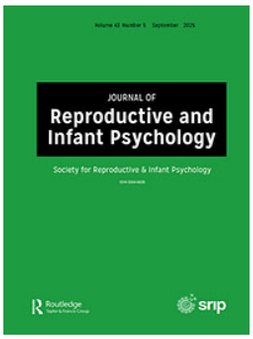

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Interparental conflict in the perinatal period: exploring clinical and community populations

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ABSTRACT

Aims/Background: Interparental conflict is a normal part of the parenting relationship, however, when it occurs frequently with animosity or acrimony, it can increase the risk of negative outcomes for both children and the parenting couple. Research has identified numerous risk factors for elevated interparental conflict, including the transition to parenthood and mental health difficulties. Despite this, the experiences of interparental conflict in families diagnosed with clinical mental health difficulties during the perinatal period remain unclear. This study aims to address this gap by investigating whether experiences of interparental conflict differ between families who are, and are not, experiencing complex or severe mental health difficulties during this period.

Design/Methods: This study compares reports of perinatal interparental conflict from COSI trial participants (ISRCTN18308962) accessing NHS Perinatal Mental Health Services in England with families without a diagnosis of mental health difficulties.

Results: The findings indicate that overall experiences of interparental conflict differ significantly between the two populations. Additionally, differences are observed in specific dimensions of conflict behaviour.

Conclusion: This research provides new insight into interparental conflict during the perinatal period. It suggests that parents diagnosed with clinical mental health symptoms during this time may face a heightened risk of increased conflict, and its associated outcomes. Such findings are vital for early healthcare services, which could screen for these behaviours and implement preventative interventions to support families.

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Interparental conflict; perinatal; mental health; parenting relationship; coparenting

Interpersonal conflict is a typical part of all relationships but holds a pivotal role within the coparenting context. Interparental conflict (IPC) in this work is defined as disagreements that 'occur frequently, are expressed with animosity/acrimony, and/or are poorly resolved' (Harold et al., 2016) and is considered a construct distinct from domestic violence or abuse (Department for Work and Pensions, 2022). Conflict behaviours are typically categorised as either constructive or destructive. Constructive conflict resolution often manifests as

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cooperative or problem-solving behaviours, which positively influence coparent relationship quality (Kanter et al., 2022; Warmuth et al., 2020). In contrast, destructive behaviours are characterised by expressions of anger or hostility, negatively impacting families when experienced with high intensity and frequency (Warmuth et al., 2020). Notably, destructive behaviours are linked to a heightened risk of parental separation and children developing internalising and externalising disorders (Birditt et al., 2010; Warmuth et al., 2020).

Risk factors for elevated IPC

Preventing the negative impact of destructive IPC is crucial for supporting child development and mitigating the long-term economic consequences of childhood difficulties (Doyle et al., 2009). To aid identification of families needing support, risk factors for elevated IPC have been identified. These include negative child temperament (e.g. irritability), low levels of perceived social support, divorced relationship status, and economic pressures (Amato, 2010; Calkins et al., 2024; Lau & Wong, 2008; J. Y. Lee et al., 2023).

The transition to parenthood has emerged as a significant risk factor for increased conflict, possibly due to the introduction of novel stressors, such as financial adjustments and increased fatigue, during this time (Camisasca et al., 2016; Giallo et al., 2013; Nylin et al., 2021). The Spillover Hypothesis (Erel & Burman, 1995) explains this association as external stressors reducing parents' capacity to effectively respond to the needs of others. Thus, the perinatal period is a crucial time of adjustment for families, and an opportune period for early intervention.

Parental mental health symptoms present additional risk for heightened destructive conflict, however, the direction of the relationship between IPC and depressive symptoms remains unclear (Gustavson et al., 2012; Whisman, 2001). The relationship between IPC and mental health difficulties is significant as up to 29% of birthing parents worldwide are estimated to experience depressive or anxiety symptoms postpartum (Al-Abri et al., 2023; Nielsen-Scott et al., 2022). Nevertheless, little evidence examines the association between clinical mental health difficulties and IPC specifically within the perinatal period (Ray et al., 2023). As such, understanding the experiences of perinatal IPC in families diagnosed with clinical mental health difficulties remains limited.

Greater insight into IPC between families' with and without mental health symptoms is critical for healthcare services to identify parents at a higher risk of increased conflict and its associated outcomes. This gap in understanding prevents the implementation of IPC screening measures and supportive intervention within healthcare services, despite various evidence-based programmes such as the New Beginnings Program being available (Wolchik et al., 2009). In England, NHS Perinatal Mental Health Services (PMHS) engage over 57,000 birthing parents diagnosed with complex/severe mental health difficulties and offer support up to two years postpartum (NHS England, 2024). These services are ideally placed to facilitate screening for destructive IPC behaviours and deliver targeted interventions.

Current study

This study aims to address the gap in the literature by providing a novel overview of IPC among parents accessing an NHS PMHS and comparing these findings with

a community sample of birthing parents in England. The following research questions are investigated:

(1) Do birthing parents accessing NHS PMHS and parents without a mental health diagnosis experience perinatal IPC differently?
(2) Is there an association between IPC during the perinatal period and demographic factors?

