fit better the data: Couple satisfaction at Time 1 → Coparenting at Time 2 → Coparenting at Time 3 → Parental self-efficacy at Time 3.

Model for Parental Self-efficacy as a Task Specific Domain.

When parental self-efficacy was operationalized as confidence in performing caregiving tasks relevant to the infant's developmental stage, important differences emerged between mothers and fathers. Although a significant total indirect effect of couple relationship satisfaction during the third trimester of pregnancy on task-specific parental self-efficacy at six months postpartum was found for both parents, the magnitude and timing of these effects differed across gender.

In this regard, a further finding was that prenatal couple relationship satisfaction exerted a significant direct effect on parental self-efficacy at six months postpartum for mothers but not for fathers. This asymmetry may reflect the differential salience of the prenatal period for parental role development. During pregnancy, mothers undergo relevant biological and psychological transformations that, combined with societal expectations regarding motherhood, make the prenatal period an important context for the anticipation of the maternal role. Prenatal couple relationship satisfaction may therefore exert a more direct and lasting influence on mothers' parental self-efficacy by

shaping the relational context within which maternal representations and emotional bonding with the infant begin to consolidate, processes that emerge more markedly and earlier in mothers than in fathers (Kaźmierczak & Karasiewicz, 2019).

Significant indirect effects through coparenting quality at three and six months postpartum were found for both mothers and fathers, suggesting that the coparenting relationship constitutes a relevant mediating pathway for both parents, but this indirect effect was stronger for fathers than for mothers. For fathers, the coparenting relationship emerges as the more heavily weighted mechanism through which early couple satisfaction shapes later parental confidence. This is consistent with the broader literature suggesting that the paternal role develops more gradually (Barrett & Charlot, 2025) and is more contingent on postnatal relational and contextual factors. Taken together, these findings suggest that while supportive coparenting constitutes an important resource for both parents, fathers appear to derive comparatively greater benefit from the ongoing process of coparenting development in fostering their confidence in performing developmentally relevant caregiving tasks.

The results also revealed differential additional mediation pathways for each parent. Early postnatal coparenting at three months postpartum emerged as a particularly salient mediator for fathers' later task-specific parental self-efficacy, whereas coparenting at six months postpartum was a significant mediator for mothers' confidence in caregiving tasks. These timing differences

may reflect reciprocal and intertwined processes within the parental couple across the postpartum period. Specifically, fathers' early experiences of support and inclusion within the coparenting relationship may facilitate their engagement and learning in caregiving activities, which in turn could contribute to more positive coparenting experience for mothers at later stages – dynamics that may subsequently strengthen mothers' confidence in developmentally specific childcare tasks. However, as such reciprocal pathways were not modelled in the present study, this interpretation should be regarded as tentative and warrants empirical examination in future research.

Model for Parental self-efficacy as a general domain. When parental self-efficacy was measured as a general domain, no direct effect of couple satisfaction in the third trimester of pregnancy on parental self-efficacy at six months postpartum was observed. However, for both mothers and fathers, a significant total indirect effect was found, as well as a specific indirect effect through coparenting at three months postpartum and at six months postpartum.

Taken together, these findings suggest that couple satisfaction during the third trimester of pregnancy influences parental self-efficacy at six months postpartum through a gradual and progressive development of the coparenting relationship after the child is born, and the subsequent development of coparenting exerts an equivalent influence on parental self-efficacy in mothers and fathers. The present model highlights the important role of postnatal

coparenting development in shaping parental self-efficacy as a general domain for both parents.

Moreover, a specific indirect effect through coparenting at six months postpartum remained significant for mothers. This pattern — of both single and double mediation of coparenting— may be also explained by family and infant developmental changes during six months postpartum. In the context of a more initially satisfying couple relationships, mothers may perceive greater and more diverse forms of support from fathers at six month postpartum, which may in turn strengthen mothers' confidence in their parental role.

6.4 The interdependence of coparenting representations and parental self-efficacy at six moth postpartum.

Objective 3 examined the interdependence between coparenting representations and parental self-efficacy at six months postpartum using the Actor-Partner Interdependence Model (APIM). As preliminary analyses indicated non intraclass correlation (ICC) between partners on the task-specific self-efficacy measure, the APIM was estimated exclusively for the general domain of parental self-efficacy, controlling for depressive symptoms, housing arrangement, and type of health insurance coverage.

The hypothesized partner effects were not supported. It was expected that one parent's coparenting experience would predict the other parent's self-

efficacy above and beyond the effect of their own coparenting experience; however, these interpersonal effects were not observed. Nevertheless, the significant covariance between partners' coparenting experiences within the parental couple underscores the relevance of examining these processes within a dyadic framework. Given the inherently shared and relational nature of coparenting, both partners' coparenting experiences are meaningfully intertwined, and each parent's coparenting was found to predict their own parental self-efficacy. Taken together, these findings suggest that while partner effects on parental self-efficacy may not operate through coparenting directly, the dyadic context remains an important unit of analysis when studying family and individual adjustment processes, as individual experiences within the couple are embedded in and shaped by shared relational dynamics.

Strength and limitations of the present study

The present study has several strengths, particularly the repeated measures design and the inclusion of both mothers and fathers. Assessing the variables of interest at subsequent times allows to address various predictors of parental self-efficacy across the transition to parenthood, whereas including both parents expand our understanding of self-efficacy in fathers, who are often underrepresented in parenting studies.

In addition, the inclusion of two distinct operationalizations of parental self-efficacy—one reflecting a general sense of competence in the parental role

and the other focusing on confidence in specific childcare tasks—makes it possible to capture differences linked to gendered assumptions about parental roles. This distinction is theoretically important for understanding maternal and paternal role constructions and adaptation during the transition to parenthood. Lastly, using dyadic analysis contributes to our understanding of the interdependence nature of parental self-efficacy development in new parents.

We considered two postpartum time points, which represents another strength of our study. The three-month postpartum assessment served as an intermediate time point within the first year. This stage was selected to assess coparenting given that previous studies have shown that triadic family dynamics are typically established and become meaningfully organized by approximately three months after the child's birth (McHale et al., 2004). The six-month postpartum assessment was defined as the final time point within the first year of life, as this stage is generally characterized by greater stability for both mothers and fathers. By this time, theory suggests that parents have typically developed higher levels of competence, acquired practical caregiving skills and navigated the most demanding challenges of the early postpartum period (Cowan & Cowan, 1992). Moreover, paternal involvement and participation in childcare tend to increase around six months postpartum (Belsky et al., 1983; Lawrence et al., 2010).

However, the present study also has important limitations. The sample was recruited using a convenience strategy and included couples who

voluntarily sough participation. As a consequence, the sample differs from the general Chilean population, as outlined at the beginning of the Discussion section. In particular, participants were, on average, highly educated, largely satisfied with their income, and predominantly involved in relatively long-term and stable relationships. These characteristics restrict the generalizability of the findings. Attrition further limits the generalizability of the results. Parents who remained in the study differed from those lost to follow-up on several demographic characteristics, including relationship length and age, and—importantly—on key study variables such as maternal prenatal depressive symptoms and fathers' prenatal parental self-efficacy expectations. Given that we do not have further information about these participants lost to follow-up, future studies should address the causes underlying these patterns.

Although more than 700 individuals initially responded to the online recruitment advertisement, only 259 couples completed the first assessment and provided sociodemographic information. It was therefore not possible to examine potential differences between couples who participated in the study and those who expressed initial interest but did not enroll, thus limiting the assessment of selection and attrition biases. In addition, several groups were excluded from the analyses, including couples who separated during the study period, couples with twins, families in which the infant experienced prolonged hospitalization, and couples in which one partner presented a severe mental health disorder. Consequently, the present findings cannot be generalized to

families facing these more complex and potentially stressful circumstances. Future research should explicitly examine parental self-efficacy in more diverse and vulnerable family contexts, in order to capture the full range of early parenting experiences.

A further limitation of the present study refers to the selected instruments. Firstly, some of the instruments, such as the Karitane Parenting Confidence Scale (KPCS), have not been formally validated in Chile. In other cases, such as the Coparenting Relationship Scale (CRS), the versions previously validated in Chile were not fully adequate to capture the specific dynamics of coparenting during the postnatal period. In addition, questionnaires did not function equivalently for mothers and fathers. Guided by the results of measurement invariance analyses, it was therefore necessary to remove a number of items in order to achieve metric equivalence across parents. This methodological decision is important to acknowledge, as the resulting total scores are not directly comparable with those reported in studies using the original, unmodified versions of the instruments. Full details of the confirmatory factor analysis, measurement invariance analyses and the associated decision-making process are provided in the Annex 1.

Furthermore, even for instruments previously validated in Chile—namely the Parenting Evaluation Scale (EEP) and the Dyadic Adjustment Scale (DAS)—the subscale structures did not show stable reliability across time points and parents. For this reason, total scores were used for all measures,

regardless of whether the original instruments included subscales (EEP, DAS, CRS and KPCS) or not (Beck Depression Inventory; BDI).

All measures employed in the study were based on self-report. This choice is theoretically justifiable given that the primary outcome—parental self-efficacy—is fundamentally a cognitive construct. Self-report instruments are therefore well suited to capturing parents' parental self-efficacy and other subjective experiences (such as perception of coparenting relationship and couple satisfaction) that may influence it. Nevertheless, reliance on self-report data entails well-known limitations, particularly in relation to social desirability. Future studies would benefit from incorporating observational assessments of coparenting and couple interactions, which could complement self-reported data and provide a more comprehensive understanding of the relational processes influencing parental self-efficacy.