It is hypothesised that parents diagnosed with clinical mental health difficulties will report higher levels of destructive IPC compared to those with no mental health symptoms.

Materials and methods

Sample

Data was collected from 532 birthing parents in England. A priori power analysis confirmed that this sample size was sufficient to detect a small-to-medium effect size (Cohen's $d = 0.3$) with 90% power. All participants were aged ≤ 18-years with a child aged ≤ 12-months. Full descriptive statistics are presented in Table 1.

Clinical sample

Data for the clinical sample was drawn from the COSI trial (Rosan et al., 2023), comprising parents accessing an NHS PMHS due to diagnosed mental health difficulties (n = 150). The average age of parents was 31.04 years (SD = 5.06), and the average child age was 21.26 weeks (SD = 12.06). Ninety-four percent of parents were in a relationship, and all were coparenting with their child's biological or legal parent. Most participants identified as heterosexual (87%) and a White ethnicity (95%). All but one birthing parent identified as a woman.

Community sample

Participants in the community sample (n = 382) had no diagnosis of mental health difficulties. Most participants were aged 25–34 years (range = 18–54), and the average child age was 23.13 weeks (SD = 12.41). Two participants were coparenting with a non-biological parent, and 97% were in a relationship. Most participants identified as heterosexual (91%) and White ethnicity (97%). Two birthing parents identified as non-binary, with the remainder identifying as women.

Measures

Interparental conflict

IPC was measured using the *Conflict and Problem-solving Strategy Scales-Short Form* (CPSS-SF; Helland et al., 2021), an 18-item tool derived from Kerig's (1996) *Conflict and Problem-solving Scales* (CPS). Early evaluations of the CPSS-SF indicate a strong correlation with the CPS and acceptable fit across diverse family structures (Helland et al., 2021). CPSS-SF respondents report the frequency of behaviours such as 'listen to the other's point of view' exhibited by themselves and a coparent. Items are scored on a 4-point scale, and

Table 1. Sample Descriptive Statistics.

Variable	Clinical Sample (Mean, SD/n, %)		Community Sample (Mean, SD/n, %)	
Child age (weeks)	*M* = 21.26, *SD* = 12.06		*M* = 23.13, *SD* = 12.41	
Disability	Disability reported	n = 19, 12.67%	Disability reported	n = 21, 5.5%
	No disability reported	n = 131, 87.33%	No disability reported	n = 361, 94.5%
Relationship status	In a relationship	n = 143, 95.33%	In a relationship	n = 373, 97.64%
	Not in a relationship	n = 7, 4.67%	Not in a relationship	n = 9, 2.36%
Coparenting status	The baby's biological or legal parent	n = 147, 98%	The baby's biological or legal parent	n = 380, 99.5%
	A non-biological or legal parent	n = 0, 0%	A non-biological or legal parent	n = 2, 0.5%
	Missing	n = 3, 2%	Missing	n = 0, 0%
Any other children	Yes	n = 61, 40.7%	Yes	n = 147, 38.5%
	No	n = 88, 58.7%	No	n = 231, 60.5%
	Prefer not to say	n = 1, 0.67%	Prefer not to say	n = 2, 0.52%
	Missing	n = 0, 0%	Missing	n = 2, 0.52%
Income	High-income	n = 79, 52.67%	High-income	n = 268, 70.16%
	Low-income	n = 71, 47.33%	Low-income	n = 114, 29.84%
Sexual orientation	Heterosexual	n = 131, 87.33%	Heterosexual	n = 351, 91.88%
	In another way	n = 19, 12.67%	In another way	n = 31, 8.12%
Gender	Woman (including trans woman)	n = 146, 97.33%	Woman (including trans woman)	n = 375, 98.17%
	Non-binary	n = 0, 0%	Non-binary	n = 2, 0.52%
	In another way	n = 1, 0.67%	In another way	n = 0, 0%
	Prefer not to say	n = 1, 0.67%	Prefer not to say	n = 2, 0.52%
	Missing	n = 2, 1.33%	Missing	n = 3, 0.79%
Religion	Buddhist	n = 1, 0.67%	Buddhist	n = 1, 0.26%
	Christianity	n = 42, 28%	Christianity	n = 136, 35.6%
	Hindu	n = 1, 0.67%	Hindu	n = 0, 0%
	Muslim	n = 1, 0.67%	Muslim	n = 1, 0.26%
	Any other religion	n = 0, 0%	Any other religion	n = 4, 1.05%
	None	n = 96, 64%	None	n = 235, 61.52%
	Prefer not to say	n = 9, 6%	Prefer not to say	n = 2, 0.52%
	Missing	n = 0, 0%	Missing	n = 3, 0.79%
Ethnicity	Asian or Asian British	n = 3, 2%	Asian or Asian British	n = 1, 0.26%
	Black or Black British	n = 0, 0%	Black or Black British	n = 1, 0.26%
	Mixed	n = 2, 1.33%	Mixed	n = 3, 0.79%
	Other Ethnic Group	n = 1, 0.67%	Other Ethnic Group	n = 0, 0%
	White (British, Irish, or other White background)	n = 143, 95.33%	White (British, Irish, or other White background)	n = 373, 97.64%
	Missing	n = 1, 0.67%	Missing	n = 4, 1.05%

grouped into six subscales: cooperation, avoidance, child involvement, stalemating, verbal aggression, and physical aggression. All birthing parents in the study completed the CPSS-SF online, reporting their own behaviour in the last month and a coparent's behaviour.

Demographic information

Participants in the clinical sample completed a demographic questionnaire designed for the COSI trial. Participants in the community sample completed a 13-item subset of this questionnaire relevant to the current study, reporting on income, living arrangements, relationship status, and protected characteristics.

Procedure

Data for the clinical sample was collected as part of the COSI trial (trial registration: ISRCTN18308962). Information about the trial was presented to parents accessing an NHS PMHS in England who met several criteria, including a score ≥ 1.1 on *the Clinical Outcomes in Routine Evaluation-10* (Barkham et al., 2013) to confirm the presence of mental health difficulties. These parents received trial information from the research team over email and a subsequent recruitment phone call to answer any queries and complete consent procedures. Study questionnaires were completed online, and all data was pseudonymised to protect participant identity. Full details regarding the recruitment and data collection procedures for the clinical sample are outlined in the trial protocol (Rosan et al., 2023).

Community sample participants were recruited via advertisements on social media and online parenting platforms in England. Advertisements included a link to access the participant information sheet and consent form online. Participants were able to access all study documents and complete the questionnaires anonymously without contacting the study team. However, researcher contact details and details of support networks for parents experiencing IPC or domestic abuse were provided in these documents. The absence of a diagnosed mental health difficulty was confirmed in the consent form.

Written informed consent was provided by all study participants prior to inclusion in this research. The study received ethical approval from the UCL Research Ethics Committee (24877/001).

Patient and public involvement and engagement

An *Expert by Experience* panel comprising parents with lived experience of mental health difficulties contributed to the design of this study. The panel provided guidance selecting the CPSS-SF and assisted in the development of all participant-facing study materials.

Results

A small amount of missing data (<4%) in the CPSS-SF dataset was replaced using mean series imputation before calculating subscale scores. Missing values for relationship status (<1%) and income (<5%) were also replaced.

Exploratory analysis confirmed that the two study populations were comparable, with no significant differences in child age ($U(150, 382) = 31{,}150$, $p > .05$) or participant relationship status (Fisher's Exact Test, $p = .167$). A significantly higher number of participants reporting a disability (excluding mental health difficulties) ($X^2(1, n = 532) = 7.961$, $p = .005$) and lower income ($X^2(1, n = 532) = 14.527$, $p < .001$) were observed in the clinical sample compared to the community group.

Preliminary evaluation of the CPSS-SF

Reliability testing of the CPSS-SF indicates an acceptable Cronbach's Alpha for all CPSS-SF subscales measuring birthing parent behaviour in the clinical sample. However, Cronbach's Alpha values for clinical sample coparent avoidance (α=.648) and physical aggression (α=.671) are under the acceptable threshold (Nunnally & Bernstein, 1994). Cronbach's Alpha values for community sample avoidance, stalemating, and physical aggression are below the acceptable threshold. Full reliability testing is detailed in Table 2.

IPC between clinical and community samples

To evaluate group differences in IPC, participant income and relationship status were controlled for due to their prominence in IPC literature (J. Y. Lee et al., 2023; S. J. Lee et al., 2022). Participant reports of disability were controlled for due to variation between the two study samples.

MANCOVA analyses revealed a significant between-group difference in IPC (Pillai's Trace = .071, $F(12, 516) = 3.271$, $p < .001$, partial $\eta^2 = .071$). Post-hoc power analysis indicated that the achieved power (1 - β) of this analysis was .99.

Analysis of CPSS-SF subscales (see Table 3) suggested that higher levels of birthing parent cooperation behaviour were reported in the community sample compared to the clinical group. However, the reverse was observed for stalemating and verbal aggression behaviours. Mean coparent scores indicated that avoidance, stalemating, and physical aggression behaviours were more frequently reported within the clinical population than the community sample.

Covariate influences on IPC

Participant income, relationship status, and disability were covariates of interest included in MANCOVA analyses (see Table 3 for detailed subscale results).

Table 2. CPSS-SF Cronbach's Alpha values.

Subscale	Clinical Sample Birthing Parent α	Clinical Sample Coparent α	Community Sample Birthing Parent α	Community Sample Coparent α
Cooperation	.719	.892	.735	.838
Avoidance	.758	.648	.673	.488
Child involvement	.823	.846	.780	.824
Stalemating	.769	.713	.670	.672
Verbal aggression	.822	.871	.721	.738
Physical aggression	.757	.671	.491	.423

Table 3. MANCOVA Results for Each CPSS-SF Subscale.