The present study tested a specific theoretical causal pathway in which family relational processes were assumed to influence parental self-efficacy. However, as outlined in the Theoretical Framework and within a family systems perspective, influences within the family are bidirectional. It is therefore equally plausible that parents who perceive themselves as more competent in their parental role may be more willing to engage in coparenting dynamics.

In addition, relevant variables such as employment status following parental leave and possible changes in family processes associated with

mothers' return to paid work were not assessed. Future research could explicitly examine the impact of mothers' return to work on coparenting dynamics, parental involvement and parental self-efficacy, particularly in dual-earner families, in order to clarify how work–family transitions shape early family functioning and its influence in parental self-efficacy.

Despite these limitations, the results of these study contribute to a deeper understanding of the contribution of couple satisfaction and coparenting on parental self-efficacy during the transition to parenthood in Chilean couples

7. Conclusions

Interparental relationships play a relevant role in the development of parental self-efficacy for both mothers and fathers. The present findings highlight the mediating role of coparenting in the association between couple satisfaction and parental self-efficacy in both parents. In particular, coparenting appears to be a stronger influence on fathers' confidence in performing childcare tasks relevant to the infant's developmental stage. Furthermore, both maternal coparenting representations and maternal mental health appear as relevant contributors to fathers' parental self-efficacy.

Overall, the results provide a nuanced perspective on the pathways within the parental couple that contribute to self-efficacy, as well as on differences in how the parental role is constructed and experienced by mothers and fathers during the transition to parenthood. The study thus extends existing

evidence on the influence of interparental relationships on parental self-efficacy, helping to clarify both the significance of these relationships and the mechanisms through which they operate to shape parents' confidence while accounting for gender differences.

Although no significant partner effects of coparenting experience on parental self-efficacy were found, these findings carry relevant implications for intervention. The fact that both parents' coparenting experiences were meaningfully correlated within the couple underscores the importance of understanding shared relational dynamics and their influence on individual adaptation to the transition to parenthood.

The present findings carry several practical implications for perinatal care and family intervention. Results highlights the need to consider the family as a whole during the perinatal period for prevention and promotion purposes within healthcare services. It also underscores the importance of including fathers in perinatal care, both for their individual well-being and for the benefit of the parental couple adaptation to parenthood. Interventions aimed at promoting parental adjustment may therefore benefit from targeting the coparenting relationship as a shared system rather than addressing each parent in isolation, as strengthening family process may support parental adjustment for both mothers and fathers. Results also underscore the importance of attending to the family during pregnancy, as relational factors in this period contribute to the development of relevant family and individual dynamics at postpartum period.

Screening for difficulties in relational dynamics during pregnancy could help identify couples at risk for poorer postpartum adjustment and allow for early intervention, to promote infant, parents and family wellbeing.

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Annexes

Annex 1 . Measurement Invariance

For all instruments across all time points, confirmatory factor analyses (CFA) were conducted separately for mothers and fathers as an initial step prior to testing measurement invariance between mothers and fathers.

Measurement invariance across gender was tested using multi-group CFA. Configural and metric invariance were examined sequentially, in accordance with best-practice recommendations for conducting dyadic analyses proposed in this study (Common Fate Model and the Actor–Partner Interdependence Model). Configural invariance assesses whether the same general factor structure holds across groups. Metric invariance examines whether factor loadings are equivalent between groups (Putnick & Bornstein, 2016). To stablished metric invariance, the configural and metric models were compared using the following criteria: a non-significant Chi square difference test (using the Satorra- Bentler scaled chi-square for MLR estimation or the Difftest procedure for WLSM estimations) , ΔCFI<.01, ΔRMSEA <. 015. When invariance was not achieved, partial invariance analyses were conducted by freeing factor loadings that produced the greatest improvement in model fit (Svetina.et al., 2020) Any item with a freely estimated loading was subsequently excluded from the calculation of scale scores used in the dyadic analyses. All required procedures for conducting measurement invariance analyses with dyadic data were followed,

which includes the specification of correlated error terms for the same items and factors across partners (Sakaluk et al., 2021).

Coparenting Relationship Scale

Confirmatory Factor Analysis (CFA) were conducted to examined model fit separately for mothers and fathers. The data were treated as categorical and the Weighted Least Squares Mean and Variance (WLSMV) estimator was used, as it is appropriate for categorical data and to account for non-normality distributions (Liang & Yang, 2014).

The prenatal version of Coparenting Relationship Scale (CRS_PV; Lindroos et al.,2023; Chilean version- Bennett et al., 2026a) was tested for the third trimester of pregnancy. For the three and six moth postpartum assessments, were tested the Brief version of Coparental Relationship Scale (CRS-B; Feinberg et al., 2012; Chilean version-Bennett et a., 2026b), and the validated Chilean full version of the instrument (Contreras-Farah et al., 2023). However, the best fitting model at both postpartum time points corresponded to the same selection of item used in the Prenatal version of Coparenting Relationship Scale. This is conceptually consistent with the transition to parenthood, during which coparenting dynamics are still emerging; thus, items that are more informative during third trimester of pregnancy may also capture the core aspects of coparenting at three and six months postpartum. Correlation

between items 32 (How often in atypical week, when all 3 of you are together, do you argue with your partner about your child, in the child's presence?) and 33 (How often in atypical week, when all 3 of you are together argue about your relationship or marital issues unrelated to your child, in the child's presence?), were model due to their similarity in wording and modification index suggestions. Additionally, when testing configural invariance between mother and father, difficulties arose with item 34 and 35 given their low variability in the sample. Consequently, items 34 and 35 were removed from the separated CFAs, and from the invariance assessments presented. This version of the instrument has a two factor structure: Cooperative Coparenting (item 1, 2, 3, 6,10, 14, 18,19, 23,24,25,26,28) and Coparental Conflict (31, 32,33).

Table 13 presents model fit indices for the CRS, in separated CFAs for mothers and fathers and the invariance assessments across the three time points . At time 2, partial metric invariance was achieved when items 2 (My relationship with my partner is stronger now than before we had a child), 3(My partner asks my opinion on issues related to parenting) and 14 (My partner is sensitive to our child's feelings and needs) were freely estimated. Therefore, these items were excluded from the calculation of total score and reliability for mothers and fathers at Time 2. At time 3, partial metric invariance was achieved when items 3 and 14 were freely estimated. Therefore, these items were likewise excluded from the computation of total scores and reliability at Time 3.

Table 13

Results of CFA and dyadic measurement invariance test for couples on the Coparenting Relationship Scale.

	Models	***X²*** **WLSMV**	**(*Df*)**	**CFI**	**RMSEA**	**RMSEA 90%CI**	***Difftest* (Δdf),*p***	**ΔCFI**	**ΔRMSEA**
T1	CFA mothers	180.647***	102	.98	.057	0.043 - 0.071			
	CFA fathers	204.699***	102	.97	.066	0.053 - 0.079			
	1. Configural	543.642***	440	.99	.032	0.022 - 0.040			
	2ª. Metric	545.241***	451	.99	.030	0.019 - 0.039	12.542(11),*p=.32*	=.0	=.02
T2	CFA mothers	274.675***	102	.96	.088	0.076 - 0.101			
	CFA fathers	244.188***	102	.96	.084	0.070 - 0.097			
	1. Configural	655.468***	440	.97	.048	0.040 - 0.055			
	2ª. Metric (partial invariance)	645.344***	449	.97	.045	0.037 - 0.052	12.628(9*), p=.18*	=.0	=.03
T3	CFA mothers	276.432***	102	.94	.090	0.078 - 0.103			

CFA fathers	243.419***	102	.96	.083	0.070 - 0.096			
1. Configural	603.248***	440	.97	.042	0.033 - 0.050			
2ª. Metric (partial invariance)	602.221***	450	.97	.040	0.031 - 0.048	14.039(10)=.17	.0	-.02

χ² Chi-square statistic, WLSMV Weighted Least Squares Mean and Variance, DF Degree of Freedom, CFI Comparative Fit Index, RMSEA Root Mean Square Error of Approximation, CI Confident Indices. p<.05, p<.01**, p<.001****

Couple Satisfaction

For Dyadic Relationship Scale. Confirmatory Factor Analysis (CFA) were conducted to examined model fit separately for mothers and fathers. The data were treated as categorical and the Weighted Least Squares Mean and Variance (WLSMV) estimator was used, as it is appropriate for categorical data and to account for non-normality distributions (Liang & Yang, 2014). Item 17 (How often have you or your partner left home after an argument?) and 20 (Have you ever regretted getting married or living with your partner?) were excluded at all time points for low variability in this sample.

Table 14 presents model fit indices for the DAS, including separated CFAs for mothers and fathers and the invariance assessments across the three time points. A total of 30 items and four factor model such as Consensus (1, 2, 3, 5, 7, 8, 9, 10, 11, 12,13, 14, 15), Cohesion (24, 25, 26, 27, 28), Satisfaction

(16,18,19, 21, 22, 23, 31,32) and Expression of Affection (4, 6, 29, 30) was used.

At Time 1, partial metric invariance was achieved when item 29 was freely estimated. Therefore, this item was excluded of study dyadic analysis at Time 1.

At Time 2 and 3, item 27 was excluded when running CFA separately for mothers and fathers, due to extremely low loadings for both models and fathers. At Time 2, partial metric invariance was achieved when item 29 was freely estimated. Therefore, this item was excluded of study dyadic analysis at Time 2.

Table 14

Results of CFA and dyadic measurement invariance test for couples on the Dyadic Adjustment Scale.