Variable	CPSS-SF Subscale	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta^2
Study Group	Birthing Parent Cooperation	4.863	1	4.863	5.153	**.024***	.010
(clinical/community sample)	Birthing Parent Avoidance	1.403	1	1.403	.649	.421	.001
	Birthing Parent Child Involvement	3.782	1	3.782	1.931	.165	.004
	Birthing Parent Stalemating	29.635	1	29.635	11.910	**<.001*****	.022
	Birthing Parent Verbal Aggression	33.208	1	33.208	15.515	**<.001*****	.029
	Birthing Parent Physical Aggression	1.064	1	1.064	2.983	.085	.006
	Coparent Cooperation	.035	1	.035	.017	.898	.000
	Coparent Avoidance	8.105	1	8.105	4.013	**.046***	.008
	Coparent Child Involvement	7.612	1	7.612	3.539	.061	.007
	Coparent Stalemating	17.276	1	17.276	8.125	**.005****	.015
	Coparent Verbal Aggression	8.160	1	8.160	3.378	.067	.006
	Coparent Physical Aggression	2.183	1	2.183	6.409	**.012***	.012
Relationship Status	Birthing Parent Cooperation	3.154	1	3.154	3.342	.068	.006
(in a relationship/not in a relationship)	Birthing Parent Avoidance	26.687	1	26.687	12.344	**<.001*****	.023
	Birthing Parent Child Involvement	.021	1	.021	.011	.917	.000
	Birthing Parent Stalemating	2.500	1	2.500	1.005	.317	.002
	Birthing Parent Verbal Aggression	1.278	1	1.278	.597	.440	.001
	Birthing Parent Physical Aggression	.348	1	.348	.977	.323	.002
	Coparent Cooperation	44.078	1	44.078	20.712	**<.001*****	.038
	Coparent Avoidance	1.556	1	1.556	.771	.380	.001
	Coparent Child Involvement	10.545	1	10.545	4.902	**.027***	.009
	Coparent Stalemating	19.786	1	19.786	9.305	**.002****	.017
	Coparent Verbal Aggression	34.516	1	34.516	14.287	**<.001*****	.026
	Coparent Physical Aggression	4.014	1	4.014	11.785	**<.001*****	.022
Income	Birthing Parent Cooperation	6.006	1	6.006	6.364	**.012***	.012
(high-income/low-income)	Birthing Parent Avoidance	11.773	1	11.773	5.446	**.020***	.010
	Birthing Parent Child Involvement	5.688	1	5.688	2.905	.089	.005
	Birthing Parent Stalemating	24.871	1	24.871	9.996	**.002****	.019
	Birthing Parent Verbal Aggression	3.645	1	3.645	1.703	.192	.003
	Birthing Parent Physical Aggression	.520	1	.520	1.458	.228	.003
	Coparent Cooperation	37.537	1	37.537	17.639	**<.001*****	.032
	Coparent Avoidance	6.780	1	6.780	3.357	.067	.006
	Coparent Child Involvement	1.267	1	1.267	.589	.443	.001
	Coparent Stalemating	8.466	1	8.466	3.981	**.047***	.007
	Coparent Verbal Aggression	4.787	1	4.787	1.981	.160	.004
	Coparent Physical Aggression	1.898	1	1.898	5.573	**.019***	.010

(*Continued*)

Table 3. (Continued).

Variable	CPSS-SF Subscale	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta^2
Disability (disability reported/no disability reported)	Birthing Parent Cooperation	2.546	1	2.546	2.698	.101	.005
	Birthing Parent Avoidance	1.767	1	1.767	.817	.366	.002
	Birthing Parent Child Involvement	1.411	1	1.411	.720	.396	.001
	Birthing Parent Stalemating	.835	1	.835	.335	.563	.001
	Birthing Parent Verbal Aggression	3.948	1	3.948	1.845	.175	.003
	Birthing Parent Physical Aggression	2.646	1	2.646	7.419	**.007****	.014
	Coparent Cooperation	.071	1	.071	.033	.855	.000
	Coparent Avoidance	3.156	1	3.156	1.563	.212	.003
	Coparent Child Involvement	.834	1	.834	.388	.534	.001
	Coparent Stalemating	9.450E−5	1	9.450E−5	.000	.995	.000
	Coparent Verbal Aggression	2.585	1	2.585	1.070	.301	.002
	Coparent Physical Aggression	.017	1	.017	.048	.826	.000

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

Relationship status

Relationship status was significantly associated with total CPSS-SF scores (Pillai's Trace = .104, F(12, 516) = 4.982, $p < .001$, partial $\eta^2 = .104$). Specifically, birthing parents not in a relationship reported higher levels of avoidance, and coparent child involvement, stalemating, verbal aggression and physical aggression behaviours compared to those in a relationship. Conversely, significantly higher levels of cooperation behaviour were reported by coparents in a relationship.

Income

Participant weekly income categorised as either 'high-income' (≥£393) or 'low-income' (≤£392) (Office for National Statistics, 2023) was significantly associated with CPSS-SF scores (Pillai's Trace = .058, F(12, 516) = 2.633, $p = .002$, partial $\eta^2 = .058$). Notably, high-income was significantly related to greater birthing parent and coparent cooperation scores. By contrast, low-income was associated with higher stalemating, birthing parent avoidance, and partner physical aggression.

Disability

Birthing parent reports of disability were significantly associated with CPSS-SF scores (Pillai's Trace = .047, F(12, 516) = 2.098, $p = .016$, partial $\eta^2 = .047$). Specifically, higher physical aggression scores were reported by birthing parents with a disability, compared to those without a disability.

Interaction effects

To further explore the role of covariates, MANCOVA analyses explored the interaction between study variables. A significant interaction between participant relationship status, study sample, and CPSS-SF scores was identified (Pillai's Trace = .182, F(24, 1030) = 4.292, $p < .001$, partial $\eta^2 = .091$). However, due to the low number of participants categorised as 'not in a relationship', this variable was not analysed further.

No significant interaction effects were found for disability reports (Pillai's Trace = .067, F(12, 1030) = 1.482, $p = .064$, partial $\eta^2 = .033$). This variable was excluded from subsequent analyses.

Income

A significant interaction between participant income, study group, and IPC behaviours was reported (Pillai's Trace = .086, F(24, 1030) = 1.930, $p = .005$, partial $\eta^2 = .043$).

No significant difference in birthing parent cooperation was observed between income groups within the community sample (see Table 4 for all subscale interaction results). In the clinical sample, however, participants with higher income reported significantly greater cooperation scores compared to those with lower income (see Figure 1). A similar pattern was observed for reports of coparent cooperation. In the clinical sample, income showed a stronger relationship with CPSS-SF cooperation scores than in the community group, with higher income associated with greater cooperation (see Figure 2).

Birthing parent stalemating scores significantly interacted with income and study group. As shown in Figure 3, clinical sample participants exhibited a greater disparity in

Table 4. MANCOVA Interaction Results Between Income, Study Group, and CPSS-SF Subscales.

Interaction	CPSS-SF Subscale	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta^2
Study group * income (clinical sample/community sample * high-income/low-income)	Birthing Parent Cooperation	11.659	2	5.830	6.235	**.002****	.023
	Birthing Parent Avoidance	12.362	2	6.181	2.854	.059	.011
	Birthing Parent Child Involvement	7.766	2	3.883	1.981	.139	.007
	Birthing Parent Stalemating	36.899	2	18.450	7.528	**<.001*****	.028
	Birthing Parent Verbal Aggression	13.771	2	6.886	3.248	**.040***	.012
	Birthing Parent Physical Aggression	1.822	2	.911	2.566	.078	.010
	Coparent Cooperation	42.630	2	21.315	10.041	**<.001*****	.037
	Coparent Avoidance	6.803	2	3.402	1.686	.186	.006
	Coparent Child Involvement	5.237	2	2.618	1.214	.298	.005
	Coparent Stalemating	12.633	2	6.317	2.976	.052	.011
	Coparent Verbal Aggression	10.416	2	5.208	2.159	.117	.008
	Coparent Physical Aggression	3.317	2	1.658	4.875	**.008****	.018

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

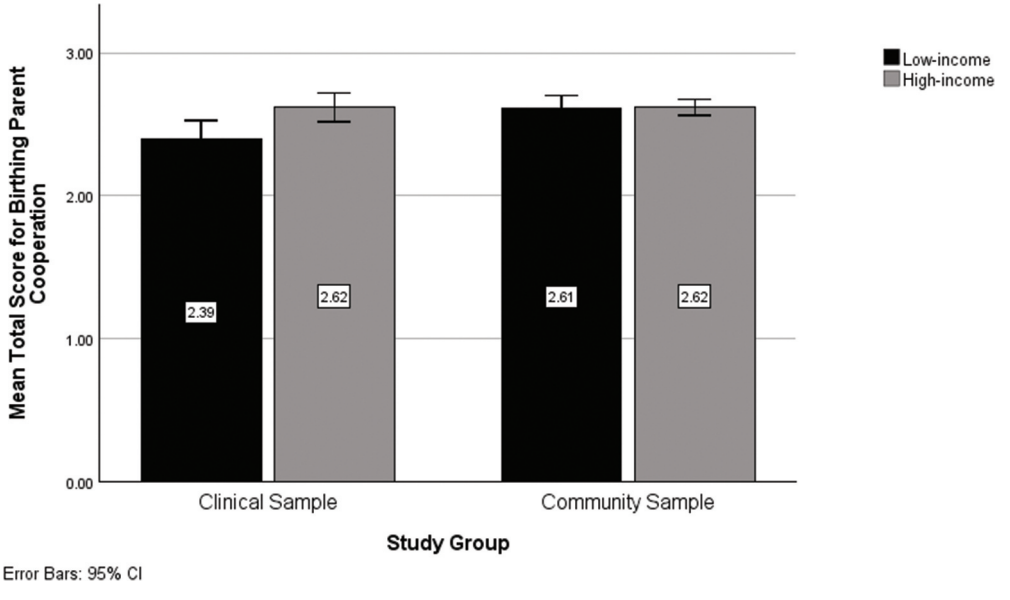

Figure 1. Histogram of the mean total score for birthing parent cooperation by study group and income.