	Models	***X²*** **WLSMV**	***(Df)***	**CFI**	**RMSEA**	**RMSEA 90%CI**	***Difftest* (Δdf),*p***	**ΔCFI**	**ΔRMSEA**
T1	CFA mothers	608.826***	399	.96	.048	.040 - .055			
	CFA fathers	537.792***	399	.97	.039	.030 - .047			
	1. Configural	1982.743***	1652	.96	.029	.024 - .034			
	2ª. Metric (partial invariance)	1997.119***	1677	.96	.029	.023 - .033	36.499(25), *p=.06*	.0	.0
T2	CFA mothers	512.152***	371	.98	.042	.033 - .050			
	CFA fathers	544.389***	371	.96	.048	.039 - .057			
	1. Configural	1788.379***	1538	.97	.027	.021 - .033			
	2ª. Metric (partial invariance)	1805.944***	1562	.97	.027	.021 - .032	34.701(24), *p=.07*	.0	.0

T3	CFA mothers	531.074***	371	.97	.046	.037 - .055			
	CFA fathers	565.009***	371	.95	.050	.042 - .058			
	1. Configural	1847.964***	1538	.96	.031	.025 - .036			
	2[a]. Metric	1848.838***	1563	.96	.029	.024 - .035	31.338(25), *p=.17*	.0	.002

χ^2 Chi-square statistic, WLSMV Weighted Least Squares Mean and Variance, DF Degree of Freedom, CFI Comparative Fit Index, RMSEA Root Mean Square Error of Approximation, CI Confident Indices. p<.05, p<.01**, p<.001****

Parental Self-efficacy Instrument: Parental Evaluation Scale (EEP).

Confirmatory factor analyses (CFA) were conducted to examine model fit separately for mothers and fathers. The data were treated as continuous, and the Maximum Likelihood Robust (MLR) estimator was used, as it appropriately accounts for non-normal distributions.

Table 15 presents the model fit indices for the EEP, including separate CFAs for mothers and fathers and the invariance assessments across the three time points. The scale exhibited a two-factor structure: Negative attitudes towards parenting (items 1, 4, 6, 7, 8, 9, and 10) and Positive attitudes towards parenting (items 2, 3, and 5). Although item 6 (“Being a parent has not been as fulfilling as I had hoped”) has a cross-loading in the original scale, in the present

sample it showed a stronger loading on the Negative attitudes towards parenting factor.

At Time 1, a correlation between the error terms of item 2 (“I feel that I am doing a good job as a parent”) and item 5 (“I believe that the decisions I make regarding the rearing of my baby are the most appropriate ones”) was specified across all models for this wave, due to their conceptual similarity. In addition, partial metric invariance were achieved when item 4 (“My interests and talents lie in other areas of my life, not in parenthood”) was freely estimated. Consequently, this item was excluded from the calculation of total scores and reliability for mothers and fathers at Time 1.

At Time 2, a correlation between the error terms of item 3 (“Being a parent makes me feel fulfilled and happy”) and item 6 (“Being a parent has not been as fulfilling as I had hoped”) was specified across all models for this wave, due to wording similarity. The correlations observed between these items, which belong to different factors, may be explained by the fact that in the original scale item 6 exhibited cross-loadings on both factors. This suggests that the items may share underlying theoretical commonalities, even though item 6 did not load strongly on the *Positive attitudes towards parenting* subscale in the present sample. Partial metric invariance was achieved when item 8 (“The demands of parenthood make me feel tense and distressed”) was freely estimated, and this

item was therefore excluded from the calculation of total scores and reliability for mothers and fathers at Time 2.

At Time 3, correlations were specified between the error terms of items 3 and 6, and between items 8 (“The demands of parenthood make me feel tense and distressed”) and 9 (“I feel that, in general, the tasks of parenthood do not allow me to enjoy my baby”), due to their conceptual similarity. With these adjustments, both configural and metric invariance were established.

Table 15

Results of CFA and dyadic measurement invariance test for couples on the Parental Evaluation Scale.

	Models	S-Bχ ²ML	S-Bχ ²MLR	(*Df*)	Factor correction	CFI	RMSEA	RMSEA 90%CI	ΔS-BX² (df),p	ΔCFI	ΔRMSEA
T1	CFA mothers		47.314	33		.97	.043	.000 - .069			
	CFA fathers		44.234	33		.97	. 038	.000 - .065			
	1. Configural	207.489**	191.935*	152	1.081	.96	. 034	.015 - .047			
	2ª. Metric (partial invariance)	231.006***	209.367**	161	1.103	.95	.036	.020 - .049	15.95(9),*p=.06*	.01	.002
T2	CFA mothers		59.656**	33		.93	.061	.035 - .086			
	CFA fathers		53.766*	33		.93	.056	.026 - .082			
	1. Configural	224.709***	211.085**	152	1.065	.93	.042	.027 - .056			
	2ª. Metric (partial invariance)	241.361***	222.977***	161	1.082	.93	.042	.028 - .055	12.163(9),*p=.2*		
T3	CFA mothers		69.250***	32		.91	.075	.050 - .099			

CFA fathers		34.601	32		.99	.020	.000 - .057				
1. Configural	206.094**	201.306**	150	1.024	.94	.040	.024 - .054				
2ª. Metric	217.885**	209.519**	160	1.040	.94	.038	.022 - .052	9.212(10), *p=.5*	.0	.002	

χ² Chi-square statistic, WLSMV Weighted Least Squares Mean and Variance, DF Degree of Freedom, CFI Comparative Fit Index, RMSEA Root Mean Square Error of Approximation, CI Confident Indices. p<.05, p<.01**, p<.001****

Parental Self-efficacy Instrument: Karitane Parenting Confidence Scale (KPCS).

Confirmatory factor analyses (CFA) were conducted to examine model fit separately for mothers and fathers. The data were treated as continuous, and the Maximum Likelihood Robust (MLR) estimator was used, as it appropriately accounts for non-normal distributions.

Table 16 presents the model fit indices for the KPCS, including separate CFAs for mothers and fathers and the invariance assessments across the three time points. As the scale has not been validated in Chile, confirmatory analyses were conducted considering previous versions of the questionnaire from other countries. In the present sample the instrument exhibited a one-factor structure, consistent with findings from the Brazilian (Pereira et al., 2018) and Nepali (Shrestha et al., 2016) version of the questionnaire. Items 9 and 12 were

removed across the three time points for mothers and fathers, due to low factor loadings.

At Time 3, several items showed sparse response distributions, with only a single response in one category (the scale was originally designed using a four-point Likert scale). Specifically, for mothers this occurred for items 2, 4, 9, 10, and 14, and for fathers for items 4, 7, 8, and 10 (with item 7 for fathers showing a single response in two categories). To address this issue, these items were recoded by collapsing the sparse category into the adjacent response category.

The correlation between total scale scores computed using the original responses and those computed using the recoded responses was very high for both mothers ($r = .99$, $p < .001$) and fathers ($r = .99$, $p < .001$). In addition, the reliability of the scale using the original responses was $\alpha = .75$ and $\omega = .74$ for mothers, and $\alpha = .80$ and $\omega = .81$ for fathers. The reliability of the recoded scale was similar (mothers: $\alpha = .75$, $\omega = .74$; fathers: $\alpha = .80$, $\omega = .81$). These results suggest that the recoding procedure did not meaningfully affect scale properties. Therefore, the recoded scale was used in the analysis of the study at Time 3.

In addition, at Time 3, configural and metric invariance was achieved when the error correlation of items 7(I am confident about playing with my baby) for mothers and fathers was fixed to -.99.

Table 16

Results of CFA and dyadic measurement invariance test for couples on the Karitane Parenting Confidence Scale.

	Models	***X²*** **WLSMV**	**(*Df*)**	**CFI**	**RMSEA**	**RMSEA 90%CI**	***Difftest* (Δdf),*p***	**ΔCFI**	**ΔRMSEA**
T1	CFA mothers	122.296***	65	.98	.061	.044 - .078			
	CFA fathers	128.629***	65	.97	.065	.048 - .081			
	1. Configural	347.916**	285	.98	.031	.017 -.041			
	2ª. Metric	361.476**	297	.98	.030	.017 - .041	17.28(12), *p=.13*	.0	.1
T2	CFA mothers	114.655***	65	.96	.059	.041 0.077			
	CFA fathers	128.133***	65	.96	.069	.051 - .087			
	1. Configural	372.320***	285	.96	.038	.026- .048			
	2ª. Metric	373.340**	297	.97	.034	.022 - .045	10.78(12), *p=.54*	.-01	.04
T3	CFA mothers	110.707***	65	.94	.058	.039 - .076			
	CFA fathers	131.908***	65	.96	.072	.054 - .089			
	1. Configural	443.225***	286	.92	.051	.042 - .060			

2ª. Metric	447.745***	298	.92	.049	.039- .058	17.58(12), *p=.13*	.0	.002

χ^2 Chi-square statistic, WLSMV Weighted Least Squares Mean and Variance, DF Degree of Freedom, CFI Comparative Fit Index, RMSEA Root Mean Square Error of Approximation, CI Confident Indices. p<.05, p<.01**, p<.001****

Mental Health instruments

Confirmatory Factor Analysis (CFA) were conducted to examine model fit separately for mothers and fathers for both the Beck Depression Inventory (BDI) and the Stress subscale of the Depression, Anxiety and Stress Scale (DASS). The data were treated as categorical and the Weighted Least Squares Mean and Variance (WLSMV) estimator was used, as it is appropriate for categorical data and to account for non-normality distributions (Liang & Yang, 2014). An initial model including a second-order factor structure, in which BDI formed one factor and the DASS stress subscale formed the other, was considered; however, this model did not converge at the configural level and was therefore not pursued further.

Table 17 presents model fit indices for the BDI and DASS, including separated CFAs for mothers and fathers and the invariance assessments across the three time points. For BDI, a one factor structure was established. Additionally, a correlation between errors of item 15 (Loss of energy) and 20 (Tiredness or fatigue) was specified for mothers and fathers at all three time points due to their conceptual similarities. At time 1, partial metric invariance was achieved when item 10 (Crying) and 15 were freely estimated. Therefore,

these items were excluded from the calculation of total score and reliability for mothers and fathers at Time 1. At Time 2, metric invariance was achieved when the error correlation of items 9(Suicidal thoughts or wishes) for mothers and fathers was fixed to 0. At time 3, configural and metric invariance was established when the error correlation of items 9 for mothers and fathers was fixed to 0, and the residual variance of terms of item 9 were constrained to 0.

For DASS stress subscale, a one factor structure was established as well. Additionally, a correlation of item 3 (I felt very nervous) and 4 (I noticed that I was becoming restless.) was established due to their similarities in content. At time 1,partial metric invariance was achieved when item 4 was freely estimated. Therefore, this item was excluded from the calculation of total score and reliability for mothers and fathers at Time 1.

Table 17

Results of CFA and dyadic measurement invariance test for couples on the Mental Health Instruments.

	Models	***X*^{2} WLSMV**	**(*Df*)**	**CFI**	**RMSEA**	**RMSEA 90%CI**	***Difftest* (Δdf),*p***	**ΔCFI**	**ΔRMSEA**
T1 BDI	CFA mothers	279.333***	189	.95	.045	0.034 - 0.056			
	CFA fathers	274.178***	188	.98	.045	0.033 - 0.056			
	1. Configural	928.857***	795	.97	.027	0.018 - 0.034			

	2ª. Metric (partial invariance)	949.233***	813	.97	.027	0.018 - 0.034	28.025(18*); p=.06*	.0	.0
T1 DASS	CFA mothers	49.746***	13	.98	.110	0.079 - 0.143			
	CFA fathers	28.912**	13	.99	.073	0.037 - 0.109			
	1. Configural	117.875***	67	.98	.057	0.040 - 0.074			
	2ª. Metric (partial invariance)	119.464***	72	.98	.053	0.036 - 0.070	5.380(5);*p=.37*	.0	.004
T2 BDI	CFA mothers	359.051***	188	.95	.064	0.054 - 0.075			
	CFA fathers	358.299***	188	.93	.067	0.056 0.077			
	1. Configural	989.367***	795	.95	0.033	0.026 - 0.040			
	2ª. Metric	1007.361***	816	.96	.033	0.025 - 0.039	31.802(21)*p=.06*		
T2 DASS	CFA mothers	19.060	13	.99	.046	.000 - .088			
	CFA fathers	14.598***	13	.99	.025	0.000 - 0.076			
	1. Configural	93.424*	67	.99	.042	0.018 - 0.062			
	2ª. Metric	102.399***	73	.98	0.043	0.020 - 0.061	9.876(6), *p=.13*		
T3 BDI	CFA mothers	334.177***	188	.94	. 061	0.050 - 0.071			
	CFA fathers	339.390***	188	.94	.063	0.052 -0.074			
	1. Configural	974.334***	795	.96	.033	0.025 - 0.040			
	2ª. Metric (partial invariance)	981.663***	816	.96	.031	0.023 - 0.038	24.226(21), *p=.28*		
T3 DASS	CFA mothers	66.854***	13	.94	0.140	0.108 - 0.175			
	CFA fathers	20.649	13	.99	.054	0.000 - 0.096			
	1. Configural	125.567***	67	.97	.064	0.047 - 0.082			
	2ª. Metric (partial invariance)	120.147***	73	.98	.055	0.037 - 0.073	1.840 (6), *p=.93*		

χ^2 Chi-square statistic, WLSMV Weighted Least Squares Mean and Variance, DF Degree of Freedom, CFI Comparative Fit Index, RMSEA Root Mean Square Error of Approximation, CI Confident Indices. p<.05, p<.01**, p<.001****

Annex 2. Factor Structured for Coparenting Relationship Scale and Couple satisfaction

Confirmatory factor analyses (CFAs) and factor loadings for **couple satisfaction** and **prenatal coparenting** were conducted using the subsample of mothers and fathers expecting their first child together (regardless of whether one or both partners had children from previous relationships; *n* = 202).

Tables 18 and 19 present the factor loadings and factor correlations for the **couple satisfaction** instrument for mothers and fathers. In this subsample, **items 17, 19, and 20 were excluded** due to insufficient variability, which adversely affected CFA estimation and overall model fit.

Table 18

Factor loadings for Dyadic Adjustment Scale (DAS) for mothers and fathers.

Item	Consensus		Cohesion		Satisfaction		Expression of affection	
	(m)	(f)	(m)	(f)	(m)	(f)	(m)	(f)
1 Managing family finances.	.60***	.69***						
2 Recreational activities.	.70***	.78***						
3 Religious matters.	.28***	.45***						
5 Friends.	.62***	.57***						
7 Conventionalism (appropriate or correct behavior).	.73***	.74***						
8. Philosophy of life.	.70***	.75***						
9. Relationship with each other's families.	.44***	.68***						
10. Aspirations, goals and other important matters	.81***	.77***						
11. Amount of time spent together.	.64***	.79***						

12. Major decision-making.	.80***	.84***						
13. Household chores.	.61***	.69***						
14. Leisure interests.	.68***	.78***						
15. Career decisions	.66***	.68***						
24. Do you and your partner share interests outside the home?			.67***	.74***				
25. Have a stimulating exchange of ideas.			.49***	.62***				
26. Laugh together.			.71***	.56***				
27. Discuss an issue calmly.			.30**	.27**				
28. Work together on a project.			.71***	.69***				
16. How often have you discussed or considered divorce, separation, or ending the relationship?					.80***	.60***		
18. In general terms, how often do you think that things between you and your partner are going well?					.74***	.67***		
21. How often do you fight with your partner?					.79***	.64***		
22. How often do you and your partner lose your patience with each other?					.70***	.66***		
23. Do you kiss your partner?					.31*	.43**		
31. Please circle the number that best describes your level of happiness, taking into account your relationship as a whole.					.62***	.42***		
32. How do you feel about the future of your relationship.					.39***	.63***		
4 Displays of affection.							.79***	.73***
6 Sex life.							.77***	.77***
29. Being too tired to have sex.							.40***	.25*
30. Not showing love.							.60***	.60***

****p<.001, **p<.01, *p<.05*

Table 19

Correlations between DAS Subscale

Sub-scales for mothers	1	2	3	Sub-scales for fathers	1	2	3
1.Consensus	-			1.Consensus	-		
2.Cohession	.68***	-		2.Cohession	.56***	-	
3.Satisfaction	.71***	.61***	-	3.Satisfaction	.63***	.50***	-
4.Expression of Affection	.81***	.65***	.78***	4.Expression of Affection	.68***	.46***	.70***

****p<.001*

Tables 20 and 21 present the factor loadings and factor correlations for the **prenatal coparenting** instrument for mothers and fathers. In this subsample, **items 34 and 35 were excluded** due to insufficient variability, which adversely affected CFA estimation and overall model fit. The error terms of Items 32 and 33 were allowed to correlate, given the similarity in their wording.

Table 20

Factor loadings for Prenatal Coparenting Relationship Scale for mothers and fathers.

Item	Cooperative coparenting		Coparental conflict	
	(m)	(f)	(m)	(f)
1. My partner will be a good parent.	.80***	.72***		
2. My relationship with my partner will be stronger after we have the child.	.77***	.68***		
3. My partner will ask my opinion on issues related to parenting.	.63***	.61***		
6. My partner and I will have the same goals for our child.	.70***	.70***		
10. My partner will tell me I am doing a good job or otherwise let me know I am being a good parent.	.80***	.78***		
14. My partner will be sensitive to our child's feelings and needs.	.72***	.33***		
18. My partner will have a lot of patience with our child.	.58***	.64***		
19. We will often discuss the best way to meet our child's needs.	.72***	.69***		
23. My partner will be willing to make personal sacrifices to help take care of our child.	.68***	.58***		
24. We will grow and mature together through experiences as parents.	.72***	.82***		
25. My partner will appreciate my efforts at being a good parent.	.88***	.89***		
26. When I feel I am at my wits end as a parent, my partner will give me the extra support I need.	.83***	.79***		
28. My partner will make me feel that I'm best possible parent for our child.	.86***	.83***		
31. I will sometimes find myself having a mildly tense or sarcastic interchange with my partner.			.75***	.69***
32. My partner and I will argue about our child, in the child's presence.			.78***	.69***
33. My partner and I will argue about our relationship or marital issues unrelated to our child, in the child's presence.			.53***	.60***

****p<.001, **p<.01, *p<.05*

Table 21

Correlations between CRS-P Subscale

Sub-scales for mothers		Sub-scales for fathers	
1.Cooperatve Coparenting	-	1.Cooperatve Coparenting	-
2.Coparental Conflict	-.66***	2.Coparental Conflict	-.71***

****p<.001*

Annex 3. Original models of Specific Objective 2

Model 1: Couple satisfaction at Time 1 → Coparenting at Time 1 → Coparenting at Time 2 → Parental self-efficacy at Time 3.