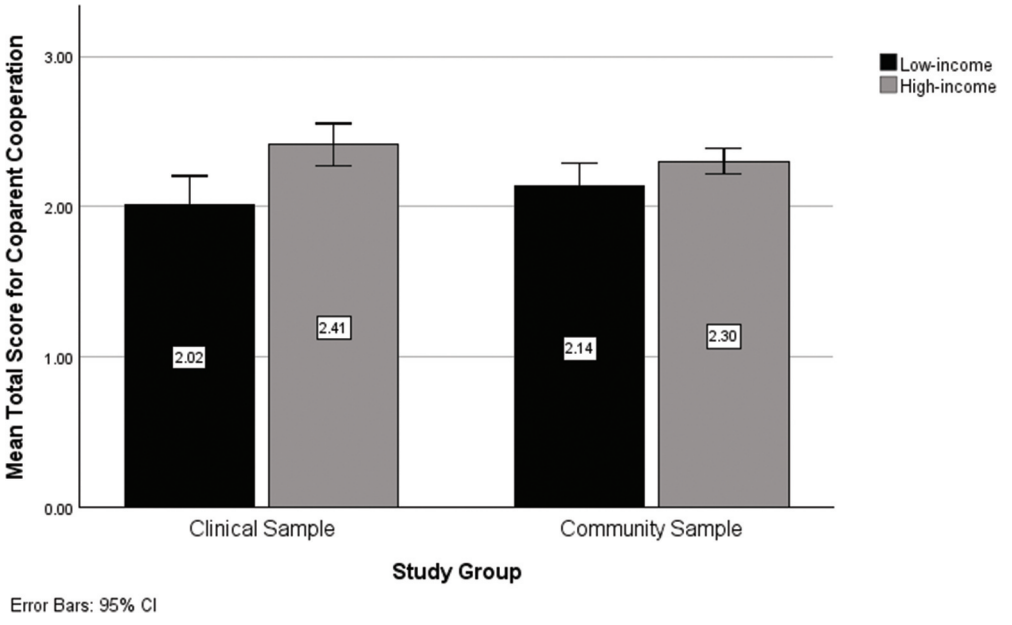

Figure 2. Histogram of the mean total score for coparent cooperation by study group and income.

stalemating scores between income groups than those in the community sample. The highest stalemating scores were reported by low-income participants in the clinical group.

A similar pattern was observed for verbal aggression. Clinical sample participants with low-income reported significantly higher verbal aggression than those with high-income, a disparity more pronounced than in the community sample (see Figure 4).

An interaction between coparent physical aggression, study group, and income was also identified. No significant differences in coparent physical aggression scores were observed between community sample income groups. However, clinical group participants with low-income reported significantly higher physical aggression behaviours compared to those with high-income (see Figure 5).

Discussion

This study explores perinatal IPC among families in England. The findings support the hypothesis that experiences of IPC significantly differ between birthing parents with and without diagnosed mental health difficulties. Specifically, families accessing NHS PMHS reported significantly lower levels of cooperation but higher levels of avoidance, stalemating, verbal aggression, and physical aggression compared to those without mental health symptoms. These results align with previous research linking mental health difficulties to elevated levels of IPC (Kuersten-Hogan et al., 2021; Ramchandani et al., 2011).

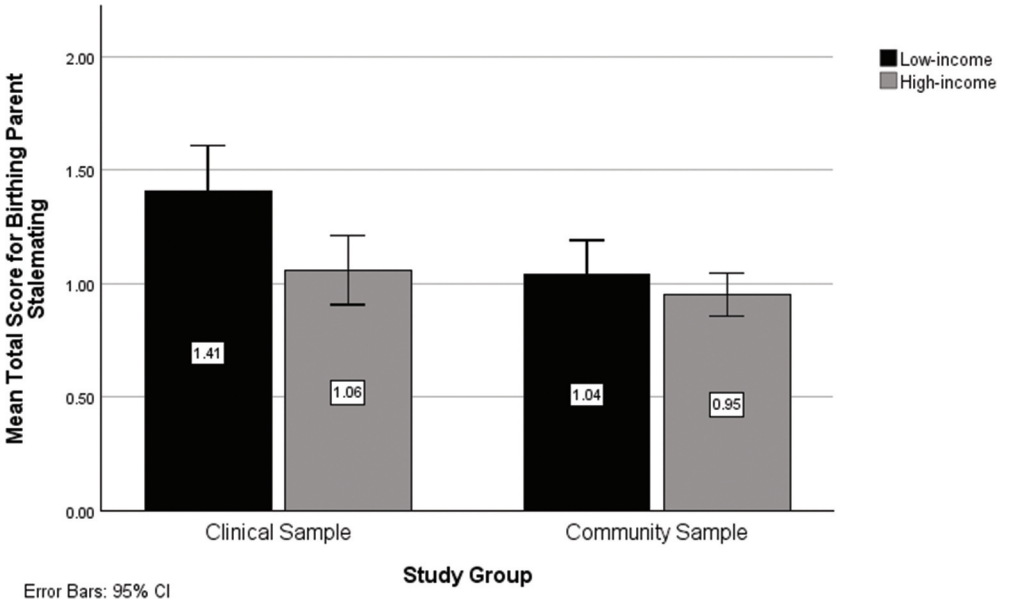

Figure 3. Histogram of the mean total score for birthing parent stalemating by study group and income.

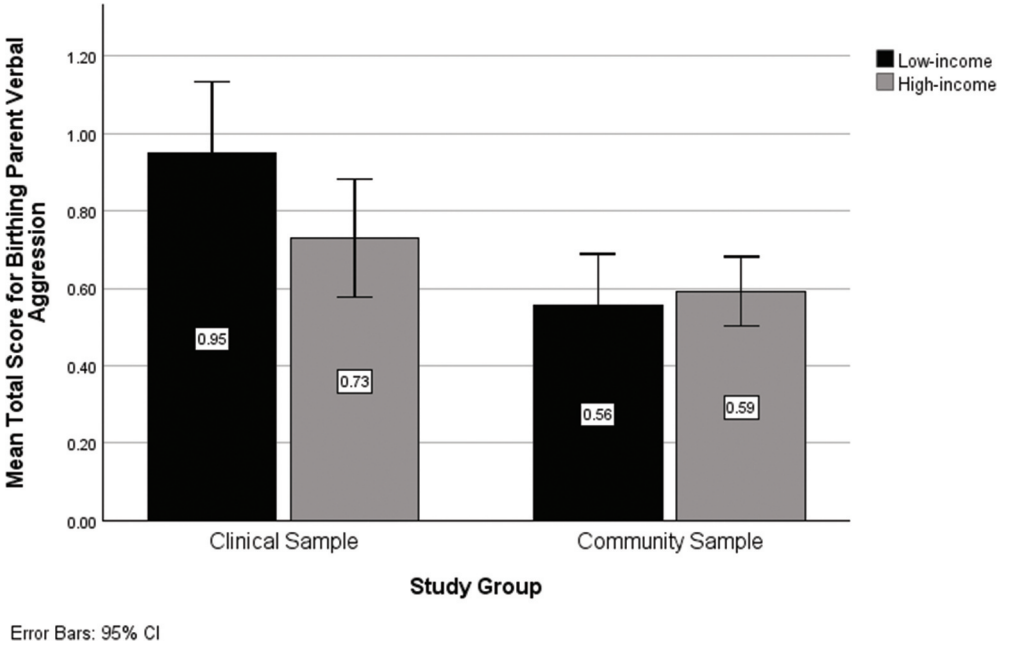

Figure 4. Histogram of the mean total score for birthing parent verbal aggression by study group and income.

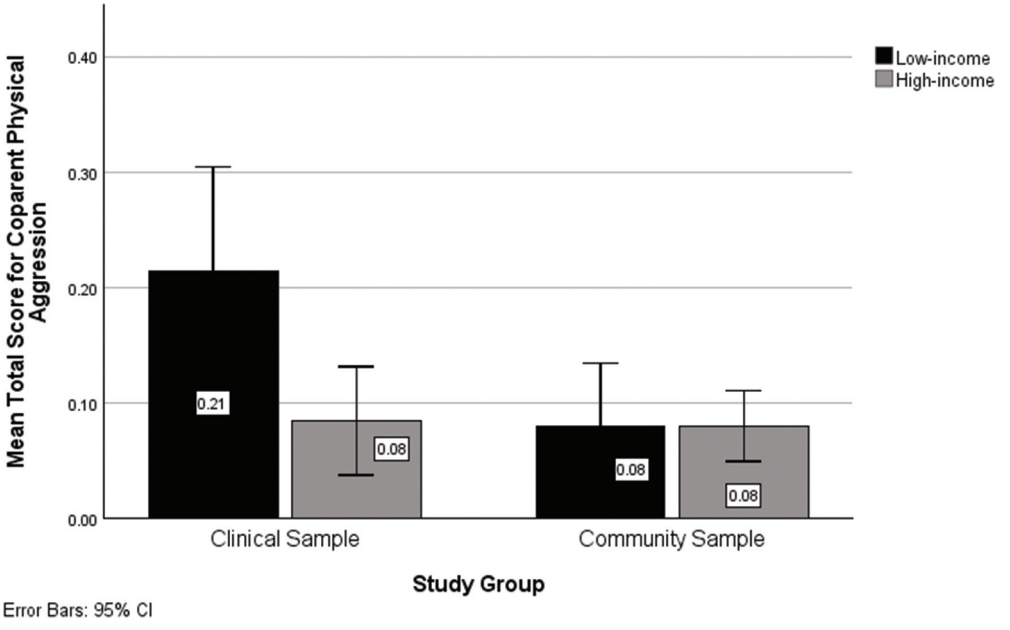

Figure 5. Histogram of the mean total score for coparent physical aggression by study group and income.

IPC and mental health difficulties

This study advances understanding of IPC by synthesising risk presented by parental mental health difficulties and the transition to parenthood (Pilkington et al., 2015; Ray et al., 2023). The findings suggest that parents experiencing perinatal mental health difficulties are at a greater risk of engaging in destructive IPC. This has critical implications for healthcare services, highlighting the need to identify families at risk and develop pathways for providing intervention. Within the UK, NHS PMHS are uniquely placed to integrate IPC screening into routine assessments for parents experiencing perinatal mental health difficulties. These services are also positioned to deliver parenting interventions targeting destructive IPC behaviours. However, implementing such recommendations faces significant challenges, including staff motivation, and limited resources (Addington et al., 2010; Laker et al., 2014). To address these barriers, policymakers must recognise the importance of perinatal IPC and support healthcare services in implementing these changes.