Model for Parental Self-efficacy as a General Domain. Figure 11 presents the model examining the indirect effect of couple satisfaction at Time 1 on parental self-efficacy (general domain) at Time 3 through coparenting at Times 1 and 2. A stability path was included by adding parental self-efficacy at Time 2 to the model. Accordingly, we modelled the effect of coparenting at Time 1 on parental self-efficacy at Time 2 (β = .27, p = .001 for mothers; β = .33, p < .001 for fathers) and the autoregressive effect of parental self-efficacy at Time 2 on parental self-efficacy at Time 3 (β = .57, p < .001 for mothers; β = .46, p < .001 for fathers).

We controlled for the effects of depressive symptoms at Time 1 on coparenting at Time 1 (β = −.05, p = .34 for mothers; β = −.04, p = .43 for fathers), coparenting at Time 2 (β = .04, p = .65 for mothers; β = −.02, p = .82 for fathers), parental self-efficacy at Time 3 (β = −.15, p = .058 for mothers; β = −.13, p = .09 for fathers), and parental self-efficacy at Time 2 (β = −.23, p = .003 for mothers; β = −.23, p = .001 for fathers).

Additional covariates were included as indicated by preliminary analyses. Housing arrangement was controlled for in the regressions predicting fathers'

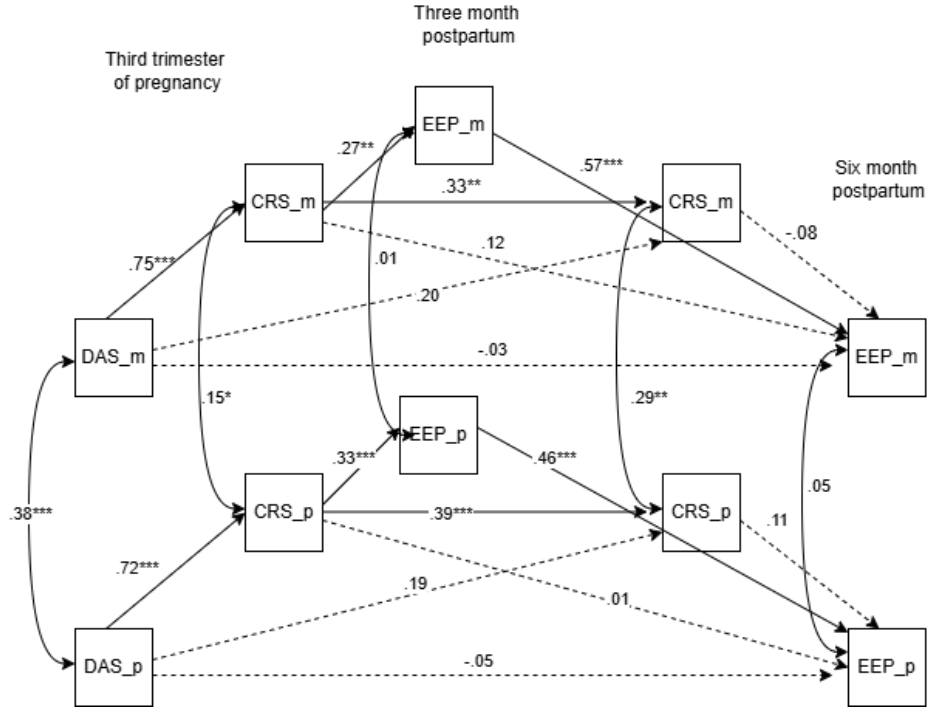
coparenting at Time 1 (β = .04, *p* = .42), coparenting at Time 2 (β = −.06, *p* = .43), and fathers' parental self-efficacy at Time 3 (β = −.04, *p* = .61). Perception of income was controlled for in the regression predicting mothers' parental self-efficacy at Time 3 (β = .12, *p* = .039).

The model showed acceptable fit to the data: $\chi^2(52) = 131.913$, $p < .001$; CFI = .91; RMSEA = .081, 90% CI [.064, .099]. A significant indirect effect was found from couple satisfaction at Time 1 to parental self-efficacy at Time 3 through coparenting at Times 1 and parental self-efficacy at Time 2, for both mothers (β = .11, 95% bootstrap CI [.03, .23]) and fathers (β = .11, 95% bootstrap CI [.04, .21]).

The model explained 46% of the variance in parental self-efficacy at Time 3 for mothers and 28% for fathers. In addition, it accounted for 62% and 54% of the variance in coparenting at Time 1, and 23% and 30% of the variance in coparenting at Time 2, for mothers and fathers, respectively. The model also explained 18% of the variance in parental self-efficacy at Time 2 for mothers and 20% for fathers.

Figure 11

Double mediation of coparenting at Time 1 and 2 in the relationship on couple satisfaction and parental self-efficacy as a general domain.



Note: p<.05, **p<.01, p***<.001. DAS_m Couple satisfaction in mothers, DAS_p Couple satisfaction in fathers, CRS_m Coparenting in mothers, CRS_p Coparenting in fathers, EEP_m parental self-efficacy in mothers, EE_p parental self-efficacy in fathers. The model controlled for housing arrangement for fathers, perception of income for mothers and depressive symptoms at Time 1 for mothers and fathers.*

Model for Parental Self-efficacy as a Task-Specific Construct. Figure 10 presents the model examining the indirect effect of couple satisfaction at Time 1 on parental self-efficacy (task-specific) at Time 3 through coparenting at Times 1 and 2. A stability path was included by adding parental self-efficacy at Time 2 to the model. Accordingly, we modelled the effect of coparenting at Time 1 on parental self-efficacy at Time 2 (β = .15, p = .13 for mothers; β = .28, p < .001 for fathers) and the autoregressive effect of parental self-efficacy at Time 2 on

parental self-efficacy at Time 3 (β = .57, p < .001 for mothers; β = .57 , p < .001 for fathers).

We controlled for the effects of depressive symptoms at Time 1 on coparenting at Time 1 (β = −.05, *p* = .35 for mothers; β = −.04, *p* = .42 for fathers), coparenting at Time 2 (β = .04, *p* = .65 for mothers; β = −.02, *p* = .79 for fathers), parental self-efficacy at Time 3 (β = −.16, *p* = .04 for mothers; β = .01, *p* = .88 for fathers), and parental self-efficacy at Time 2 (β = −.30, *p* = .005 for mothers; β = −.18, *p* = .02 for fathers).

Additional covariates were included as indicated by preliminary analyses. Housing arrangement was controlled for in the regressions predicting fathers' coparenting at Time 1 (β = .04, *p* = .42), coparenting at Time 2 (β = −.06, *p* = .45), and fathers' parental self-efficacy at Time 3 (β = −.01, *p* = .93). Perception of income (β = .01, *p* = .90) and level of education (β = .06, *p* = .27) were controlled for in the regression predicting mothers' parental self-efficacy at Time 3.

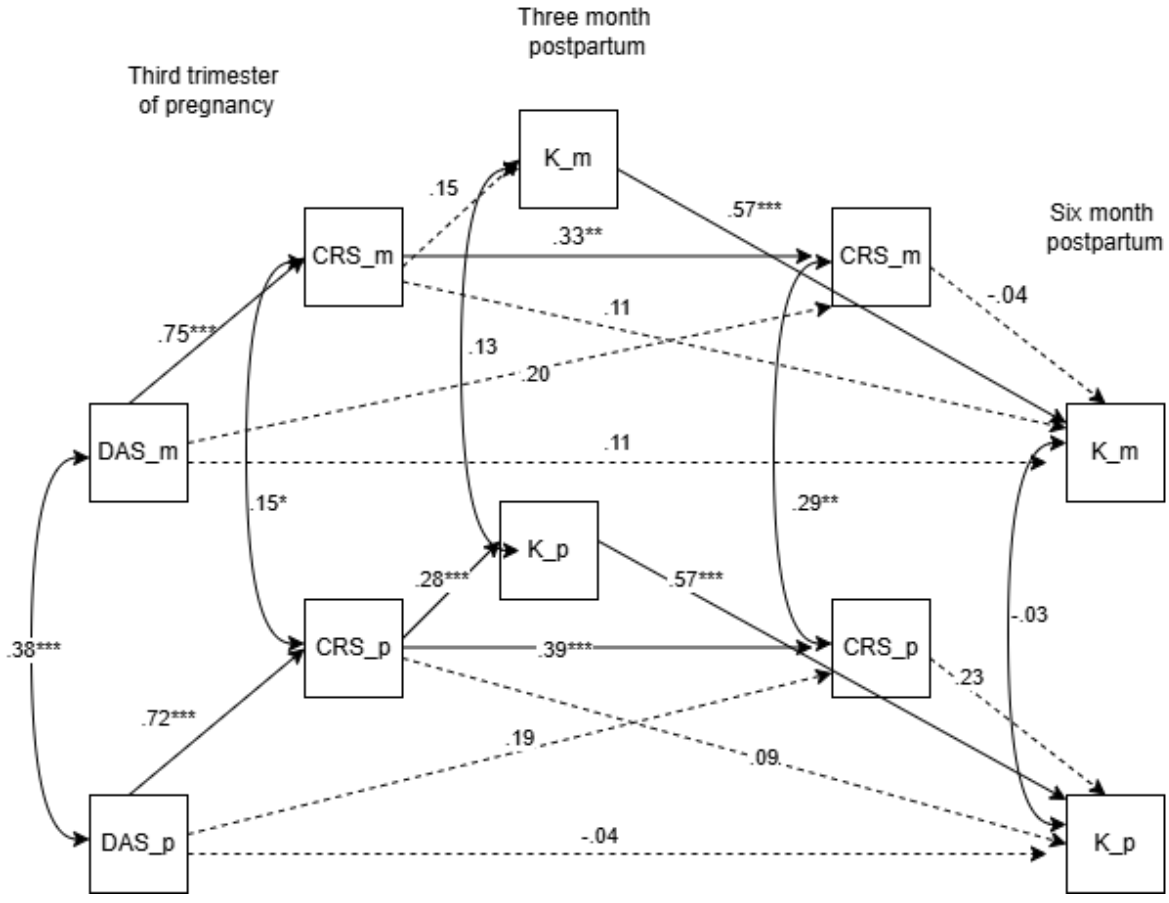
The model showed acceptable fit to the data: $\chi^2(63) = 144.172$, *p* < .001; CFI = .91; RMSEA = .07, 90% CI [.058, .090]. A total direct effect of couple satisfaction on parental self-efficacy was found for mothers (β = .24, 95% bootstrap CI [.003, .11]) and for fathers (β = .25, 95% bootstrap CI [.03, .14]). For fathers, a total indirect effect was also found (β = .29, 95% bootstrap CI [.03, .18]). Furthermore, for fathers, a significant specific indirect effect emerged from couple satisfaction at Time 1 to parental self-efficacy at Time 3 through sequential coparenting at Times 1 and 2 (β = .06, 95% bootstrap CI [.003, .05]), as well as through coparenting at Time 1 and parental self-efficacy at Time 2 (β = .11, 95% bootstrap CI [.01, .08]).