In contrast with previous literature linking depressive symptoms to increased avoidance behaviour, the current study identified no difference in birthing parent avoidance between clinical and community samples (Crockenberg & Leerkes, 2003; Parade et al., 2014). This discrepancy may be attributed to the CPSS-SF, a new tool still under evaluation. Although early assessments indicate reliability across parents with low wellbeing and varying family structures (Helland et al., 2021), evaluation in this study suggests that reliability of the avoidance subscale within community sample participants is below the recommended threshold. It is therefore possible that the CPSS-SF is not suitable to

identify avoidance behaviours in this population. Further psychometric evaluation of the CPSS-SF is needed to determine its suitability across perinatal populations. It is also feasible that the discrepancy with previous evidence may reflect variations in diagnoses. The study does not consider if IPC varies across differing mental health typologies and symptom severity. For example, depression and bipolar disorder are distinctly associated with avoidance and aggressive behaviours respectively (Látalová, 2009; Quigley et al., 2017). This should be considered by future research.

Risk factors for elevated IPC

The study highlights the influence of demographic variables on IPC within clinical populations. Consistent with previous research, an interaction between IPC, mental health, and relationship status was identified (Amato, 2010; Jeong et al., 2024), suggesting that relationship status may differentially impact IPC in parents with and without clinical mental health difficulties. However, the analysis is limited by the small number of participants not in a relationship. Further investigation of this interaction within a larger and more diverse sample of parents is required to better understand the role of relationship status in IPC within clinical populations. Developing this understanding will enable healthcare services to tailor relational support according to the specific needs of families.

Extensive evidence suggests socioeconomic status is associated with destructive IPC (J. Y. Lee et al., 2023; Williams et al., 2015). The results of this study concur, reporting an association between low-income and elevated avoidance, physical aggression, and stalemating. These findings are further underscored by the significant interaction between income, CPSS-SF scores, and study group. Given that income, mental health difficulties, and IPC are individually associated (Fisher et al., 2012; J. Y. Lee et al., 2023; Ray et al., 2023), this result is not unexpected. However, the association between low-income and greater coparent physical aggression and birthing parent stalemating and verbal aggression *within the clinical sample only* is notable. This suggests that parents experiencing clinical mental health difficulties *and* low socioeconomic status may be at a heightened risk of destructive conflict during the perinatal period. The differing influence of income on IPC behaviours for individuals with mental health difficulties is valuable for healthcare services, highlighting an important risk factor to aid the identification of families who would benefit from relational support.

Limitations

This study has several limitations in terms of sample diversity. Most participants identified as having a White ethnic background (97%), a proportion significantly higher than that observed in the general population of England and Wales (Office for National Statistics, 2022). It is plausible that the recruitment procedures may have impacted sample diversity. The recruitment of clinical sample participants was restricted to individuals accessing NHS PMHS, which is limiting as racial disparities in mental healthcare are widely reported (Jimenez et al., 2013). Although it is possible that the online recruitment procedures for the community sample may have restricted accessibility of the study, it is not likely that this impacted the ethnic diversity of the sample. Previous literature does indicate that online surveys are preferred by

individuals who are younger or have accessed higher education, but no difference in participation across ethnic groups is observed (Mlikotic et al., 2016; Sykes et al., 2010). As evidence suggests higher rates of mental health difficulties within minority ethnic groups, further research exploring IPC in a more diverse population is critical (Bhugra et al., 2014; Gov.uk, 2022).

It is also feasible that the sample is not representative of income groups across England. The study classified participant weekly income as high or low based on the Office for National Statistics guidelines. However, the average weekly income in the UK is £668 (Office for National Statistics, 2024), a value much greater than the threshold used (£393). Although low-income is often associated with mental health difficulties (Allen et al., 2014), the low-income lower than the UK average may cause a bias in the data.

Additionally, only 2% of participants were not in a relationship. This contrasts with the 16% of single-parent families in the UK (Office for National Statistics, 2024). Given that single-parent or separated families often report higher levels of conflict (Dorsey et al., 2007; Malcore et al., 2009), a more inclusive sample might have shown higher CPSS-SF scores. This limits the generalisability of the study findings to the wider UK population.

The use of the CPSS-SF also presents some limitations. All reports of conflict behaviour were provided by the birthing parent. Previous evidence indicates that individuals may show a bias in perceptions of both their own, and their coparent's behaviour (LaBuda & Gere, 2023; Lemay, 2014). Further, the CPSS-SF is yet to be validated within a UK perinatal population. Preliminary evaluation of the tool in this study indicates that several scales are below the accepted threshold of reliability. Consequently, the accuracy of the study results may be influenced by the format of the CPSS-SF. Future research regarding perinatal IPC would benefit from multiple respondents and measures to corroborate reports of conflict behaviour.

Conclusion

This study provides evidence that IPC during the perinatal period is experienced differently by families where the birthing parent has, or does not have, a diagnosis of clinical mental health difficulties. The findings suggest that parents experiencing clinical mental health symptoms during this time may be particularly vulnerable to elevated rates of destructive IPC. Furthermore, income and relationship status appear to have differential influences on IPC for parents with mental health difficulties. Given the array of negative outcomes associated with destructive IPC, these findings are critical for guiding healthcare services in identifying families who would benefit from relational support and targeted interventions.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

The anonymised datasets generated during the study will be available as de-identified data upon request from Peter Fonagy and Camilla Rosan (p.fonagy@ucl.ac.uk; camilla.rosan@annafreud.org), beginning 12 months and ending 5 years after the COSI Trial primary publication and pre-planned secondary analysis following approval of a methodologically sound proposal and a signed data-sharing agreement.

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