The model explained 56% of the variance in parental self-efficacy at Time 3 for mothers and 46% for fathers. In addition, it accounted for 62% and

54% of the variance in coparenting at Time 1, and 23% and 30% of the variance in coparenting at Time 2, for mothers and fathers, respectively. The model also explained 15% of the variance in parental self-efficacy at Time 2 for mothers and 14% for fathers.

Figure 12

Double mediation of coparenting at Time 1 and 2 in the relationship on couple satisfaction and parental self-efficacy as a task specific.



Note: p<.05, **p<.01, p***<.001. DAS_m Couple satisfaction in mothers, DAS_p Couple satisfaction in fathers, CRS_m Coparenting in mothers, CRS_p Coparenting in fathers, K_m parental self-efficacy in mothers, K_p parental self-efficacy in fathers. The model controlled for housing arrangement for fathers, perception of income and level of education for mothers and depressive symptoms at Time 1 for mothers and fathers.*

Annex 4. Instruments.

Cuestionario de Datos Sociodemográficos:

Introducción: La siguiente encuesta busca conocer información general sobre usted y su familia, así como algunos antecedentes de salud, suyos y de su bebé.

NOMBRE COMPLETO: _____

EDAD: _____

FECHA DE NACIMIENTO: _____/_____/_____

TELÉFONO DE CONTACTO: _____

OTRO TELÉFONO DE CONTACTO (otra persona): _____

CORREO ELECTRONICO: _____

COMUNA DE RESIDENCIA: _____

A. Nacionalidad:_____ _____

B. Relación de pareja actual:
   - ☐ Convive con el padre de su bebé
   - ☐ Casada

¿Hace cuánto tiempo están juntos? _____

¿Hace cuánto tiempo viven juntos?_____

C. ¿Tiene otros hijos?
☐ No
☐Si, tengo otros hijos con mi pareja actual
☐Si, tengo hijos con una relación anterior

D. En caso de tener otros hijos, ¿Cuántos son?_____ ¿Qué edad tienen?_____

E. ¿Cuál es el máximo nivel educacional terminado?:

Básica incompleta ☐

Básica completa ☐

Media incompleta ☐

Media completa ☐

Estudios superiores incompletos ☐

Estudios técnicos completos ☐

Estudios universitarios completos ☐

F. ¿Cuántos años totales de estudio ha completado? (Escuela y estudios superiores en total):_____

G. En la actualidad ¿está llevando a cabo un trabajo remunerado?:

☐ No ☐ Sí
¿Cuál?:_____
_____
_

H. ¿Está cursando algún estudio en la actualidad?:

☐ No ☐ sí

¿Qué tipo de estudios está cursando?:_____

I. ¿A qué sistema previsional de salud pertenece?, ya sea como cotizante o

carga

☐ Sistema público de salud público FONASA grupo A

☐Sistema público de salud público FONASA grupo B

☐Sistema público de salud público FONASA grupo C

☐Sistema público de salud público FONASA grupo D

☐Sistema público FONASA no conoce grupo

☐FF.AA y de Orden

☐ISAPRE

☐Otro sistema ¿Cuál?: _____

☐Ninguno

☐No sabe

J. ¿Cuán bien diría usted que le va financieramente a su hogar en estos días? Usted diría que…

☐ Viven de manera acomodada

☐ Les va bien

☐ Les alcanza justo para llegar a fin de mes

☐ Se les hace difícil llegar a fin de mes

☐ Se les hace muy difícil llegar a fin de mes

☐ No sabe

☐No responde

K. ¿En qué tipo de vivienda vive usted?

☐ Propia ☐ Compartida con otro familiar ☐ Arrendada ☐ Otro_____

L. Cuántas personas viven en su hogar?_____

VARIABLES OBSTRETICAS PREVIAS (para madre)

M. ¿Ha experimentado alguna perdida/aborto? No ☐ Sí ☐ ¿Cuántas?_____

N. ¿El embarazo ha sido concebido por reproducción asistida? No ☐ Sí ☐

VARIABLES SALUD ACTUALES

O. ¿De cuantas semanas de gestación está?_____

P. Con qué tiempo de gestación comenzaron los chequeos de embarazo _____

Q. ¿Ha presentado alguna dificultad de salud durante el embarazo? (para madre): sí ☐ no ☐

En caso de que si, ¿Cuál/es?

_____

R. ¿Está tomando algún medicamento? (para madre): No ☐ Sí ☐ ¿Cuál/es?_____

S. Actualmente ¿ha presentado síntomas o ha sido diagnosticada con alguno/s de los siguientes?

☐ Síntomas de depresión ☐ Me han diagnosticado con depresión

☐ Síntomas de ansiedad/estrés elevado ☐ Me han diagnosticado con cuadro ansioso.

☐ Otro trastorno o dificultad emocional ¿Cuál?: _____

☐ No he presentado ninguna de estas dificultades.

T. ¿Está recibiendo tratamiento psicológico o farmacológico por dificultades de salud mental?

No ☐ Sí ☐ ¿Cuál/es?_____

U. En el pasado (previo a su embarazo actual) ¿ha presentado síntomas o ha sido diagnosticada con alguno/s de los siguientes?

☐ Síntomas de depresión ☐ Me han diagnosticado con depresión

☐ Síntomas de ansiedad/estrés elevado ☐ Me han diagnosticado con cuadro ansioso.

☐ Otro trastorno o dificultad emocional ¿Cuál?:
_____

☐ No he presentado ninguna de estas dificultades.

V. Su embarazo fue:

☐ Planificado

☐ No planificado, pero deseado.

☐ No planificado y me ha costado o costó asumirlo.

☐ Otro.

W. ¿Ha buscado información sobre temáticas como embarazo, maternidad y paternidad?

No ☐ Sí ☐ ¿Por qué vía?_____

X. ¿Has asistido a clases prenatales? No ☐ Sí ☐

Y. ¿Tiene otros hijos? No ☐ Sí ☐

VI. APOYO SOCIAL

W. Mencione por orden las tres primeras personas por quien más se ha sentido apoyada durante este período (embarazo, postparto). Indique parentesco o relación con esa persona

1 _____

2 _____

3 _____

X. ¿Alguien te acompaña con frecuencia a los chequeos de embarazo?(para madre)

No ☐ Sí ☐
¿Quién?_____
___

Y. ¿Quieres ser acompañada en el momento del parto por alguien cercano?(para madre)

No ☐ Sí ☐ ¿Por quién?_____
_

Dyadic Adjustment Scale (DAS)
La mayoría de las personas tienen desacuerdos en sus relaciones. Por favor indique más abajo el grado de acuerdo o desacuerdo entre Ud. y su pareja en cada uno de los temas de la siguiente lista…

___ 1. Manejo de las finanzas familiares.
___ 2. Actividades recreativas.
___ 3. Asuntos religiosos.
___ 4. Demostraciones de afecto.
___ 5. Amigos.
___ 6. Vida sexual.
___ 7. Convencionalismos (conductas adecuadas o correctas).
___ 8. Filosofía de vida.
___ 9. Relación con la familia del otro.
___ 10. Aspiraciones, metas y otros asuntos importantes.
___ 11. Cantidad de tiempo compartiendo juntos.
___ 12. Toma de decisiones mayores.
___ 13. Tareas del hogar.
___ 14. Intereses dentro del tiempo libre.
___ 15. Decisiones laborales.

INDICADORES	
Siempre de acuerdo	= 5
Casi siempre de acuerdo	= 4
Ocasionalmente en desacuerdo	= 3
Frecuentemente en desacuerdo	= 2
Casi siempre en desacuerdo	= 1
Siempre en desacuerdo	= 0

Por favor indique más abajo cuán a menudo ocurren las siguientes situaciones entre Ud. y su pareja.
___ 16. ¿Cuán seguido han discutido o considerado el divorcio, separación, o término de la relación?
___ 17. ¿Cuán seguido Ud. o su pareja se ha ido de la casa después de una pelea?
___ 18. En términos generales, ¿cuán a menudo piensa que las cosas entre Ud. y su pareja andan bien?
___ 19. ¿Confía en su pareja?
___ 20. ¿Se ha arrepentido alguna vez de haberse casado o convivido con su pareja?
___ 21. ¿Cuán a menudo pelea Ud. con su pareja?
___ 22. ¿Cuán a menudo Ud. y su pareja se colman la paciencia?

Todo el tiempo	= 1
La mayoría del tiempo	= 2
Mas veces sí que no	= 3
Ocasionalmente	= 4
Raramente	= 5
Nunca	= 6

___23. ¿Besa Ud. a su pareja?

Todos los días	= 4
Casi todos los días	= 3
Ocasionalmente	= 2
Rara vez	= 1

___24. ¿Ud. y su pareja comparten intereses fuera de casa?

Todos	= 4
La mayoría	= 3
Algunos	= 2
Muy pocos	= 1
Ninguno	= 0

¿Cuán a menudo diría que ocurren los siguientes eventos entre Ud. y su pareja?

Nunca	= 1
Menos de una vez al mes	= 2
Una o dos veces al mes	= 3
Una vez al día	= 4
Muy a menudo	= 5

___25. Tener un intercambio estimulante de ideas.
___26. Reírse juntos.
___27. Discutir calmadamente un asunto.
___28. Trabajar juntos en un proyecto.

Si	= 1
No	= 2

Hay algunos temas sobre los cuales algunas veces las parejas están de acuerdo y a veces en desacuerdo. Indique si alguno de los siguientes ítems ha causado problemas en su relación de pareja en las últimas semanas.

___29. Estar muy cansado para tener sexo.
___30. No demostrar amor.

31. Los números de la siguiente línea representan los diferentes grados de felicidad en su relación de pareja. El punto medio .feliz. representa el grado de felicidad existente en la mayoría de las relaciones. Por favor marque con un círculo el número que mejor describe su grado de felicidad, tomando en cuenta la totalidad de su relación.

32. Por favor marque con un círculo una de las siguientes afirmaciones que mejor describe cómo se siente Ud. acerca del futuro de su relación de pareja.

5 Deseo intensamente que mi relación de pareja tenga éxito, y podría hacer cualquier cosa para lograrlo,
4 Deseo mucho que mi relación de pareja tenga éxito, y haré todo lo que pueda para lograrlo.
3 Deseo mucho que mi relación de pareja tenga éxito, y haré lo que más pueda para lograrlo.
2 Me gustaría que mi relación de pareja fuera exitosa, pero no puedo hacer mucho más de lo que hago para lograrlo.
1 Me gustaría que mi relación de pareja fuera exitosa, pero me niego a hacer algo más de lo que ya hago para lograrlo.
0 Puede que mi relación nunca sea exitosa, y no hay nada más que yo pueda hacer para lograrlo.

Coparenting Relationship Scale(CRS)

En el cuestionario se presentan una serie de frases que describen situaciones habituales de crianza en conjunto con su pareja. Para cada afirmación, seleccione la respuesta que describe mejor la manera en que trabajan juntos como padres de su bebé.

0	1	2	3	4	5	6
Casi nunca cierto para nosotros	De vez en cuando cierto para nosotros	A veces cierto para nosotros	Normalmente cierto para nosotros	Muy a menudo cierto para nosotros	Muchísimas veces cierto para nosotros	Siempre cierto para nosotros

1	Creo que mi pareja ejerce bien su rol como padre/madre	0	1	2	3	4	5	6
2	Mi relación con mi pareja es más fuerte ahora que antes de haber tenido un/a hijo/a.	0	1	2	3	4	5	6
3	Mi pareja pide mi opinión sobre cuestiones relacionadas con la crianza	0	1	2	3	4	5	6
4	Mi pareja presta una gran atención a nuestro/a hijo/a	0	1	2	3	4	5	6
5	A mi pareja le gusta jugar con nuestro/a hijo/a	0	1	2	3	4	5	6
6	Mi pareja me deja el trabajo más duro a mi							

7	Mi pareja y yo tenemos los mismos objetivos para nuestro/a hijo/a	0	1	2	3	4	5	6
8	Mi pareja todavía quiere centrarse en sus cosas en lugar de ser un padre/madre responsable.	0	1	2	3	4	5	6
9	Es más fácil y más divertido jugar cuando estoy solo/a con el/la hijo/a, que cuando está mi pareja también presente	0	1	2	3	4	5	6
10	Mi pareja y yo tenemos ideas diferentes sobre cómo educar a nuestro/a hijo/a	0	1	2	3	4	5	6
11	El otro padre o madre, me dice que estoy haciendo un buen trabajo o de otra manera me hace saber que estoy siendo un buen padre/madre	0	1	2	3	4	5	6
12	Mi pareja y yo tenemos diferentes ideas con respecto a la comida, el sueño y otras rutinas de nuestro/a hijo/a.	0	1	2	3	4	5	6
13	Mi pareja a veces hace bromas o comentarios sarcásticos sobre la forma en que me comporto como padre/madre.	0	1	2	3	4	5	6
14	Mi pareja no confía en mis capacidades como padre/madre.	0	1	2	3	4	5	6
15	Mi pareja es sensible a los sentimientos y necesidades de nuestro/a hijo/a	0	1	2	3	4	5	6
16	Mi pareja y yo tenemos planteamientos diferentes para el comportamiento de nuestro/a hijo/a.	0	1	2	3	4	5	6
17	Mi pareja intenta demostrarme que cuida mejor que yo a nuestro/a hijo/a.	0	1	2	3	4	5	6
18	Me siento cercano a mi pareja, cuando le veo jugar con nuestro/a hijo/a	0	1	2	3	4	5	6
19	Mi pareja tiene mucha paciencia con nuestro/a hijo/a	0	1	2	3	4	5	6
20	Mi pareja no se hace cargo de la parte que le corresponde en la crianza.	0	1	2	3	4	5	6
21	Cuando los tres estamos juntos, mi pareja compite conmigo para captar la atención de nuestro/a hijo/a.	0	1	2	3	4	5	6
22	Mi pareja boicotea mi crianza.	0	1	2	3	4	5	6
23	Mi pareja está dispuesto a hacer sacrificios personales para ayudar a cuidar de nuestro/a hijo/a.	0	1	2	3	4	5	6

24	Estamos creciendo y madurando juntos a través de las experiencias como padres.	0	1	2	3	4	5	6
25	Mi pareja aprecia lo mucho que yo trabajo para ser un buen padre/madre	0	1	2	3	4	5	6
26	Cuando estoy al límite como padre/madre, mi pareja me da el apoyo adicional que necesito.	0	1	2	3	4	5	6
27	El estrés de la paternidad ha hecho que mi pareja y yo nos distanciemos.	0	1	2	3	4	5	6
28	Mi pareja me hace sentir como que soy el mejor padre/madre posible para nuestro/a hijo/a.	0	1	2	3	4	5	6
29	A mi pareja no le gusta que nuestro/a hijo/a le moleste	0	1	2	3	4	5	6
30	La crianza nos ha dado un proyecto de futuro	0	1	2	3	4	5	6

Nunca	De vez en cuando (1 o 2 veces por semana)	A veces	Normalmente (1 vez al día)	Muy a menudo	Muchísimas veces (varias veces en el día)	Siempre

31	Tiene un intercambio ligeramente tenso o sarcástico con su pareja	0	1	2	3	4	5	6
32	Discute con su pareja acerca de su hijo/a, en presencia del hijo/a	0	1	2	3	4	5	6
33	Discute acerca de temas de su relación con su pareja, no relacionados con su hijo/a, en presencia del hijo/a?	0	1	2	3	4	5	6
34	Uno o ambos de ustedes se dicen mutuamente cosas crueles o hirientes entre sí delante del hijo/a?	0	1	2	3	4	5	6
35	Se grita uno al otro cuando su hijo/a puede oírlos	0	1	2	3	4	5	6

Karitane Parental Confidence Scale (KPCS)

Por favor elija la respuesta que más se acerca a como se siente generalmente.

1. Me siento segura de que puedo alimentar a mi bebé (o no aplica, mi pareja alimenta al

bebé)

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

2. Puedo calmar a mi bebé

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

3. Me siento segura de que puedo ayudar a mi bebé a establecer una buena rutina para

dormir.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

4. Sé que hacer cuando mi bebé llora.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

5. Entiendo lo que mi bebé trata de decirme.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

6. Puedo calmar a mi bebé cuando está angustiado.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

7. Me siento segura de jugar con mi bebé.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

8. Si mi bebé tiene una gripe o fiebre leve, estoy segura de que puedo manejar esta

situación

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

9. Estoy segura de que mi pareja estará allí para mi cuando necesite apoyo.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

10. Estoy segura de que mi bebé está bien.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

11. Puedo tomar decisiones acerca del cuidado de mi bebé.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

12. Ser madre/padre es muy estresante para mí.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

13. Siento que estoy haciendo un buen trabajo como madre/padre.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

14. Otras personas piensan que estoy haciendo un buen trabajo como madre/padre.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

15. Me siento segura de que personas estarán allí para mi cuando necesite apoyo.

a). No, casi nunca

b). No muy frecuentemente

c). Si, algunas veces

d). Si, la mayoría del tiempo

Escala de Evaluación Parental (EEP)

Por favor responda qué tan de acuerdo se encuentra con cada una de las siguientes afirmaciones.

	Muy en desacuerdo Muy de acuerdo									
	1	2	3	4	5	6	7	8	9	10
1. Me siento constantemente criticada o evaluada por otros en mi rol de madre										
2. Siento que hago un buen trabajo como madre										
3. El ser madre me hace sentir satisfecha y feliz										
4. Mis intereses y talentos están en otras áreas de mi vida, no en la maternidad										
5. Considero que las decisiones que tomo en relación a la crianza de mi bebé son las más acertadas										
6. Ser madre no ha sido tan satisfactorio como yo esperaba										
7. Se me hace realmente difícil decidir cómo criar a mi bebé										
8. Las exigencias de la maternidad me hacen sentir tensa y angustiada										
9. Siento que en general las tareas de la maternidad no me permiten disfrutar a mi bebé										
10. Siento que no he logrado ser el tipo de madre que me gustaría										

Beck Depression Inventory (BDI-IA)

1. Tristeza
0 No me siento triste.
1 Me siento triste gran parte del tiempo
2 Me siento triste todo el tiempo.
3 Me siento tan triste o soy tan infeliz que no puedo soportarlo.
2. Pesimismo
0 No estoy desalentado respecto del mi futuro.
1 Me siento más desalentado respecto de mi futuro que lo que solía estarlo.
2 No espero que las cosas funcionen para mí.
3 Siento que no hay esperanza para mi futuro y que sólo puede empeorar.
3. Fracaso
0 No me siento como un fracasado.
1 He fracasado más de lo que hubiera debido.
2 Cuando miro hacia atrás, veo muchos fracasos.
3 Siento que como persona soy un fracaso total.
4. Pérdida de Placer
0 Obtengo tanto placer como siempre por las cosas de las que disfruto.
1 No disfruto tanto de las cosas como solía hacerlo.
2 Obtengo muy poco placer de las cosas que solía disfrutar.
3 No puedo obtener ningún placer de las cosas de las que solía disfrutar.
5. Sentimientos de Culpa
0 No me siento particularmente culpable.
1 Me siento culpable respecto de varias cosas que he hecho o que debería haber
hecho.
2 Me siento bastante culpable la mayor parte del tiempo.
3 Me siento culpable todo el tiempo.
6. Sentimientos de Castigo
0 No siento que este siendo castigado
1 Siento que tal vez pueda ser castigado.
2 Espero ser castigado.
3 Siento que estoy siendo castigado.
7. Disconformidad con uno mismo.

0 Siento acerca de mi lo mismo que siempre.
1He perdido la confianza en mí mismo.
2 Estoy decepcionado conmigo mismo.
3 No me gusto a mí mismo.

8. Autocrítica

0 No me critico ni me culpo más de lo habitual
1 Estoy más crítico conmigo mismo de lo que solía estarlo
2 Me critico a mí mismo por todos mis errores
3 Me culpo a mí mismo por todo lo malo que sucede.

9. Pensamientos o Deseos Suicidas

0 No tengo ningún pensamiento de matarme.
1 He tenido pensamientos de matarme, pero no lo haría
2 Querría matarme
3 Me mataría si tuviera la oportunidad de hacerlo.

10. Llanto

0 No lloro más de lo que solía hacerlo.
1 Lloro más de lo que solía hacerlo
2 Lloro por cualquier pequeñez.
3 Siento ganas de llorar pero no puedo.

11 Agitación

0 No estoy más inquieto o tenso que lo habitual.
1 Me siento más inquieto o tenso que lo habitual.
2 Estoy tan inquieto o agitado que me es difícil quedarme quieto
3 Estoy tan inquieto o agitado que tengo que estar siempre en movimiento o haciendo algo.

12 Pérdida de Interés

0 No he perdido el interés en otras actividades o personas.
1 Estoy menos interesado que antes en otras personas o cosas.
2 He perdido casi todo el interés en otras personas o cosas.
3.Me es difícil interesarme por algo.

13. Indecisión

0 Tomo mis propias decisiones tan bien como siempre.
1Me resulta más difícil que de costumbre tomar decisiones
2 Encuentro mucha más dificultad que antes para tomar decisiones.
3 Tengo problemas para tomar cualquier decisión.

14. Desvalorización

0 No siento que yo no sea valioso
1 No me considero a mí mismo tan valioso y útil como solía considerarme
2 Me siento menos valioso cuando me comparo con otros.
3 Siento que no valgo nada.

15. Pérdida de Energía

0 Tengo tanta energía como siempre.
1. Tengo menos energía que la que solía tener.
2. No tengo suficiente energía para hacer demasiado

3. No tengo energía suficiente para hacer nada.

16. Cambios en los Hábitos de Sueño

0No he experimentado ningún cambio en mis hábitos de sueño.
1ª. Duermo un poco más que lo habitual.
1b. Duermo un poco menos que lo habitual.
2a Duermo mucho más que lo habitual.
2b. Duermo mucho menos que lo habitual
3ª. Duermo la mayor parte del día
3b. Me despierto 1-2 horas más temprano y no puedo volver a dormirme

17. Irritabilidad

0 No estoy tan irritable que lo habitual.
1 Estoy más irritable que lo habitual.
2 Estoy mucho más irritable que lo habitual.
3 Estoy irritable todo el tiempo.

18. Cambios en el Apetito

0No he experimentado ningún cambio en mi apetito.
1ª. Mi apetito es un poco menor que lo habitual.
1b. Mi apetito es un poco mayor que lo habitual.
2a. Mi apetito es mucho menor que antes.
2b. Mi apetito es mucho mayor que lo habitual
3ª . No tengo apetito en absoluto.
3b. Quiero comer todo el día.

19. Dificultad de Concentración

0 Puedo concentrarme tan bien como siempre.
1 No puedo concentrarme tan bien como habitualmente
2 Me es difícil mantener la mente en algo por mucho tiempo.
3 Encuentro que no puedo concentrarme en nada.

20. Cansancio o Fatiga

0 No estoy más cansado o fatigado que lo habitual.
1 Me fatigo o me canso más fácilmente que lo habitual.
2Estoy demasiado fatigado o cansado para hacer muchas de las cosas que solía
hacer.
hacer.
3 Estoy demasiado fatigado o cansado para hacer la mayoría de las cosas que solía

21. Pérdida de Interés en el Sexo

0 No he notado ningún cambio reciente en mi interés por el sexo.
1Estoy menos interesado en el sexo de lo que solía estarlo.
2 Estoy mucho menos interesado en el sexo.
3 He perdido completamente el interés en el sexo.

Depression Anxiety and Stress Scale DASS-21

Por favor lea cada frase y marque el número 0, 1, 2 o 3 para indicar en qué medida esa frase describe lo que le pasó o sintió durante la última semana. No hay respuestas buenas o malas. Marque según su primera impresión, no se detenga demasiado en cada frase.

Las opciones de respuesta son:

0 No describe nada de lo que me pasó o sentí en la semana

1 Sí, esto me pasó o lo sentí en alguna medida o en algún momento.

2 Sí, esto me pasó bastante o lo sentí muchas veces.

3 Si, esto me pasó mucho, o casi siempre.

1.	Me costó mucho calmarme.	0 1 2 3
6.	Me descontrolé en ciertas situaciones.	0 1 2 3
8.	Sentí que estaba muy nervioso/a.	0 1 2 3
11.	Noté que me estaba poniendo intranquilo/a.	0 1 2 3
12.	Se me hizo difícil relajarme.	0 1 2 3
14.	No soportaba que nada me apartara de lo que estaba haciendo.	0 1 2 3
18.	Sentí que estaba muy irritable.	0 1 2 3

Annex 5. Informed Consent

Consentimiento Informado para participar en Investigación (Informed Consent to Participate in Research)

He sido invitado/a a participar en la investigación “Relaciones interparentales y autoeficacia parental durante la transición a la parentalidad”, que tiene como investigadora principal a la Ms. Ana Flavia Bennett Escalona. El objetivo de este estudio es evaluar la influencia de las relaciones interparentales durante la transición a la parentalidad en la autoeficacia parental a los 6 meses postparto. Mejorar el conocimiento en esta área de estudio, podría aportar a conocer nuevas formas de apoyar la adaptación de las parejas en el primer año de vida de su bebé.

Mi participación consiste en responder cuestionarios online sobre salud mental, autoeficacia parental, y sobre las relaciones que mantengo con mi pareja, principalmente desde nuestros roles como madre y padre. El proceso de completar los cuestionarios tendrá una duración aproximada de 20 minutos. Completaré estos cuestionarios durante el tercer trimestre de embarazo, y a los 3 y 6 meses de edad de mi bebé.

Me han explicado que la información recogida a través de este cuestionario será confidencial y no individualizada, esto significa que las respuestas no podrán ser conocidas por otras personas ni tampoco ser identificadas en la fase de publicación de resultados. Si lo deseo puedo tener acceso al informe final global del estudio, previa solicitud a la investigadora responsable.

Entiendo que mi participación es voluntaria y no remunerada, y que me puedo retirar en cualquier fase del estudio, sin tener que dar una justificación de la causa, en el momento que lo considere pertinente, sin que esto tenga consecuencia alguna.

En caso de cualquier duda puedo contactarme con la investigadora principal, Ms. Ana Flavia Bennett Escalona, al teléfono (569) 31228001 o al mail

abennette@udd.cl, en el momento que lo estime pertinente para cualquier asunto relativo a mi participación. Además, en caso de cualquier otra consulta sobre mis derechos como participante de este estudio puedo contactarme con el Dr. Francisco Ceric, Presidente del Comité de Ética Institucional UDD, fceric@udd.cl. Dicha institución no tiene acceso a mis datos obtenidos del estudio.

Dejo constancia que he leído la información, he tenido la oportunidad de hacer preguntas, y han sido respondidas satisfactoriamente, a partir de lo cual acepto participar en el proyecto de Investigación señalado.

__ **Sí. Acepto voluntariamente participar en este estudio y he recibido una copia del presente documento**.

Firma participante:

Fecha:

Firma Investigador(a) a cargo: